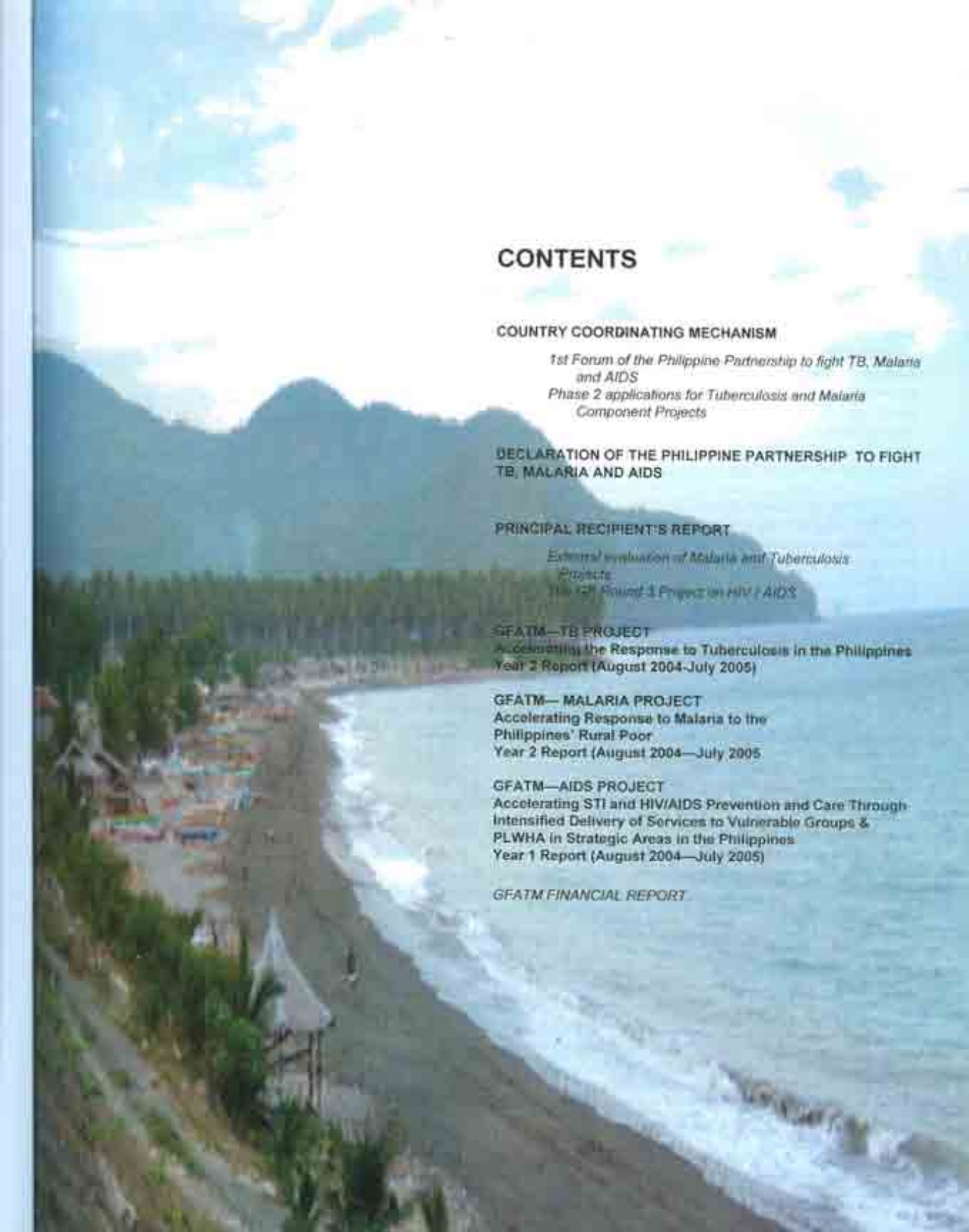
ANNUAL REPORT

2004 — 2005

Global Fund to Fight AIDS, TB and Malaria in the Philippines

Tropical Disease Foundation

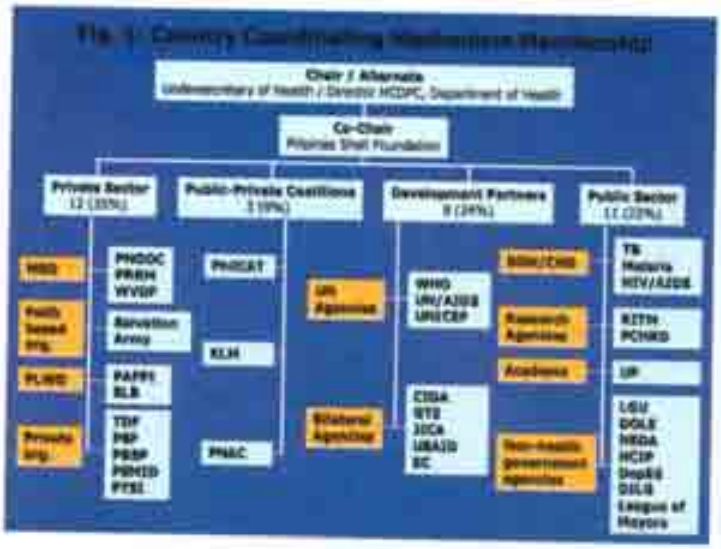


CONTENTS

The Country Coordinating Mechanism

The Country Coordinating Mechanism (CCM) was created through a Department of Health Administrative Order 5 March 2002 expanding the membership and terms of reference of the National Infectious Disease Advisory Committee to include various private sector stakeholders as members of a stand alone committee. The CCM is responsible for oversight function over the proposal and implementation of the Global Fund projects in the Philippines. Policy guidelines for the CCM have been developed to define the selection of CCM members, their roles and responsibilities and policies on decision making, conflict of interest issues, and procedures for grant proposal development and monitoring of the project implementation.

CCM membership is broad, gender balanced, and ensures that all relevant partners are involved. Nominees from the different sectors were chosen and following a selection process, CCM members were chosen among them. There are now 34 members of the CCM comprising 11 (32%) from the public sector, 12 (35%) from the private sector, 3(9%) representing public private coalitions, and 8(24%) representing multilateral and bilateral development partners.



1st Forum of the Philippine Partnership to fight TB, Malaria and AIDS

To ensure a transparent and equitable selection of membership to the CCM, the Philippine Partnership to fight Tuberculosis, Malaria and AIDS was launched in its 1st forum on June 4, 2005. All stakeholders interested in the control and prevention of the three diseases participated. There were nine sectors in the civil society and governmental agencies that participated, including the Department of Health, local government units as well as non-health public agencies, the academe; non-governmental and community-based organizations (NGOs/CBOs); people living with HIV/AIDS, TB and/or malaria; private sector and professional organizations; faith-based organizations (FBOs); public-private coalitions; and multilateral and bilateral development partners. A declaration of support and participation in the fight against tuberculosis, malaria and AIDS was adopted by the partnership.

Phase 2 application for Tuberculosis and Malaria Component Projects

The two projects were approved for Phase 2 funding to cover the last three years of the project: 2005-2008. The rating obtained for the two projects were A for PHL-202-G02-Tuberculosis (GFTCP) and B1 for PHL-202-G01-Malaria (GFMCP); with A rating for PHL-202-G02-T and B1 rating for PHL-202-G02-M making the former 1 in 5 and the latter as 1 in 14 within projects in those categories approved for Phase 2 funding in the Western Pacific Region.

GF Fifth Round Proposals

In the preparation of the proposal for the Global Fund 5th round, an advertisement soliciting concept proposals on the control of TB, malaria and AIDS was published to ensure equitable participation of all interested stakeholders. Appropriate concept proposals were chosen and incorporated into the national proposal for the scaling up on the control program for HIV/AIDS, malaria, and tuberculosis.

The proposals for malaria and HIV/AIDS were rated Category 2 and have both successfully submitted clarifications to the Technical Review Panel (TRP) while the initial category 3 rating for the tuberculosis proposal was successfully appealed and is currently undergoing clarifications to the TRP.

Lessons learned:

From external evaluations of the GF projects, implementation has been found to be effective and efficient. Public-private partnership and local coalitions with the development of grassroots support and technical assistance including support for procurement and supply management from the UN agencies have facilitated the implementation and monitoring and evaluation of program implementation. Community participation through social mobilization to increase knowledge of the community about these diseases and the services available has created a greater demand for the services and improved health seeking behaviour. The support of the GF portfolio manager, Ms. Sandii Lwin, during the Phase I of both the malaria and tuberculosis component projects has greatly assisted the implementation of the GF projects.

Ethelyn P. Nieto, MD, MPH
Undersecretary of Health for Health Operations
Jaime Lagahid, MD
Director III, Infectious Disease Office
Secretariat, Country Coordinating Mechanism

Declaration of the Philippine Partnership to fight TB, Malaria and AIDS

Involving multisectoral representatives from the civil society, the government sector, developmental partners and all interested stakeholders in the fight against TB, malaria and AIDS, the 1st Forum was convened 4 June 2005 at the Philippine International Convention Center;

Recognizing that the Philippines is the 9th of 22 high-burden countries for TB, and that malaria is highly endemic in 28 provinces contributing 90% of all cases of malaria nationally, both undermining the productivity and societal well-being of patients affected;

Understanding that although HIV prevalence in the Philippines has been less than 1% in the past several decades, there is a need for greater vigilance in its prevention so that it may not further fuel the TB epidemic;

Recalling the significant socioeconomic impact of TB, malaria, and HIV/AIDS on the productivity of the country and the sense of urgency to control and prevent these diseases in the Philippines;

Realizing that we have only 10 more years in which to meet the targets as enunciated in the Millennium Development Goals of the Philippine government;

- ***We, the delegates*** to the 1st Forum of the Philippine Partnership ***affirm our solemn commitment to*** pursue the following consensus objectives:
- ***Strengthening*** partnerships between the Department of Health and the Local Government Units and the civil society such as private medical practitioners, nongovernmental organizations (NGOs), faith-based organizations, the private sector including those infected and affected with the three diseases, in the control and prevention of TB, malaria, and HIV/AIDS so that proven strategies could be effectively implemented;
- ***Ensuring*** the quality of the currently available strategies against TB, malaria, and HIV/AIDS so that all people will have access to effective prevention, diagnosis and treatment;
- ***Accelerating and adapting*** these strategies to emerging challenges like multi-drug resistant TB and malaria and co-infection with HIV/TB;
- ***Applying*** emerging technologies, when available, to the control of TB, malaria and HIV/AIDS;
- ***Mobilizing*** more resources, both in cash and in kind, to facilitate our push towards the 2015 targets and beyond.

The participants of the 1st Forum of the Philippine Partnership to fight TB, malaria, and AIDS hereby issue the following statement:

1. **We are heartened to note the initiative of the Philippine Partnership:**

- to involve a broad spectrum of stakeholders to participate in the control and prevention program of these three diseases;
- to engage the civil society to assist the government health sector in the Department of Health and the Local Government Units;
- to support the public - private partnership currently pursuing collaborative work with the government sector against the three diseases;
- to advocate in mobilizing resources from international financial instruments like the Global Fund to fight AIDS, Tuberculosis and Malaria to augment the limited resources of government in its fight against these three diseases.

2. **We are encouraged by the significant results obtained by the government sector and its partners in its control programs against these diseases:**

- the rapid expansion of the DOTS strategy against TB undertaken by the National TB Program and the planned mainstreaming of DOTS-Plus to DOTS in response to the

emerging MDR-TB burden;

- the rapid expansion of the diagnostic and treatment centers in the 26 highly endemic provinces for malaria;
- the expansion and up scaling of preventive strategies such as effective behavior change communication (BCC) including condom use, adequate management of sexually transmitted infections (STI), and access to treatment, care and support services for HIV/AIDS;
- the recent declaration of government pro-poor agenda to address vital social needs to lift our poorest citizens out of poverty including job creation, expanded educational opportunities and better health care for all Filipinos.

3. **Despite the above significant strides made against these three diseases sustained action is imperative.**

- ***Consolidate, sustain, and advance the achievements*** made since the inception of the Partnership, demonstrating its efficacy and added value, mobilizing a wider range of stakeholders and strengthening relations with the donor community such as the GFATM;
- ***Enhance political will and commitment*** to ensure the sustainability and effectiveness of the programs;
- ***Promote involvement of people infected and affected*** to draw better understanding, meaningful contribution, and proactive participation in the control and prevention efforts of these diseases;
- ***Mobilize civil society, NGOs and the private sector,*** thereby creating grassroots demand on the one hand and stimulating interest and commitment of the private and corporate sectors on the other;
- ***Generate socioeconomic benefits*** to those infected and affected by these diseases, thereby benefiting the community at large as a poverty alleviation strategy;
- ***Increase interest and investment for research and development,*** focusing on the improvement of diagnostic tests, search for better and affordable drugs, socio-behavioral research, and development of effective vaccines against the three diseases.

Having declared the above on 4 June 2005 at the 24th International Congress of Chemotherapy, Philippine International Convention Center, we mandate the Country Coordinating Mechanism to report to the Philippine Partnership progress made in achieving our agreed objectives.

International Journal of Antimicrobial Agents, 265 (2005) S8.

Tuberculosis (TB) is a contagious disease. Like the common cold, it spreads through the air. When infectious people cough, sneeze, talk or spit, they propel TB germs, known as bacilli, into the air. A person needs only to inhale a small number of these to be infected.

Most people infected with TB will never develop active TB disease. However, those with compromised immune systems—the sick, malnourished or people living with HIV—are particularly susceptible. Left untreated, each person with active TB disease will infect on average between 10and 15 people every year. The best way to prevent TB is to treat and cure people who have it.

HIV/AIDS, Tuberculosis and Malaria: The Status and Impact of the Three Diseases

Principal Recipient's Report

Significant strides have been made and likewise, significant accomplishments were achieved in the second year of the GF projects in the Philippines. It is in light of these that we end the Phase I of the two projects, the GF Tuberculosis Component Project (PHL-202-G02-T) and the GF Malaria Component Project (PHL-202-G01-M) and the first year of the GF HIV/AIDS Component Project (PHL-2003-G03-H) with a sense of great satisfaction and pride.

External Evaluation of Malaria and Tuberculosis Projects

The goal of the malaria GF project is to reduce the malaria morbidity by 70% and mortality by 50% in the 26 priority provinces at the end of 2008 using 2001 baseline data through increasing the proportion of febrile patients receiving early diagnosis and appropriate anti-malarial therapy, reducing malaria transmission through vector control, strengthening the capacity for implementation of sustainable community-based malaria control. At the end of the second year, the program included all the 26 high burden provinces in the country.

The external evaluation of the GFMCP was undertaken in December 2004 until January 2005 with four sites visited by WHO Malaria Experts: Dr. Kevin Palmer and Dr. Eva Kristophel: Kalinga, Apayao; Tuguegarao, Cagayan; Palawan; Mindoro. The major advances noted of the malaria project were 1) the efficient expansion of network for diagnosis & treatment to the grassroots level through the barangay microscopy centers and RDT sites, 2) strengthened Rural Health Units (RHU), 3) a decrease in malaria cases in some areas, 4) an increased awareness about malaria control, and 5) the active involvement of the municipalities who developed a proprietary ownership of the project.

The TB project aims to reduce TB mortality and morbidity by 50% in 2010 through incressed case detection from 58% of estimated cases (all types) of TB in 2003 to 85% in 2007 through: the enhancement of DOTS in the public sector and the establishment of PPMD nationwide and treatment of MDR-TB in the GLC approved DOTS-Plus pilot project. The external evaluation of the GFTCP consisted of the evaluation of the Private Public Mixed DOTS undertaken by WHO experts Dr. Knuth Lonroth, Dr. Pieter van Maaren, and JICA expert Dr. Masachi Suchi. Impressive achievements were noted in the GFTCP with 71.7% overall case detection in the 2.9 million populations covered by these PPMD units, 8% being contributed by the PPMD units. The case detection increased from 21% to 104% with an increase noted also in the public sector DOTS units and an additionality of 4.6% to 54.1%. Treatment outcome a 2-month sputum smear conversion of 85% to 92% which is a good predictor for cure in these cases. The external evaluation of the DOTS-Plus component was undertaken by a team headed by Dr. Ernesto Jaramillo, STOP TB Unit, WHO HQ with Dr Michael Voniatis, WR, Dr Philippe Glaziou, WPRO, and the participation of Dr Nymadawa Naranbat, Manager, Mongolia National Tuberculosis Control Programme last 9-12 December 2004. The extent of implementation of the recommendations made by the last GLC monitoring visit is impressive. A DOTS-Plus Task force was established and is working out a plan to expand DOTS-Plus in Metro Manila. A council of experts for the management of MDR-TB is now in operation. The chief health officers of Quezon City and Makati City are now fully supportive of decentralizing DOTS-Plus and its full integration into the DOTS strategy. Through the support of the GFATM, the project is able to provide ancillary drugs for free to patients suffering adverse drug reactions during the MDR-TB treatment. All these contribute to explain the major progress achieved in some indicators such as culture negativization (82%), and default (4%). TDF has established collaboration with the Lung Center of the Philippines, a tertiary level Department of Health hospital that treats 40-60 MDR cases per year with own funds, for implementing DOTS-Plus strategy.

The progress achieved, the commitment of the TDF and its staff, and the clear support from the NTP and local health authorities, are getting this project very close to become a worldwide centre of excellence in the management of MDR-TB.

The GF Round 3 Project on HIV/AIDS

The national goal of the National AIDS program is to prevent the further spread of STI/HIV/AIDS infection & reduce its impact on those already infected & affected through prevention by behavior change and management of sexually transmitted infection (STI) in vulnerable populations and support, care, and treatment of people living with HIV/AIDS. The Sub-recipient of this project is the Philippine NGO Council for Reproductive Health. The activities include 1) Prevention through a) social mobilization and advocacy, b) outreach and education, c) capacity building of service providers and vulnerable groups, d) improved sexually transmitted infections (STI) services and surveillance, e) strengthened monitoring and evaluation and 2) Care, support and treatment through a) improvement & expansion of voluntary counseling and testing (VCT), b) development of partnership mechanisms for care, treatment & support (PLHAs, service providers & key stakeholders), c) improvement and expansion of clinical services in health facility, d) establishment of home & community care. To undertake these activities, the project partners include the local government units LGU) through the Social Hygiene Clinics in 11 provinces/cities, HIV core teams in the 6 Hubs in the Research Institute for Tropical Medicine, San Lazaro Hospital, Philippine General Hospital, Vicente Sotto Memorial Center in Cebu, Don Mariano Marcos Memorial Center in Region I, and in the Davao Medical Center in Region XI. It has also engaged 18 non governmental organizations to undertake community-based activities. This project is just nearing its first year implementation and will be evaluated in November 2005 in preparation for the Phase II application.

Acknowledgement

We acknowledge with thanks the support of the GF portfolio manager for the Phase 1 of the GFMCP and GFTCP and the first year for HIV/AIDS, Ms. Sandii Lwin, who has greatly assisted the partners in the successful implementation of the GF projects in the Philippines.

Thelma E. Tupasi, MD
President
Tropical Disease Foundation

The Global Fund TB Project in the Philippines: Year 2 Report (August 2004 – July 2005)

Accelerating the Response to Tuberculosis in the Philippines

In 2003, the Tropical Disease Foundation (TDF) was elected by the Country Coordinating Mechanism of the Philippines as the Principal Recipient (PR) of the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM) – TB Component under grant number PHL-202-G02-T-00. As PR, TDF is responsible for the management, implementation and delivery of agreed targets and deliverables of the project. In keeping with the performance-based funding principle of the Global Fund, TDF has four major institutions as partners in the operation and implementation of the project and in the delivery of services.

The four core arms of operation and implementation of the GF TB project (all operating under the GF guidelines, norms and policies), which we call the four pillars of the TB program (Figure 2), are as follows:

The overall goal of the Global Fund TB project is to reduce the prevalence, incidence and mortality due to tuberculosis by half in 2010.

The Department of Health (DOH) for quality DOTS implementation, the World Vision Development Foundation (WFDF) for social mobilization and community organization, the Philippine Coalition against Tuberculosis (PhilCAT) for public-private mix DOTS program and the TDF DOTS-Plus clinic for the management of Multi-drug Resistant Tuberculosis (MDR-TB).

The overall goal of the Global Fund TB project is to reduce the prevalence, incidence and mortality due to tuberculosis by half in 2010 (Table 1). To achieve this goal, the project aims to (1) increase the case detection rate for the estimated TB cases (all types) from 58% in 2003 to 85% in 2008 and cure at least 85% of new smear positive cases, and, (2) to utilize the Green Light Committee (GLC) approved DOTS-Plus project for multi-drug resistant TB (MDRTB) cases. This report presents the accomplishments regarding these two objectives during the period October 2004 to July 2005.

Objective 1: To increase the case detection rate for the estimated TB cases (all types) from 58% in 2003 to 85% in 2008 and cure at least 85% of new smear positive cases through:

1a. Enhancement of DOTS in the public sector

The Department of Health (DOH) is the main stakeholder in the TB program implementation through the National TB Program (NTP). The agency is responsible for ensuring access of basic public health services to all through the provision of quality health care and regulation of health goods and services providers. Given this mandate, DOH is both a stakeholder in the health sector and a policy and regulatory body for health. As a major player, DOH is a technical resource, a catalyzer for health policy and a political sponsor and advocate for health issues on behalf of the health sector. As an implementer of the Global Fund project, it contributes to the improvement of case detection and case holding by enhancing the quality of DOTS in the public sector through the conduct of fixed-dose combination (FDC) therapy training, laboratory external quality assurance training and training on hospital-based NTP DOTS (Table 2).

1b. Increased demand for TB services through social mobilization

Among the interventions in combating tuberculosis in the country is the increased involvement of the civil society through organized communities. It is in this aspect that World Vision Development Foundation, Inc. plays an important role. To achieve this, WVDFI facilitated the formation of TB taskforces/support groups in the community. The members of an organized task force participate in case detection and case holding (by acting as treatment partners) and become advocates for TB control.

Currently, 140 task force organizations, in 5 provinces and 6 cities (Figure 3), are actively involved in TB program, which is twice as much as what has been promised. The involvement of these task force organizations contributed an additional 2,800 TB symptomatics. The number of TB symptomatics identified is 1,481% higher compared to the number committed for the period (2,800/189).

1c. Engaging private practitioners in TB control through Public-Private Mix DOTS (PPMD)

Another aim of the project is to improve case detection by engaging private health care providers through the nationwide establishment of public-private mix DOTS (PPMD).

Seventy PPMD units (58 publicly-initiated and 12 privately-initiated) in 16 regions is targeted to be estab-

Fig. 2: Four Pillars of GF TB Component

Table 1. Goals and Major Indicators GFATM TB Component

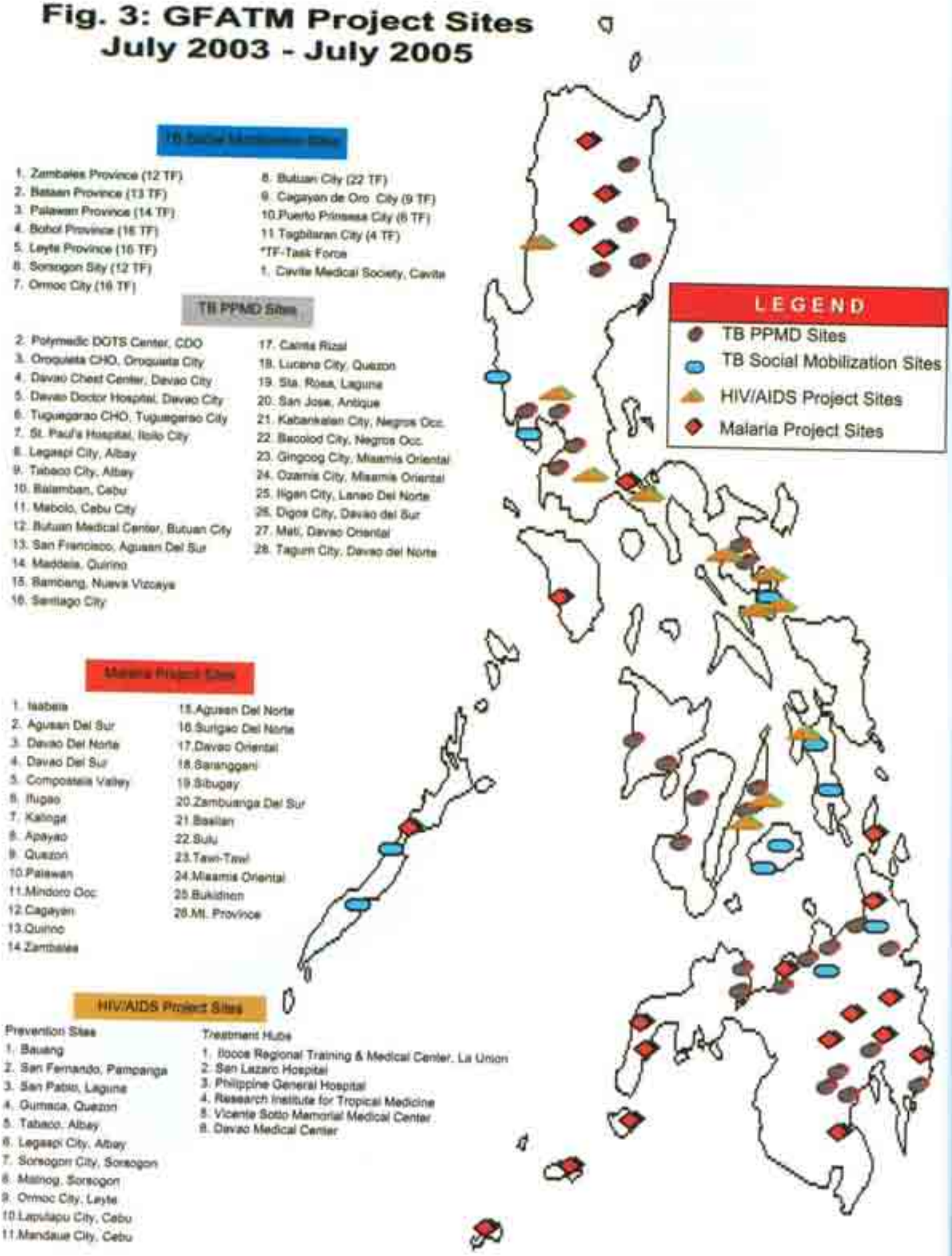
Goal: To reduce the TB prevalence, incidence and mortality by half in 2010.

Indicators	2000 Baseline	2008 Target
Prevalence of smear (+) cases	1.1/100,000 population	1.6/100,000 population
Incidence of smear (+) cases	139/100,000 population	84/100,000 population
TB mortality rate	36.0/100,000 population	19.2/100,000 population

Table 2. Enhancement of Quality DOTS in the Philippines Department of Health, 2003 - 2005

Activities / Targets	Year 1	Year 2
Training courses on Fixed dose combination	37	
Medical technologists trained on External Quality Assurance	138	
Service delivered trained on hospital-based DOTS		97

Fig. 3: GFATM Project Sites July 2003 - July 2005



TB Social Mobilization Sites

1. Zambales Province (12 TF)
2. Bataan Province (13 TF)
3. Palawan Province (14 TF)
4. Bohol Province (16 TF)
5. Leyte Province (16 TF)
6. Sorsogon Sity (12 TF)
7. Ormoc City (16 TF)
8. Butuan City (22 TF)
9. Cagayan de Oro City (9 TF)
10. Puerto Princesa City (6 TF)
11. Tagbilaran City (4 TF)

*TF-Task Force

1. Cavite Medical Society, Cavite

TB PPMD Sites

2. Polymedic DOTS Center, CDO
3. Oroquieta CHO, Oroquieta City
4. Davao Chest Center, Davao City
5. Davao Doctor Hospital, Davao City
6. Tuguegarao CHO, Tuguegarao City
7. St. Paul's Hospital, Iloilo City
8. Legaspi City, Albay
9. Tabaco City, Albay
10. Balamban, Cebu
11. Mabolo, Cebu City
12. Butuan Medical Center, Butuan City
13. San Francisco, Agusan Del Sur
14. Maddela, Quirino
15. Bambang, Nueva Vizcaya
16. Santiago City
17. Calinta Rizal
18. Lucena City, Quezon
19. Sta. Rosa, Laguna
20. San Jose, Antique
21. Kabankalan City, Negros Occ.
22. Bacolod City, Negros Occ.
23. Gingoog City, Misamis Oriental
24. Ozamis City, Misamis Oriental
25. Iligan City, Lanao Del Norte
26. Digos City, Davao del Sur
27. Mati, Davao Oriental
28. Tagum City, Davao del Norte

Malaria Project Sites

1. Isabela
2. Agusan Del Sur
3. Davao Del Norte
4. Davao Del Sur
5. Compostela Valley
6. Ifugao
7. Kalinga
8. Apayao
9. Quezon
10. Palawan
11. Mindoro Occ
12. Cagayan
13. Quirino
14. Zambales
15. Agusan Del Norte
16. Surigao Del Norte
17. Davao Oriental
18. Saranggani
19. Sibugay
20. Zamboanga Del Sur
21. Basilan
22. Sulu
23. Tawi-Tawi
24. Misamis Oriental
25. Bukidnon
26. Mt. Province

HIV/AIDS Project Sites

Prevention Sites

1. Bauang
2. San Fernando, Pampanga
3. San Pablo, Laguna
4. Gumaca, Quezon
5. Tabaco, Albay
6. Legaspi City, Albay
7. Sorsogon City, Sorsogon
8. Matnog, Sorsogon
9. Ormoc City, Leyte
10. Lapulapu City, Cebu
11. Mandaue City, Cebu

Treatment Hubs

1. Ilocos Regional Training & Medical Center, La Union
2. San Lazaro Hospital
3. Philippine General Hospital
4. Research Institute for Tropical Medicine
5. Vicente Sotto Memorial Medical Center
6. Davao Medical Center

lished by 2008. Currently, 28 PPMD units are in operation in 8 regions (Figure 3). To supervise and monitor the activities of the PPMD units, a National Coordinating Center (NCC) and eight Regional Coordinating Centers (RCCs) have been established.

As important as the establishment of service delivery points in the areas is the building of human resource capacities in order to accelerate the scale-up of case finding and case holding activities and ensure that the quality of services is high. Four hundred ninety eight (498) private referring physicians were trained on DOTS (Figure 4) as of July 2005.

For the quarter ending July 2005, 352 private physicians have participated in DOTS through referral of patients to the PPMD units either for diagnosis, for treatment or both. Their involvement resulted in a cumulative total of 736 new smear positive TB cases referred from private practitioners to PPMD units since the project started.

Objective 2: To utilize the Green Light Committee approved DOTS-Plus Project to treat Multidrug-Resistant Tuberculosis (MDRTB).

The Tropical Disease Foundation (TDF) is a pioneer in DOTS-Plus for the management of multi-drug resistant tuberculosis (MDRTB) and has been the implementing partner in charge of providing the services for MDR-TB patients.

For the year ending July 2005, 325 MDRTB cases have been detected , and 224 of them have been enrolled for treatment.

To improve treatment adherence and minimize default from treatment, decentralized implementation of DOTS-Plus has been undertaken through the involvement of DOTS facilities, both in the public sector and those of faith-based organizations. A cumulative total of 33 health facilities in Metro Manila has participated in DOTS-Plus activities, whereby each DOTS unit has at least one MDR patient under treatment being supported by the project. This is 330% higher (33/10) than what was planned in 2003.

A total of over 500 people – from health centers, faith-based organizations and community support groups – were trained in the second year in diagnosis and management of MDRTB.

Households contact tracing of patients with MDRTB was undertaken to determine prevalent infection and disease. As of July 2005, the number of household contacts screened was 335% what had been planned (804/240).

Phase 2 Funding Approval

The overall results of the first two years of project implementation compared to country-set targets, together with the in-country assessments by the CCM and the Local Fund Agent as well as the Global Fund evaluation of the key performance and country contextual information led to approval of Phase 2 funding to cover the remaining three years of the grant period. This will facilitate the conduct of the activities geared towards the successful treatment of more than 3,400 new smear positive TB cases by the end of the project implementation.

Phase 2 approval (and implementation) would also ensure quality services extended to more than seven hundred MDR-TB cases treated by 2008.

These figures may not be staggering if the actual burden of both TB and MDRTB in the country is taken into account, but for those whose lives will be touched by the project, these would matter most.

Implementing Partners

Department of Health

The Department of Health (DOH) is the principal health agency of the Philippines. Specifically, the Infectious Disease Office-TB Control Unit under the National Center for Disease Prevention and Control (NCDPC) in collaboration with other GOs and NGOs is responsible for policy/guidelines, standards, regulation, quality assurance, regulations and drug procurement pertaining to TB control. This office is directly working for the TB program activities in the public sector under the GFATM.

The DOH as an implementer of the GFATM contributes to the improvement of case detection and case holding through enhancement of quality DOTS in the public sector. DOH also oversees the implementation of the GFATM TB project to ensure its compliance to NTP policies and directions.

The Centers for Health Development (CHD) are the

regional arm of the DOH. The CHDs directly work with the Local Government Units (LGUs) in terms of project implementation through technical support, monitoring and evaluation, resource mobilization as well as ensuring policy adherence.

Key Result Areas

A. Policy Development:

Implementing guidelines for the Technical Working Group for TB (TWG-TB) were developed in support of the TB activities under the GFATM. With the transition from single dose formulation to fixed dose combination, the Global Fund provided financial resources for the reproduction of the FDC manual for doctors and nurses (2,000 manuals) as well as that for midwives and volunteer health workers as treatment partners (1,500 manuals).

Administrative Order 140 series of 2004, is the order for the implementation of hospital based NTP DOTS in the retained DOH hospitals and LGU hospitals (provincial, city and district). This AO was signed in March 2004.

B. Capacity Development

From the first year implementation, training courses on the use of Fixed Dose Combination (FDC) were conducted in line with a major policy change of the DOH on the utilization of FDCs from Single Dose Formulation (SDF). Selected areas were identified for training on FDC initially as advance implementation sites. Such trainings were conducted for trainers and health implementers like: physicians, nurses, midwives and volunteer health workers in the regions, provinces, cities and municipalities. Although initially only 37 training courses were planned, a total of 92 training courses were undertaken to ensure the nationwide

The overall results of the first two years of project implementation led to the approval of Phase 2 funding.

implementation of the policy on FDC within the year.

During the second quarter the National Consultative Workshop was conducted with the participation of all regional NTP coordinators, CHD Directors and international and local partners in TB control. Basic microscopy training for microscopists was conducted during the third quarter with a total of 35 health implementers trained.

In the second year, training on the enhancement of public DOTS through external quality assessment (EQA) was undertaken. A total of 138 medical technologists, representing 1 model province per region, were trained on EQA. These trained personnel will serve as a pool of trainers and will be responsible for the training of other medical technologists in their respective provinces.

Under AO 140, a total of 92 NTP point persons representing selected DOH retained and LGU hospitals in 5 regions of the country underwent training on hospital-based DOTS. Further trainings for the remaining regions will be conducted in Phase 2.

A series of workshops to provide technical support for the TB diagnostic committee (TBDC), was conducted in preparation for the National Consultative Workshop conducted in February 2005.

Networking and advocacy

Networking and advocacy for TB was done in collaboration with the World Vision Development Foundation (WVDF) activities and as part of the PPMD installation package under the Philippine Coalition against Tuberculosis (PhilCAT). The GF project strengthened the partnership between public and private sector partners.

Monitoring and Evaluation

Monitoring of trainings is conducted primarily by the Regional NTP Coordinators. They also ensure that all training and teaching materials are available to the local government units (LGUs) conducting the trainings for the rural health midwives and volunteer health workers. The regional NTP coordinators then report to the central office during the National Consultative

Workshop and Program Reviews. The regional NTP coordinators can consult the central office anytime for any concerns. In the same manner, the local implementers could also consult the Provincial and/or Regional TB Coordinators. Monitoring focuses on the number of training batches conducted and fund utilization. Pre and Post-test during the orientation/training is part of the curricula to ensure quality. Request for training and post training reports are required for fund liquidation and to determine areas still for funding support. Monitoring at the central level has been limited for year 1. Most of the monitoring conducted was in line with the PPMD implementation with PhilCAT.

Through the National Consultative Workshop conducted in December 2003 funded by GFATM, the central office had an opportunity to evaluate the various trainings conducted on FDC and to identify insights and learning for subsequent trainings to be conducted with other partners.

For the year 2 activities, hospital-based NTP DOTS trainings are attended by DOH central office personnel to assist the Regional NTP coordinators on the technical part of the training.

Innovative Approaches

The GFATM FDC training courses served as a catalyst for training in other areas of the country with support from other international and local partners, paving the way for a fast tracked nationwide implementation of FDC.

With training of all MHOs, CHOs, PHOs and their nurse counterparts, there is now a pool of trainers at the local level that can address the further need for training of other health staff in the form of OJT and on site supervision.

Lessons learned, challenges and future directions

The training activities on FDC were initially hampered by the Measles Elimination Campaign activities of the local government units (LGUs). However following the campaign, the health workers managed to conduct more training activities due to the recognized need for the FDC training prior to the FDC drug utilization. Uniformity/standardized training tools were essential for the nationwide simultaneous FDC trainings.

Through the National Consultative workshops, training plans per region/province/cities/municipalities can be presented and evaluated to maintain quality of the courses and to ensure optimal utilization of funds.

There is a need to identify priority areas for monitoring by central office staff to maximize limited resources and/or to utilize resources from other external donors.

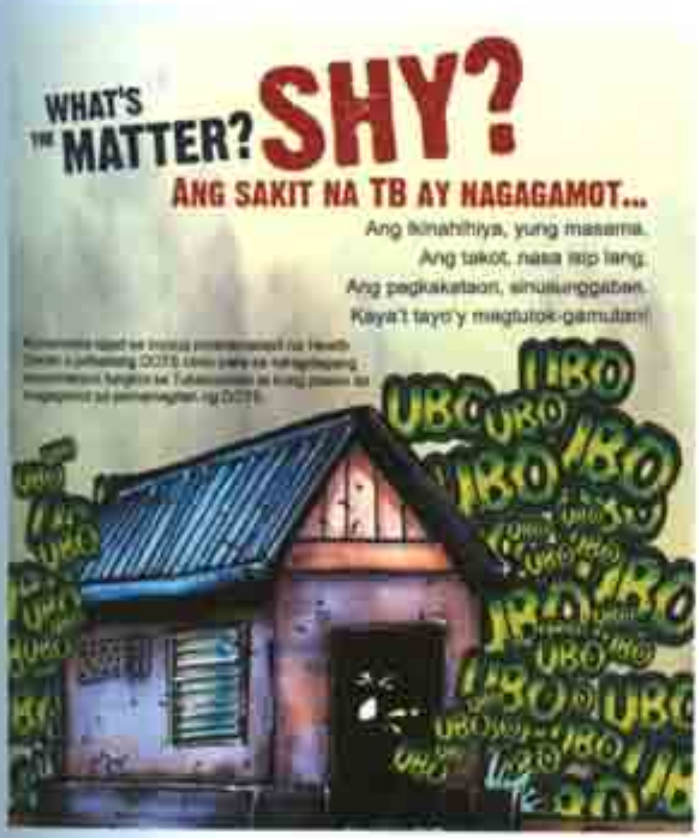
There is a need to emphasize to Local Government units that Global Fund support is for essential activities that will lead to achievement of targets and goals.

World Vision Development Foundation, Inc.

Community organizing is the expertise of World Vision Development Foundation, Inc. (WVDF). Such expertise is now being applied in the implementation of the Social Mobilization on Tuberculosis (SMT) Project under the Global Fund project as it aims to organize sustainable community-based DOTS activities in its covered areas that will increase TB symptomatics' consultation with health facilities and patient's compliance to treatment thus improving both TB case detection and cure rate in the country. To achieve such goals, WVDF facilitated formation of TB task forces in its 11 covered areas namely Sorsogon, Ormoc, Puerto Princesa, Tagbilaran, Cagayan de Oro, Butuan, Bataan, Zambales, Leyte, Palawan, and Bohol.

TB task forces are seen to contribute to all existing efforts in fighting tuberculosis as they take an active role in the advocacy, planning, health education, participation in World TB Day and Lung Month celebrations, and implementation of the Directly Observed Treatment Short Course (DOTS) strategy. WV are training these task forces to identify TB symptomatics, to refer patients to public health facilities for consulta-

The GFATM FDC training courses served as a catalyst for training in other areas of the country with support from other international and local partners, paving the way for a fast tracked nationwide implementation of FDC.



tion or diagnosis, to act as treatment partners to TB patients, and to do advocacy activities to create TB and DOTS awareness in their community and to increase demand for DOTS services. These trainings include the SMT project Orientation, TB, DOTS and NTP orientation, Basic Community Training, Leadership Training, Values Formation, Project Proposal Writing, and Communications Training.

To date, 140 task forces have been organized by WVDF to fight TB in the community. After the end of Phase 1 of the project, World Vision once again proved that communities, through the task forces, indeed contributed to the existing TB case detection rate. Looking at the table, out of the 2,097 symptomatics referred in all areas, 69% were from the task forces. Furthermore, out of the 276 new smear positive TB case discovered, 71% were referred by the task forces. TB case detection increased by almost 75%. Indeed, involving civil society in the project is a big contribution, and a complement to the existing government efforts of fighting TB.

Aside from giving referrals, the TB task forces are also in the forefront in doing advocacy activities on TB pre-

Billboard developed and distributed in 11 provinces and cities with Tibitina and a former TB patient as main models.

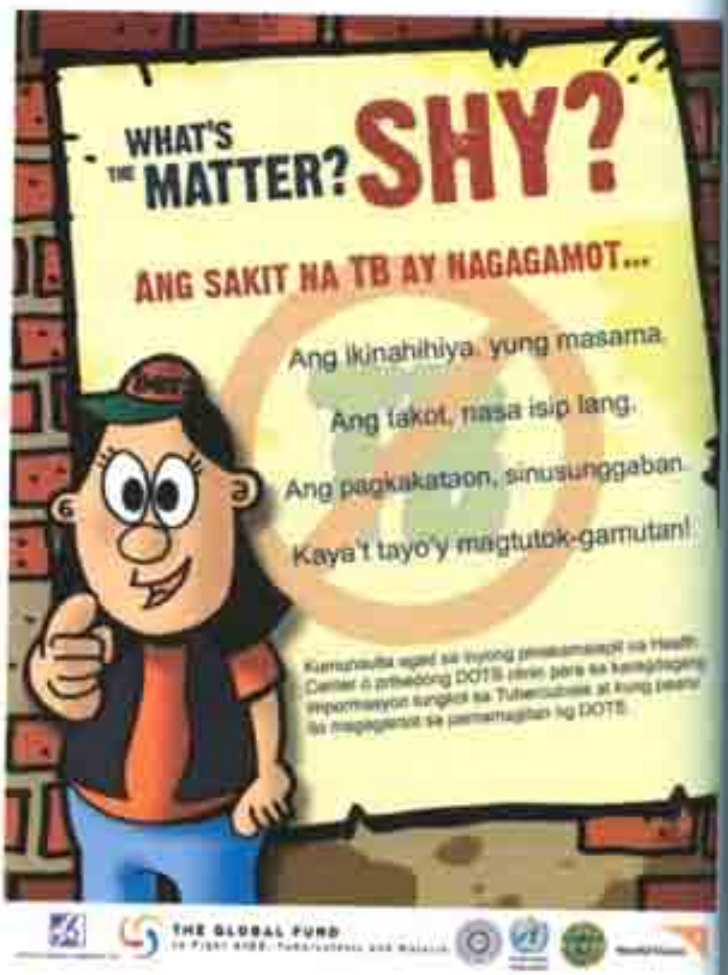
vention and control. Several innovative advocacy activities include house-to-house visits and TB case finding, TB classes, barangay(village)-based health education, purok Information, Education, and Communication (IEC) campaigns, placement of IEC materials in strategic places, and fundraising activities for the benefit of TB patients such as *sayawan* or dance party, passing of donation boxes, and cultivating a vegetable garden. Add to these the slogan, jingle, and poster making contests, signing of commitments, TB quizzes, and TB and DOTS lectures which they usually conduct during World TB Day and Lung Month celebrations.

To aid them in their conduct of advocacy activities and education campaigns, WV developed and provided them with IEC materials. One of WV's roles in the project is to come up with IEC or behavior change communication (BCC) materials to be distributed to the covered areas. This is to help achieve the project's second objective which is to have an improved health seeking behavior of the community through community-wide TB awareness raising, advocacy to access quality TB services available, and to de-stigmatize TB in the community through nationwide campaign against tuberculosis.

Some of the materials were locally produced and some were developed by WV National Office. To date, the following are the IEC/BCC produced and developed: primer, brochures, TV and radio infomercial, comics, posters, Tibilina and Tibinoy mascots, lecture flip chart, patient flip chart, bill board, t-shirts, DOTS leaflets, newsletter, sticker, bookmarks, TB modules, fan, and calendar.

The radio infomercial produced was aired on three Metro Manila stations with nationwide coverage – DZMM, DZBB and DZRH. It was then aired on local radio stations in the covered areas. Meanwhile, the 3 TV infomercials, one of which featured San Miguel basketball player Olsen Racela, were shown in ABS-CBN and GMA-7.

For the remaining 3 years of the SMT project, WVDF is expected to organize 130 more TB task forces, to train 1,950 task force members, to identify 18,932 TB symptomatics and 2,506 new smear positive cases, and to develop 3 kinds of advocacy materials.



Generous hearts. That's what the task forces have as proven by their actions. They don't just talk, they walk the talk.

Mobilizing communities. Empowering people. Saving lives.

SMT Phase 1 Project Report

Philippine Coalition Against Tuberculosis

PUBLIC-PRIVATE MIX DOTS INITIATIVE (PPMD)

PhilCAT is a coalition of 67 organizations involved in TB advocacy work, policy development and project management. It is a broad-based coalition committed to prevent, control and eliminate TB, and envisions a TB-free Philippines. It works closely with the Department of Health (DOH), Tropical Disease Foundation (TDF), World Vision, WHO, the LGUs, and other local and international health organizations. Among its important activities and achievements are the initiation of the annual commemoration of World TB Day, development of a Comprehensive and Unified Policy on TB Control in the Philippines (CUP), operationalization of DOTS service delivery models in the private sector in the country, participation in the revision of the 2001 Manual of Operations of the NTP, development of the Operational Guidelines for PPMD in the country and influencing national policies on the certification and training standards for DOTS facilities and providers.

As an implementer of the GFATM, PhilCAT intends to improve case detection through the nationwide establishment of PPMD through the following activities: a) development of an NTP policy for PPMD, b) setting up of National and Regional Coordinating Committees for PPMD (NCC – PPMD and RCC – PPMD) and installation of PPMD packages in provinces and cities through symposia, training, signing of memoranda of understanding and agreement or letters of agreement (MOU/MOA/LOA) and launching of PPMD units, and c) the monitoring and evaluation of project operations. The Project will target 16 regions and set up 70 PPMD units (58 public-initiated and 12 private-initiated) nationwide.

The Phase I initiative is currently operating in 27 cities around the country covering a population of six (6) million. In its Phase II of operations, the initiative will be expanding to 43 cities making the total population coverage of fifteen (15) million or about 19% of the country's population.

Activities

Central Planning workshops

Following the steps in the installation process, a Central Planning Workshop was conducted on December 6 - 7, 2003 at the Bayview Park Hotel in Manila. This was attended by representatives from the public and private sectors with strong background in delivering TB DOTS programs and services. Specifically, the attendees from the public sector side included TB specialists from NTP and the Centers for Health Development (CHD), local government units (LGU) and the Philippine Health Insurance Corporation (PhilHealth). On the other hand, participants from the private sector consisted of health professionals and TB experts from private and non-governmental organizations (NGO) like PhilCAT, TDFI, local PhilCAT affiliates, WVDFI and WHO. The central planning workshop was intended to orient the participants about GFATM and to plan the PPMD activities at the regional/provincial/local levels for Year One, focusing on establishing the structures, advocacy, training, PPMD unit installation and monitoring and evaluation.

By 2008, the project aims to deliver the following targets:

Creation of NCC-PPMD and RCC-PPMD

One of the outcomes of the Central Planning Workshop was the creation of the National Coordinating Committee for PPMD (NCC- PPMD) and five Regional Coordinating Committees for PPMD (RCC-PPMD). These two committees are crucial in the successful implementation of PPMD as these structures provide the forum for planning, discussion and resolution of issues concerning PPMD. They also serve as the overall coordinating body at the national level and regional levels, respectively.

The main task of the NCC-PPMD is to develop policies, technical/operational guidelines and standards for adoption of PPMD Units in their implementation of NTP-DOTS. It is the responsibility of this committee to develop schemes to efficiently utilize all existing resources as well as to enhance replication of best practices among the various PPMD units. The RCC-PPMD, on the other hand, ensures that these policies, guidelines and standards are adhered to through regular supervision and monitoring.

The DOH, PhilCAT, PhilHealth, WHO and other international partners compose the committee. The DOH Secretary issued Administrative Order No. 154, s. 2004, making the NCC-PPMD the official structure authorized to oversee PPMD implementation nationwide in collaboration with the various RCC-PPMD. One of the accomplishments of the NCC-PPMD was the

publication of the Operational Guidelines for Public-Private Mix DOTS in the Philippines.

Another 3 RCCs were formed in 2004 while 8 RCCs were added in November 2005 during the 3rd Central Planning Workshop making the total number of RCCs 16.

The PPMD Package (Installation Process)

An installation process embodied in the Operational Guidelines for PPMD includes a series of activities that ultimately leads to the establishment of a PPMD Unit. This process is organized at the local level by the PPMD Unit in collaboration with the RCC – PPMD and NCC – PPMD.

Advocacy

Commitment generation from the various partners and the private medical practitioners was a very important step in the installation of the seven PPMD units. This was generated through the conduct of 29 advocacy symposia in five regions across the country. Symposia content covered topics on TB Burden, NTP, DOTS Strategy, PPMD and PhilHealth's Outpatient Anti-TB DOTS Benefit Package. Participants were mostly private physicians, but also included other medical professionals, academics, NGO workers, politicians, etc.

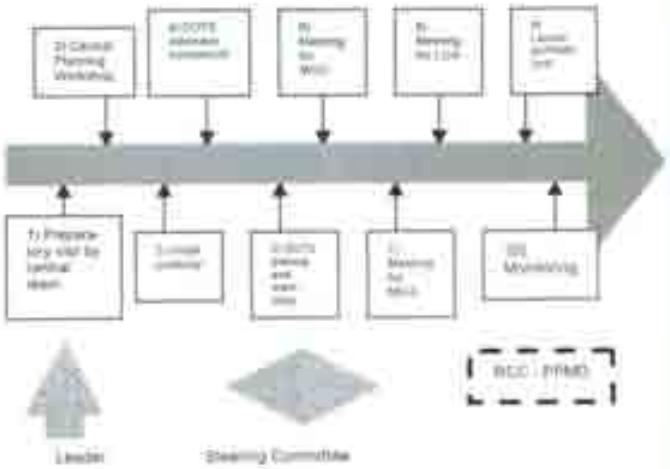
Training for DOTS Providers

Training for DOTS Providers was organized to ensure delivery of quality DOTS services to TB patients. In March 2004, PhilCAT, in collaboration with DOH, National Tuberculosis Reference Laboratory (NTRL) and the RCC – PPMD Davao Region, conducted two training courses.

The first was a five-day Basic Course on Sputum Microscopy for Medical Technologists and Microscopists of the seven PPMD units under GFATM and other PPMD Units in the region. This course aimed at providing the knowledge and skills necessary to perform quality sputum microscopy.

The second was a three-day Training for DOTS Providers. Participants included doctors and nurses from the seven PPMD Units under GFATM. This training aimed at (1) providing them a comprehensive knowledge of NTP policies and guidelines, DOTS Strategy and various NTP records and reports; and (2) developing their skills for managing the effective implementation of

PPMD Package (Installation Process)



DOTS in their respective PPMD units. A total of 64 health professionals were trained as DOTS Providers.

Training for DOTS Referring Physicians

Private physicians who signified their intention to attach themselves to a PPMD unit as *DOTS Referring Physicians* attended a Basic Course for DOTS Referring Physicians. The training provided physicians the knowledge on NTP policies and guidelines, PPMD as strategy for TB control and PhilHealth's Outpatient Anti-TB DOTS Benefit Package. The physicians also went through an exercise to identify the appropriate diagnosis, treatment and follow-up procedures for a TB patient. There were 496 private physicians who underwent this Basic Course for DOTS Referring Physicians.

Launching of the PPMD Units

The launching of the PPMD unit marked the commencement of its operation as a provider of quality DOTS services. One of the highlights of the launch is the signing of the Memorandum of Agreement (MOA) between the various PPMD partners, which states the role and function of each partner in the effective delivery of DOTS and the Letter of Agreement (LOA) between the PPMD Unit and the "DOTS Referring Physicians". A total of 28 PPMD units were launched as of July 2005.

Communications Planning

A Communications Planning Workshop was held on April 2, 2004 at the CSB International Conference Center in Manila. The workshop had two objectives: (1) identify key behavior changes toward achievement of

program goals and (2) formulate strategies to achieve desired behavior change.

The workshop was attended by program managers and implementers, representing the five RCC – PPMD and seven PPMD units, including PhilCAT, DOH and TDFI.

A final Communication Plan and a Creative Brief were the outputs of the workshop. It was decided that the following communication materials be developed for the project:

- Invitation cards for the advocacy symposium
- News articles, press release and radio broadcast for the advocacy symposium.
- PPMD Briefing Kit for distribution during the advocacy symposium
- PPMD audiovisual presentation (AVP) in various formats – VCD, DVD and VHS – to be used in lieu of the traditional lectures. The PPMD AVP was first presented in the 11th Annual PhilCAT Convention held on August 25 – 27, 2004 at the EDSA Shangri-la Hotel in Mandaluyong City. It had an international audience as well, with delegates coming from Cambodia, India, Viet Nam and the United States of America.
- PPMD Referral Forms
- PPMD Follow-up Forms
- Sponsorship of 10,000 copies of the August 2004 issue of the Health Beat, the DOH monthly health magazine with a nationwide reach. 800 copies of Health Beat were distributed in the 11th Annual PhilCAT Convention.

Monitoring of PPMD Units

- Monitoring of the PPMD units was done jointly by the PhilCAT, DOH, TDFI, WHO together with the RCC-PPMD and the provincial/city TB coordinators.
- Review of initial case finding and case holding performance of the existing seven PPMD units for the period April to July 2004 was very promising. Private practitioners referred patients to the PPMD unit and quite a number of patients had been detected through the private practitioners and the four private-initiated PPMD Units. The overall conversion rate of 93.2% at the end of the second month of treatment is evidence of an effective case holding mechanism by the PPMD units.

Internal Assessment of the GFATM-TB PPMD Project Assistance to the Philippines

- An internal assessment is conducted annually by representatives from RCC-PPMD and PPMD units. The activity is intended to review the accomplishments of the implementing units and share promising practices.

Lessons learned, challenges and future directions

The first phase of PPMD installation under the GFATM project provided the various PPMD partners at the national, regional and local levels valuable lessons, which led to an enhanced and full understanding of the various factors that facilitated PPMD, as well as factors that serve as deterrents to its successful and timely implementation.

The creation of the NCC-PPMD and RCC-PPMD with members coming from both the public and private sectors helped build, enhance and sustain collaboration for PPMD installation. The presence of a local PhilCAT coalition in each of the regional sites provided the enabling environment necessary for PPMD installation in the seven PPMD sites. The Chair of the local PhilCAT coalition served as the champion who generated the full support and commitment of the private sector, particularly the private practitioners.

Empowering the RCC-PPMD by providing them the technical and administrative skills on PPMD implementation and getting them actively involved in the planning and implementation of the various PPMD installation activities starting from the advocacy, followed by training and finally the launching is crucial in the installation process. More importantly, the RCC-PPMD is an important structure in ensuring quality DOTS service including the continuous availability of quality anti-TB drugs to all PPMD units.

In the selection of a PPMD unit, a basic consideration is a strong public system in the site that will provide the technical support and the enabling environment for quality DOTS implementation. In addition the site selected should be an area where there is a large number

of private practitioners which would be the source of referrals of TB patients.

The funding support from the Global Fund made it possible to institutionalize PPMD through the creation of the NCC-PPMD and the RCC-PPMD. The funds were necessary to initiate all the activities related to PPMD installation in the area and to monitor its implementation. More resources, however, had to be generated particularly in the establishment of a private-initiated PPMD. The RCC-PPMD and the PPMD units expressed their political commitment not only by providing additional funding but also by sharing their resources, expertise and valuable time through their voluntary participation.

The PPMD units have been successfully installed and systems are in placed for the delivery of quality DOTS. Monitoring results showed that both patients and DOTS Referring Physicians are utilizing its services. However, there were also problems and concerns common in all areas that were identified and would call for immediate response from those concerned and these included the following:

- Slow implementation of PhilHealth's outpatient anti-TB DOTS Benefit Package.
- Need to enhance participation of trained private physicians in terms of referral.
- Formalization of membership of private physicians in the PPMD Unit through an LOA.
- Sustainability of PPMD Units after project life.
- Standards in the diagnosis of smear (-), chest x-ray (+) cases in terms of procedures, recording and reporting.
- Delays in submission of programmatic and financial reports by the implementing units.

The challenges are to sustain the participation of the private practitioners, to increase utilization of the PPMD Units by both private physicians and patients, to ensure the provision of quality DOTS services, to ensure efficient delivery of the PhilHealth Outpatient Anti-TB DOTS Benefit Package and, lastly, to look into possible areas for PPMD sustainability.

Tropical Disease Foundation DOTS-Plus

Multi drug-resistant TB

The Tropical Disease Foundation (TDF) DOTS-Plus project began as a public-private mix DOTS unit formed by the TDF and the Makati Medical Center (MMC), representing the private sector, and the National TB Program (NTP) of the DOH, and Barangay San Lorenzo, the local government unit, representing the public sector. The DOTS-Plus project was initiated in 1999 to address the DOTS failures encountered among previously treated cases. This was the first pilot project approved globally by the Green Light Committee (GLC), the technical committee of the Working Group of the World Health Organization (WHO) on multidrug-resistant TB (MDR-TB) in August 2000. This provided access to 1) quality-assured concessionally priced second-line anti-TB drugs, 2) technical assistance and 3) external monitoring system ensuring rational use of drugs and participation in the creation of evidence base for policy development. Because of lack of funds, only 165 MDR-TB patients were enrolled before the start of the Global Fund TB project in July 2003.

Currently, MDRTB treatment in Metro Manila is provided by the TDF at the MMC DOTS Clinic, KASAKA in Quezon Institute and by the Lung Center of the Philippines DOTS Clinic, a public facility. To facilitate adherence to the treatment program treatment of some patients is supervised daily through their local DOTS centers in Metro Manila and in Atimonan, Quezon, a province south of Metro Manila, allowing them to come only once a week to the central DOTS-Plus facility.

GFATM support

The second main objective of the Global Fund (GF) Round 2 TB Component Project is to utilize this GLC-approved DOTS-Plus pilot project to treat 500 patients to provide a basis for policy development on drug resistant tuberculosis in the National TB Program (NTP). Since July 2003, a cumulative total of 224 patients has been enrolled with GF support, bringing the total to 389 since 1999 (Figure 5).

Aside from providing the expensive second-line anti-TB drugs for at least 18 months, the GFATM also provides enablers to patients and treatment partners in the form of monthly food baskets, transportation reimbursement, partial relocation cost, free laboratory monitoring, drugs to counter adverse drug reactions, consultations to specialists, and psychosocial support to address the multi-faceted concerns of MDRTB patients.

Centre of Excellence in MDR-TB

Since 16 February 2001 the GLC has made six site visits and the most recent was on 7-11 December 2004. In the last visit, the GLC noted that "the extent of implementation of the recommendations made by the last monitoring visit was impressive. "The GLC monitoring team noted that "the progress achieved, the commitment of the TDF and its staff, and the clear support from the NTP and local health authorities, are getting this project very close to become a worldwide centre of excellence in the management of MDR-TB". Towards this objective, two grants for the development of the Centre of Excellence in MDR-TB have been provided through a cooperative agreement with the Centers for Disease Control and Prevention (CDC) and by the Lilly Foundation through the World Health Organization. As an initial step towards this goal, the DOTS-Plus project has undertaken several training programs to develop local capacity to undertake DOTS-Plus in preparation for scaling up beyond the pilot project. As integration of DOTS-Plus to DOTS will entail capacity building it is envisioned that this Center of Excellence will become a training center in DOTS-Plus not only for partners in the Philippines but in the Asian region as well.

Table 3 shows the quarterly training activities conducted by the TDF team prior to engaging a facility in DOTS-Plus. These trainings equip health workers to manage and confidently care for MDRTB patients in their own facilities.

Delivery of treatment under DOT has been decentralized, making it possible for 50% of the MDR-TB patients to take drugs closer to their households. A treatment facility for MDRTB in the Quezon Institute "Bahay" (Home) was set up successfully housing patients, an approach that enables patients who live in far areas to get DOTS-Plus treatment. In addition to the free treatment, the patients receive the full package of social support (food, shelter, skills training, occupational therapy and health education, group discussions), making the initiative highly acceptable to patients, and making it a model for other DOTS-Plus projects. Progress was also observed in the collaboration of TDF with the Lung Center of the Philippines (LCP), a tertiary DOH hospital.

Creation of the Council for the Management of MDRTB and the DOTS-Plus Task Force

Following the GLC recommendations, the Council or Consilium for the Management of MDRTB was created through a Department Order signed by the Secretary of Health on Mar 2, 2005 composed of representatives from the DOH, TDF, LCP, Philippine Tuberculosis Society, Inc. (PTSI), Makati City Health Department, a secretariat and advisers. The general functions of the Council are as follows: a) to review MDR-TB patients awaiting treatment; b) to recommend treatment regimen based on clinical data; c) to monitor and evaluate problems related to MDR-TB management; d) to provide technical assistance in the development of MDR-TB policies and guidelines; and e) to review and evaluate the outputs of the DOTS–Plus project. The Council meets every month to discuss clinical and operational difficulties and lessons learned in DOTS-Plus implementation and, as necessary, to disseminate new guidelines on MDR-TB management.

In addition, a DOTS-Plus Task Force was created on

Delivery of treatment under DOT has been decentralized, making it possible for 50% of the MDR-TB patients to take drugs closer to their households.

April 29, 2004 to discuss the progress of DOTS-Plus expansion in a stepwise manner. This group is chaired by the Director of the Infectious Disease Office of the DOH and co-chaired by both the NTP point person for MDRTB and the TDF DOTS-Plus Program Manager. The group continues to meet for regular discussion with partners such as the National TB Reference Laboratory and the Center for Health Development- Metro Manila (CHD-MM) of the DOH.

Laboratory quality assurance by a supranational laboratory

The TDF research laboratory performs all culture and drug susceptibility testing (DST) of isolates from patients screened for MDRTB and monitors those enrolled in the DOTS-Plus project. To ensure quality assurance of laboratory services, it participates in the annual proficiency tests conducted by the Korea Institute of TB (KIT), a supranational laboratory. The performance of the TDF in the 9th and 10th rounds was outstanding. In addition, fluorescence microscopy for sputum is also under quality assurance by the National TB Reference Laboratory of Thailand, a collaborating laboratory of the International Union Against Tuberculosis and Lung Diseases (IUATLD). In two quarterly tests, only one major and one minor error with a 94% agreement were noted in the first quarter and a 100% agreement in the second.

DOTS-Plus Expansion

1. Treatment sites

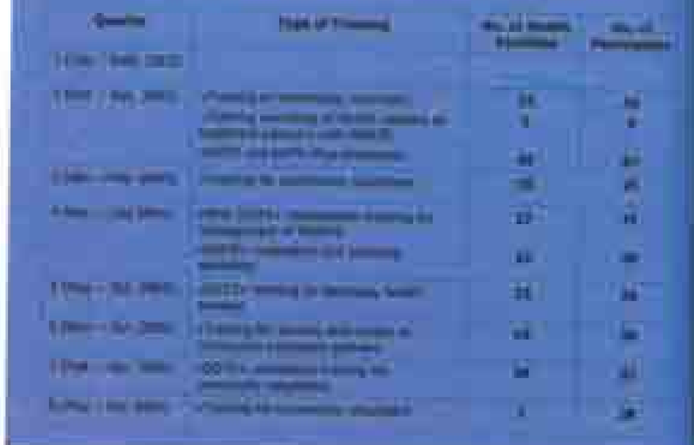
Partnerships with the public sector have been expanded allowing for a decentralization of DOTS-Plus services to the public health centers and the LCP, and faith-based groups. Figure 6 shows the 30 health facilities in Metro Manila that have at least one MDRTB patient receiving treatment with continuing supervision by TDF. These include the main site which is the MMC DOTS Clinic, two treatment satellites (KASAKA: Bahay ng Kabalikat sa Kalusugan, and the LCP), 6 faith-based organizations, one industrial clinic and 20 public health centers. Partnership has also involved a rural health unit in Atimonan, Quezon Province in Region IV-A.

a) Bahay ng KASAKA

Through partnership with the Philippine Tuberculosis

Fig. 5: Patient accrual in DOTS-Plus April 1999 - July 2005 (N=389)

Table 4: Training Activities and Participants



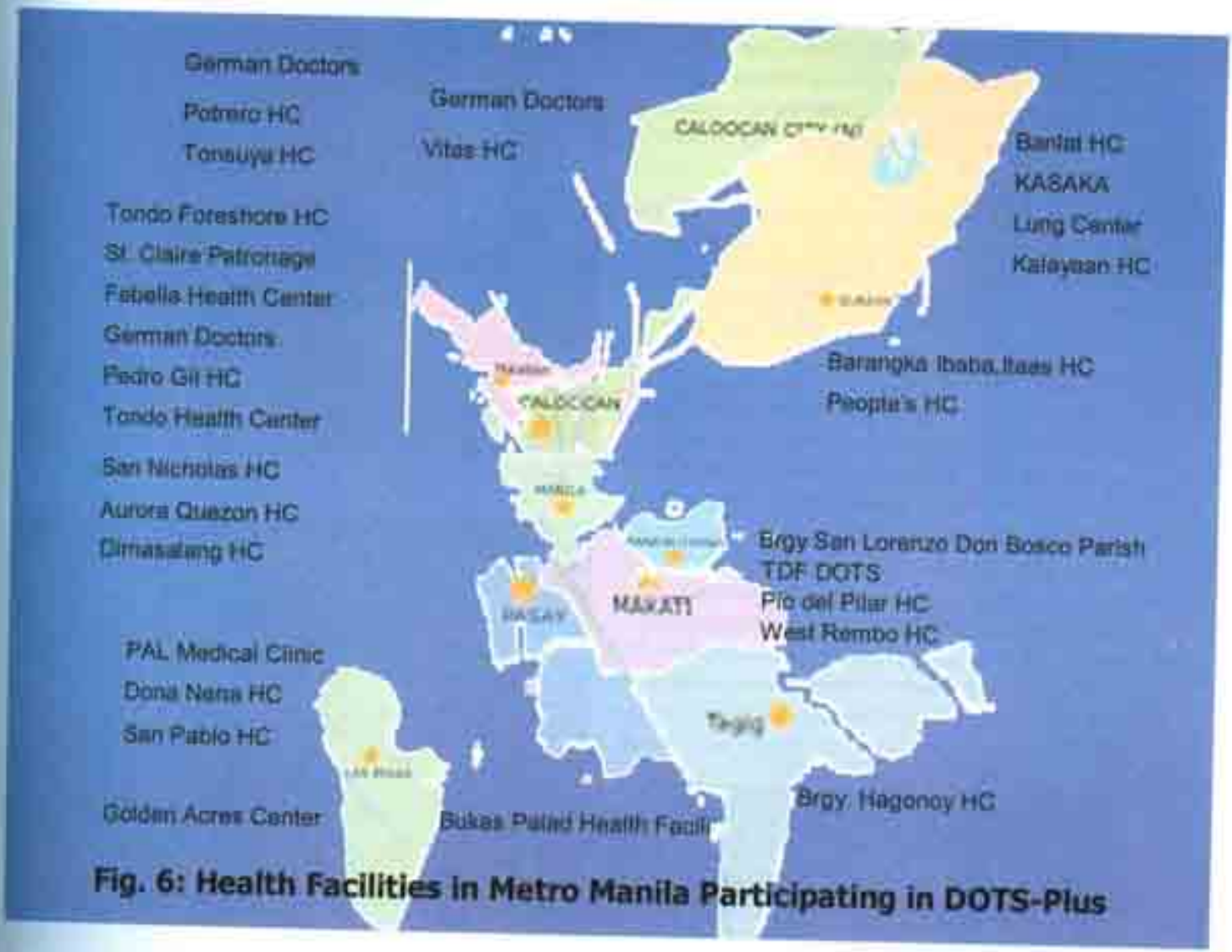


Fig. 6: Health Facilities in Metro Manila Participating in DOTS-Plus

Society, Inc. (PTSI) and through funding from the Philippine Amusement and Gaming Corporation (PAGCor), the old Teachers' Pavilion in the Quezon Institute grounds was renovated into a 28-bed MDRTB housing facility named Bahay ng KASAKA and inaugurated on June 11, 2004. This facility provides out-patient DOTS Plus services for patients who live in Quezon City and housing for patients who live far from Quezon City or Makati for the first 6-8 months after which they are expected to relocate to a place near the center or are referred to a DOTS Center in their neighborhood to continue treatment on an out-patient basis. By July 2005, 65 patients belonging to the overall cohort of TDF had been enrolled at the Bahay, 18 in-house and 47 as out-patients.

As a strategy to rehabilitate patients to becoming economically productive, TDF facilitated free training skills through the Quezon City Social Service Department such as making handicrafts and novelty items like key chains, desk flower ornaments, etc. These products are displayed and sold during national events like World TB Day and Philippine Coalition Against Tuberculosis (PhilCAT) Conventions. Gardening skills are also taught through partnership with the Nutrition Center of the Philippines (NCP), where supervised hands-on training is done in the perimeter of the Bahay. These skills make patients feel empowered and economically productive.

b) Lung Center of the Philippines (LCP)

Since March 22, 2004, the LCP initiated its own 8-bed MDRTB home and an out-patient DOTS-Plus facility as a satellite of the TDF DOTS-Plus project. Through funds from the DOH, it supports second-line drugs and enablers for an additional 20 patients apart from the GF-supported patients. A 20-day competence-based

hands-on "immersion" training on DOTS-Plus was undertaken by the LCP DOTS Center Head, a clinic physician and a nurse at the TDF DOTS-Plus project site in Makati.

The LCP laboratory medical technologist also underwent a one-month training at the TDF TB research laboratory. The first MDRTB patient was admitted in the LCP MDRTB home on January 17, 2005. By July 2005, 6 in-house and 31 out-patients had been enrolled in this satellite DOTS-Plus facility.

With the steady enrollment of more patients under the GFATM grant, involvement of more health centers is necessary to make MDRTB treatment accessible and convenient. Moreover, as more partners become knowledgeable in implementing the complex DOTS-Plus services, the responsibility is shared rather than centralized to one or a few centers. It is anticipated that DOTS-Plus will be widely available in a phased manner all throughout Metro Manila, and in selected regions outside Metro Manila within the framework of the DOTS program of the NTP.

c) Region IV-A (Atimonan Rural Health Unit)

Community-based DOTS Plus has been initiated in patients who have trained treatment partners in their neighborhood, either from among the village (barangay) health workers or faith-based organization volunteers. One example is the community-based treatment of four patients referred by a rural health unit in Atimonan, Quezon Province. These patients had their intensive phase of treatment at the Bahay.

After coordination with the NTP and with CHD- Region IV-A, and training of the Municipal Health Officer (MHO) and the Public Health Nurse and barangay health workers (BHW) of that unit, these patients are now undergoing truly community-based DOTS-Plus with the BHWs providing DOT near the patients' residence. The TDF DOTS-Plus staff together with the NTP and the Provincial NTP Coordinator visit the RHU monthly to monitor the progress of the patients and to deliver the drugs. This regional expansion is being pilot tested before further expansion to other regions in the country is undertaken.

2. Moving into the community: steps in decentraliza-

KASAKA nurse administering DOT to an MDR patient

DOT at the LCP grounds by a DOTS-Plus trained health worker

The patients meet Atimonan MHO and the TDF DOTS Plus staff to discuss their progress in the treatment course

tion

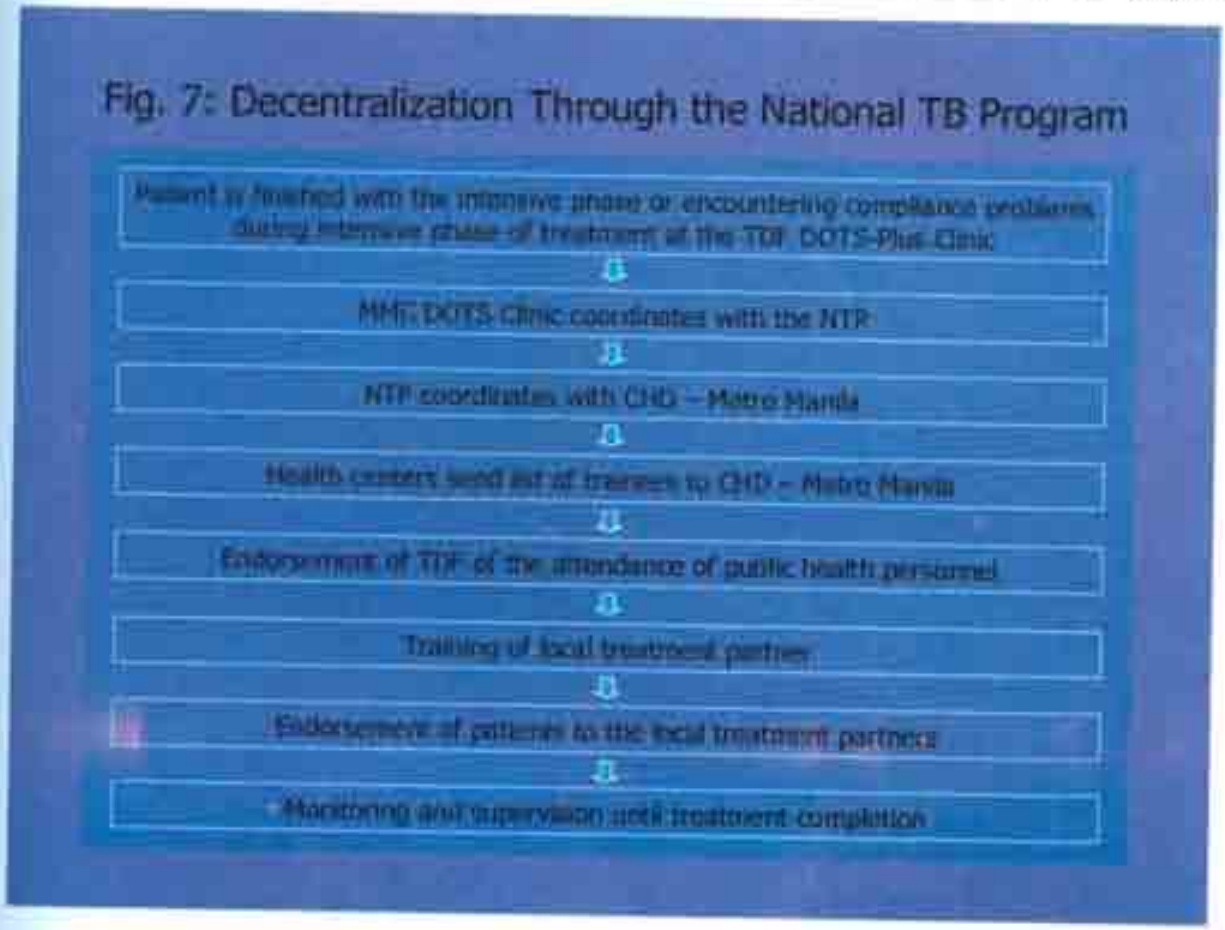
The engagement of facilities in DOTS-Plus entails a long process from the time a health center is identified by a patient to the time of actual endorsement by TDF (Figure 7).

After the intensive phase of DOTS-Plus treatment is completed, TDF DOTS-Plus staff coordinates with the NTP to plan for patient decentralization. The NTP in turn coordinates with the Metro Manila Center for Health Development (CHD-MM) after which the city NTP Coordinators submit a list of recommended trainees from the health center level. This list is submitted back to the NTP and officially endorsed to the CHD-MM and to the TDF. The training for health professionals (physicians and nurses) conducted by TDF staff lasts two days, and a separate training for health center-based community volunteers is one day.

Once the team of the health center has undergone training, the patient is endorsed by TDF to the health center which now provides DOTS-Plus treatment. Supervision and monitoring support from TDF continue after endorsement of the patients through weekly phone calls and monthly facility visits until the patient completes the 18-month course. The patients (with the exception of those living in Atimonan) continue to go to one of the three DOTS-Plus treatment centers once a week.

Patient Empowerment

Because patients are the best sources of support and encouragement to fellow patients and in order to tap the potential added human resource for DOTS-Plus, a patients' association was formed, facilitated by the DOTS-Plus Psychosocial Coordinator. This group named *Samahang Ugtas Baga*, was registered in the Securities and Exchange Commission (SEC) on June 3, 2005 with an initial membership of 13. It is the goal of the Samahan to empower patients and former patients to become active advocates for TB control and to become DOT supporters and treatment partners as well. The specific objectives of the Samahan are: a) to encourage its members to help TB symptomatics get correct diagnosis; b) to encourage its members to help TB patients, especially MDR-TB patients, to comply with treatment; c) to represent members and TB patients including MDR-TB patients at activities related to



promoting a TB-free Philippines; d) to help raise funds for promoting TB control in the Philippines and for assisting MDR-TB patients; and e) to provide livelihood assistance to MDR-TB patients. "Bonding Days" are organized to gather the patients together and discuss issues that pertain to the association.

In addition to patient organization, regular weekly group discussions and counseling presided by a Consultant on Psychology have been undertaken to help patients cope with the psychosocial issues of MDR-TB treatment. This is an active intervention to promote adherence to treatment which has been found to be effective by patients.

Additionality to strengthen DOTS-Plus

Existing partnerships have enabled the DOTS-Plus project in the Philippines to receive non-GFATM funding from various sources, mainly for training and data management.

1. Training

External trainings were attended for the continuing education and capacity building of staff within the TDF DOTS-Plus project. Its senior Clinic Physician attended the Training on Drug Management conducted by WHO in Cairo, Egypt on May 9-12, 2005. From May 9-13, 2005, the Executive Officer/Program Manager attended the First DOTS-Plus Consultants' Training conducted by the GLC, WHO in the WHO Collaborating Center at the State Agency for TB and Lung Disease in Riga, Latvia and the WHO Training Course on TB and TB/HIV for Program Managers and Consultants at the Sondalo Hospital through the Collaborating Center in Tradate, Italy on May 18-31, 2005. Another medical officer from the MMC DOTS Clinic attended the Course on Operational Research conducted by the Centers for Disease Control in Malawi on June 12-19, 2005.

2. Enhanced data management

In September 2004, the Centers for Disease Control and Prevention (CDC) in Atlanta, Georgia, provided support through a cooperative agreement entitled "Improving effectiveness of the Diagnosis of TB in the Philippines". One objective of this grant was to enhance the data management system for DOTS-Plus and DOTS as a backup of the TB component of the Global Fund project for the Philippines through the use of the Electronic Medical Records (EMR) system and the Electronic TB Register (ETR), respectively. The EMR is a web-based system which enables real-time encoding of data from DOTS-Plus and DOTS patients, such as sputum results and drug regimens. Installation of the system and training of TDF staff were done in October 2004, and continued fine-tuning of the system followed through teleconference and site visits of the *Partners In Health* staff from Boston. The EMR is now operational with the clinic, the laboratory, and the pharmacy staff entering simultaneously data of DOTS-Plus and DOTS patients of TDF.

Application of the EMR in the two other treatment sites is being planned. Based on a request by TDF, a module on adverse events will be added to the EMR.

Mainstreaming DOTS-Plus to DOTS

The DOTS-Plus project has gone beyond the pilot phase and is now in the expansion phase to mainstream DOTS-Plus to DOTS in the NTP.

It is the long-term goal of the project to establish a program of management for MDR-TB in the country in line with the policies and guidelines of the National TB Program (NTP) towards policy development. This would include case finding, treatment, and monitoring and supervision guidelines for MDRTB patients decentralized towards the NTP framework.

Health center staff in a DOTS-Plus training eager to learn

A life changed, not just through pills

After having been treated for TB twice with the treatment outcome 'failure', Edgar (not his real name) approached the DOTS-Plus clinic. He lived in a rural place, 4 to 5 hours drive south of Manila where the DOTS-Plus clinic is. He did not have relatives in Manila where he could stay during his 18 to 24 months long treatment. But fortunately for him, the Tropical Disease Foundation (TDF), the implementer of the DOTS-Plus program in the Philippines in collaboration with the National TB Program of the Department of Health, received local support to open a housing facility in the Quezon Institute grounds. In this centre, opened in June 2004, multidrug-resistant TB (MDR-TB) patients like Edgar live and get free treatment as well as food and care. The Philippines Tuberculosis Society, Inc. (PTSI) owns the centre and allows free use of the facility.

Because he was separated from his family while being treated, he became depressed and was eventually referred to a psychiatrist. Due to other patient and staff support, he improved. He kept himself busy with gardening in the MDR-TB facility and maintained a positive outlook in life. His family was his inspiration.

Direct observation of therapy: the patient and his treatment partner, the local mid-

Ten months later, he and three co-patients from the same place in the province, were allowed to move back to their place since the local governmental health centre there had been trained to take care of MDR-TB patients, with TDF making monthly monitoring visits.

Today, Edgar is nearing the end of his treatment and is involved in farming activities. The lime trees around his house offer the fruit juice he needs to drink his PAS, one of the second-line drugs in his MDR regimen (see photo). PAS needs to be taken with an acidic drink.

Beneficial for him was that during his stay in the MDR housing facility in Manila, TDF facilitated training on vegetable gardening, offered by the Nutrition Center of the Philippines, a partner NGO, and the training was put in practice in the perimeter of the facility. This was financed with GF money through the so-called "enablers", a means to support MDR-TB patients in overcoming obstacles to the long treatment and difficult recovery. Being cured and being re-united with his children and his wife who for a while had seemed to be giving up on her

The Global Fund Malaria Project in the Philippines Year 2 Report (August 2004 – July 2005)

Accelerating the Response to Malaria in the Philippines' Rural Poor

The Philippine Malaria Global Fund project is in line with the Millennium Development Goals (MDGs) and Roll Back Malaria targets. It aims to reduce malaria associated mortality by 50% in 2010 and another 50% by 2015. This is to be achieved by providing access and use of correct, affordable and appropriate treatment within 24 hours of onset of symptoms to at least 60% of those suffering from malaria. In addition, suitable personal and community preventive measures such as insecticide-treated mosquito nets should be provided to at least 60% of those at risk of malaria, particularly pregnant women and children under five.

The goal of the Philippine GF project is to reduce malaria morbidity by 70% and mortality by 50% compared to 2001 with corresponding rates of 60 cases per 100,000 and 0.38 deaths per 100,000, respectively, in the 26 priority provinces by 2008. It also aims to reduce the annual parasite index from 5/1,000 in 2001 to less then 1/1,000 by the end of the project.

Its three-pronged objective of (1) increasing diagnosis and treatment, (2) improving vector control measures and (3) strengthening community-based malaria control will focus on the country's rural poor, especially the indigenous peoples (IP) who have long been ravaged by this disease in areas with minimal health services.

The population at-risk of malaria are found in the 26 targeted priority provinces, where malaria ranks among its 10 top leading causes of morbidity. It is also a top leading cause of mortality in some of these areas, specially in the Autonomous Region of Muslim Mindanao (ARMM) provinces of Sulu, Tawi-tawi and Basilan.

Support from this Global Fund Malaria project is intended to augment the government's meager resources in malaria control. The strategies are aimed at capacity building at the local government level, quality assurance in diagnosis, treatment and vector control, and community organizing and mobilization, advocacy, and health education in affected communities. These strategies should lead to increased community participation and enhanced health governance following the continuing devolution of health programs at the provincial and municipal government.

Capacity building of service providers such as the Rural Health Unit staff, medical technologists, barangay microscopists, hospital-based physicians and field-based malaria program managers, coupled with provision of commodities such as microscopes, laboratory supplies, drugs and insecticides and bednets encompass the curative and preventive aspects of disease control. This was complemented by the creation of provincial management

committees to ensure grass root implementation by the municipal and barangay action teams under the oversight of the provincial and municipal health officers. Community organizers play a major role in advocacy, health promotion, and health education strategies. These are now in place in the 26 provinces, with some LGUs taking the lead responsibility with committed resource counterparts. The Philippine Malaria Information System (PhilMIS) was started on Year 2, which aims to improve the reporting system through computerized data entry and networking with the regional and central data centers.

Partnerships

The project's implementation is a partnership between public and private organizations. Phase 1, Years 1 and 2, was managed with a Sub-recipient, the Philippine Rural Reconstruction Movement (PRRM). As the project begins Phase II, management was completely turned over to the Principal Recipient, the Tropical Disease Foundation, Inc. with its main partners, the Department of Health (DOH) and the World Health Organization (WHO). The implementers of the project are the local government units (LGUs) at the provincial and municipal levels. The project is advised by a Technical Working Group (TWG) composed of the Infectious Disease Office of DOH represented by the central and regional offices including the Research Institute for Tropical Medicine (RITM), San Lazaro Hospital and the National Epidemiology Center, the World Health Organization and it's Roll Back Malaria Program (RBM); Pilipinas Shell Foundation, Inc; Kilusan Ligtas Malaria, ACT Malaria; National Commission on Indigenous Peoples and the University of the Philippines College of Public Health.

The project focuses on the expansion of the capacity of DOH, LGUs, and other partners to reach out to underserved communities especially among the indigenous peoples where the high burden of malaria persists. In its second year, the project expanded to 15 more provinces from the 11 provinces in the first year so that it has now completely covered the 26 target provinces.

Objective 1: To increase the proportion of febrile patients receiving prompt and appropriate anti-malarial therapy .

Increasing access to prompt malaria diagnosis and treatment

Lack of access to prompt diagnosis and treatment by patients coming from poor, underserved and remote areas is a fundamental problem in the efforts to control malaria in the Philippines. Often, people would delay consultation because they do not have the resources to travel to the nearest diagnostic facility that is usually the Rural Health Unit (RHU) or district hospital located in the town or they wait for the Provincial Health Teams to visit their area. However, the difficulties of the patient do not end by gaining access to a health facility. A significant number of municipalities highly burdened with malaria do not have trained medical technologists and, where available, the skills for malaria microscopy are inadequate. RHUs and hospitals often lack laboratory supplies for the preparation of blood smears and good microscopes for quality diagnosis.

Once the patient is diagnosed with malaria, he/she will most likely spend for the medicines because the RHUs lack anti-malarial drugs. Under the decentralized health services, the municipalities are responsible for the procurement of the first line drugs. However this is not possible due to the lack of budgetary allocation or other competing priorities. Patients are therefore left to procure the medicines and they also cannot afford the full course of treatment leading to inadequate compliance. In those given free drugs, compliance is also poor due to lack of understanding about its importance.

The first objective of the Global Fund Malaria Component addresses the problem of access to prompt diagnosis and treatment by bringing the malaria diagnostic and treatment services closer to the people, especially those who are most vulnerable to the disease. The project aims to (1) expand the diagnostic services up to the barangays (villages) by establishing barangay malaria microscopy centers (BMMCs) and rapid diagnostic test (RDT) sites (2) improve the quality of diagnosis through trainings of medical technologists and barangay microscopists (3) training of health staff in the management of malaria (4) ensuring the availability of laboratory and drug supplies and (5) intensifying the promotion for the use of diagnostic facilities and compliance to treatment by the patients. It is expected that

these would result to an increase in case detection by 25% at the end of 2004 and 50% by 2005 and a reduction in the number of cases is projected by 2006 onwards.

Training on malaria diagnosis

The IDO-DOH is mainly responsible for training courses on malaria diagnosis, assisted by the DOH regional offices - Centers for Health Development (CHD) and the RITM, with technical guidance provided by the AusAID-DOH-WHO RBM project. Basic Malaria Microscopy runs for a period of 12 days for medical technologists and 35 days for barangay microscopists. Training on the use of RDT is given. Barangay health workers are trained for 1.5 days. The project makes use of Paracheck Pf which detects falciparum malaria only. These RDTs are tested for their quality at the quality assurance (QA) facility in RITM established by WHO.

A total of 1,098 health care workers were trained, 9 are actually deliverables from year 1 and the rest are additional requests or initiatives from the local government units. Except for 3 medical technologists, all the trainees were able to pass the course.

Of the 273 medical technologists, 69 were hired (as medical technologists or laboratory technologists) by the project for a period of one year but with a signed memorandum of agreement with the local government units that the LGU will eventually absorb these medtechs and provide their salaries. They can provide diagnostic services for malaria and other diseases in their area. The same is true for the 163 barangay microscopists and RHU-based microscopists. All the 672 barangay health workers trained in the use of RDTs were volunteers.

A QA system for malaria microscopy developed by the RITM National Reference Laboratory for Malaria and the Malaria Control Program – DOH, with support from AusAID WHO RBM project and ACTMalaria, has been pilot-tested in 5 of the 26 provinces. Medical technologists and barangay microscopists were asked to submit 25 slides per quarter for 2 quarters for validation. Results show that on the average, their accuracy is 80 to 90% with only one getting a 40% error. With some refinements, the system will be expanded to other provinces. There is also a QA system for RDTs in the field being pilot tested in 4 provinces.

Training on clinical management of malaria

The training courses on clinical management of malaria are conducted by DOH together with the San Lazaro Hospital, RITM, the University of the Philippines College of Public Health and with technical guidance from AusAID-DOH-WHO RBM project. The Basic Malaria Management Course prepares the 33 trained municipal health officers and other RHU staff of the local government units to take on the responsibility for malaria control and to put into practice a malaria program in a truly devolved setting. The training also discusses extensively the National Guidelines for Malaria Chemotherapy. Severe Malaria Management Training delves on proper management of severe malaria for district, community and provincial hospital doctors. A total of 199 were trained this year.

Distribution of microscopes, RDT kits, laboratory supplies and anti-malarial drugs

A total of 223 biological microscopes intended for the 2nd batch of GF provinces (15 provinces) were distributed to the barangay microscopy centers and RHUs on the 2nd year. Microscopy validators responsible for the QA system will also be provided with microscopes when the QA system is fully implemented in 2006. 70 sets of microscopes intended for the barangay microscopy centers of Palawan were procured partially in the second year. These microscopes are valued at US $ 66,539. For RDT sites, Paracheck Pf kits were distributed. Laboratory supplies amounting to US $ 196,304 were also provided for these facilities. First line (3.8M

tablets chloroquine, 1.3M sulfadoxine pyrimethamine and 2.395M primaquine), second line (12,960 packs of Coartem) and third line (76,800 quinine tablets and 38,460 ampules) anti-malarial drugs were made available to the newly established diagnostic centers and the existing health facilities such as the RHUs, BMMCs in Palawan and provincial and district hospitals.

Establishment of health facilities with diagnostic and treatment services

With the training and the provision of supplies, a total of 1,152 malaria diagnostic and treatment facilities have been established. The operations and maintenance of these health facilities are now the responsibility of the local government units. Supervision at the barangay and municipal levels are under the Municipal Health Officers and at the provincial level, the Provincial Health Officer. These health executives need the support of their local chief executives, the mayors and governors for budgetary allocation, legislation and other management support. Technical assistance comes mainly from the CHDs represented by the Regional Malaria Coordinators and the Provincial Health Team Office (PHTO). The structures that allow these different independent groups to converge are the Provincial Management Committee (ProvManCom), the Municipal Action Committee (MAC) and the Barangay Action Team (BAT). These groups represented by the core players – the LGU, the Department of Health and the Provincial Management Team in behalf of the GF project management makes the decisions and particularizes GF national plans to the provincial and municipal level. The structures allow other stakeholders to participate such as the Department of Education and non-government organizations interested in the control and prevention of malaria.

Contribution of Newly-Established Health Facilities to Case Detection

The setting up of BMMCs and RDT sites in strategic locations and remote areas have made it easier for people to have access to malaria diagnosis and treatment. While information has yet to be established on how much of the febrile patients have been diagnosed and treated within the ideal 24 hours, initial data coming from some provinces presented in Figures 8 and 9 show that a significant number of the cases are now detected in the newly established health facilities.

Monitoring and Supervision

The Technical Working Group has established its monitoring system which will be done in 3 levels. The provincial level implements and supervises the operations; the regional level will be responsible for regular and more frequent visits. The TWG members at the national level, together with the sub-recipient and principal recipient, conduct quarterly visits. Further, the system has already incorporated participation of the National Epidemiology Center of the Department of Health in the Monitoring Team that will eventually be tasked to sustain and implement the M and E system.

At present, data are still being manually organized but the setting up of the Philippine Malaria Information System (PhilMIS) will generate computerized data and reports from the provinces. Sixteen provinces have already been given orientation and provided with the hardware and software for PhilMIS. Four provinces have their PhilMIS in operation and their reports are now being generated from the system.

Insights, Challenges and Lessons

Improvement in the selection of sites for health facilities

The project was confronted with several challenges in the course of its implementation where valuable insights and lessons can now be learned. Foremost of these is the selection of locations for barangay microscopy centers and RDT sites. Although the Technical Working Group has set guidelines for selection of sites prioritizing endemicity and remoteness of the area, decisions on where to establish the BMMC and RDT sites were influenced by politics or failure to validate chosen locations due to a weakness in coordination between the field-based project staff and the provincial malaria coordinators in the area. There are BMMCs and RDT sites, which, after one year of implementation, have detected only a few or zero cases. This could have been avoided if a system has been established for a more thorough review on the appropriateness of the areas selected or recommended by the local government units.

Sustainability of trained health service deliverers

While the local government units have been very sup-

portive of the project, some are finding it hard to absorb the medical technologists and the barangay microscopists who were hired. Excluding Tawi-Tawi, Sulu and Basilan where 24 medical technologists have not yet been trained, 61.6% (56/91) of medical technologists and 60% (102/170) of the barangay microscopists whose project contracts have lapsed were hired by the LGUs. However, most were hired on a casual basis, renewable every 3 months. Some are given incentives equivalent to half the amount they used to receive from the project. In some cases, a number of barangays have agreed to pool their resources to be able to keep the microscopists to service them. Clearly, sustainability of the gains made by these health facilities poses a great challenge. A few of the medical technologists and barangay microscopists have decided to look for other employment.

Strengthening recording and reporting

Reports from the RDT sites are oftentimes incomplete or lacking. Malaria status report both from the field and the hospitals, including information on severe malaria and cases among under five years old are still difficult to collect on schedule and needs further verification. Contributing to the confusion in the field is that the reporting requirements of the Malaria Control Program and the GF projects from the DOH personnel are not harmonized. It is expected that once the PhilMIS is fully operational the paper based systems will be discontinued and reporting will be harmonized to improve the source of data reliability and allow for prompt and timely reporting.

Moving Forward, Future Directions

In Phase 2, the project will work on strengthening the operations of the malaria diagnostic and treatment facilities. Reports from the field will be collected and organized so that informed decisions can be made on whether to retain and strengthen, close, or shift to an RDT site. The TWG has prepared an algorithm to help in decision-making.

Hospital medtechs will also be the focus for Phase 2 microscopy trainings. The project will train 64 medtechs coming from 3 referral hospitals per province. Palawan, which accounts for almost half of the cases nationwide, has around 290 barangay microscopists who were trained in 2000 and, therefore, needs refresher courses in microscopy. The project has com-

Figure 8. Proportion of slides examined and RDTs used per type of diagnostic facility in selected provinces

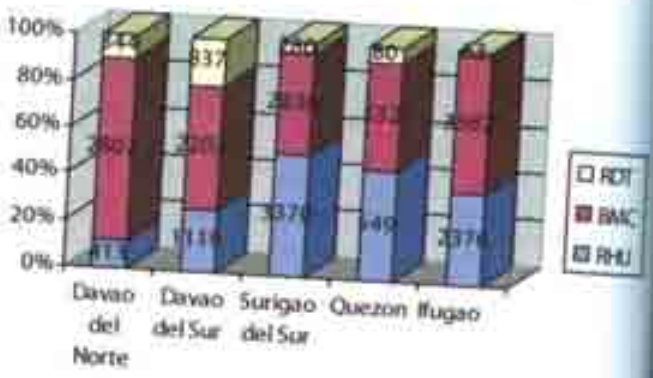
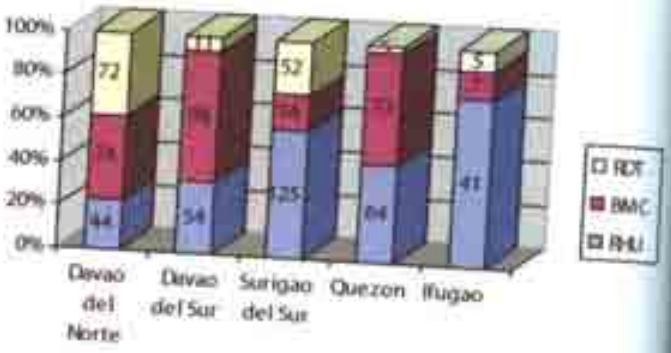


Figure 9. Proportion of malaria cases detected per type of diagnostic facility in selected provinces



mitted to give refresher courses including new microscopes for 128 barangay microscopists to improve malaria diagnosis. Trainings on preventive maintenance of microscopes are also planned so the LGUs will be prepared to troubleshoot problems and do minor repairs of microscopes.

As mentioned above, referral hospitals in the 26 project provinces will soon be established for the management of severe, complicated or resistant malaria cases. These hospitals will be supported to be able to deliver quality health services for such cases.

The QA system will be expanded to the other provinces to ensure accuracy of malaria diagnosis. Regular monitoring shall be conducted, and the provinces will be assisted in the utilization of the data and information generated to improve program implementation. PhilMIS shall be fully operational in the first eleven provinces by the end of the third year.

Management structures at the provincial, municipal and barangay level will be mobilized and given more responsibility to make decisions on the allocation of LGU resources for salaries of service deliverers, drugs, lab supplies, insecticides and nets; advocacy and mobilization of local resources. The project will ensure that allocation of resources shall be based on malaria status.

Objective 2: To reduce malaria transmission (vector aspect)

The project's main strategy for vector control is the regular use of insecticide-treated bednets. It has been proven effective in decreasing transmission by protecting susceptible individuals in highly endemic areas. The priority recipients of the bednets are the indigenous peoples (IP) in the remote areas, who are most at risk for malaria and have little access to services and preventive measures. A major challenge of the project is to develop the appropriate strategies in order to raise their level of awareness and influence them to adapt the practice of regular bednet use.

Among the major activities are: 1) identification of target recipients through a survey or updating of masterlist from past distributions, 2) development of distribution scheme, 3) social preparation of target communities and, 4) mass treatment and distribution of bednets.

The Project Management Team (PMT) is responsible for coordinating with the provincial and municipal implementers (PHOs and RHUs, respectively), as well as the PHTO in ensuring that the stated activities are conducted in a smooth and timely manner. However, the implementers play the major role in facilitating the entire process. This is to instill a sense of ownership not only for the activities but also for the responsibility and outputs.

On the second year of project implementation, distribution of bednets for the first eleven provinces was completed, and subsequently started in the fifteen year 2 provinces. Guidelines for distribution followed the original guidelines set by the TWG. This was modified upon the recommendations of the external evaluation team. It was assessed that while targets were reached in terms of distribution, the actual coverage did not ensure control of transmission of malaria. At best, there was only personal protection on an individual or family basis, but not for the entire population at risk.

The following revisions were therefore recommended: 1) priority barangays in priority municipalities should be the target sites for distribution, 2) there should be 2 to 3 persons per net, hence, large families may be allocated more than one net to achieve complete protection for all the members, and; 3) there should be at least 80% coverage of the population where majority of malaria cases are found.

To ensure sustainability and augment the already limited resources for malaria control activities, a revolving fund was set up from the proceeds of counterpart contributions from the recipients or the LGU. This was facilitated through a three-tiered distribution scheme:

Full/heavy subsidy: Nets were given for free or for a token contribution of Php 50 (USD 0.93) or less from the recipients from all IP families. However, during actual determination of which families should fall under the different schemes, LGUs and implementers agreed that non- IP families who cannot afford to give any counterpart or could only give less than Php 50 would also fall under this scheme.

Partial subsidy: Counterparts of more than Php 50 were given by the families not classified as IPs.

Social Marketing: In order to increase the revolving fund, a third scheme was piloted in several year 1 provinces. Through this strategy, bednets would be sold

at cost with the distributor or outlet getting a commission from the sales to serve as incentive. The different provinces were given the freedome of selecting the outlet/distributor. The Provincial Management Committee, in coordination with the PMTs, may establish a tie up with private outlets, individuals or entities to distribute the nets to communities at cost. Barangay Health Workers and other health service providers (RHU staff) are the possible individuals who may be tapped to distribute the nets. A 20% commission is given for each net 'sold' by the outlets or distributors.

With these as guide, distribution was done in the fifteen Yr 2 provinces and likewise completed in the first batch of provinces.

IP households receiving bednets at full / heavy subsidy

Targets for distribution of bednets under full/heavy subsidy were exceeded by 12.3% (95,412/84,970). This was due to the decision of local government units (LGUs) and implementers to provide the nets for free or at P50 or less. This helped ensure that the people's inability to give counterparts would not be a deterrent in availing the bednets.

Bednets distributed through partial subsidy

The second year of implementation ended with still 36.8% of bednets for distribution under the partial subsidy, attaining 63.2% of the target (114,717/181,361). There were difficulties encountered particularly in the Autonomous Region of Muslim Mindanao (ARMM) where peace and order situation is a constant problem. Accessibility issues were likewise hindering factors since many are island barangays in this region. Some LGUs could not immediately decide on the counterparts of the community. Nevertheless, distribution in the ARMM provinces and the collection of community counterparts can be considered a favorable outcome, considering the difficulty in soliciting community participation and LGU involvement in these areas.

For the eleven Yr 1 provinces, a total of Php 2,589,393.16 worth of bednets, insecticides and first line drugs were procured using the revolving funds. LGUs also gave counterparts for the plastic bags used for retreatment, transport of bednets, and snacks for the survey enumerators and volunteers who assisted in the treatment and distribution of nets.

These figures clearly show that communities and LGUs have come to appreciate the importance of bednets in the control of malaria and are fulfilling their responsibility in putting health as a priority. Completion of distribution is expected to be completed for these areas by the first quarter of Phase II (Yr 3).

Bednets distributed through Social Marketing

Less than half, 36.8% (6,24/16,901) of the targeted nets were distributed through a social marketing scheme. Some implementers distributed through health facilities like the Rural RHUs and through booths during celebration of LGU foundation day. Responses of LGUs and implementers varied across the eleven provinces where this scheme was piloted. A major challenge to the acceptability of the scheme is that bednets have been distributed in these areas at full/heavy and partial subsidy.

Retreatment of nets

A retreatment rate of 61.6% was achieved for the first eleven provinces that have distributed nets in the first year. Retreatment posed a big challenge for the implementers and project staff due to the mobility of IPs resulting from their economic activities, who were majority of the recipients. A major problem is finding the right timing for doing the re-treatment with the availability of the community. Inaccessibility of communities due to poor road network and remoteness of most IP villages as well as security concerns are also among the other factors contributing to the challenge of attaining the targeted retreatment rate. Strategies employed to overcome these constraints were actual house-to-house campaign for retreatment (specially for IP households), retreatment in the target communities by the Community Organizers and with proper timing of activity taking into account the economic activities, weather and other local functions. These same strategies would be continued as further retreatment would be pursued in the second phase of project implementation.

Net Ownership

At the end of Year 2, a total of 275,827 households in the 26 provinces already own an ITN. There are 65,739 remaining households that need to be given bednets. This variance is due to the difficulty in the actual distribution of the nets in some areas. One of the constraints is armed conflicts or peace and order problem within and around the areas, and weather conditions.

With the initial campaign of bednet distribution, there is heightened awareness among LGUs and communities on the importance of treated bednets in the control of transmission of malaria. The completion of distribution in the second phase of the project will ride on this momentum.

Insights and Learnings

Need for careful planning

Careful planning is crucial. Possible and actual constraints to the distribution, treatment and retreatment of the bednets should be considered. It is important that the economic activities, social events and the cultural practices and beliefs of the target populations be factored in during the planning and scheduling of these activities.

The role of the Community Organizers is key to ensuring this. Being the frontliners, they are most familiar with the people's way of life and the community's activities. They would be in the best position to facilitate the planning with the members of the community.

Prioritizing target sites and recipients

There were still some provinces that distributed nets based on equality instead of equity—ie. where there is a greater need for protection and transmission control. Political biases and social considerations influenced the identification of target sites and recipients. This led to inadequate coverage in several areas.

The LGUs and the provincial management teams were reminded to redirect prioritization and distribution of nets to the municipalities and barangays which contribute majority of malaria cases in the province. This should be the basis for identification of distribution sites in the succeeding quarters.

Importance of social preparation and IEC campaign

There should be adequate and timely dissemination of accurate and appropriate information about the importance of the use of insecticide treated nets, the details of the distribution day, and correct process of treating the nets. Missing out on any of the above information was seen to be a factor in the variance in the actual nets distributed using the various subsidy schemes.

The people have to be ready to participate in the activity and more importantly, to practice the desired behavior which is consistent use of bednets. This is also

central to convincing people to have their bednets re-treated during the set time. They will only accept the idea if they know that it will be beneficial to them and if the activity fits into the rest of their priorities.

Willingness of people to invest in their health

The turnout of counterpart collections from the bednet recipients is a clear illustration of how people are willing to invest in their own health. Even if the target populations belong to the lower economic brackets, they still contributed their share in order to avail of a net, knowing that their families will be protected.

Objective 3. To strengthen local capacity for implementation of sustainable community based - malaria control program

Central to the third objective is strengthening the LGU capacity to implement a sustainable community-based Malaria Control Program.

Key strategies include *social mobilization, advocacy and intensified information, education and communication (IEC).* In keeping with their mandate, LGUs may and should implement health programs and provide health services to address priority health problems of their constituents. Since the Malaria Control Program has been traditionally run by DOH, the LGUs lack the capability to manage the program.

At the outset, few LGUs provided support for procurement of antimalarial drugs and other logistical requirements for MCP services. The project aims to lay the foundation for the integration of action plans for Malaria Control into the local development plans of the provinces and municipalities. This way, the operations of the Malaria Microscopy Centers and provision of preventive and curative services will be sustained. Furthermore, the community shall be mobilized for greater participation in the prevention and control of malaria.

Major activities include development of action plans for Malaria Control at the provincial and municipal levels, lobbying for the integration of MCP plans into the LGUs' annual development plans with budget allocation, formation of LGU-NGO partnerships and development and implementation of IEC package.

Number of networks and partnerships involved (public, private, NGOs/CBOs)

A total of 245 beyond the targeted 162 networks and partnerships were established. These project committees are active and functional.

Noteworthy are the outputs of the province of Apayao. To promote the sustainability of the malaria control program, Provincial and Municipal Action Committees were established and Barangay Brigada Malaria was organized.

Formation of Brigada Malaria was approved by all seven local chief executives (LCEs) and all 73 barangay councils. The municipal ordinances approved include preventing sari-sari stores from selling antimalarial drugs, permitting pharmacies to sell antimalaria drugs only to those with prescription and conducting monthly stream cleaning. Barangay resolutions on mosquito net retreatment and monthly stream clearing were likewise issued.

Support for Field Health Workers

The qualitative barometer of established networks and partnerships especially for local government units' (LGUs) support could be gauged by how many project hired personnel were integrated into the LGU work force and how much budget for Malaria Control Program (MCP) was allocated. Table 4 shows that 154 out of the targeted 261 (59%) Medical Technologists and Barangay Malaria Microscopists were absorbed and being supported by the LGUs. However, this level of integration ranged from employment on a casual or contractual basis to or a permanent position in the actual plantilla.

Budget Allocation for Malaria Control Activities

Table 5 shows that a total of Php 6,802,251.00 (USD 121,469) was allocated for malaria control activities by LGUs from the provincial, municipal and barangay level. This amount was spent in support of provision of diagnostic services, commodities and salaries for integrated medical technologists and barangay microscopists in the LGU health personnel.

In Year 1, gathering of baseline data and planning for MCP at all levels was the primary thrust. In Year 2, the organization of management committees and other multi-sectoral partnerships along with the implementation of plans and consolidation of these networks and partnerships were the major outputs.

The second year of project implementation was also a transition period with Year 1 provinces setting the stage for takeover of responsibilities and support by the local implementers. Mobilization of communities was a benchmark to achieve for all 26 provinces. Building of capacities for partners and local organized group was done on varying scales to equip them to manage a sustainable community-based malaria control program.

This could be seen in the province of Cagayan where the support of the Governor and active involvement of the Regional Malaria Coordinator (RMC), Provincial Health Officer (PHO), and the Provincial Health Team Leader (PHTL) is evident. The formation of Municipal Action Committees (MACs), barangay action committees (BACs), and involvement of the Local Health Board (LHB) together with the LCEs has paved the way for activities to be conducted down to the grass roots. Regular and timely coordination and lobbying of health personnel from the province (with support from GFMC Provincial Management Team) down to the municipal and barangay LCEs resulted to the delivery of diagnostic and treatment services for malaria.

The establishment of Malaria Financing Organization in the province of Quirino is a noteworthy effort. Through the coordination of the various offices (PHO, PHTO), this group was organized at the grassroots level with the purpose of resource mobilization for malaria control activities. After obtaining legal recognition from the LGU, this organization embarked on fund sourcing and resource generation activities that would help sustain the health services currently being provided by the Malaria Microscopy Centers; ensure availability of drugs and bednets. Seed money for this would come from the LGU-counterparts and monthly membership dues of community members. This scheme is being piloted in an area, particularly the most endemic. This project had been presented and approved by the Provincial Management Committee (ProvManCom). The organizational structure, policies, and terms of reference have been finalized and disseminated to all concerned. At present, it is recommended that this Malaria Financing Organization be evaluated to determine whether this could be replicated to other areas.

Number of provinces with IEC packages

Health Promotion is a major component of this project. It lends essential support to the first two objectives and facilitates the behavioral changes desired to ensure prevention of the transmission of malaria.

Provinces were expected to develop IEC packages. This consisted of 1) a health promotion plan, 2) development of IEC materials, 3) school-based malaria education, and 4) celebration and institutionalization of malaria awareness campaigns. This led to the recruitment, training and fielding of 1,046 personal sellers (Malaria Advocates).

At the close of Yr 2, 26 provinces had IEC packages although some are considered only in the initial stages especially the Year 2 provinces. Table 6 shows the different activities conducted.

Number of people reached with Behavioral Change Communication (BCC) activities

The different forms of BCC have been employed in the 26 provinces with large turnouts for mass information dissemination activities where 326,621 individuals were reached which was more than the target of 234,508.

Insights and Learnings

The importance of active involvement of the Provincial Health Officer

Outputs have been quite impressive in provinces where the Provincial Health Officer has a good grasp of what needs to be done for MCP and how to mobilize the participation of various partners. The leadership of the PHO, in partnership with the PHTL/Provincial Malaria Coordinator, is essential in the planning, implementation, monitoring and evaluation of activities for MCP. They are the ones who can push the LCEs to put malaria control on their agenda.

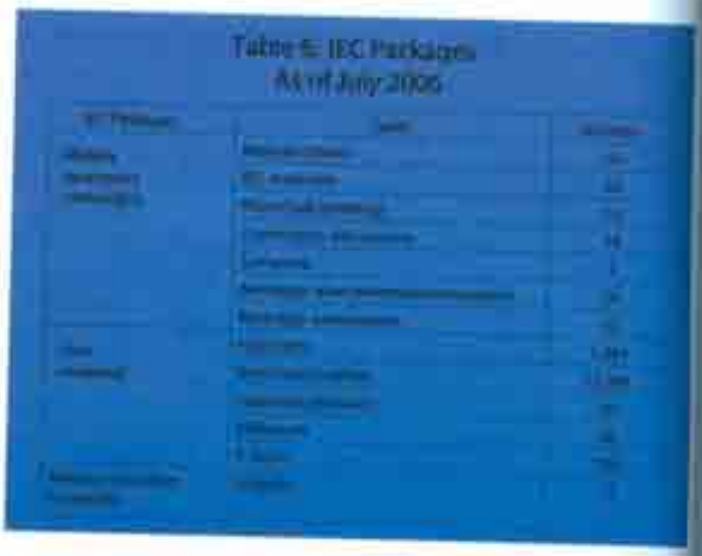
Supportive LCEs spell the difference

Noted all through out project implementation is the positive reception and support of many Local Chief Executives. They initiated the issuance of local ordinances with regard to bednet use and re-treatment, stream clearings, and establishment of microscopy centers. Indeed, there can be no sustainability of initial efforts and investments if the program is not institutionalized in the local agenda.

Community organizing is a major component for sustainability

The frontliners of field operations particularly for the third objective are the field staff workers. The basic tasks of formation of organized groups and 'selling' malaria control as a means to improve quality of life in the communities were taken on by the PMTs and the Community Organizers in partnership with the local health workers. They are the ones who are able to penetrate the remote island and mountain communities to conduct IEC activities and promote the diagnostic and treatment services being made available through the project. The distribution of bednets and facilitation of their retreatment were likewise accomplished through the partnerships established through community organizing efforts. This strategy was also appreciated by the external evaluators and had recommended that capacity building for the staff be pursued.

Table 5. IEC Packages
As of July 2005



Capacity building activities for IEC officers and organized personnel sellers

Equipping IEC officers and personal sellers/advocates is just one among the priorities of the project where effective management and sustainability is concerned. Fora and provincial conferences were conducted intended to assist and provide better appreciate on health promotion and advocacy. Training of local malaria advocates on the basics of communicabon and malaria helped multiply the health educators in the community.

Need to clarify roles and accountabilities in malaria control at various levels

A consistent source of confusion and sometimes conflict, is the unsettled issue of the devolution of the Malaria Control Program to the LGUs. It is stipulated in the Local Government Code of 1993 that LGUs have the mandate and responsibility to implement health programs that address priority health problems in their locality. However, the structures and operations of the Department of Health(DOH) remain the same as far as MCP is concerned. Hence, the LGUs, particularly their respective health offices, have always assumed that malaria control is not their responsibility but that of the DOH. Furthermore, there is a clamor from the LGUs for an official policy on this matter. This would help clarify the terms of reference and pave the way for the relevant stockholders to take on their role and develop community ownership of the project.

Strengthening LGU-NGO partnerships by expanding membership

The management committees or action teams formed at the provincial, municipal and barangay level need to be trained on the various aspects of malaria control and community mobilization. Specific areas for strengthening include knowledge and skills on advocacy, and budgeting processes both in the government sector and private organizations.

The established action committees at various levels may be further strengthened by expanding the membership to include community-based People's Organizations (POs) and non-government organizations (NGOs). This will help ensure that the interests of those at the grassroots level would be represented and even contributions and active participation mobilized. To strengthen these partnerships, regular meetings must be held and periodic activities to help mobilize resources and disseminate information on malaria prevention must be held especially among LGUs for the integration of field health personnel and logistic counterparts.

This should be a major focus of project management in the second phase. The Primary Recipient is developing strategies for advocacy and social mobilization towards sustainability of the project.

When I bid my 3 year old child good-bye that morning, she was inconsolable until I promised I'd be back in 2 days with the largest and prettiest sea shell I can find. A hiccup, a tight hug and I was off to Panglima Tahil. Reports of a malaria outbreak have reached us and the Provincial Health Officer together with the Provincial Malaria Coordinator organized a mission that would assist the Rural Health Unit of Panglima. Aboard a small boat, our team of 5 and the boatman set out for the affected island barangay 3 hours away, together with 3 boxes of drugs, lab supplies, rapid diagnostic kits, insecticides and 2 bales of mosquito nets. The sky was a perfect blue, the sea was calm. I expected a cramped and boring trip so I started to doze off as the 3 chickens, which I believed to be our lunch and dinner, cackled incessantly in the background. Forty minutes later, the sea started to churn. In the beginning, there was only the splashing of water, then, our clothes became soaked. Suddenly, there was water everywhere and we got ourselves busy scooping water out of the boat. We found ourselves collectively saying our prayers aloud as the waves became bigger, the heavens turned dark, the wind howled and our boat was tossed like a toy. Then, there it was, an 8-foot wave looming before us. I closed my eyes and completely surrendered my fate to the Almighty, certain of my death. But it never came. There was only silence which was broken by the chorus of cackling chickens and then there was rejoicing. After what seemed like hours, our boatman was able to steer us close to safe shores. There was jubilation as the villagers met our team and we related the perils we had at sea. We rested for about 30 minutes and then we had to face the tasks at hand. At the end of the day, we were able to examine 142 patients of which 38 were found positive for malaria and who were consequently treated; distributed 200 nets treated with insecticides and 85 families attended the health education class. The villagers also planned how the same situation can be avoided in the future. The next day, as we were boarding our boat dreading our sea voyage, a small girl ran towards us and gave me a large, pretty pink sea shell. I looked forward to coming home.

Community Organizer
Provincial Management Team – Sulu
Global Fund Malaria Component

photograph: Dr. Stephan Rosseau

The Global Fund HIV/AIDS Project in the Philippines

A Year of Challenge — August 2004 – July 2005

Accelerating STI and HIV/AIDS Prevention Through Intensified Delivery of Services to Vulnerable Groups and People Living with HIV/AIDS in Strategic Areas in the Philippines

The Global Fund (GF) AIDS Project "**Accelerating STI and HIV prevention and care through intensified delivery of services to vulnerable groups and PLWHA in strategic areas in the Philippines**" was approved in the 3rd round of proposals for the HIV/AIDS Component. The first phase of this 5-year project has been implemented since August 2004 and will end by May 2006. The activities and events that transpired during its first year of implementation are abridged in this report.

GOAL

The main goal of the GF AIDS project in the Philippines is to contribute to the national goal of preventing the further spread of STI/HIV/AIDS infection and reduce its impact on those already infected and affected. Its specific objectives are categorized under two components: (1) **Prevention** - to improve behavior change communication and STI management among vulnerable and poor population such as people in prostitution (PIPs), men having sex with men (MSMs), and migrant workers in 11 of the 48 identified risk sites and (2) **Care, Support and Treatment** - To scale up voluntary counseling and testing (VCT), support, care and treatment for people living wit HIV/AIDS (PHAs) and their families in four geographic areas (Manila, La Union, Cebu and Davao).

TARGET SITES AND BENEFICIARIES

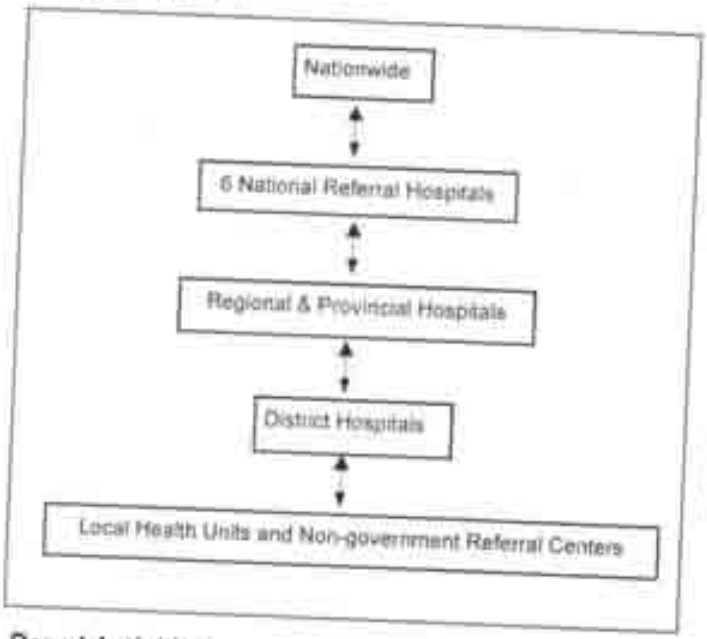
The activities for the **Prevention** component are conducted in the 11 identified risk sites and the **Care, Support and Treatment** component in the six treatment hubs shown in **Figure 1.** It is estimated that the following numbers of beneficiaries are located in the 11 targeted risk sites: People in prostitution (PIPs) - 13, 500; Men having sex with men (MSM) – 5, 500; Injecting drug users (IDU) in two sites - 1, 000; Migrant workers -18, 200. The number of PHAs for 2002 was estimated at 6,000. The achievement of the care objective is expected to lead to better support, care and treatment for 40 percent of estimated PHAs by 2008.

IMPLEMENTATION MECHANISM

Mechanisms for the implementation of the project is through (a) subgranting to NGOs and organized PHA communities; (b) services in Social Hygiene Clinics

(SHCs) of local government units (LGUs) in the 11 project sites, namely: Bauang, La Union; San Fernando City, Pampanga; San Pablo City, Gumaca, Legaspi City; Tabaco, Sorsogon City; Matnog, Mandaue City; Lapulapu City; and Ormoc City; (c) services in identified referral hospitals namely Research Institute for Tropical Medicine (RITM), San Lazaro Hospital (SLH), Philippine General Hospital (PGH), Ilocos Training and Regional Medical Center (ITRMC), Don Mariano Memorial Medical Hospital (DMMMH), DVSMH, Davao Medical Center (DMC); and (d) partnership with LGUs in the project sites.

Area Coverage



Multi-Sectoral Partnership

The project is implemented through a multi-sectoral partnership that involves government agencies including Department of Health (DOH), Department of Interior and Local Governments (DILG), LGUs of the 11 project sites, national and local NGOs, multilateral agencies like UN Theme Group on AIDS (UNAIDS), and World Health Organization (WHO). The Global Fund principal recipient, the Tropical Disease Foundation (TDF) and the sub-recipient which is the Philippine NGO Council for Population, Health and Welfare (PNGOC),works with 18 implementing NGOS: Rotary Club of San Fernando, La Union; ReachOut Foundation, Inc.; Pearl S. Buck Foundation, Inc. (PSPFI); Leyte Family Development Organization (LEFADO); Pinoy Plus Association (Pinoy+); Positive Action Foundation Philippines, Inc. (PAFPI); The Library Foundation, Inc (TLF); Mayon Integrated Development Alternatives and Services (MIDAS); Convergence for Sustainable Human Development, Inc. (CHSDI); Remedios AIDS Foundation (RAF); BIDLISIW Foundation; Free Rehabilitation, Economic, Education, and Legal Assistance Volunteers Association (FREELAVA), Inc.; PATH Foundation Philippines, Inc. (PFPI); Alliance Against AIDS in Mindanao (ALAGAD), Inc; Bicol Reproductive Health Information Network (BRHIN), Inc.; and Media for Development and Integrated Advancement

Broad Activities

The following activities are undertaken to achieve the specific objectives:

Prevention	Care, Support and Treatment
• Social mobilization and advocacy at the national and local levels	• Improvement and expansion of VCT
• Community outreach and education	• Development of partnership mechanisms for care, treatment and support (PHAs, service providers and key stakeholders)
• Capacity building of service providers and vulnerable groups	• Improvement and expansion of clinical services in health facilities
• Improved STI services and surveillance	• Establishment of home and community care
• Strengthening, monitoring and evaluation of interventions	

(MeDIA), Inc. The roles and functions of the partner agencies and their expected/possible contributions to the Global Fund HIV/AIDS Project are as follows:

- **Department of Health**
  - **National AIDS/STDS Prevention and Control Program** (NASPCP)
    - ◊ Technical assistance to and capability building of Six hospitals (Hospital AIDS Network and 11 identified Social Hygiene Clinics (STI- Comprehensive Medicine)
  - **STD/AIDS Cooperative Central Laboratory** (SACCL)
    - ◊ Provide training in STI/HIV for the Global Fund sites (11 risk zones)
    - ◊ Monitor the STI/HIV testing centers
    - ◊ Provide technical assistance in mapping out the capabilities of the testing centers in the 11 project sites
  - **National Epidemiology Center** (NEC)
    - ◊ Coordinate, collaborate, analyze and prepare report to the Philippine National Aids Council (PNAC) on CRIS
    - ◊ Outcome and impact indicators
  - **San Lazaro Hospital** (SLH) & **Research Institute for Tropical Medicine** (RITM)
    - ◊ Provide technical assistance in the development of clinical practice guidelines
    - ◊ Act as trainers
    - ◊ Design training programs on counseling, medical Mx and lab Dx
    - ◊ Design and implement counseling and support / prescription (Rx) programs
  - **Centers for Health Development** (CHDs) I, II, III, IV, V, VII, VIII and IX
    - ◊ Coordinate with and provide technical assistance to LGUs and NGOs involve in the project
    - ◊ Assist in the promotion of VCT
    - ◊ Monitor medical support and services rendered to patients
    - ◊ Assist in project monitoring and evaluation
- **Philippine National AIDS Council (PNAC)**
  - ◊ Assist in the coordination with the multi-sectors, especially the members of PNAC
  - ◊ Provide assistance in advocacy
  - ◊ Assist in project monitoring and evaluation
- **Department of Interior and Local Government (DILG)**
  - ◊ Assist in the coordination with local chief executives (LCEs) with help from DILG regional, provincial, city municipal offices
  - ◊ Provide assistance in advocacy
  - ◊ Provide political inputs
  - ◊ Assist in project monitoring and evaluation
  - ◊ Conduct advocacy and social mobilization activities including the establishment of Local AIDS Councils
  - ◊ Provide medical and counseling services to target clients
  - ◊ Assist in the promotion of VCT
  - ◊ Coordinate with local NGOs involved in the project
- **World Health Organization (WHO)**
  - ◊ Provide technical support in training, advocacy, planning HIV/AIDS program on condom use, care and support, prevention, surveil-

lance, monitoring and evaluation

- ◊ Provide available reference materials
- ◊ Technical support in terms of planning, proposal writing and review
- ◊ Assistance in procurement of drugs and commodities
- ◊ Training/fellowship through DOH biennium funds based on priority identified by DOH

- **United Nations Theme Group on HIV/AIDS**
  - ◊ Provide technical assistance

- **Non-Government Organizations (NGOs)**
  - ◊ Conduct outreach education and communication activities among target beneficiaries
  - ◊ Conduct advocacy and social mobilization activities
  - ◊ Provide services for voluntary counseling and testing (VCT)
  - ◊ Submit regular reports on project activities
  - ◊ Assist in monitoring and evaluation

Benefits to the LGUs, local NGOs and Target Clients

Prevention of STIs and HIV/AIDS is a good governance practice endorsed and supported by the United Nations and the national government. The local health system will gain indirectly in capacity building and system improvement that are geared to ensure long term project sustainability of appropriate health services. The PNGOC-GF AIDS Project will provide the LGUs and local NGOs with appropriate capability enhancement trainings on behavior change communication and care, support and treatment. It will also help strengthen their health facilities (Social Hygiene Clinics and selected hospitals).

Care and Support activities have enhanced improvement and expansion of voluntary counselling and testing; development of partnership mechanisms involving the positive community, service providers and key stakeholders, improvement and expansion of clinical services on HIV/AIDS care and treatment in health facility, and establishment of home and community care for PHAs - including educational activities. The PHAs can now avail of ARVs and drugs for STIs and opportunistic infections. They now avail of community-based treatment including palliative care.

PHILIPPINE ZONES AT RISK OF HIV/AIDS

A baseline study was initially conducted to collect qualitative and quantitative data from 11 zones that were identified as at risk of HIV infection by the Philippine National AIDS Council. These zones were classified into three clusters. The first cluster included those located in northern,central and southern parts of Luzon, namely Bauang municipality in La Union, San Fernando City in Pampanga, San Pablo City in Laguna, Gumaca municipality in Quezon. The second cluster included areas found in the Bicol region - Legazpi City,Tabaco in Albay, Sorsogon City and Matnog municipality in Sorsogon. The third cluster was in the Visayan islands and these included the cities of Lapulapu and Mandaue in Cebu province, and Ormoc City in Southern Leyte.

The research focused on the policies and programs of the local government units regarding STIs/HIV/AIDS, the prevalence rate of the foregoing diseases, the government(GO) and non-government (NGO) health services and facilities for STIs/HIV/AIDS, the number of people living with HIV/AIDS (PLHA) who received support, care and treatment from GO and NGOs, and the sexual establishments as well as cruising places for

prostitution. Key informant (KI) interview, records and document review, observation of the sexual establishments and cruising sites for prostitution, and personal interview survey were the research methods used for the study. A total of 102 key informants were interviewed from the 11 zones. These included local government executives, members of health committees/ local health board, health providers, and recruitment agency personnel. The survey which utilized non-probability particularly purposive sampling design, covered a total of 1,726 respondents—708 (266 registered and 442 freelance) women in prostitution (WIP), 222 men who have sex with men (MSM), 50 injecting drug users (IDUs), and 746 overseas Filipino workers (OFWs).

The survey covered a description of their profiles, use of prohibited drugs, sexual activities with regular and non-regular sexual partners in the past three months, condom use, STI experiences and treatment-seeking behavior, knowledge about HIV transmission, and sources of information about HIV. Additional data were collected from the OFWs particularly their receiving countries, occupation, participation in the pre-departure orientation seminar, problems met abroad and in the Philippines, and the methods that they had used to protect themselves from STIs and other problems.

Baseline Study Findings

A majority of the local government officials from the eleven zones were aware of RA 8504 or the Philippine AIDS Prevention and Control Act of 1998. Six zones have supported RA 8504 by formulating local ordinances mainly on the compliance of the WIP for regular medical check up at the local public health facilities. Only Bauang municipality has a local AIDS Council. The municipality of Matnog has recently passed an ordinance creating a municipal AIDS Council. Three zones have allotted funds for STI services-- Lapu-lapu City earmarked P250,000 for the improvement of its social hygiene clinic. It, however, relies on the city health office (CHO) to undertake programs on HIV/ AIDS promotion. The municipality of Bauang allocated a total of P700,00 (P300,000 in 2003 and P400,000 in 2004) for programs/projects that support RA 8504. Ormoc City has budgetted P50,000 for medicine, blood examination and information drive for STI/HIV/AIDS.

Health Facilities

In terms of public and private health facilities for STI/HIV/AIDS present in the 11 zones—only the cities of Legazpi and Mandaue have the following: RHU/CHO/ MHO, a government hospital, a social hygiene clinic, a private hospital and private clinic. Nine zones have social hygiene clinics. The same number of zones have rural health units/city health office/municipal health office (RHU/CHO/MHO) that also provide STI/HIV/ AIDS services. Four cities have government hospitals—San Pablo, Legazpi, Lapu-lapu, and Mandaue. Only three cities (Legazpi, Lapu-lapu, and Mandaue) have private hospitals that provide STI services. Only the municipality of Gumaca and the cities of Legazpi and Mandaue have private clinics which provide and STI/HIV services.

One of the NGOs during the World AIDS day celebration

All social hygiene clinics (SHC) or RHU/CHO/MHO that provide STI services have physicians public health nurses who have undergone some training on STIs/ HIV/AIDS. Not all SHCs, however, have all the other types of health personnel. Only nine have medical technologists while six have sanitary inspectors. Four SHCs have midwives and four have laboratory technicians or microscopists. The training received by health providers from five zones were on STI syndromic management. Only two zones have health providers who have had comprehensive training on STI/HIV/AIDS. The key informants from the health facilities have expressed the need for training on STI/HIV/AIDS prevention, management and counseling for their current staff.

All the 11 zones' health facilities do not provide HIV antibody testing service. The STI services provided by the health facilities are mainly Smear and Gram stain tests, diagnosis and treatment of STI. Counseling is

provided in nine zones usually by the doctor. Other services given by one half of the zones' health facilities include the provision of information materials, health education about the diseases, referral of patients to other health institutions, individual and group counseling. Only the cities in Cebu link up with local NGOs that provide STI/HIV/AIDS counseling services.

In general, the various zones do not have all the 20 basic equipment of a social hygiene clinic. Bauang, Gumaca, and Matnog municipalities do not have these equipment in their health facilities. Tabaco City whose social hygiene clinic received support from Japan International Cooperating Agency (JICA) for the improvement of its STI services and facilities, has the most number of equipment (13 out of 20). The other large cities have one half or few of the basic SHC equipment.

Disease Prevalence

Although the zones' health facilities recorded STI cases in the past year (2003) and in the past eight months of 2004, the number of cases varied. Large cities particularly Legazpi, Tabaco, Lapu-lapu and Mandaue have recorded the most number of clients. San Pablo City has no data in 2003 and has recorded few cases in 2004. Sorsogon, Matnog, Ormoc, and Bauang have reported few STI cases in the past two years. No data were obtained about the specific types of STIs of the recorded cases and information about the clients' occupation. There are no prevalence rates of STI/HIV in the various zones. There are also no services from the GOs and NGOs for people who are living with HIV/AIDS (PLHA).

Less than 10 per cent of all the WIP, MSM, and IDUs said that they have experienced abnormal discharges or sores in their sexual organs. Two fifths of those who had STIs consulted government health facilities.

Cruising Areas and Target Clients

Videoke bars and restaurants are the most common sexual establishments in all the eleven zones. Selected streets and barangays are the second most popular cruising areas especially for freelance WIP. Other places include port area, bus stations, malls, town plaza, public market and schools.

The survey findings show that a majority of the WIP, MSM and IDUs are single and in their twenties while the OFWs are mostly married and older usually in their thirties. The majority of the respondents are out of school and they have had formal, mainly secondary education. OFWs have more collegiate education than the other vulnerable populations.

The OFWs have worked mainly in the Middle East and East Asia. About one half of the male OFWs worked in the Middle East and the same proportion of women went to East Asia, mainly to Japan. Two fifths of the female OFWs worked as domestic helpers while less than one third are entertainers. One tenth are health professionals. About a quarter of the male OFWs, on the other hand, are seafarers and the same proportion are construction workers. About one tenth are service workers.

A majority of the OFWs claimed that they have not encountered problems while working abroad. About one fifth of the women, however, disclosed that they had experienced maltreatment from their employers and from others. Less than one fifth of the men reported that they were maltreated. One tenth of the men expressed difficulties in having multiple sex partners. Few women, however, experienced the foregoing problem. Sexual abuse and STIs were experienced by few male and female OFWs. A majority of the OFWs have attended Predeparture Orientation Seminar (PDOS) but a large proportion did not recall that they had HIV/AIDS topic in their orientation seminar. Except for the IDUs, about one fifth of the WIP and MSM have tried drugs in the past six months. Few have used injecting drugs. Close to two thirds of the IDUs have shared their equipment with others. About one half claimed that they had these cleaned prior to usage.

Condom Usage

A majority (87.2%) of the respondents have had sex in the past six months. Over one half reported that they had never used condoms in the past three months. About a quarter said that they sometimes used condoms and only one tenth said that they always did. The WIP had an average number of three sexual partners in the past week. MSM, on the other hand, had slightly more sexual partners in the past month. Over one third of the WIP and close to one fourth of the MSM have regular male sexual partners. The mean number of their regular partners is 1.3. The WIP have more paying regular partners than the MSM. Close to three fourths did not use condoms with their regular sex partners.

Over one fifth of the WIP and over one third of the MSM have non-regular sex partners. Their mean number of non-regular partners is 1.9. The MSM have more non-regular sexual partners than the WIP. The WIP, however, have more paying non-regular sexual partners than the MSM. The majority of both types of respondents did not use condoms the last time they had sex with their non-regular sexual partners. About two fifths of all the sexually- active WIP and MSM have both regular and non-regular sexual partners.

Knowledge, Attitudes and Practices

Eight statements about HIV transmission were read to the respondents to determine their level of knowledge. Over one half of the respondents have a low level of knowledge regarding HIV transmission. About one third have moderate level of knowledge and over one tenth have high level of knowledge. A majority of the WIP and MSM, and less than one half of the IDUs have low knowledge level. The OFWs have the highest level of knowledge among the four categories of respondents.

Among the 11 zones, San Fernando City, Gumaca, and Bauang had the highest proportion of respondents with low levels of knowledge of the disease transmission. Sorsogon City, on the other hand, has the lowest proportion of respondents with low level of knowledge while Ormoc City has the most number of respondents with high knowledge level.

There appears to be no difference in the level of knowledge with condom use. A majority of the respondents with low, moderate and high knowledge of HIV transmission were never users of condoms in the past three months. A large proportion of the respondents (from one third to close to one half) continue to have incorrect knowledge about HIV transmission particularly about having a good diet as preventative of HIV, and the acquisition of HIV from public toilets, from sharing food with an HIV-infected person, and from mosquito bites.

The majority said that they were able to get information about HIV mainly from television and health providers. These two sources of information were also perceived as the most credible by the respondents. If they would have signs and symptoms of HIV, the respondents said that they would consult a medical doctors and they would go to the hospital.

With the use of two indicators of sexual risk—never used condoms in the past three months and low level of knowledge of HIV transmission—the study attempted to identify the zones that are of greater risk than the others.

When the WIP, MSM, and OFWs' scores to the above indicators were computed and ranked, the results showed that the most risky of the 11 zones is the municipality of Bauang and the least risky are the cities of Tabaco and Mandaue. Among the three clusters, it appears that the other Luzon areas are the most risky, followed by the Visayas and the Bicol area. While all zones in the other Luzon cluster zones are found as the most risky areas, the other two clusters have zones which tend to be more risky than the other zones within each cluster. For example in the Visayas, Ormoc held more risky status than the cities of Mandaue and Lapu-lapu. Matnog often deviated from the least risky positions of the other three cities in Bicol.

When the scores of the WIP of the different zones were compared, it appears that the WIP of Matnog have the most risky status while the WIP from Mandaue, Lapu-lapu and Tabaco are the least risky WIP.

When the scores of the MSM from the 11 zones were compared, the rank has changed. San Fernando City's MSM turned out to be the most risky while Bauang, surprisingly have the least risky MSM. One possible explanation for the situation in Bauang is the presence of a NGO that provides STI/HIV/AIDS information and services for MSM in this municipality.

When the scores of the OFWs from the different zones were compared, Legazpi was not included because close to one half of its OFWs did not answer the question about condom use. The most risky OFWs among the 10 zones are in Lapu-lapu City followed by Bauang, and San Fernando City. The least risky are found in Mandaue, followed by Tabaco, and then by Matnog OFWs. A possible explanation to why Lapu-lapu City has the most risky OFWS may be associated with the fact that more than two fifths of the survey respondents were seafarers who did not use condoms in the past three months.

PROJECT OPERATIONS

During the initial phase of the project, the GF-AIDS Technical Working Group (TWG) was created from the AIDS Project Coordinating Group (APCG) which is a bigger body with multi-sectoral constitution. The mem

World AIDS Day ,1 December 2004

bers of the AIDS-TWG were composed of representatives of the following institutions/organizations: PNAC, DILG, NASPCP, NEC, SACCL, SLH, RITM, Pinoy+, TDF, PNGOC, WHO, UNAIDS, USAID.

Operations Planning

A **National Operations Planning** was conducted from 9-12 August 2004. The Project Manual of Operations was developed jointly by members of the TWG. There were 19 prevention, care and support projects by NGOs in the 11 project sites and treatment hubs. Implementation systems and mechanisms were established. A **Project Proposal Writeshop** for NGOs was then conducted at the Pearl Manila Hotel from 19-23 September 2004, participated by 15 NGOs including 2 PHA self-help groups. A **Project & Fund Management Workshop** for NGO Partners was part of the groundwork where prospective NGO Implementers were trained on programmatic & financial management at the Oasis Hotel, Angeles City from 11-15 October 2004. **Cluster Operations Planning Workshop** for Visayas & Mindanao was conducted at the Garwood Park Hotel, Cebu City from 28 – 30 October 2004. Dr. Pilar Jimenez, principal investigator for the baseline study for the HIV/AIDS project sites presented the findings to the participants of this workshop.

Capacity Building

A major undertaking of the project was capacity building of service providers. Several trainings were conducted for government personnel and NGO project staff and volunteers.

- ***Government personnel***
  - *Comprehensive STI training including VCT* for SHC personnel (30 pax from 9 sites comprising of 12 MDs, 10 RNs, 8 MTs)
  - *Sentinel STI Etiologic Surveillance System (SSESS)* training (2 batches)
  - *HIV proficiency training for 10 SHC Medical Technologists*
  - *Integrated HIV Behavioral and Serologic Surveillance System (IHBSS)*
  - *Training on the use of the Country Response Information System (CRIS) software*

Training of 69 medical health professionals (Physicians, nurses, medical technologists) who are members of the HIV/AIDS Core Teams (HACT) of the 6 treatment hubs and 21 satellite hospitals all over the country and 3 non-medical professionals from NGOs (Social workers and psychologist) Participants were given comprehensive HIV/AIDS Clinical Management training.

- ***NGO project staff and volunteers***
  - *Training of project staff in 11 project sites on project and fund management*
  - *Training of Peer Educators per target clientele* in 11 project sites

NGO Activities

The first **Symposium on STI/HIV/AIDS for Migrant Workers** sponsored by the Global Fund AIDS Project was held at the Golden Valley Hotel, Cebu City October 27, 2004 where participants were given the global & national situation on HIV/AIDS, basic information on STI/HIV/AIDS & how it relates to their personal lives as migrant workers.

PROJECT IMPLEMENTATION REVIEW

An Annual Partners' Meeting was held last 25-28 July 2005 at the Heritage Hotel, Pasay City. Each project site presented its accomplishment report covering the first year period. The reports were consolidation of both LGU (CHO/SHC) and NGO accomplishments in the project sites and vis-a vis the targets of the Global Fund AIDS project. Thus the partners within each project site consulted and worked together way in advance to put together the joint report.

A total of 105 participants, guests and members of the working group attended the First Annual Partners' Meeting for GFTAM-AIDS Project which was held in cooperation with the Department of Health (DOH), the Tropical Disease Foundation Inc. (TDF), the Philippine NGO Council on Population, Health and Welfare (PNGOC), the Philippine National AIDS Council (PNAC) and the various partner NGOs and local government units (LGUs) in at least twelve (12) sites in the Philippines.

During the opening program, USEC Benjamin de Leon, Chairperson of PNGOC, gave the welcome remarks. He mentioned, "this would be the best time to revisit the project of GFATM and look at how the projects were implemented and how they could be implemented more effectively in the following year." PNGOC Executive Director Dr. Eden Divinagracia introduced the participants to the meeting who came from the target areas. Guests from other support agencies such as the World Health Organization (WHO) and the USAID were also represented during the meeting.

Dr. Thelma Tupasi, President of TDF, highlighted the background of how TDF became the principal recipient of GFATM. As a financial instrument facilitated by the UN to fight TB, malaria and HIV/AIDS, the GFTAM was a result of the militant campaign of activists in HIV/AIDS. It intended to highlight the importance of public-private partnerships in project implementation. The project was initiated/facilitated by DOH with the intention of providing funds to a private foundation that could work together with the department in the implementation stages. Partnership between the government sector (DOH and LGUs) and all relevant NGOs in the communities was the essence of the project. Dr. Tupasi noted that while the prevalence and incidence of HIV/AIDS was one of the lowest and slowest in the Asia-Pacific region, there should be continuing efforts to prevent an upsurge. "Education, especially for the high-risk groups, is key to prevention. The challenge, therefore, is for partners to work out the best possible way to prevent another upsurge and increase in incidence rate."

Ms. Irene Fonacier-Felizar, Executive Director of Lunduyan Inc. delivered the keynote address with the following highlights: "The AIDS proposal for Global Fund started in the womb of the Philippine National AIDS Council. The conception process went on naturally. There were tough periods when it was at the conception stage and tougher even when it reached the implementation stages. First, the main challenge was unavailability of baseline data. There were many population groups that we wanted to assist but the lack of data became a hindrance. Hence, the question: are you building that body of knowledge now? Second challenge was the sources of data. We do not know

who has this information? Are we doing that part now? The third challenge was the Global Fund theme which changes every year. Thus, if we were caught unready to provide the information required by the funding agency, we would be left out without support. GF Phases 1, 2 and 3 was implemented in a scenario of "low and slow." We are still watching out for GF Phases 4 and 5. Now that we are on our first year, we have to see this project on our full term – up to the fifth year. Our experiences now should be fed to others who could get lessons, advise, etc., so we can ensure the achievement of targets and a significant level of success. We may need to implement changes. Give PNAC a chance to support your projects, too. In order to generate results beyond the Fund, PNAC could help secure funds and support (from other sources) and, together, we will secure the future."

Status of HIV/AIDS in the Philippines. Dr. James Piad, Medical Specialist IV at PNAC Secretariat presented the status of HIV/AIDS in the Philippines. He noted that the first case of AIDS was documented in 1984 and as of June 2005, a total of 2,295 (30% AIDS, 70% asymptomatic) cases were recorded. It was in 1986 when HIV/AIDS was declared a notifiable disease and the Philippine government's responses started in 1987 with activities such as the DOH AIDS registry, information campaign at DECS, a DOH counseling hotline and the National Sentinel Surveillance in 1989. By 1993, the total number of cases was recorded at 102, with 11 deaths already occurring during the same period. In the same year, STD control was integrated in the program, a Medium Term Plan was formulated in the following year along with the organization of Pinoy Plus. The Philippine HIV/AIDS strategy was formulated in 1995 and as new cases were recorded, other government agencies such as DECS, now DepEd, started the HIV/AIDS education and incorporated this in formal and non-formal education programs. This was followed by DILG and DFA. By 1997, other foreign-assisted programs were also implemented and STD/AIDS became one of the priorities at DOH.

Dr. Piad highlighted the Philippines' responses which included the following: a) enactment and popularization of RA 8504, b) production and development of various manuals, information, education and training materials for different target groups, c) active involvement of the DILG and support for local government initiatives, d) involvement of the Philippine National Police, e) production of handbook for CHED, and f) various training programs for caregivers, medical technologists, men in uniform, OFWs and medical clinics for OFWs, embalmers, and other relevant sectors. The early part of 2000 saw Congress conducting hearings on the implementation of RA8504 and the active involvement of POEA for education and orientation programs for OFWs. As of June 2005, the number of cases reached 2,295 and more activities for HIV/AIDS prevention and control would be expected in the future. The DOH allocated some Php20 Million for ARV and drugs for OIs and a

INTERNATIONAL AIDS CANDLELIGHT MEMORIAL

review of RA8504 was being undertaken.

Status of the Global Fund AIDS Project in the Philippines. Dr. Roderick E. Poblete, Medical Specialist IV, PNAC Secretariat presented the status of the first year of implementation of Global Fund AIDS Project in the Philippines. Dr. Poblete cited the accomplishments of the project for the first year. Dr. Poblete noted that GFATM's grant fund was US$5.5 Million over a five-year period. The challenge now would be for partners to make an impact on the first two years of the project so that the group could get funds to implement until the fifth year. Actual accomplishments per site would be presented by each partner in the succeeding sessions of the meeting. In addition, Dr. Poblete explained that each local government policy would definitely need supporting data in order to generate action from the municipal or city council, which could eventually enact a local ordinance.

Project Site Reports

For **Prevention Component**, the partner organizations presented their accomplishments per project indicator per NGO partner for each target site of the GFATM. Among the issues raised were: absence of clear guidelines as to responsibilities of CHO & NGO partners relative to the reporting system; recurring concern of drug abuse among FSWs, need to intervene for the minor MSMs; and the uncertainty of LGU support.

The **Care, Support and Treatment** component of the program was developed based on the trend of HIV/STI statistics, dwindling resources of government and private sector, rapid turnover of health personnel and the Medium-Term Plan for HIV/AIDS control in the Philippines and RA 8504. The activities of this component were thus focused on: a) technical assistance for sub-national programs, b) technical collaboration for program development, c) technical consultancy, and d) support to operations.

The care and treatment response for PWLHAs included ARVs, OIs, STI drugs, palliative care, VCT, community-based treatment, care and support. The national coverage of the program was rooted at the communities through the local health units and the non-government referral centers, then to the district hospitals, the regional and provincial hospitals, and the six national referral hospitals. The following plans and strategies were adopted: a) to sustain the responses in this area with continuous advocacy to the local stakeholders, b) to strengthen the current local AIDS structure to provide them capacity to respond to HIV/AIDS and allow the efficient use of their own resources, c) to expand and build the scope of local HIV/AIDS response, and d) to expand implementation of areas newly mapped out with increased groups practicing high-risk behaviors.

The **Harm Reduction Program for Injecting Drug Users** was highlighted by Dr. Carmina Aquino, Executive Director of PATH Foundation Philippines Inc. Dr. Aquino provided a background and history of IDUs in the Philippines, the harm reduction concept in HIV/AIDS and past activities conducted in connection with this program. The harm reduction program was brought to the attention of health sector leaders in the late 1980s. Because of the risky behavior of IDUs, the threat of HIV/AIDS and other blood borne diseases, several organizations became involved in this program in 1995. In the Philippines, there were three lead NGOs, the ASEP, USPF and Kabalikat. Similar efforts were being done in Nepal during the same period. Target sites for the Philippines were Cebu, Marikina, Tondo and Cubao. Later, the cities of Davao, Gen. Santos and Zamboanga were included.

The program included the following: a) comprehensive education, b) limited needle exchange program, c) harm reduction program on-and-off, and d) LGU/CHO cooperation. The major issues addressed by the program were: IDUs being marginalized and IDUs with poor access to formal health services and information. As such, unsafe injecting practices exposed IDUs and their significant others to drug related harm such as HIV and other blood related diseases. Dr. Aquino explained that a community outreach peer education integrating limited needle/syringe program encouraged IDUs to reduce the practice of unsafe injecting and sexual behaviors. At the same time, PEs mobilized them to link with an STI referral network. The presentation also highlighted some issues relevant to the Comprehensive Drug Act and nubain as the most widely used/abused by IDUs. The program was designed to be for prevention and control of health consequences associated with unsafe injecting and sexual behavior practices. As such, the view on drug use was in terms of being a public health issue rather than a law and order issue.

For the GF AIDS project the objective of the HRP for

M and E Training (January 21, 2005) Country Response Information System training conducted by UNAIDS Consultants, Dr. Matthew Cooke and Dr. Martin Filko

Is this an impossible dream? Not at all. Over the last year, dramatic changes have shaped our view of the possible."

- Dr. Peter Piot, UNAIDS Executive Director, in KEEPING THE PROMISE: Summary of the Declaration of Commitment on HIV/AIDS, UNAIDS, 2002.

IDUs was "to improve behavior change communication and STI management among IDUs." At the end of the project the outcomes would be: a) increased proportion of IDUs with HRP information, b) decreased proportion of IDUs who share injecting equipment, c) increased proportion of IDUs using condoms in the last high-risk sexual encounter, d) increased proportion of IDUs who can cite at least two acceptable ways of protecting themselves from HIV/AIDS/STI infection. To achieve these, the activities included: preparing community and gathering support, and community outreach peer education program.

For the needle syringe program, Dr. Aquino explained that the primary objective was to ensure that sterile injection equipments were used with every injection to break the chain of transmission of HIV and other blood borne infections. Based on a knowledge and means approach to behavioral change, people should be provided with information about the changes needed and with the means to make these changes. Under this program, sterile syringes and other "works" for administering drugs, and condoms should be provided. A provision for distribution and collection and disposal should similarly be included.

GFTAM's Monitoring and Evaluation System

Mr. Joel Atienza mentioned that the NEC's commitment to the GFTAM project included: (a) measuring impact indicators through the Serologic Surveillance and Sentinel STI Etiologic Surveillance; (b) measuring outcome indicators through the HIV Behavioral Surveillance; and (c) monitoring progress of project through the Country Response Information System (CRIS). Mr. Atienza presented the GFTAM's impact and outcome indicators that form the core of the project's monitoring and evaluation system. He cited that the GF's set of indicators would focus on certain aspects depending on the level of the project. Specifically, Level 0 of the project would focus on activity indicators, Level 1 would focus on people trained, Level 2 would focus on service points supported, and Level 3 would be on people reached. Figure 10 shows the project targets and accomplishments from August 2004 to July 2005. The following Tables 7 to 9 present a summary of the output and impact indicators for the project.

Figure 10: Targets vs. accomplishments August 2004 to July 2005

Cumulative progress to date

Objective 1	**To improve behavior change communication & STI management among vulnerable groups**			
SDA 1	**Other: Intensify social mobilization and advocacy campaign**			
Indicator 1		**Target**	**Actual**	0 % 50 % 100 % 150 %
Level 0-Process/Activity Indicator	Number of consultative meetings organized	320	323	100%
Level 0-Process/Activity Indicator	Number of sites with local HIV/AIDS policies	5	5	100%
Level 0-Process/Activity Indicator	Number of dissemination forums conducted	32	32	100%
Level 0-Process/Activity Indicator	Number of sites with at least 2 special events & other advocacy activities	11	11	100%
Level 2-Service Points supported	Number of self help groups organized	18	24	133%
Level 3-People reached	Number of people involved in self-help groups	100	129	129%
SDA 2	**Outreach and education activities**			
Indicator 1		**Target**	**Actual**	0 % 50 % 100 % 150 %
Level 2-Service Points supported	Number of IEC & training materials produced	449552	382552	85%
Level 0-Process/Activity Indicator	Number of learning group session held	1508	1643	109%
Level 3-People reached	Number of Migrant workers reached by prevention service	3579	4548	127%
Level 3-People reached	Number of condoms distributed	1785456	1335586	75%
Level 3-People reached	Number of PIPs reached by prevention services	4797	5941	124%
Level 3-People reached	Number of MSMs reached by prevention services	2930	4248	145%
Level 3-People reached	Number of IDUs receiving harm reduction interventions	800	800	100%
SDA 3	**Other: Build capacities of service providers, peer educators, community health outreach workers**			
Indicator 1		**Target**	**Actual**	0 % 50 % 100 % 150 %
Level 1-People trained	Number of trained service providers, peer educators & CHOWs	839	1174	125%
Level 0-Process/Activity Indicator	Number of visits & meetings conducted with peer educators	881	1692	137%
SDA 4	**Other: Improved STI services**			
Indicator 1		**Target**	**Actual**	0 % 50 % 100 % 150 %
Level 2-Service Points supported	Number of sites with basic lab facilities on STI services	11	11	100%
Level 2-Service Points supported	Number of sites with adequate inventory of STI drugs	11	11	100%
Level 3-People reached	% people diagnosed given standard STI treatment	24	0	0%
Level 2-Service Points supported	Number of sites with at least 2 health care providers trained on STI	11	11	100%
Level 1-People trained	Number of trained peer educators handling counseling on STIs	360	91	25%
SDA 5	**Other: Strengthen monitoring and evaluation mechanism for tracking progress in implementation**			
Indicator 1		**Target**	**Actual**	0 % 50 % 100 % 150 %
Level 1-People trained	Number of sites with at least 2 staff trained on M & E	11	11	100%
Level 0-Process/Activity Indicator	Number of dissemination forums conducted	20	20	100%
Level 2-Service Points supported	Number of sites equipped & connected for M & E	11	11	100%
Level 0-Process/Activity	Number of sites submitting reports on time & validated	11	11	100%

Targets vs. accomplishments August 2004 to July 2005

Objective 2	To scale up VCT, support, care & treatment for people living with HIV/AIDS (PLHAs) & their families in 4 geographic areas			
SDA 1	Other: Improvement and expansion of VCT			
Indicator		Target	Actual	0 % 50 % 100 % 150 %
Level 1-People trained	Number of staff trained on VCT (Basic & advanced training)	195	139	71%
Level 2-Service Points supported	Number of sites offering VCT	17	17	100%
Level 0-Process/Activity indicator	Number of advocacy meetings conducted	72	53	74%
Level 3-People reached	Number of HIV+ cases referred from VCT sites to 8 hospitals for treatment and care	140	25	18%
Level 2-Service Points supported	Number of IEC materials on VCT developed	1	5	500%
Level 2-Service Points supported	Number of IEC materials on VCT distributed	15000	200	1%
Level 0-Process/Activity indicator	Number of learning group sessions on VCT & care conducted	35	51	146%
Level 3-People reached	Number of people receiving counseling and testing	300	45	15%
SDA 2	Other: Development of partnership mechanisms for care, treatment & support involving the positive community, service providers and key stakeholders			
Indicator		Target	Actual	0 % 50 % 100 % 150 %
Level 3-People reached	Number of positive people who are actively involved in PHA groups	125	140	112%
Level 0-Process/Activity indicator	Number of local governments allocating budgets for care & support	2	1	50%
Level 3-People reached	Number of people who receive care & support through PHA care sites	239	342	143%
SDA 3	Other: Improvement and expansion of clinical services on HIV/AIDS care and treatment in health facilities			
Indicator		Target	Actual	0 % 50 % 100 % 150 %
Level 1-People trained	Number of service providers trained on HIV/AIDS care and treatment in health facility	69	108	157%
Level 0-Process/Activity indicator	Average percentage of time out of stock for indicator drugs	70	22	31%
Level 2-Service Points supported	Number of health facilities implementing universal precautions	17	17	100%
Level 3-People reached	Number of people receiving prophylaxis & treatment for opportunistic infections &/or ARV	120	46	38%
SDA 4	Other: Establishment of home and community care for PLHAs including educational activities			
Indicator		Target	Actual	0 % 50 % 100 % 150 %
Level 3-People reached	Number of people who received home visits through peer support networks	113	122	108%
Level 1-People trained	Number of people from affected families & community-based care givers trained	150	139	93%
Level 0-Process/Activity indicator	Number of community based organizations actively mobilized for care & support	24	26	108%

Table 7. Expected Results: Impact Indicators

Impact Indicators	Baseline (2002)	Target (2008)
HIV prevalence among vulnerable groups (PIP, MSM, IDUs & Migrant Workers) in the 11 targeted sites Interviewed	<1%	<1%
STI prevalence among the 11 targeted sites	Gonorrhea (24%) Syphilis (7%) – data from WHO/ WPRO/DOH consensus report in 3 cities)	Reduce by 50%
Percentage of PLHAs receiving adequate support, care & treatment	4%	40% of estimated PLHAs

Table 8. Outcome Indicators: For improved BCC

Outcome Indicators	Baseline	Targets			
	Year 1	Year 2	Year 3	Year 4	Year 5
Number of STI cases treated (trend is expected to reduce over time because of condom use)	3,240	2,835	2,430	2,025	1,620
% of condom use among vulnerable groups	RFSW: 40% FLSW: 25% MSM: 14% IDU: 5%	RFSW: 50% FLSW: 35% MSM: 24% IDU: 10%	RFSW: 60% FLSW: 45% MSM: 34% IDU: 15%	RFSW: 70% FLSW: 55% MSM: 44% IDU: 20%	RFSW: 80% FLSW: 55% MSM: 54% IDU: 25%
Proportion of IDU who shared injecting equipment	80%	70%	60%	30%	20%
No. of MSM reached with targeted HIV/AIDS intervention	1100	2200	3000	4000	5500
Improved knowledge of migrant workers on STI/HIV/ AIDS	30%	50%	60%	70%	80%
Number of LGU complying with RA 8504	0	4	7	9	11

Table 9. Outcome Indicators: For care and support

Outcome Indicators	Baseline	Targets			
	Year 1	Year 2	Year 3	Year 4	Year 5
Percentage of PHA receiving adequate support, care and treatment in 4 geographic areas	4% of estimated no. of PHA	10% of estimated no. of PHA	20% of estimated no. of PHA	30% of estimated no. of PHA	40% of estimated no. of PHA

Issues Raised / Problems Encountered

There was a delay in the delivery of Antiretrovirals (ARVs), drugs for opportunistic infections and other reagents and this posed as a problem in program implementation. One important target indicator for Year 1 (Patients given ARVs/drugs for OIs) was not achieved because of unavailability of drugs. The ARVs and OI drugs arrived only in August 2005 (beginning of Year 2).

There were several reports of fast turn over or dropping out of peer educators which has an overall effect in the implementation of activities such as peer education and learning group sessions among target groups. This problem was actually expected considering the mobile nature of the clients.

Another significant issue was the establishment of the ARV Guidelines (distribution, cost recovery, repurchase, administration, adherence/compliance to treatment) which would be satisfactory to all stakeholders. The operationalization of Country Response Information System (CRIS) remains an issue to be resolved.

Lessons learned

In policy advocacy projects, NGOs have learned to work with most of government systems and structures in order to reach target goals. Partnership with LGUs should be strengthened to appropriately respond to issues related to HIV/AIDS particularly on care, support and treatment services. Allocation from LGU for care, support and treatment for PLHAs and affected families should be advocated.

It is important that strategies be formulated to capture attention of vulnerable groups and make them commit to the project. Using Peer Education as a strategy, would result to reaching out to the most "hard-to-reach" clients. Collaboration with the Social Hygiene Clinic is very important, especially for STI diagnosis and treatment among vulnerable groups. Behavior change communication messages to target groups should be "uniformed and standardized" to get maximum results during education.

Learning group session on VCT would defeat its purpose if voluntary testing will not take place because of incapacity of individuals to pay for HIV antibody testing. Appropriate psychosocial and educationalactivities should be conducted based on preparedness and willingness of PLHAs and affected families. It was realized that peer support group meeting should be conducted among PLHAs only to enhance support system among themselves.

From Year 1 experiences, the project staff recognised that project structure could give a unique opportunity to build partnership between the government organizations and the civil society, represented by Non-Governmental Organizations (NGOs). Tremendous efforts have been made to establish an organizational network that has increased NGOs capacities to address the major issues in the affected communities. However, the overall project implementation needs to scale up to achieve more important targets of the first phase of the project. With the present system, the NGOs provide significant support to the development of HIV/AIDS prevention, care and support services within the national program. Based on networking and good working relationships, the project implementing NGOs have a major potential to increase their respective capacity and services coverage.

FUTURE PLANS

In order to capture attention of vulnerable groups, it is important to come-up with Local Policies for the prevention of STIs and HIV/AIDS, both in the barangay and the city levels. This is important to maintain and sustain education activities with high risk population considering their individual behavior, needs, culture, orientation, beliefs, work environment, types of customers and their mobility.

To receive funding for the second phase of the project, the CCM will submit a funding request by the 18th month (January 2006) and the project needs to be assessed by the Global Fund. To prepare for this assessment, the Tropical Diseases Foundation) GFATM principal recipient, has requested UN Theme Group on HIV/AIDS for an external evaluation of the first phase of the project. The External Evaluation team will visit selected sites of the project, the project's implementing partners, including NGOs, Social Hygiene clinics and treatment hubs. This appraisal is expected to identify the major strengths and constraints of the project, and propose recommendations and suggest actions to improve the project's performance.

Life Stories.....

from the Global Fund AIDS Project Experience

Leaving the "Trade"

Mary Jane is a 17 years old resident of Mandaue City. She became a mother at the early age of 15. She was six months pregnant with their second child when her husband left her for another woman. With no permanent job, she decided to live with her parents, who could barely support Mary Jane's 5 other brothers and sisters. With low educational attainment and failing to find a decent job after giving birth to her second child, Mary Jane was forced to engage in sex work. One night, she met a Peer Educator from Bidlisiw Foundation who taught her how to protect herself from sexually transmitted infections. She then became an active participant of the activities of the program and was sent to several training courses, such as the "Training and Entrepreneurial Development Program". Materials and equipment were given to her on a rent-to-own basis, allowing Mary Jane to start her own business. Her initial earnings was only P50.00 per day but it was sufficient to respond to the needs of her children. Though Mary Jane is still involved in sex work, she hopes to leave this kind of work one day and focus on the business she has started.

An Encounter with Police and Media: A Peer Educator's Experience

During the conduct of one of their learning group sessions (LGS) for children trapped in prostitution, a group of peer educators from BIDLISIW were arrested and brought to the police station. They were not given the chance to explain and was even threatened to be charged with "illegal recruitment." The project staff of BIDLISIW immediately responded and talked with the police officers at the station and patiently explained the project. After much interrogation, the peer educators were eventually released and the officers apologized for the misunderstanding and requested the staff to return and give them a "desensitization" seminar. The staff then deemed it necessary to include the Philippine National Police in the council. They also developed an identification card which they wear when working in the area to identify them as health workers and avoid further incidents.

With the police incident resolved, the organization faced yet another challenge—the media, who negatively reported the incident and attacked the organization's credibility and motives. Soon after, BIDLISIW was flooded with text messages and phone calls from their clients, whose rights were violated by the station's unfair and inaccurate reporting. BIDLISIW called up the radio station and asked for a public apology, but this was not given. This experience taught the project staff that most people still lack awareness and sensitivity to issues concerning HIV and prostitution. The radio station seemed to be more concerned in getting high ratings than helping the marginalized sector of society.

Indeed, , the project still has a long battle to fight.....

TROPICAL DISEASE FOUNDATION, INC.
Principal Recipient of Global Fund - Supported Programs

CONSOLIDATED STATEMENTS OF RECEIPTS AND DISBURSEMENTS
(in US Dollars)

For the fiscal	MALARIA 2005	MALARIA 2004	MALARIA Sub-	TUBERCULOSIS 2005	TUBERCULOSIS 2004	TUBERCULOSIS Sub-	HIV/AIDS 2005	HIV/AIDS 2004	HIV/AIDS Sub-	GRAND
RECEIPTS										
Funds	**25207**	47240	72447	**21015**	13328	34344	**76497**	15060	22710	**12950**
Inter-	**5627**	2969	8596	**2836**	1533	4369	**773**	0	773	**13738**
	25263	47269	72533	**21044**	13344	34388	**76574**	15060	22717	**12964**
DISBURSE-										
Ad-	**19104**	15641	34746	**23520**	49273	28447	**96705**	0	96705	**72864**
Bacte-	**0**	0	0	**48388**	14613	63001	**0**	0	0	**63001**
Cohort	**0**	0	0	**42451**	9161	51612	**0**	0	0	**51612**
Com-	**81314**	12988	21120	**0**	0	0	**11160**	0	11160	**22236**
Cost of	**0**	0	0	**19693**	76823	27375	**0**	0	0	**27375**
Drugs	**10202**	13087	23290	**27028**	37753	64782	**19959**	0	19959	**10803**
En-	**0**	0	0	**49076**	10483	59559	**0**	0	0	**59559**
House-	**0**	0	0	**6275**	929	7204	**0**	0	0	**7204**
Hu-	**78521**	18774	97295	**37687**	91331	46821	**36067**	0	36067	**18018**
IEC	**0**	0	0	**48125**	30703	78828	**0**	0	0	**78828**
Infra-	**13176**	35003	48180	**10877**	50012	15878	**72423**	0	72423	**71301**
Moni-	**17998**	10679	19066	**25352**	10104	35456	**73921**	0	73921	**30004**
Net-	**0**	0	0	**1252**	547	1799	**0**	0	0	**1799**
Social	**0**	0	0	**29814**	13853	31199	**0**	0	0	**31199**
Planne	**0**	0	0	**49611**	64339	11395	**0**	0	0	**11395**
Sur-	**0**	0	0	**1422**	138	1560	**0**	0	0	**1560**
Profi-	**0**	0	0	**1071**	0	1071	**0**	0	0	**1071**
Screen	**0**	0	0	**27384**	0	27384	**0**	0	0	**27384**
Train-	**66251**	18014	84266	**15182**	49425	20125	**33284**	0	33284	**13767**
Up-	**0**	0	0	**0**	4855	4855	**0**	0	0	**4855**
Pro-	**31740**	45263	77004	**14643**	12102	26745	**72741**	16	72757	**11102**
	31831	27674	59505	**20848**	97514	30600	**13205**	16	13205	**10331**
EXCESS OF RE-	**-**	**19595**	**13028**	**19536**	**35928**	**37882**	**-**	**15060**	**95126**	**26329**

TROPICAL DISEASE FOUNDATION, INC.

Principal Recipient of Global Fund - Supported Programs

NOTES TO FINANCIAL STATEMENTS
For the fiscal year ended July 31, 2005

NOTE 1 – PROGRAM PROFILE

The Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM) was founded in January 2002 as a partnership of national governments from donor and developing countries, non-governmental organizations, affected communities, corporations, foundations and international organizations. The Fund is a grant-making organization, which provides financial resources to improve underlying health systems for the advancement of global health through the control and prevention of AIDS, TB and Malaria. It expects programs to be country-driven, with strong partnerships in both public and private sectors, and with transparent accountability.

The Tropical Disease Foundation, Inc. (TDFI) was nominated and elected to be the Principal Recipient (PR) for the GFATM programs in November 2002. The PR must be a legal entity that can receive and manage the funds on behalf of the GFATM. The PR is responsible for the financial management and administration of the program, including receiving and disbursing the funds to the program implementers, overseeing and managing the proposed procurement, and submitting regular financial and programmatic progress reports to the GFATM and to the Country Coordinating Committee Mechanism (CCM). As PR, the TDFI shall be responsible to the GFATM for the overall implementation of the program.

Sub-recipients (SR) are institutions that have transparent financial systems with the capacity in place to enable the implementers to carry out the prepared activities and will receive and manage GFATM funds from the PR on behalf of the program component. The SR shall be responsible to the PR for the program monitoring and financial management to ensure proper utilization of funds.

The Philippine Rural Reconstruction Movement, Inc. (PRRM) is the SR for the Malaria Component while the Philippine NGO Council on Population, Health and Welfare, Inc. (PNGOC) is the SR for HIV/AIDS Component. The TB Component has no SR, the PR operates directly with the Implementers. These Implementers are Philippine Coalition Against Tuberculosis, Inc. (PhilCAT), World Vision Development Foundation, Inc. (WVDF) and the Department of Health (DOH) and Tropical Disease Foundation Inc. - Directly Observed Treatment Short Course Clinic (TFDI-DOTSPlus Clinic).

With the Implementation Letter Number 1 from the Global Fund, agreed and signed by the Principal Recipient last June 24, 2004, the starting and ending dates for the Malaria and Tuberculosis programs have been moved from July 1, 2003 to August 1, 2003 and from June 30, 2005 to July 31, 2005, respectively. This Implementation Letter serves as an amendment to the Grant Agreement to put that date change into effect. The starting and ending dates for the HIV/AIDS Program are August 1, 2004 and July 31, 2006, respectively.

NOTE 1 – PROGRAM PROFILE, continued

The start date for the first quarterly period set in Annex A of the Grant Agreement shall be deemed to have begun from the Program Starting Date, as amended by the Implementation Letter, and the terms for all subsequent quarterly periods as amended, respectively.

Global Fund will grant for over two (2) years as stated on the Agreements US$ 7,244,762 for Program Malaria, US$ 1,434,487 for Program Tuberculosis, and US$ 3,496,865 for Program HIV/AIDS.

NOTE 2 – SIGNIFICANT ACCOUNTING POLICIES

Basis of financial statements preparation

The Principal Recipient fund accounted for in these financial statements pertains to the grants received from the Global Fund only. The Principal Recipient maintains a US Dollar and a Philippine Peso bank account. Remittances from the Global Fund are coursed through the US Dollar bank account. All disbursements for both programs are done in the Philippine Peso and US Dollar bank accounts.

The Principal Recipient's statement of receipts and disbursements of funds in US Dollars have been prepared on the basis of cash received and disbursements made, which is a comprehensive basis of accounting other than the accounting principles generally accepted in the Philippines.

Under the fund accounting method, receipts from grants are recognized when received rather than at the time of commitment of the grantor and disbursements are recognized when paid rather than when incurred.

NOTE 3 – PROGRAM GOALS AND OBJECTIVES

Malaria component

Goal: To reduce malaria morbidity by 70% and mortality by 50% in the 26 priority provinces by the end of 2008; to significantly reduce the malaria burden so that it will no longer affect the socio-economic development of individuals and families in endemic areas.

Objective 1: To increase the proportion of febrile patients receiving early diagnosis and appropriate anti – malaria therapy.

Objective 2: To reduce malaria transmission (vector aspect).

Objective 3: To strengthen capacity for implementation of sustainable community-based malaria.

NOTE 3 – PROGRAM GOALS AND OBJECTIVES, continued

The above objectives were implemented by The Philippine Rural Reconstruction Movement, Inc. (PRRM). In addition, program management and administration is handled by the Tropical Disease Foundation, Inc.

Tuberculosis component

Goal: To halve the prevalence, incidence and mortality of tuberculosis (TB) by 2010 in accordance with the National TB Control Program (NTP) plan. By the end of 2007, it shall have detected 85% of all TB cases and cured at least 85% of them.

Objective 1: To increase the case detection rate of the estimated tuberculosis cases from 58% in 2003 to 85% in 2007 through Nationwide establishment of Private-Public Mix DOTS (PPMD) being implemented by Philippine Coalition Against Tuberculosis, Inc. (PhilCAT) and the enhancement of DOTS in the public sector which is implemented by the Department of Health (DOH), specifically by improving the service side of TB control through trainings, and the World Vision Development Foundation, Inc. (WVDF) by improving the demand side through social mobilization.

Objective 2: To utilize the Green Light Committee (GLC)-approved DOTS-Plus pilot project for policy development in MultiDrug Resistant TB (MDR-TB). The Implementer of this objective is the Tropical Disease Foundation Inc. - Directly Observed Treatment Short Course Clinic (TFDI-DOTSPlus Clinic).

The program management and administration of Tuberculosis component is controlled by the Tropical Disease Foundation, Inc.

HIV/AIDS component

Goal: By the end of 2009, prevalence of HIV among vulnerable groups is less than 1%, while prevalence of STI is reduced by 50% among PIPs in the 11 risk sites. Also, 40% of estimated number of PHAs are identified through Voluntary Counseling and Testing (VCT) services and receive adequate care, treatment and support.

Objective 1: To improve behavior change communication and STI management among vulnerable groups. Five activities to achieve this are as follows:

a. Intensify social mobilization and advocacy campaign;
b. Outreach and education activities;
c. Build capacities of service providers, peer educators, Community Health Outreach Workers (CHOW);
d. Improvement of STI services, and

NOTE 3 – PROGRAM GOALS AND OBJECTIVES, continued

e. Strengthen monitoring and evaluation mechanism for tracking progress in implementation.

Objective 2: To scale up VCT, support, care and treatment for the people living with HIV/AIDS (PLHAs) and their families in four geographic areas. This will be accomplished through the following activities:

a. Improvement and expansion of VCT;
b. Development of partnership mechanisms for care, treatment and support involving the positive community, service providers and key stakeholders;
c. Improvement and expansion of clinical services; and
d. Establishment of home and community care for PLHAs including educational activities.

The program management and administration of HIV/AIDS component is also managed by the Tropical Disease Foundation, Inc.

NOTE 4 – OTHER MATTERS

• Tropical Disease Foundation, Inc. handles the transactions and maintains the records of the Department of Health (DOH) and Tropical Disease Foundation, Inc. - Directly Observed Treatment Short Course Clinic (TFDI-DOTSPlus Clinic).

• As of August 2005, the PRRM still has unliquidated advances amounting to P 16.6 million. In its terminal report on February 28, 2006, liquidations in the approximate amount of P 4 million were made, leaving a balance of P 12.4 million as of said date.

External Evaluation

Sixth Monitoring Visit of the Green Light Committee to the DOTS-Plus Pilot Project of the Tropical Disease Foundation at the Makati Medical Center (Metro-Manila, Philippines)

Background
On the 23rd August 2000, the Green Light Committee (GLC) approved a DOTS-Plus pilot project to be implemented in the Makati Medical Center, Makati City, Metro Manila, The Philippines, by the Tropical Disease Foundation (TDF). Five visits have been carried out to monitor the progress achieved and to provide technical assistance in implementing the project. The last visit took place 9-12, December 2003 and had the objective of assessing the progress achieved in the project. On 25 February 2004, the GLC approved the application for expanding the cohort of MDR-TB patients for treatment to 750 patients, after TDF provided satisfactory results on proficiency testing for drug susceptibility testing (DST). This new cohort will be funded by the grant of the Global Fund to Fight Against AIDS Tuberculosis and Malaria (GFATM) to the Philippines. A new monitoring visit took place from 6-10 December 2004 by Dr M Voniatis (WHO country office), Dr P Glaziou (WHO/WPRO), Dr E Jaramillo (WHO-GLC Secretariat) and Dr N Naranbat (NTP manager of Mongolia) as an observer (see annex 1 for terms of reference for this mission).

The mission briefed Dr J Lagahid (Director III, Officer in Charge, Office of Infectious Diseases, National Center for Disease Prevention and Control); Dr R Vianzon (NTP manager), and Dr J M Olivé, WHO-country representative, on the purpose of the visit. The mission visited the site of the DOTS-Plus project, DOTS sites in the catchment area of the project and the Lung Center of the Philippines, and the Quezon Institute at Quezon City.

Main findings

The extent of implementation of the recommendations made by the last GLC monitoring visit is impressive. A DOTS-Plus Task force was established and is working out a plan to expand DOTS-Plus in Metro Manila. A council of experts for the management of MDR-TB is now in operation. The chief health officers of Quezon City and Makati City are now fully supportive of decentralizing DOTS-Plus and its full integration into the DOTS strategy.

Ninety eight patients of the new GLC-approved cohort are now enrolled on treatment. Delivery of treatment under direct observation is being decentralized, making possible for 50% of the MDR-TB patients to take drugs closer to the household. A lodge setup by TDF is now successfully housing 18 patients that receive directly observed treatment for MDR-TB. This approach is enabling access to patients who live in areas far away from DOTS clinics. The full package of social support they receive (education, counseling, food, occupational therapy, shelter and treatment) makes the initiative highly acceptable to patients, and model for other DOTS-Plus projects.

The Quezon Institute and the Lung Center of the Philippines in Quezon City have a lot of potential for taking a more active role in the management of MDR-TB in Metro Manila. However, the health care staff at the Quezon Institute holds unfounded fears about TB infection risk. These fears seem to be a major factor to explain why only one MDR-TB patient was found hospitalized, while the rest of big wards remained empty by the time this mission visited the Hospital.

TDF has established collaboration with the Lung Center Philippines, a tertiary level Department of Health hospital that treats 40-60 MDR cases per year with own funds, for implementing DOTS-Plus strategy. The Lung Center has a very well equipped TB laboratory that can contribute to facilitate diagnosis of MDR-TB and monitoring of treatment response to treatment for MDR-TB if quality assurance is provided by the national reference laboratory, the National TB Reference Laboratory (NTRL). The current participation of clinical staff of the Hospital in the MDR-TB council will facilitate its further participation in the decentralization of DOTS-Plus.

Thanks to the support of the GFATM the project is able to provide ancillary drugs for free to patients suffering adverse drug reactions during the MDR-TB treatment. All these contribute to explain the major progress achieved in some indicators such as culture negativization (82%), and default (4%).

The TDF laboratory has its culture and DST activities quality assured by the supranational reference laboratory of Korea. The NTRL cannot provide the quality assurance for smears since the TDF laboratory uses a different technique (auramine and rodamine stain). Options for the TDF to receive quality assurance by the NTRL for both smear and culture were explored.

A representative national DRS survey (cluster sampling) is being implemented by the NTP with technical assistance from Japan (JICA) and WHO. Data collection was completed; results will be released in the next weeks. Unfortunately, the protocol does not allow for stratification for the different retreatment categories.

The most recent draft of the paper on cost-effectiveness of DOTS-Plus was discussed with Dr T Tupasi, first author. Some additional input was agreed, especially information on the most recent treatment outcome results.

The progress achieved, the commitment of the TDF and its staff and the clear support from the NTP and local health authorities, are getting this project very close to become a worldwide centre of excellence in the management of MDR-TB. However, there are still some areas for improvement. For example, there is not yet systematic surveillance of HIV infection amongst MDR-TB patients diagnosed and enrolled in the project. Handling of data is an area in which progress has been made but it is still insufficient. Duplicated data downloading is not being done; there is not a manual of operations with clear description of functions and processes for data collection and analysis; and ad-hoc programme functions to detect inconsistencies are not being run.

The future of DOTS-Plus in the Philippines was discussed in detail with the representatives of the NTP, TDF, and WHO country, regional and headquarters level). There was consensus in the need to take advantage of the momentum created by the success in the DOTS-Plus project, the support from the GFATM, the expansion of the DOTS strategy and the progress in the 'public private mix' approach, to make management of MDR-TB an integral component of the TB control strategy in the Philippines.

The mission debriefed Dr J Lagahid, Dr R Vianzon, Dr T Tupasi and her staff at the TDF, Dr D I Ahn, RA WPRO, and the coordinating team of the GFATM project on the findings and main recommendations.

Recommendations

The NTP to pursue mainstreaming of DOTS-Plus into DOTS in Metro-Manila, and to selected sites in other provinces where DOTS strategy is fully implemented and doing well. A plan for a stepwise integration of MDR-TB management in the 'public private mix' sites being established in the Philippines should be developed.

The NTP and Department of Health to ensure that all laboratories conducting smears and culture and participating in the DOTS-Plus decentralization are fully quality assured by the NTRL, and that the full protocol approved by the GLC for the TDF is implemented should second-line anti TB drugs procured through the GLC mechanism will be used.

The NTP and the TDF to consider the Quezon Institute as a potential hospital for MDR-TB patients, once the appropriate measures for controlling infection risk are in place and the unfounded fears of health care workers are resolved.

The TDF and NTP to design and implement a systematic plan for HIV surveillance in MDR-TB cases enrolled in the project, giving access of TB patients to counseling and testing services for HIV, in coordination with the national AIDS programme.

Tropical Disease Foundation

Medical Plaza Makati, Rms. 2002-2004

Ayala cor. De la Rosa Sts., Salcedo Village, Makati City

Fax:888-0944; Tel. No. 888-0488; 840-0714;840-2176