SUBJECT : Notice of Funding Opportunity
Request for Application No. 72049218RFA00001

PROGRAM TITLE : TB Platforms for Sustainable Detection, Care and Treatment

The United States Agency for International Development (USAID) is seeking applications from qualified organizations to implement the “TB Platforms for Sustainable TB Detection, Care and Treatment Activity in the Philippines.”

This funding opportunity is open to all organizations, i.e., nongovernmental organizations, universities, consortiums, for-profit organizations willing to forego their fees, etc. See Section III of this Request for Application (RFA) for eligibility requirements.

Subject to the availability of funds, an award of a Cooperative Agreement will be made to that responsible organization whose application best meets the objectives of this RFA and the selection criteria contained herein. While one (1) award is anticipated as a result of this RFA, USAID reserves the right to fund any or none of the applications received.

For the purposes of this RFA, the term “Grant” is synonymous with “Cooperative Agreement”; “Grantee” is synonymous with “Recipient”, and; “Grant Officer” is synonymous with “Agreement Officer”. Eligible organizations interested in submitting an application are encouraged to read this RFA thoroughly to understand the type of program sought, application submission requirements, and evaluation process.

To be eligible for award, the applicant must provide all information as required in this RFA and must meet eligibility standards in Section III. This RFA is posted on www.grants.gov, and may be amended. Potential applicants should regularly check the Grants.gov website to ensure they have the latest information pertaining to this RFA, including amendments. It is the responsibility of the applicant to ensure that the entire RFA has been received from the internet in its entirety. USAID bears no responsibility for data errors resulting from transmission or conversion processes. If you have difficulty registering on www.grants.gov or accessing the funding opportunity, please contact the Grants.gov Helpdesk at 1-800-518-4726 or via email at support@grants.gov for technical assistance.
Please be advised that each applicant is required to:

1. Be registered in SAM (www.sam.gov) before submitting an application;

2. Provide a valid DUNS number (http://fedgov.dnb.com/webform) in its application, and;

3. Continue to maintain an active SAM registration with current information at all times during which it has an application or plan under consideration by a Federal awarding agency, or an active Federal award. The Federal awarding agency may not make a Federal award to an applicant if the applicant has not fully complied with the DUNS and SAM requirements by the time the Federal awarding agency is ready to make a Federal award.

The successful applicant will be responsible for ensuring the achievement of the program objectives. Please read each section of this RFA.

Questions should be sent by email to the point(s) of contact identified in Section IV. The deadline for questions is shown above. Responses to questions received prior to the deadline will be furnished to all potential applicants through an amendment to this RFA and will be posted in www.grants.gov. Questions received after the deadline for questions/clarifications will not be entertained.

Issuance of this RFA does not constitute an award commitment on the part of the USAID nor does it commit USAID to pay for any costs incurred in the preparation or submission of comments/suggestions or an application. Applications are submitted at the risk of the applicant. All preparation and submission costs are at the applicant’s expense.

Thank you for your interest in the programs of USAID/Philippines.

Sincerely,

/s/
Sandra Jansen
Agreement Officer
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ABBREVIATIONS AND ACRONYMS

aDSM   Active TB Drug-safety Monitoring and Management
AIDS   Acquired Immune Deficiency Syndrome
AMELP  Activity Monitoring, Evaluation and Learning Plan
ARMM   Autonomous Region in Muslim Mindanao
AuTuMN Australian Tuberculosis Modeling Network
BHW    Barangay Health Worker
CALABARZON Cavite, Laguna, Batangas, Rizal and Quezon Provinces (also known as Region 4A)
CA     Cost of Application
CBO    Community-based Organizations
CDR    Case Detection Rate
CFR    Code of Federal Regulations
CLA    Collaboration, Learning and Adapting
COP    Chief of Party
ComPCare Community-based Programmatic Management of Drug Resistant TB Care
DetecTB Diagnostic Enhanced Tools for Extra Cases of Tuberculosis (DetecTB)
DOH    Department of Health
DOTS   Directly Observed Treatment Short-course/ Delivery of Tuberculosis Services
DR TB  Drug-Resistant Tuberculosis
DS TB  Drug-Sensitive Tuberculosis
FAST   Finding TB cases Actively, Separating safely, and Treating effectively
FDA    Food and Drug Administration Philippines
GFATM  Global Fund to Fight AIDS, TB and Malaria
GPH    Government of the Philippines
iDOTS  Integrated Delivery of Tuberculosis Services
ICRC   The International Red Cross and Red Crescent Movement
IMPACT Innovations and Multi-sectoral Partnerships to Achieve Control of Tuberculosis
IPT    Isoniazid Preventive Therapy
ITIS   Integrated Tuberculosis Information System
JATA   Japan Anti-Tuberculosis Association
HIV    Human Immunodeficiency Virus
HLGP   Health, Leadership and Governance Program
HR     Human Resources
HRH    Human Resources for Health
HUC    Highly Urbanized City
KMITS  Knowledge Management and Information Technology Service
KOFIH  Korean Foundation for International Healthcare
LGU    Local Government Units
LOE    Level of Effort
LPA    Line Probe Assay
<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Full Form</th>
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<tbody>
<tr>
<td>LTBI</td>
<td>Latent Tuberculosis Infection</td>
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<tr>
<td>M&amp;E</td>
<td>Monitoring and Evaluation</td>
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<tr>
<td>MDR-TB</td>
<td>Multi-Drug Resistant Tuberculosis</td>
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<td>MOFA</td>
<td>Japanese Ministry of Foreign Affairs</td>
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<tr>
<td>NAP</td>
<td>U.S. National Action Plan to Combat Multidrug-Resistant Tuberculosis</td>
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<tr>
<td>NCR</td>
<td>National Capital Region (also known as Metro Manila)</td>
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<tr>
<td>NGO</td>
<td>Non-governmental Organization</td>
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<td>NTP</td>
<td>National Tuberculosis Program</td>
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<tr>
<td>PHC</td>
<td>Primary Health Care</td>
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<td>PICT</td>
<td>Provider Initiated Counseling and Testing</td>
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<td>PhilHealth</td>
<td>Philippine Health Insurance Corporation</td>
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<td>PhilSTEP 1</td>
<td>Philippine Strategic Tuberculosis Elimination Plan Phase 1</td>
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<td>PLHIV</td>
<td>People Living with HIV</td>
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<td>PMDT</td>
<td>Programmatic Management of Multi-Drug Resistant Tuberculosis</td>
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<td>PPM</td>
<td>Public-Private Mix</td>
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<tr>
<td>PPR</td>
<td>Performance Plan and Report</td>
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<td>RFA</td>
<td>Request for Application</td>
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<td>RHU</td>
<td>Rural Health Unit</td>
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<td>RR TB</td>
<td>Rifampicin Resistant Tuberculosis</td>
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<tr>
<td>SBCC</td>
<td>Social and Behavior Change Communication</td>
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<td>SCM</td>
<td>Supply Chain Management</td>
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<tr>
<td>SDN</td>
<td>Service Delivery Networks</td>
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<td>TB</td>
<td>Tuberculosis</td>
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<tr>
<td>TREAT-TB</td>
<td>Technology, Research, Education and Technical Assistance for Tuberculosis</td>
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<tr>
<td>TSR</td>
<td>Treatment Success Rate</td>
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<tr>
<td>USAID</td>
<td>United States Agency for International Development</td>
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<td>USG</td>
<td>United States Government</td>
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<td>UHC</td>
<td>Universal Health Coverage</td>
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<td>WHO</td>
<td>World Health Organization</td>
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<tr>
<td>XDR-TB</td>
<td>Extensively-Drug Resistant TB</td>
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SECTION I: ACTIVITY DESCRIPTION

A. OVERVIEW

The United States Agency for International Development (USAID), through a competitive process, plans to invest in a five-year cooperative agreement entitled, “TB Platforms for Sustainable TB Detection, Care and Treatment” (TB Platforms) that aims to improve the TB situation in the Philippines by bolstering essential supportive and cross-cutting TB interventions at the regional, local government unit (province, city, municipal) and community levels to increase TB and drug-resistant TB case detection and treatment success rates while also decreasing default rates.

Authorizing Legislation

The authorizing legislation for this anticipated cooperative agreement is the Foreign Assistance Act of 1961, as amended, and the award will be subject to 2 Code of Federal Regulations (CFR) 700 and 2 CFR 200 – Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards. The following are applicable for the administration of the resultant award:

- For U.S. organizations, 2 CFR 200 and 2 CFR 700, and the Standard Provisions for U.S. Non-Governmental Recipients are applicable
- For non-U.S. organizations, the Standard Provisions for Non-U.S. Non-Governmental Recipients will apply.

For purposes of this RFA, the words “activity”, “program”, or “project” are used interchangeably to refer to “TB Platforms for Sustainable TB Detection, Care and Treatment”.

1. Introduction

In 2016, the Department of Health (DOH) embarked on its Philippine Health Agenda, which focuses on financial risk protection, better health outcomes, and a health system that is responsive and provides access to services. This agenda will require bureaucratic systems that are effective and agile, strategic approaches to engender better health outcomes and stakeholder vigilance over policies, budgets and systems. USAID’s long and successful relationships with the Department of Health and other key stakeholders at both the national and sub-national level provide a platform for USAID to have an impact on the broad range of critical health problems and the underlying systems issues facing the country. USAID is committed to helping the Philippines achieve its ambitious health goals by implementing a focused, results-oriented program that fully leverages Filipino capacity, systems and resources.
USAID has developed a suite of activities - referred to collectively as the USAID/Philippines Health Project (2017-2022) - that together will seek to achieve sustainable, transformative impact. The “TB Platforms” activity represents one of several activities that make up USAID’s overall investments in the Philippines health sector. The tuberculosis or TB activity will work closely with USAID, other USAID activities, the Department of Health, the Global Fund and its principal recipients and sub-recipients and a range of Filipino stakeholders and organizations to achieve the broader vision and support the attainment of the Philippine Health Agenda.

2. USAID/Philippines Health Project 2017-2022

The USAID/Philippines Health Project (2017-2022) will support the Philippines by improving the health for underserved Filipinos. For the Philippines to meet its own health goals and achieve the United Nations Sustainable Development Goals for health, a far greater proportion of Filipinos must consistently practice healthy behaviors and seek and receive quality care through a functioning and sustainable health system. Embedded in the Project purpose is a three-pronged set of sub-purposes designed to: 1) strengthen individual healthy behavior; 2) fortify the quality of health services to push for more patient-centered approaches; and 3) bolster and institutionalize the key public health systems needed to support these behaviors and services. By 2022, each activity will contribute to USAID’s overall goals that uphold the Government of the Philippines’ Health Agenda.

In cooperation with government, non-government organizations, civil society organizations, other donors, public and private service providers, and underserved citizens, USAID will work in partnership with the Philippine government and other key stakeholders to “improve the health of underserved Filipinos” under this project. Significant changes are expected at the individual, community, services, and systems levels and many of these expected outcomes will depend on positive changes at different levels of the health system.


3. Health Project Activities

USAID/Philippines will execute the 2017-2022 Health Project through a combination of state-of-the-art field platforms, roll-out of innovations and system strengthening activities, along with monitoring, evaluation, learning and adapting. The suite of project activities related to tuberculosis will include:

- Five tuberculosis technical activities that transfer state-of-the-art experience in

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1 “Underserved” in the primary context of this Project, refers to people exposed to or with tuberculosis or multi-drug resistant tuberculosis; youth and adults at risk for unwanted, early pregnancy and childbirth; and pregnant women (and partners) in need of antenatal care and life-saving, safe delivery for themselves and their newborns.
behavior change, quality improvement and equitable access to services, as well as working with the Department of Health and other stakeholders to develop and help roll out innovations in partnering, service delivery and technologies.

- Four systems strengthening activities designed to make local ownership a reality by fortifying regional health governance, central and regional health financing and resource management, supply chain management and human resources, while institutionalizing leadership and technical training, supply chain management and policy development, currently being buttressed by USAID and other donors, into the Department of Health.

- A Collaborating, Learning and Adapting activity that will assist USAID to define and report on the quantitative and qualitative progress, define a strategic research and analysis agenda in cooperation with stakeholders, evaluate data quality, conduct impact and program evaluations and develop tools and opportunities for dissemination and adaptation.

Table 1 and Chart 1 provide information of Health Project Activities. For descriptions of USAID’s implementing activities please refer to Annex A.

### Table 1: USAID Health Project TB Activities

<table>
<thead>
<tr>
<th>Tuberculosis</th>
<th>Health Systems Strengthening</th>
</tr>
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<tbody>
<tr>
<td>TB Platforms for Sustainable TB Detection, Care and Treatment</td>
<td>Health Leadership and Governance Program</td>
</tr>
<tr>
<td>TB Innovations &amp; Health Systems Strengthening</td>
<td>Universal Health Care</td>
</tr>
<tr>
<td>Treat TB Technical Assistance</td>
<td>Supply Chain Management</td>
</tr>
<tr>
<td>World Health Organization Technical Advisor</td>
<td>Human Resources for Health</td>
</tr>
<tr>
<td>Technical Assistance and Support Contract Technical Advisor</td>
<td>Health Financing</td>
</tr>
<tr>
<td></td>
<td>Collaboration, Learning and Adapting</td>
</tr>
</tbody>
</table>
B. BACKGROUND

1. Tuberculosis in the Philippines

While the WHO Global Tuberculosis Report 2016 shows that the Philippines met the 2015 TB targets of declining incidence rate in 2011 and halved prevalence and mortality rates compared to the 1990 baseline, results from the 2016 TB Prevalence survey present a different picture of high TB prevalence and overall burden of TB. These results provide further evidence that TB continues to be a significant health problem for the country. It is the eighth leading cause of morbidity and mortality (Philippine Health Statistics, 2013). In 2015, there were an estimated 324,000 new cases of TB, and 286,544 cases were registered with
the National TB Program (NTP). The number of estimated multidrug-resistant TB (MDR-TB) /rifampicin-resistant TB (RR-TB) incident cases was 17,000 (WHO Global Tuberculosis Report 2016). In terms of absolute number of incident cases of TB and MDR-TB, the Philippines is listed as one of the 30 high burden countries in both of these categories.

As a high TB burden country, the Philippines is performing poorly in terms of case-finding. According to the 2016 TB prevalence survey, the Philippines has 1,159 cases per 100,000 population, which is 2.5 times higher than previously estimated. Results of the survey suggest that the Philippines has the highest recorded prevalence estimate from any country that has undertaken a TB prevalence survey since 2007. Smear-positive TB prevalence was 434 per 100,000 (95% CI 350-518). Bacteriologically confirmed prevalence in men was estimated to be 1,713 per 100,000 (95% CI 1482-1943) and in women, 627 per 100,000 (95% CI 516-739).

The Philippines is also struggling with drug-resistant TB (DR-TB) in terms of case-finding (with 24 percent CDR) and treatment outcomes (with approximately 43 percent TSR in DR-TB). This means that of the roughly 17,000 estimated cases, only about 4,080 cases were detected and initiated on treatment; and of those who were initiated on treatment, only about 1,750 cases were successfully treated. The number of those diagnosed with MDR-TB who refused to start treatment is unknown. The Philippines is conducting drug susceptibility testing (DST) for only five percent of people with newly notified DR-TB cases, which is significantly lower than the WHO target of 20 percent. Sixty-seven percent of people who are DR-TB retreatment patients undergo drug susceptibility testing. This is also lower than the WHO target of 100 percent, therefore, more work is needed in this area.

The country has data from three national TB surveys (1981–1983, 1997, 2007, and 2016). Between 1997 and 2007, there was a trend of gradual, but modest decline in terms of incidence, prevalence (annual reduction of two percent of sputum-smear positive [SS+] and 4.7 percent of culture positive), and annual risk of infection. However, this rate of decline is not rapid enough to achieve TB elimination by 2035, which WHO has defined to be an incidence rate of 10 per 100,000 population. With an estimated TB incidence rate of 550 per 100,000 population, and its current incidence rate decline of 1.5 percent per year, the Philippines may reach elimination only in another 150-200 years. There is an urgent and pressing need for more strategic, innovative, and impactful interventions to achieve this goal of TB elimination. Please see Annex B for statistics about TB.

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2. Government of Philippines TB Elimination Activities

The Department of Health’s National TB Control Program, is mandated to provide technical leadership to implement the TB control program through development and issuance of national policies, standards and guidelines; management of program logistics and data; coordination with key stakeholders in harmonizing resources; and monitoring and evaluation. Some public and private hospitals and a few Public-Private Mix Directly Observed TB Short-course (DOTS) units are also part of the TB referral network which means that they either refer or directly provide TB services to their patients. Thus far, the NTP has not taken steps to include private stand-alone physicians into the TB referral network but this policy may change by 2018.

Nationwide expansion of TB testing in children has been part of the NTP since 2004 but to date, execution remains highly variable per region (between 2-27 percent of notified cases) and is plagued by drug and commodity stockouts.

**Legal framework:** Since 1929 when Republic Act 3573 was approved, tuberculosis has been included as reportable cases. This was reiterated in 2001 by Department Circular No. 176 s. 2001. However, in 2008, the Department of Health removed tuberculosis from the list of reportable cases by virtue of Administrative Order No. 2008-0009. In 2016, Republic Act 10767 was approved and is otherwise known as the *Comprehensive Tuberculosis Elimination Plan Act*. It stipulates that all public and private health centers, hospitals and facilities shall observe the national protocol on TB management and shall notify the DOH of all TB cases. The law, however, is unclear about the role of private practitioners and reporting. Although the law does not explicitly mention mandatory reporting, the law’s implementing rules and regulations provide guidance on mandatory reporting but do not describe a mechanism or discuss the consequences of not reporting.

Section 4 of Republic Act No. 9711, also known as the Food and Drug Administration Act of 2009, stipulates that one of the Food and Drug Administration’s (FDA) roles and responsibilities is to reinforce the post-market surveillance system in monitoring health products as defined in this Act as well as incidents of adverse events involving such products. In 2016, the DOH decided to establish some pharmacovigilance and post-market surveillance activities under the responsibility of the Pharmaceutical Division of the DOH. It will be a new challenge for this division to coordinate with the FDA to implement the reporting responsibilities required by the Act. To date, the policy has yet to be released.
**National Strategic Plan**: In 2016, the implementation period of the National Strategic Plan for TB Control known as the Philippine Plan for Action to Control Tuberculosis ended. Thus, the Government of the Philippines (GPH) developed the Philippine Strategic TB Elimination Plan Phase 1 (PhilSTEP1), the first of a series of three medium-term plans, intended to steer the NTP towards its vision of a “TB-free Philippines”. The six-year year plan is mandated by Republic Act 10767 or the *TB Elimination Plan Act of 2016* to reduce TB incidence and mortality, reduce catastrophic costs for affected families and provide responsive TB services. The PhilSTEP targets below are initial targets that are in the process of being updated based on the results of the 2016 National TB Prevalence Survey.

**Box 2: PhilSTEP1 Impact Targets by 2022***
- Reduce number of TB deaths by 50 percent from 14,000 to 7,000 deaths
- Reduce TB incidence rate by 25 percent from 322/100,000 to 243/100,000
- Reduce to zero the percentage of TB-affected households that experience catastrophic costs due to TB**
- At least 90 percent of patients are satisfied with services from DOTS facilities

*Targets will be finalized based on the results of the National TB Prevalence Survey.
**Baseline will be determined by the ongoing catastrophic cost study.

**Table 2: PhilSTEP1 Outcome Targets by 2022***

<table>
<thead>
<tr>
<th>Indicators</th>
<th>Baseline 2015</th>
<th>Target in 2022</th>
</tr>
</thead>
<tbody>
<tr>
<td>Treatment Coverage (Case Detection Rate)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>● Susceptible TB</td>
<td>92%**</td>
<td>≥ 92% 90%</td>
</tr>
<tr>
<td>● Multi-Drug Resistant TB</td>
<td>32%</td>
<td></td>
</tr>
<tr>
<td>TB Treatment Success Rate</td>
<td></td>
<td></td>
</tr>
<tr>
<td>● Susceptible TB</td>
<td>92%</td>
<td>≥ 92% 85%</td>
</tr>
<tr>
<td>● Multi-Drug Resistant TB</td>
<td>49%</td>
<td></td>
</tr>
<tr>
<td>Case Fatality Ratio</td>
<td>4%</td>
<td>&lt;4%</td>
</tr>
<tr>
<td>Latent TB Infection treatment coverage</td>
<td></td>
<td></td>
</tr>
<tr>
<td>● Household child contacts (&lt;5 years old)</td>
<td>14%</td>
<td>90%</td>
</tr>
<tr>
<td>● PLHIV</td>
<td>43%</td>
<td>90%</td>
</tr>
</tbody>
</table>

*TTargets will be finalized based on the 2016 National TB Prevalence Survey
**Based on underestimated TB incidence and over-diagnosed TB cases

In order to achieve the key targets for the National Strategic Plan (PhilSTEP1), the NTP is planning to roll out several new TB policies in 2017. These policies include adopting the 9-month regimen as a standard regimen for MDR-TB; introduction of the new drugs, Bedaquiline (BDQ) and Delamanid (DLM) to treat DR-TB; changing the TB service delivery
model into one that combines both drug sensitive (DS)-TB and DR-TB diagnosis and treatment at peripheral facilities (e.g., rural health unit (RHU) level); adopting an inclusive approach where all health providers and facilities are engaged; and further expansion of Xpert MTB/RIF to eventually become the primary diagnostic tool for TB. All of these changes will require the NTP to update, modify and roll-out current algorithms, standard operating procedures and guidelines.

3. Donor Support and Other Partners

Domestic funding, Global Fund resources and non-Global Fund donor funding for TB have grown in recent years. USAID is the U.S. government's lead agency for international TB work. The Philippines is considered a USAID priority country in the fight to eliminate TB and aids the Philippines government’s objective to reach every person with TB, cure those in need of treatment and prevent the spread of the disease and new infections.

The Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM) is the single most important source of external funding in the Philippines for TB prevention, treatment, and care. The GFATM has been providing assistance to the Philippines for over ten years. The current GFATM TB grant’s Principal Recipient is the Philippine Business for Social Progress (PBSP). This grant started in January 2014 and will end in December 2017, and has a total approved budget of $113,731,624. While almost half of the grant budget is allocated for supplies and consumables (such as TB medications), PBSP also focused on MDR-TB case detection and laboratory strengthening. PBSP works closely with USAID so that there is no duplication of work and support is complementary. A major challenge for the Government of the Philippines will be sustaining and institutionalizing priority components of the Grant, particularly patient enablers and manpower augmentation. There is also a need to bolster the Grant’s technical approach and monitoring and evaluation activities.

The NTP received approval for a new GFATM funding request of $78.5 million, for a grant covering the period 2018-2020. The three investment areas of the GFATM grant are: mainstreaming service delivery systems for drug resistant TB cases; finding missing cases through strategic engagement of non-RHUs, including private facilities; and expanding TB-HIV collaboration. The Global Fund Board also approved the country’s request during the same period for a separate tranche of $10 million of “catalytic funding” that is focused on finding missing TB cases through private sector engagement and systematic screening of high risk groups. The catalytic funding is estimated to help find at least 89,000 cases. Lastly, if additional funds become available, the Philippines could receive up to $34.8 million through the prioritized above allocation request (PAAR). Priorities for PAAR include systematic screening for detection and treatment of 66,000 missing cases, procurement of GeneXpert OMNI, detection of additional DR TB cases and expansion of GeneXpert Alert. Under this new round of funding, the Philippines could receive up to $123.3 million dollars.

From 2008-2012, the Japanese Ministry of Foreign Affairs (MOFA) and Japan Anti-Tuberculosis Association (JATA) funded a quality TB control project in urban areas of Metro Manila and Quezon City. Its focus was on reaching underprivileged people in the community by bridging the gap through networks among non-government organizations.
From 2012-2016, the Korean Foundation for International Healthcare (KOFIH) funded the Diagnostic Enhanced Tools for Extra Cases of Tuberculosis (DetecTB) project. Project sites included Puerto Princesa City and chosen municipalities of Palawan province. The project’s main objective was to increase case detection of all forms of TB to 10 percent or more in target areas. The KOFIH employed modern, fast and reliable diagnostic equipment such as digital chest radiography, Light Emitting Diode-Fluorescence Microscope (LED-FM) and molecular identification of TB bacilli through the Xpert MTB/RIF Assay.

The International Red Cross and Red Crescent Movement (ICRC) focuses its work to find cases in jails and prisons. Since 2013, the ICRC has worked in two pilot sites to implement a four-year pilot project with technical support from USAID’s IMPACT project. Moving forward, the organization plans to work in Regions 3 and 4A jails but will shift its focus to improving access to primary health care through integrating TB services in detention centers.

With the backing of the NTP in the Philippines and financial support from the GFATM through the Special Initiative on Optimizing Value for Money and Financial Sustainability (SI-VFM), the Australian Tuberculosis Modeling Network (AuTuMN) conducted an analysis aimed at providing epidemiological projections of the TB epidemic in the Philippines and the impact of interventions on the TB epidemic. Some of the findings from the analysis may be used to determine the best use of resources to maximize health outcomes to enhance country TB programs.

The World Health Organization through its Western Pacific Regional Office is expected to continue its technical assistance to activities such as regional Green Light Committee missions, the Joint Program Review, and other upcoming activities.

4. United States Government (USG) Priorities for Tuberculosis

The U.S. government’s global tuberculosis efforts are led by USAID to prevent tuberculosis transmission, renew endeavors to find unidentified cases, strengthen the capacity of national tuberculosis programs, build country capacity to use existing resources, and expand the development of new tuberculosis diagnostics, drugs and vaccines. Since 2000, USAID has provided technical support for TB prevention, treatment, and care in the Philippines. USAID will guarantee that all current programming is aligned with the U.S. Government’s Global TB Strategy 2015-2019 and the U.S. National Action Plan to Combat Multidrug-Resistant Tuberculosis (NAP), which will accelerate the achievement of the WHO End TB Strategy and the Global Plan to END TB.

The new USAID/Philippines Health Project (2017-2022) builds on decades of experience from past USAID programming, including an external 2016 health portfolio evaluation. This evaluation recommended that USAID assist to expand access to TB care, encourage expanded use of rapid tests for diagnosis, improve mandatory notification systems, provide quality communication programs, roll-out the shorter MDR-TB treatment regimen
nationwide, and focus TB interventions in high burden regions. The next phase of USAID programming will closely align with the objectives of the Government of the Philippines as outlined in the Philippine Health Agenda 2016-2022 and in the National Strategic Plan and PhilSTEP1.

Box 3: Government of the Philippines and USG Plans and Strategies

Government of the Philippines National Plans and Strategies:
- Philippine Health Agenda
- Comprehensive TB Elimination Plan Act of 2016
- Philippine Strategic Tuberculosis Elimination Plan (2017-2022) (PhilSTEP1)
- Philippine eHealth Strategic and Framework Plan (PeHSP) (2016 and beyond)
- DOH Information System Strategic Plan (2015-2017)

United States Government and USAID Strategies:

The NAP identifies a set of targeted interventions that address the core domestic and global challenges posed by MDR-TB and extensively drug resistant TB (XDR-TB). Recommended interventions represent the U.S. Government’s contributions to reversing the worldwide spread of MDR-TB and should inform policy-development processes around the world. The National Action Plan is an attempt to articulate a comprehensive strategy, mobilize political will and spur additional financial and in-kind commitments from bilateral and multilateral donor partners, the private sector and the governments of all affected countries.2

The goals of the National Action Plan are to:

1. Strengthen domestic capacity to combat MDR-TB;
2. Improve international capacity and collaboration to combat MDR-TB; and
3. Accelerate basic and applied research and development to combat MDR-TB.

USAID/Philippines has performed an analysis of actions needed to fulfill the NAP milestones and determined the following to be necessary for implementation in coordination with the NTP and other partners under the current solicitation:

- Under the NAP (milestone 2.1.2), the Philippines should develop and scale up community-based MDR-TB care and treatment services for patients with DR-TB. While initial programs such as Community-based Programmatic Management of Drug Resistant TB Care (ComPCare) and Integrated Delivery of Tuberculosis

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2 https://obamawhitehouse.archives.gov/sites/default/files/microsites/ostp/national_action_plan_for_tuberculosis_20151204_final.pdf
Services (iDOTS) have been piloted, aggressive scale up is needed to cover all high-burden regions and provinces.

- Under the NAP (milestone 2.2.1), the Philippines should develop and scale-up medical screening of high-risk individuals for DS-TB and DR-TB. While some provinces have piloted contact investigation and screening of family members, it has not been institutionalized and sustained.

- Under the NAP (milestone 2.2.1), the Philippines should introduce regular monitoring activities of sites, delivering DR-TB and patient-centered care activities, to safeguard sustained quality and adherence to the national protocols and practices. Onsite mentoring and supervision have been proven to both improve personnel capacity and increase their confidence in health care delivery.

- Under milestone 2.2.3, improvement of infection control practices in healthcare facilities as well as congregate settings need to be evaluated and improved to prevent TB transmission and the development of new cases. In addition, under the same milestone, the country should introduce healthcare worker surveillance and screening in facilities responsible for diagnosis and treatment by December 2018 and scale-up in all high-burden regions by the end of 2020.

C. KEY ISSUES AND CHALLENGES

1. Healthy Behaviors

In order to achieve desired social and behavior change outcomes to eliminate tuberculosis, evidence-based interventions before, during and after the provision of TB services are essential. Additional focus to generate demand should be matched by supportive community norms that motivate clients to consult and seek TB care. When clients access services, they should feel empowered through heightened knowledge about the disease and through the respectful care they receive from trained health providers. As patients undergo treatment, supportive systems should boost their adherence, secure zero interruptions in treatment and enhance their ability for better self-care after treatment. More data gathering, assessment and analysis is needed to develop and shape appropriate and targeted approaches and interventions that will result in improved case detection, appropriate treatment seeking behavior and treatment adherence.

Inadequate health-seeking behavior

The 2016 National TB Prevalence Survey shows that among people with TB symptoms, around 41 percent take no action, approximately 40 percent self-medicate, and only 19 percent seek consultation with a medical provider. Thus, the survey findings show that National TB Program is missing over 80 percent of presumptive TB cases. Health-seeking behavior is determined by many socio-cultural and socio-economic factors that include age, gender, social stigma, self-stigma, distance to health care services, direct and
opportunity costs, awareness of TB as well as quality of health care providers. Some patients are not accessing the health system or accessing services late, and many people with TB are “missed” at the lower levels of the health system. Advocacy around TB has been weak, contributing to limited political commitment. Additionally, civil society and patient engagement has been insufficient, thus marginalizing the involvement of key affected populations in TB policy-making and program planning, operationalization, monitoring and evaluation.

**Missing TB cases and slow initiation on treatment**

According to the National TB Prevalence Survey, it is estimated that about 50 percent of TB cases are not notified to the National TB Program from both the public and private sectors. Case finding is largely passive and there is limited active contact tracing. Since close contacts of TB patients have a five to ten times higher risk of acquiring TB, strengthening TB services at the lower levels of the health system, outreach activities, and screening of close contacts will help the NTP detect more TB cases. An understanding of vulnerable groups is not yet guiding targeting of interventions. There is also a need to promptly initiate on treatment all those who are diagnosed. Patients need easy access to TB services which should ideally be available at the first point of contact. Slow initiation on treatment is due to factors such as limited availability of laboratory and treatment services, out-of-stock consumables and medications, treatment initiation delays and unwillingness of patients to initiate treatment. Last but not least, TB surveillance and screening among primary health care staff and staff dealing with infectious diseases need to be conducted regularly.

**Weak adherence to DR-TB treatment**

Barriers to accessing and continuing TB treatment include financial, geographic, lack of knowledge about the disease and inadequate provider support that is focused on addressing the needs of patients. Also, for patients treated for DR-TB, poor management of adverse drug reactions leads to loss to follow up, according to a recent study. Bringing services closer to the patients and being flexible in addressing individual patient needs will be important for improving the quality of TB and DR-TB care. The next few years will be critical as the NTP moves into a different model of TB service provision where both DR and DS-TB services will be available at the rural health unit (RHU) level.

2. **Quality of Services**

**Insufficient and limited engagement of private health care providers**

The scale and importance of the private medical sector cannot be underestimated, since about half of all people with symptoms of TB seek healthcare from hospitals or private physicians, and an estimated 50 percent of TB patients are managed outside of the NTP. The management of TB cases outside of the NTP is unmonitored and unregulated. Chest x-rays are often employed without sputum examination, and even if diagnosis is made
correctly, there is no government oversight of the quality of TB treatment. As a result, with no default tracing or case-holding mechanisms in place, providers struggle to ensure that their patients complete their TB treatment. Also, there is a need for stricter enforcement of the mandatory reporting provision of the TB Law for stand-alone physicians.

Pharmacies need to be engaged as they are also major sources of care—especially for people who prefer to self-treat. Another major challenge is that the sale of drugs in private pharmacies is not strictly regulated. A study using 2007 to 2011 procurement and sales data of TB treatment drugs in the Philippines showed that in 2011 alone, 2.4 times the number of notified cases could have been placed on treatment and treated for at least the intensive phase.\(^3\) This suggests significant out-of-pocket expenditures and severe underreporting of TB cases and/or misuse of drugs due to overdiagnosis, overtreatment or improper dispensing. There is a need for more stringent implementation of the Pharmacy Law.

Public Private Mix (PPM) approaches worldwide have suffered from limited sustainability as there has been no plan for national expansion or for financing after the end of a project cycle. Thus, any initiative undertaken should include a clear plan for both expansion and sustainability, with an emphasis on building on local institutions and health system processes. Explicit policies articulating the acceptance of private sector engagement as a long-term sustainable strategy is crucial as is the clear outlining of their collaborative and regulatory relationship with the NTP. This means that meaningful and sustainable inclusion of the private sector by the NTP into its TB diagnostic and treatment network needs to be undertaken. Government contracting mechanisms should be reviewed and reexamined to pave the way for contracting the private sector. The NTP should consider all potential partners which may include stand-alone physicians, hospitals, medical and allied medical professional schools and training institutions, pharmacies, workplaces, and various types of non-government, government, and community based organizations.

Although several PPM models have been successfully piloted in the Philippines, institutionalizing PPM practices and ensuring that activities continue once the pilots end, have been challenging. Furthermore, these pilots have not always considered governance tools which have a greater likelihood of being applicable and sustainable nationwide. There is a need to examine the governance tools that are currently used or could be used by the public sector to improve the performance of private providers in general, with TB as a specific tracer condition. Of particular importance is the need to review, possibly revise and strictly monitor the implementation of the Comprehensive and Unified Policy for TB Control in the Philippines which was signed in 2003 to strengthen coordination of TB control efforts at all levels and within all agencies of government and private sector.

Inconsistent quality of TB services

Neither the rapid increase in clinically diagnosed cases, nor the reasons for the high proportion of negative Xpert MTB/RIF results in presumptive MDR-TB patients are well understood and need to be examined. Quality diagnostic and treatment services need to be made available at point-of-care establishments. There is also limited attention to and low detection of pediatric TB. There is a need to progressively and significantly transition Programmatic Management of Drug-Resistant TB (PMDT) services from the GFATM to the NTP. Decentralization of diagnostic and treatment services to expand access is paramount. One important area is also the integration of TB services with other Department of Health (DOH) programs such as maternal and child health, nutrition, HIV, and noncommunicable diseases. Service delivery at the peripheral level is performed by the same individuals, even if program management from national to provincial levels is siloed. Further, there is a need to define the parameters and operationalize a “patient-centered approach” at the local level. The capacity of health providers to deliver patient-centered, respectful care that is free from stigma and discrimination at all levels of the system needs to be strengthened, maintained and monitored.

In order to improve the safety of patients receiving new drugs and regimens, WHO recommends NTPs to adapt and apply special pharmacovigilance practice, called active TB drug safety management and monitoring - aDSM. Currently only 10 treatment centers in the country are applying aDSM to patients on the shortened treatment regimen and on bedaquiline (BDQ). Drug safety management and monitoring will need to accompany the roll out of new drugs and shorter treatment regimen in more than 700 treatment facilities.

Insufficient infection control practices

In the past, limited attention had been given to TB infection control. Today, addressing the issue of TB infection control in congregate and health care settings is a key component in combating the spread of TB nationwide. However, this will require additional attention and resources beyond routine activities. Special attention should be paid to TB infection control in health facilities, in congregate settings, and among healthcare workers among whom there is an elevated risk of TB transmission. These are all significant concerns for the TB elimination push.

Limited number of functional Service Delivery Networks

In order to make quality TB services easily accessible to patients, functional Service Delivery Networks (SDN) will need to be present in every local government unit (LGU). The SDN for TB is a network of public and private facilities and health care providers that can provide TB diagnostic and treatment services as per clinical practice guidelines and the NTP Manual of Procedures. SDNs should also include private stand-alone practice physicians whom patients usually visit first before any other health service provider. It also includes community-based organizations (CBOs), patient support groups, and non-governmental organizations (NGOs) that can provide referral and
support services and may also serve as treatment partners. It is imperative that services are located close to the patient and are easily accessible in order to eliminate the need for multiple visits and multiple service delivery points to visit. In addition, routine TB screening needs to be fully integrated into all primary health care services (maternal and child health, family planning, immunization, etc.) so that every patient is screened for TB during every point of contact with the health system. This is a challenge since DOH programs are siloed vertically at the central and regional levels but need to be horizontally integrated at the service delivery level. Complicating this problem is a devolved system where policies and guidelines are crafted at the national level yet the implementation unit is at the provincial level and below where prioritization rests on the Local Government Executives. Policies and guidelines need to be crafted with operational issues in mind.

Services for DR-TB at all levels of the health system, including diagnosis, treatment, and management of the supply chain, are currently provided separately from services for drug-sensitive TB and are centralized in large health facilities and hospitals. This has resulted in a parallel program which constrains access to health services for DR-TB patients and severely limits sustainability and performance of the program. In response to the urgent need to make services more patient-focused, the NTP has recently begun to decentralize and integrate DR-TB services at local health facilities. The NTP has an ambitious plan to offer the shorter treatment regimen for DR-TB in every treatment facility in the country but the uptake of these services has been slow.

**Underperforming TB diagnostic and laboratory system**

A successful TB control program should have an accessible, fully functional, and quality-assured laboratory and diagnostic system supported by a strong specimen transport and referral network. Despite significant allocations of financial and human resources to strengthen the National TB Reference Laboratory and laboratories at the decentralized and health facility levels, data quality and analysis, utilization rates and turnaround time to report results vary. In public sector facilities, the external quality assurance (EQA) system which is designed to check the quality and accuracy of sputum smear microscopy tests, is not fully functional nationwide because of limited human resources at the provincial level. For private laboratories, there is no EQA system, thus very few private labs are quality-assured. High contamination rates, low recovery rates, and a long backlog of tests for culture and drug susceptibility testing (DST) pose further challenges to quality assurance and access to treatment. Furthermore, not all laboratories are adequately staffed and not all laboratories are open daily during weekdays.

Many facilities have not established systems designed to facilitate access for patients. Deterrents to accessing testing and diagnostic services include lengthy travel and waiting times to submit samples and return for results, and high out-of-pocket costs for chest x-rays and transportation to testing sites. Absence of a reliable and consistent specimen transport system forces many patients to travel to facilities for testing. Although new molecular testing technologies such as GeneXpert are being rolled out nationwide, some GeneXpert sites are under-utilized. As new technologies such as GeneXpert and Line
Probe Assay (LPA) are scaled up, considerable investments in training and supervision must be made to prepare and link the diagnostic and laboratory system to quality treatment and counseling services.

3. Health Systems

**Limited data and insufficient monitoring and evaluation**

There is a need for quality and timely recording and reporting of technical and financial program data to guide patient and program management. TB and other primary health care (PHC) staff at all levels do not have sufficient knowledge and experience with data analysis or how to analyze and use this data for future planning. Also, very little data is collected on the behavior of patients and affected communities. Improving data analysis and interpretation will help TB staff to properly program new activities, modify existing ones and adopt behavioral components. In consideration of the internet connection problems in the country, both online and offline methods of recording and reporting must be available to RHUs. The development of the Integrated Tuberculosis Information System (ITIS), the system that tracks TB data nationwide, is way behind schedule. Challenges with the system include: an incomplete laboratory and other additional modules, patchy geographic implementation, delayed data entry, and inconsistent data validation processes. The process of conducting data quality checks also needs improvement. Monitoring and evaluation activities must be conducted frequently and regularly with upper level supervisors engaging RHU staff in discussions on how to address identified challenges. In this case, supportive supervision may be explored as a useful approach.

**Persistent financing challenges and program sustainability**

Despite steady increases in the overall national budget for health, the NTP budget has remained flat-lined over the past six years due to slow utilization of its allocated funds. Furthermore, efficiency of spending of the NTP sub-allotted budget to the Regional Offices is unknown. Use of the budget for TB has been constrained largely due to the cumbersome government procurement process, which affects outsourcing of technical services and supply of TB medicines. As a result, the NTP is limited in the type of financial assistance that it can provide to TB patients -despite increasing costs of care- and it must rely heavily on donor funding to support health personnel, equipment and other operational costs. This situation presents a significant risk for the sustainability of the TB program. The DOH and NTP must optimize spending, promote programmatic efficiencies, and advocate for improved procurement systems and budget allocations. Significant increases in both domestic funding and absorptive capacity are warranted.

Since 1992, health services have been decentralized to local government units, but there is still a lack of barangay, municipal, and provincial ownership as well as inadequate financing of health programs. Although Internal Revenue Allotments (IRAs) for health have increased, local health spending has not moved forward at the same pace. In an attempt to compensate for insufficient allocation of resources at the decentralized level,
the national health and national TB budgets have increased in recent years. However, as described above, persistent and systematic challenges prevent full utilization of funds at the national and regional levels. Some LGUs support the TB program through procurement of drugs and supplies, but the availability of a TB line-item budget at local levels is inconsistent. LGUs must play a greater role on health care issues to identify health issues, mobilize the community and enhance financial aid for health programs.

Although a PhilHealth TB DOTS package is available, utilization rates are low partly because of unclear guidelines on how allocation of PhilHealth payments should be made. These differences in payment allocations have led to health workers, health facilities, and referrers not receiving their due share, demotivation of health facility staff to file for PhilHealth accreditation and claims, and the deprivation of potential assistance to patients. Moreover, PhilHealth has not yet developed a benefit package to fund MDR-TB care.

**Significant gaps in supply and capacity of human resources**

Recent NTP program evaluations, as well as other analyses have revealed critical shortages of trained and qualified health personnel at all levels. As a result, the Philippines suffers from a wide variation in the quality of TB service delivery and implementation of critical management and supervision functions. While many of these gaps are being filled through donor support and donor-funded staff, this practice is unsustainable. A resilient TB workforce requires a sufficient number of qualified and trained staff. During the next three to five years of the Global Fund grant, the DOH and NTP must develop an action plan for maintaining investments in the health workforce at the national, regional and local levels. Initial results from the 2016 TB Prevalence Survey suggest that country’s TB prevalence has not shown a statistically significant decline in the past nine (9) years, therefore more health personnel will be needed to find missing cases, initiate patients on treatment and successfully cure them. The DOH has identified the need to improve all aspects of human resources for health including staff development, quality, hiring, and retention. The DOH also recognizes that additional resources are needed at all levels of the health system to maintain sufficient numbers of qualified health personnel.

New and existing health personnel currently do not have the skills and knowledge to implement new DR-TB treatment regimens nor many of the tools needed to shift their approach to more patient-centered, gender-sensitive and respectful care. More health providers need to have the skills and capacity to deliver care that is free from stigma and discrimination.

To improve the performance of health workers, there is a need to develop and put in place a systematic plan and methodology for performance monitoring and evaluation at all levels of the health system that goes beyond data collection and data quality checks. Regular and meaningful encouraging supervision visits should be conducted by appropriate staff who can provide on-the-job training, help solve problems and provide feedback. Follow-up visits should also be conducted to document progress.
Fragmented and inefficient Supply Chain Management and Pharmacovigilance

Uninterrupted supply of quality TB drugs and supplies is a cornerstone of a good TB control program. In recent years, there have been stockouts of the Purified Protein Derivative used in Tuberculin Skin Testing and there have been problems with the quality and availability of pediatric TB drugs. Procurement issues should be addressed and delivery processes should transition to a pull system. There is also a need to clarify the roles, willingness and ability of DOH Regional Offices and local government units to purchase drugs and supplies. Without a policy in place, stockouts of streptomycin are a continuing problem for most health facilities.

In addition to pharmaceutical and technology management, proper pharmacovigilance (PV) is a necessary step to provide for the safe use of medications, especially for DR-TB patients, because of the number of drugs they intake. WHO has created an active drug safety management and monitoring (aDSM) approach to help NTPs better manage adverse drug reactions among TB patients and record and report these adverse reactions to higher authorities. While the Philippines NTP has introduced an aDSM system, more substantial work is needed to finish the pilot phase and scale it up.

D. KEY RESULTS BY 2022

Listed below are some expected indicators, for which the “TB Platforms” activity will need to contribute. The required Performance Plan and Report (PPR) indicators include:

- Number of multi-drug resistant tuberculosis cases detected
- Number of multi-drug resistant tuberculosis cases that have initiated second line treatment
- Percent of successfully treated multi-drug resistant tuberculosis category 4 cases
- Tuberculosis case notification rate, all forms

It is expected that the recipient will develop an Activity Monitoring, Evaluation and Learning Plan (AMELP) that will capture TB indicators at both the provincial and regional levels. The activity will be expected to contribute to achieving the targets of the PhilSTEP1 and USG TB strategies and provide data that will be reported in the annual PPR.

E. ACTIVITY FRAMEWORK, ASSUMPTIONS AND IMPLEMENTATION PRINCIPLES

1. “TB Platforms for Sustainable TB Detection, Care and Treatment” Framework

The “TB Platforms” activity will focus on improving decentralized TB health systems by bolstering health program components at the regional, local government unit, province, city,
municipal, and community levels to increase TB and drug-resistant TB case detection and treatment success rates while also decreasing default rates.

This activity's interventions will contribute to achieving the Health Project’s Sub-purpose 1.1 (improved individual adoption of healthy behaviors), Sub-purpose 1.2 (improved community ownership/participation in healthy behaviors), Sub-purpose 2.1 (improved quality services through patient-centered approaches), and Sub-purpose 3.2 (improved fiscal, financing and human resource management). This activity will also contribute to other Sub-purposes in Sub-purpose 3 (key health systems are bolstered and institutionalized) by collaborating with other activities that will work on cross-cutting areas. The “TB Platforms” activity will provide targeted assistance to selected regions with the highest TB burden. For more information on the 2017-2022 USAID/Philippines Health Project Results Framework, please refer to Annex C.

The “TB Platforms” activity is intended to bring civil society, non-governmental partners, private health care providers, and patient groups to support the Department of Health and local government units with case finding, case holding and outreach activities. “TB Platforms” is expected to develop, test, and apply innovative and sustainable financing mechanisms and principles to increase the capacity and sustain engagement of civil society and new partners to help reduce the TB epidemic and meet the targets set in the five year PhilSTEP1. Long term sustainability of all interventions should be considered as part of initial design.

“TB Platforms” will closely coordinate its activities with the “TB Innovations and Health Systems Strengthening” activity to ensure complementarity of activities, seamless transition from national to provincial level and avoid duplication in technical assistance. Using these approaches, “TB Platforms” will aim to achieve: 1) families and communities adopt and improve healthy behaviors; 2) high-impact interventions are implemented at scale in the regions with the highest TB burden; and 3) key local health systems are bolstered to facilitate efficient and optimal delivery of quality TB services.

The “TB Platforms” activity will focus on three objectives to achieve the expected results described below:

**Table 3: Expected Results**

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<thead>
<tr>
<th>Objective</th>
<th>Expected Results</th>
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<tr>
<td><strong>Objective 1</strong> – Advance adoption and improvement of healthy behaviors of individuals and the community to prevent, detect and treat TB</td>
<td>1.1 Improved TB health care-seeking, detection and treatment enrollment and adherence 1.2 Increased detection of new TB and DR-TB cases through community approaches</td>
</tr>
<tr>
<td><strong>Objective 2</strong> – Bolster high quality patient-centered tuberculosis and drug-resistant tuberculosis treatment for adults, children,</td>
<td>2.1 Public and private health care providers deliver quality, patient-centered TB and DR-TB diagnostic and treatment services</td>
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and vulnerable populations

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<tr>
<th>Objective 3 – Expand local health system capacity to deliver tuberculosis and drug-resistant tuberculosis services to targeted populations</th>
<th>2.2 Service Delivery Networks scaled up and provide comprehensive TB detection, prevention, care and treatment services</th>
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<tr>
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<td>2.3 TB Transmission control improved in congregate settings and facilities</td>
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<tr>
<th>Objective 3 – Expand local health system capacity to deliver tuberculosis and drug-resistant tuberculosis services to targeted populations</th>
<th>3.1 Decentralized governance and finance mechanisms facilitate quality TB prevention, care and treatment</th>
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<tr>
<td></td>
<td>3.2 Data management and program monitoring supports delivery of quality TB services and drives program implementation decisions</td>
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<td></td>
<td>3.3 Improved access to TB laboratory systems that provide rapid test results for TB (DS and DR)</td>
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<td></td>
<td>3.4 Capacity of local organizations, partners and institutions to conduct outreach activities and support TB interventions increased and sustained</td>
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2. Objectives and Expected Outcomes

**Objective 1  Advance adoption and improvement of healthy behaviors of individuals and the community to prevent, detect and treat TB**

*Sub-objective 1.1 Improved TB health care-seeking, detection, and treatment enrollment and adherence*

Improvements in TB screening and detection can happen if both passive and active case finding strategies are conducted. USAID aims to strengthen not only demand for TB services, but a range of complementary behaviors, including correct and timely utilization of health services and preventive behaviors practiced outside the context of health services. Individual and community level messages and information will be crafted to address knowledge gaps and anchored to a behavioral change theory or combination of theories to effectively reach target populations. Community-based organizations and patient support groups can provide information, counseling and help to encourage early consultations and treatment initiation and adherence. Strategies to establish that there are zero treatment interruptions will need to be operationalized and barriers to accessing care should be addressed. Evidence-based and targeted, gender-sensitive messaging should be used to reduce stigma and discrimination towards people with TB. Developing trust within the health system
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and reducing TB stigma helps attract more clients, and expands screening for TB and
retention to services. The activity will collaborate with health providers, including
Rural Health Units (RHUs), barangay health workers (BHWs) and other public and
private health providers, and NGO and community partners to foster adherence, track
interrupters on the same day so that no dose is missed, and address patient causes of
interruptions. Analyzing patient pathways using the cascade of care at the LGU/RHU
level will bring current issues to the attention of health managers and USAID
partners.

Illustrative Outputs/Outcomes:

- Vulnerable populations and target groups seek TB diagnosis and treatment
- Individuals and families are aware of and utilize TB service delivery points
- Decreased lag time from symptom-appearance to consult
- Decreased delay between initial health seeking and enrollment to treatment
- Messages and approaches to detect, diagnosis and treat TB are evidence-based
  and tailored to take gender and other needs into consideration
- Community members encourage target populations to adopt priority health-
  seeking norms and behaviors (i.e. cough hygiene and early identification of
coughers)
- Community organizations, patient groups and private providers provide
  patient and gender-sensitive TB prevention, advocacy and support services to
  TB patients to improve treatment adherence
- TB patients and family members receive education and social assistance
- Stigma and discrimination against TB reduced
- Treatment interruptions and loss to follow up reduced

Sub-objective 1.2 Increased detection of new TB and DR-TB cases through
community approaches

Identification and locating new TB cases are among the main objectives of the new
Philippines TB Strategic Plan. There is a need to expand strategies to reach, screen
and evaluate individuals in populations that are at higher risk of contracting TB
infection and disease. Many individuals from these groups do not visit health
facilities nor benefit from intensified case finding in care facilities, congregate
settings and other high risk locations. WHO recommends active case finding and TB
screening for family members and close contacts of TB patients in order to find cases
early and prevent TB transmission in the community. There is a need to prioritize
populations which have a higher incidence or risk for TB than the general population
or a higher risk for disease progression once infected. These groups may either share
a specific individual-level risk profile (e.g., close contact, diabetic, People Living
with HIV (PLHIV), migrant, child, elderly) or people living in a specific geographical
location (e.g., urban slum) or a specific type of institution (e.g., homeless shelters,
orphanages, drug rehabilitation centers, prisons, and facilities for the elderly). In
order to achieve the greatest impact, effective case-detection strategies must prioritize
risk groups, settings, and delivery strategies. This approach will be bolstered through additional partnerships with CBOs and other social organizations particularly at the community level. This activity will use the data generated from the TB risk prioritization screening tool to guide systematic screening for active TB. Healthcare workers are also at a higher risk of TB exposure so TB surveillance and screening must be conducted regularly.

Illustrative Outputs/Outcomes:

- Localized TB detection strategies and plans developed to reach target populations
- Targeted screening and active case-finding for TB accelerated, with a focus on close family contacts
- New partners and civil society organizations participate in detecting cases and supporting treatment
- Sustainability plans for active participation of community based organizations implemented
- TB and DR-TB case-finding increased in both public and private facilities
- Healthcare workers at RHUs and provincial hospitals screened to detect latent TB infection and/or TB disease at earlier stages
- TB risk prioritization screening tool applied at the provincial level
- Communities and non-traditional partners engaged to refer and detect more TB cases
- Health and other social service providers identify and detect more TB cases

Objective 2  Deliver high quality patient-centered TB and DR-TB treatment for adults, children and vulnerable populations

Sub-objective 2.1 Public and private health care providers deliver quality, patient-centered TB and DR-TB diagnostic and treatment services

Successful TB program performance and controlling the TB epidemic depends on the quality of drug-susceptible and drug-resistant TB care. When treatment is successfully delivered and TB patients are cured, TB transmission stops in the community, patients return to work and TB stigma is reduced. Treatment detection, initiation on treatment and service delivery for both DS and DR-TB in the Philippines can be boosted. Delays to initiate treatment, low treatment success rates, high numbers of individuals lost to follow-up, and constant interruptions in treatment prevent the DOH from achieving WHO-set targets. Factors that need to be addressed to prevent delays in treatment initiation include the limited availability of laboratory and treatment services, unavailable consumables, and medications.

The activity is expected to conduct formative research on patient-centered care and involve patients and their families in program planning, implementation, monitoring and evaluation. These inputs will be translated into interventions at the point of
service delivery. Patient-centered approaches must be adapted to the local context and rigorously evaluated to document best practices and inform expansion strategies. Community organizations and resources may be mobilized to provide patient-centered care services. The activity will establish a sustainable system where all presumptive TB patients are accounted for using the patient pathway/cascade analysis framework. Patients who become lost in the continuum of care should be recovered, issues addressed, and followed until s/he is cured. The activity will also introduce evidence-based interventions to ensure women are appropriately reached and gender considerations are integrated into the TB program. The activity will build capacity of the regional and provincial levels to conduct audits on clinically diagnosed TB cases coming from all sources, whether public or private.

Essential to the delivery of patient-centered care are well-trained and appropriately-supervised public and private health providers who deliver respectful services to patients. Health workers must be trained and supported to encourage treatment adherence and treatment completion, maintain quality standards, and provide services that are free of discrimination and stigma. Health providers also need assistance to protect them from burn-out.

Illustrative Outputs/Outcomes:

- Individual needs of patients are addressed and client satisfaction improved
- Provider-Initiated Counselling and Testing (PICT) offered to TB patients in all health facilities at all levels of care
- RHUs host patient support groups and local NGO members to provide social encouragement to TB patients
- Public and private health providers capacitated and empowered to offer patient-centered, gender-sensitive and respectful care
- Public and private health providers supported, recognized and receive supervision
- LGU/RHU and provincial level health providers offer full range of evidence-based, high-impact TB and MDR-TB services
- RHUs adopt patient pathway/cascade of care analysis to improve services
- Eligible patients enrolled in Isoniazid Preventive Therapy (IPT) within one day of diagnosis
- Audit of clinically diagnosed cases is conducted
- New approaches and guidelines for DS-TB and DR-TB care scaled up and put in place

*Sub-objective 2.2 Service Delivery Networks scaled up and provide comprehensive TB detection, prevention, care and treatment services*

In order to sustain investments to eliminate TB, there is a need to establish province or city-wide networks of public and private health care facilities and providers who are capable of providing TB services, including information, education, referral,
diagnosis, and treatment. These facilities should be fully functional, compliant with clinical practice guidelines and the NTP Manual of Procedures, located close to clients and provide patient-centered care. The goal is for patients to be able to access the same level of high-quality TB services at any level of the system. The activity will assist LGUs to organize service delivery networks to include all possible service delivery points in the community including schools, workplaces, pharmacies, families, and community health workers. The activity is expected to support the development and testing of alternative financing mechanisms to engage private health providers and civil society organizations to participate in Service Delivery Networks. The activity is expected to operationalize a sustainable system for all SDN members to employ a standardized approach in providing disposition feedback to the referring unit and making sure that all patients are tracked and followed and that the feedback is received by the referring unit. The system should prevent intra- and inter-unit dropouts. The activity will assist in operationalizing the TB Law’s provision on case notification by providing a monitoring mechanism for this action.

Illustrative Outputs/Outcomes:

- Integrated TB and community-based care approaches scaled up across all selected regions and provinces with participation from community organizations, private providers and local institutions
- Health facilities engage communities in program planning, implementation, monitoring and evaluation
- More non-traditional health providers, e.g., stand-alone physicians, local NGOs and civil society participate in innovative and sustainable financing mechanisms and engaged in DS and DR-TB treatment delivery and monitoring
- All patients seen in health facilities screened for TB and referred for additional testing as needed
- All public and private health care providers and facilities notify TB cases to the NTP
- All service delivery points provide TB (DS and DR) services
- Health service delivery points develop and implement quality improvement plans
- New approaches for TB diagnosis, treatment and care networks scaled up and put in place

Sub-objective 2.3  TB Transmission control improved in congregate settings and facilities

Preventing TB transmission in health facilities and congregate settings is one of the essential elements of TB control. An important strategy is the internationally-developed FAST approach (Finding TB cases Actively, Separating safely, and Treating effectively) which also includes heightened awareness among healthcare workers, improved infection control practice, and separation of patients.
Administrative, environmental, and respiratory protection measures must be considered as part of a holistic approach to transmission control. Given the relatively limited resources available for control of TB transmission, the approach should prioritize the most effective interventions, demonstrate the evidence for each intervention, and develop synergies with other interventions. The activity will focus on improved execution of infection control policies and programs in facility, community, congregate and household settings. The activity will incorporate a plan to measure, assess, and prioritize the most effective evidence-based interventions to foster sustainable and improved infection control.

Illustrative Outputs/Outcomes:

- FAST approach introduced in large health facilities and congregate settings
- Provincial-level and facility infection control plans have been developed, put in place and institutionalized
- Infection control practices in health facilities established according to international standards
- Health facilities and congregate settings assessed for infection control risks and implement programs to reduce TB transmission
- Health facilities establish and apply measures to fast track patients with cough

**Objective 3  Expand local health system capacity to deliver tuberculosis and drug-resistant tuberculosis services to targeted populations**

*Sub-objective 3.1  Decentralized governance and finance mechanisms facilitate quality TB prevention, care and treatment*

The Philippines’ devolved governance system requires local government units to manage, oversee and share financing of its health programs. LGUs must therefore lead all aspects of TB control including putting policies and corresponding financial resources in place; guaranteeing that RHUs are fully functional with adequate staff, equipment, drugs, and supplies; and providing that the RHU can provide comprehensive TB services from outreach to diagnosis and treatment. LGUs must also mobilize resources from the private sector, community based organizations and other partners. The activity is expected to build upon previous and current USAID programs such as the Health Leadership and Governance Program to further encourage LGUs to bolster oversight and management of the TB program. For example, the activity will assist local TB service providers and facilities to increase reimbursements for TB interventions and utilize these reimbursements for TB-specific activities. The activity is also expected to develop, test, and apply innovative and sustainable financing mechanisms and principles to increase engagement of private providers and civil society partners. Other support will include assuring execution of local TB plans and identifying strategies to fill gaps in human resources and stock-outs of TB drugs and other commodities.
Illustrative Outputs/Outcomes:

- More facilities that provide DOTS and TB-related services accredited by PhilHealth
- Philhealth TB reimbursements utilized for TB-specific activities
- Human resources and drug augmentation funded by the LGU
- Local plans to eliminate TB put in place
- Decreased out-of-pocket costs for patients
- New approaches for strengthening local governance scaled up and institutionalized
- New approaches for expanding financing for local institutions introduced and scaled up

Sub-objective 3.2 Data management and program monitoring supports delivery of quality TB services and drives program execution decisions

Accurate and real-time data is essential for successful TB program implementation. TB managers need data on access, and utilization of health services by different types of clients as well as information on program effectiveness in order to shape management actions and improve program performance. Collection and analysis of accurate data can reveal issues to be addressed to improve program management and increase client satisfaction. The activity will identify weaknesses in data recording and reporting and work with the regional and LGU staff to design and put in place a system for data review and analysis. This system should provide regular feedback on trends, successes and needs to all levels of the health system. Working with regional and provincial TB management teams, the activity will institute sustainable systems to reinforce data verification activities and address gaps in case notification, registration and program implementation.

To secure quality TB services at all service delivery points, the activity is expected to build the capacity of supervisory units (regional and provincial levels) to provide supportive supervision in exercising their oversight functions. Furthermore, in order to ensure that meaningful supervision is conducted, local implementation challenges are addressed, and timely performance feedback is provided, the activity will encourage regular monitoring site visits which are structured, interactive, and sustainable.

Illustrative Outputs/Outcomes:

- Collection of program data, disaggregated by gender, from the primary level improved, analyzed and utilized by program managers
- Data collected is valid, accurate, reliable, timely, relevant, and complete and used to guide program decisions
- Interventions are evidence-based and well-documented
- Capacity of health staff to interpret and utilize TB program data for decision
making enhanced
● Recording, reporting, and use of data to support TB surveillance initiated
● Health providers are supervised and monitored
● Monitoring of program performance through mentoring and site visits
  enhances quality of care delivered and improves decision making at the LGU
  and provincial level
● New approaches for collecting, analyzing and using TB service data scaled up
  and institutionalized

Sub-objective 3.3 Improved access to TB laboratory systems that provide rapid test
  results for TB (DS and DR)

Access to smear, culture and DST is very limited due to the fragile sample transport
system and the great distance between health facilities and TB labs. Many diagnostic
facilities are not connected to the network, and are not managed by the regional and
provincial DOH teams. WHO has recently modified its recommendations for the use
of GeneXpert and encourages countries to test TB suspects with Xpert, as an initial
diagnostic test. In response to these changes, the DOH has ambitious plans to procure
and install up to 3,000 instruments – one for each RHU. However, technical
assistance and capacity building is urgently needed in order to bring such technology
to RHUs and close to patients. Local DOH staff will need to be trained on use of
Xpert, forecasting and estimation of cartridges and other supplies, and quality
assurance of tests performed. The immediate goal of this activity is a reduction in the
turnaround time for testing. This can be achieved by reinforcing TB diagnosis
network capabilities and linkages to treatment sites as well as by developing an
effective system for collecting and transporting specimens to laboratories for TB
diagnosis.

Illustrative Outputs/Outcomes:

● TB testing services available at initial service delivery point of care
● Suspect TB patients receive GeneXpert or Line Probe Assay (LPA) as initial
test for TB
● Decrease the delay between diagnosis and treatment with TB positive patients
  being notified and enrolled within one to two days of diagnosis
● Network of provincial and regional diagnostic facilities have been capacitated
  and bolstered
● Diagnostic capacity of LGUs, including access, specimen transport and
  quality improved
● No stock outs of Xpert cartridges and supplies have been reported from
  participating RHUs
● Timely trouble-shooting and repair of Xpert machines to support full
  functionality at all times
● New approaches for collecting, analyzing and using TB diagnostic data scaled
  up and institutionalized
Sub-objective 3.4. Capacity of local organizations and institutions to conduct outreach activities and support TB interventions increased and sustained

The 2016 National Prevalence survey has demonstrated that the Philippines has significant gaps in TB diagnosis and treatment at all levels. The DOH will not be able to achieve measurable results unless more institutions, organizations and other stakeholders are engaged at the province and community levels. LGUs and the provincial and peripheral levels, non-NTP health providers, non-traditional health actors and civil society organizations (such as local NGOs, patient groups, community groups and others) need to be engaged in outreach activities, active case finding, and home-based care of TB patients. Local civil society organizations and non-NTP providers could have better connections to local communities as well as a better understanding of local practices and beliefs. They also have direct access to barangays (communities) to conduct educational and outreach sessions, perform active case finding and support patients to complete TB and DR-TB treatment. Local NGOs and patient groups can also serve as advocates for patients and their families as they access health facilities for TB diagnosis and treatment. Initial results of the catastrophic cost study\(^4\) suggest that patients must invest their own resources to cover costs of transportation to health facilities and initial TB screening and diagnosis. Engagement of local civil society organizations will help improve access to TB diagnosis and treatment services and as a result, increase TB case detection and adherence to treatment.

To increase local level involvement and participation in TB, the activity is expected to develop, test, and apply innovative and sustainable financing mechanisms to increase engagement of civil society organizations, non-NTP health providers and other institutions which will be used to improve TB outreach and education, case finding, patient support and advocacy, and treatment adherence and care. The activity is also expected to build the capacity of these organizations to implement and sustain TB interventions and serve as advocates for patients and families. Long term sustainability of these grants should be considered as part of initial design. The activity will be expected to follow the Automated Directives System (ADS) 303.3.21.b Applicable Standard Provisions for Subawards\(^5\).

Illustrative Outputs/Outcomes:

- Civil society organizations, local NGOs and non-NTP providers implement TB outreach, care, advocacy, and case finding activities in selected provinces
- CSOs and other organizations have capacity and expertise to provide TB communication, advocacy, education, active case finding and treatment support


- CSOs and other organizations implement programs to reduce TB stigma and discrimination
- Patient support groups established and active in providing TB education and adherence support to TB and DR-TB patients
- Plan for sustainability of initiated activities implemented and capacity of CSOs and other organizations built

3. Key Assumptions

Applicants are encouraged to discuss how their technical approaches will respond to the evolving nature of the health sector. The following are a few key assumptions that applicants should consider:

1. The Government of the Philippines (GPH) continues to prioritize the NTP as part of the Philippine Health Agenda.
2. The Government of the Philippines enforces the provisions of RA 170769 and delivers on its commitment to implement the Philippine Strategic TB Elimination Plan.
3. The Global Fund approves a three year (2018-2020) grant to assist in critical gaps in the NTP activities.
4. PhilHealth continues to finance TB programs.
5. The U.S. assistance for TB remains stable, at a minimum.

4. Implementation Principles

1. Patient-Centered Care Approach

The patient-centered care approach of the WHO TB strategy consists of enabling patients to exercise their rights and fulfill their responsibilities with transparency, respect and dignity, by giving due consideration to their values and needs. Patient-centered care treats the patient as a partner instead of just a recipient, empowering patients and providers and allowing for empowered individuals. This leads to a higher likelihood of successful treatment outcomes, improved wellbeing, and financial risk protection by improving adherence to treatment. The “TB Platforms” activity will consider patient needs first in order to design interventions.

<table>
<thead>
<tr>
<th>Box 4: Standard Principles for TB Platforms for Sustainable TB Detection, Care and Treatment Activity</th>
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<tbody>
<tr>
<td>Activity</td>
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<tr>
<td>Aligned with Philippines and USG priorities</td>
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<tr>
<td>Patient-Centered</td>
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<tr>
<td>Data-driven approach</td>
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<tr>
<td>Engagement of new partners</td>
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<tr>
<td>Focus on sustainability and institutionalization</td>
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<td>Geographically focused</td>
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<tr>
<td>Gender-sensitive and gender-transformative</td>
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<td>Coordination and collaboration with all partners</td>
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Successful patient-centered care requires strong interpersonal and behavior change communication at all levels of the health system and among individuals, communities, and providers in order to transform how health services are accessed and delivered. For example, success will be measured by the number of individuals and communities who have the knowledge and awareness to get tested for TB, start treatment, and complete the course of treatment. Health providers and health facilities will possess the skills and knowledge to routinely provide quality, patient-friendly, respectful and gender-sensitive services without stigma and discrimination. At the health systems level, national policies, guidelines and processes will take into consideration the needs of patients and clients and are designed to provide respectful and patient-centered care. Social and behavior change communication interventions must therefore be designed with these individual, community, provider and system level needs in mind.

### Box 5: Core Values of Patient-Centered Care

Some core values of a patient-centered care approach include:
- universal access to care and support
- consideration for needs, perspectives, and individual experiences
- respect for the right to be informed and receive the best quality of care based on individual needs
- established of mutual trust and partnership in the patient-care provider relationship
- create opportunity to provide input into and participate in the planning and management of own care
- empowerment and activation to increase self-efficacy, independence, and involvement at all levels

2. Data-driven approach

High-quality data about the TB epidemic is central for the development of sound interventions and for making informed decisions. For TB care, health providers and program managers use information to identify causes and contributing factors to the spread of TB and to identify effective health promotion interventions to boost TB programs and outcomes. For TB interventions to be successful, they must be based on the best available data to inform planning frameworks and interventions, and subsequently to systematically engage the community and other stakeholders. All interventions must be evidence-based, their effectiveness must be evaluated and their cost-efficiency analyzed, if possible. Pre- and post-intervention analyses are also important. Conducting regular monitoring of activities to identify areas where expected outputs are not being met or where quality may need improvement and sound evaluation of interventions to determine which merit scale up are also part of this approach. The “TB Platforms” activity will be expected to contribute to achievement of the targets of the PhilSTEP 1, provide data for required U.S. government reports, and develop robust indicators to measure and track program performance.
Additional information about how the activity will be expected to work with other implementing partners and donors to achieve these results is discussed in greater detail in Section D.2 Partner and Donor Coordination and in Section G. Monitoring, Evaluation and Learning.

3. Engagement of new partners in the fight against TB

Civil society organizations such as local NGOs, patient groups, community groups as well as non-NTP health provider and other actors can bring new perspectives and resources to the provincial and LGU levels and can be engaged to conduct a wide range of TB interventions and services. These organizations and institutions can implement interventions such as active case finding, adherence and patient support, and educational sessions for patients and their families. Under the “TB Platforms” activity, the recipient is expected to develop, test and apply novel and sustainable financing mechanisms to support local organizations to implement TB education, advocacy, detection, treatment and care activities. No more than fifteen percent (15%) of the total estimated cost of the activity may be allocated to engage and build the capacity of civil society and non-NTP partners to conduct TB activities. The “TB Platforms” activity may develop new contracting mechanisms, solicit new partnerships, bolster TB and outreach capacity, and provide grants to local NGOs and CSOs. All financing activities should be accompanied by implementation of a long-term plan for sustaining these interventions beyond the life of the activity. The activity should follow the provisions of Automated Directives System 303.3.2.b. Applicable Standard Provisions for SubAwards⁷.

F. PARTNER AND DONOR COORDINATION AND IMPLEMENTATION ARRANGEMENTS

To achieve the objectives and targets of the PhilSTEP1, close coordination between the National TB Program, the Global Fund Principal Recipient and other USAID activities will be essential. The “TB Platforms” activity must prioritize work to align interventions with, complement, and fortify the activities of other partners and the DOH. The activity will participate in established NTP or USAID-led coordination mechanisms including, but not limited to: annual technical assistance harmonization meetings; USAID implementing partner and expanded technical assistance partner meetings; technical working groups; and regional, provincial, LGU, barangay coordination meetings among others. Should this activity work in the same location (e.g., region, province, LGU, barangay, health facility or RHU) as another USAID activity or partner, the “TB Platforms” activity must make every effort to jointly plan work, implement interventions and if appropriate, provide complementary assistance.

TB Innovations and Health Systems Strengthening - The “TB Innovations and Health Systems Strengthening” activity will be the lead USAID partner for helping to coordinate TB

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interventions at the national and regional levels. Given that many USAID-funded and Global Fund partners will be providing technical expertise to the NTP at the national level, close coordination and delineation of areas of responsibility will be critical. At both the national and regional levels, “TB Innovations and Health Systems Strengthening” will provide assistance to the NTP to organize and expand coordination among implementing partners. This activity will need to closely collaborate with all partners who are working on related health systems strengthening interventions such as those that address governance and finance, human resources and TB supply chain management. The activity may test and put in place new approaches at the regional, provincial and community levels, collaborating closely with the “TB Platforms” activity.

**TB Platforms** - The “TB Platforms” activity will be expected to help scale-up and institutionalize the new approaches and models pioneered and developed by the “TB Innovations and Health Systems Strengthening” activity in the regions and provinces where it is working. This activity will also play an important role putting in place and helping to roll out national policies, guidelines and approaches. The activity will inform the development of and report on execution of national strategies and plans through their experience on the ground and at lower levels of the health system. Therefore, the “TB Platforms” activity will be expected to participate in national-level and in regional-level planning and coordination meetings to shed light on implementation issues, challenges, and opportunities on the ground. A coordination mechanism between the “TB Innovations and Health Systems Strengthening” and the “TB Platforms” activities will need to be formally established at both the national and regional/provincial levels. Both activities will be expected to share best practices and lessons learned with each other and ensure seamless implementation of TB activities at the provincial level after they have been developed at the national level.

While most USAID-backed TB activities will have distinct technical areas and/or distinct government counterparts, USAID implementing partners may work on the same technical issue or with the same government counterpart. An important nexus for coordination between the “TB Platforms” and “TB Innovations and Health Systems Strengthening” activities will be in the regions where both partners are providing capacity-building support. Both partners will need to coordinate with the regional offices to determine appropriate roles and responsibilities and assure that activities are not duplicative. In most cases, the “TB Innovations and Health Systems Strengthening” activity will be the lead partner for coordinating the activities of different USAID partners at the regional level.

The “TB Platforms” activity must closely coordinate USAID-funded TB activities in the provinces and communities in which it will work. Should TB-related activities be introduced by other USAID implementing partners in those same provinces and communities, that partner must coordinate with the “TB Platforms” activity. In most cases, “TB Platforms” will be the lead USAID partner for USAID coordination in the provinces and communities where it is working.

**Coordination with the Global Fund to Fight AIDS, TB and Malaria** - The United States is the Global Fund’s largest donor and also provides funding for oversight and execution of Global Fund grants. By collaborating with the Global Fund, the U.S. Government seeks to catalyze contributions from other donors, expand the reach of U.S. Government bilateral programs,
promote country ownership and improve the sustainability of national health programs.

The Global Fund provides countries with predictable, performance-based financing and USAID strives to expand the engagement and coordination of its programs with their Global Fund counterparts to bolster results to build country-level capacity to design and operationalize sustainable programs that meet citizens’ needs. The relationship between the Global Fund and USAID involves close coordination of resources so that funding and programs are complementary and not duplicative. This activity is expected to provide technical expertise and wrap-around technical support to the Global Fund Principal Recipient. Regular meetings and joint work planning and monitoring visits will be essential. Please see Annex D for more information about how USAID and Global Fund activities will assist the Department of Health.

G. GEOGRAPHIC FOCUS

The activity will be focused in geographic areas of the Philippines with the highest TB burden (i.e. regions with the highest number of estimated TB cases in 2016). Throughout the life of the activity as new data become available, USAID, in collaboration with the DOH and NTP, may identify other geographic areas where the TB burden is high and where the need for technical assistance and capacity building is greatest to focus TB interventions.

Given the currently available TB burden data, USAID, in collaboration with the NTP, will work with the Recipient to prioritize activity interventions in two to three regions at the beginning of the activity. In collaboration with USAID and the NTP, the activity may be expected to expand to additional regions throughout the life of the activity in order to expand coverage of underserved populations at risk of contracting TB.

The activity will be expected to coordinate closely with the NTP, USAID and other partners to select provinces and regions, determine specific interventions, and agree on principles of engagement in order to maximize efficiency of investments in TB. More information about activity collaboration is located in Section F. Partner and Donor Coordination. Please also see Annex B for statistics about TB.

H. GENDER CONSIDERATIONS

USAID/Philippines staff completed a Gender analysis to inform the design of new activities for the Philippines Health Project. Key findings related to tuberculosis detection, prevention, treatment and care from the analysis are summarized here. A full description of expected approaches for Gender is located in Annex E.

In the Philippines, TB is twice as common among males compared to females. Men and women may also experience different risk factors and exposure to TB, which can be addressed through gender-sensitive tailored interventions. Determinants and differences in accessing TB knowledge, decision-making to seek care and preferred health care site are other important gender-related factors. Once an individual decides to seek care, subsequent barriers to care also
differ: women may lack the financial resources or autonomy to visit a clinic and/or men may be unable to miss work to attend a clinic during regular hours. Adherence and treatment success rates may also differ between the two sexes.

The success of TB programs and progress towards the elimination of TB requires gender-sensitive and gender-transformative programming because it is important for delivering patient-centered care. USAID expects the applicant to delve into the gender-based differences related to TB in order to thoughtfully design, execute and monitor interventions that most effectively reach target groups while contributing to equitable access to quality care.

The “TB Platforms” activity is expected to contribute to reducing gender disparities in accessing and benefitting from tuberculosis care and treatment services. The activity is also encouraged to contribute to empowering and increasing the capability of women and girls to realize their right to seek healthcare services and to influence decision-making regarding health care. Furthermore, as gender barriers often prevent men and boys from seeking services, the activity will work to transform negative masculinities that prevent men and boys from taking care of their own health as well.

To provide greater focus on gender equality and women’s empowerment in this activity, the activity will prepare a Gender Action Plan that, among others, will include the following:

- Collection of sex-disaggregated data and monitoring of all people-level indicators and use of gender analysis tools to identify potential gender gaps and constraints as well as recommend and take actions to address the gaps.
- Incorporation of gender-sensitive and gender-transformative situational analyses of behavior change strategies and activities.
- Completion of gender-responsive consultations to encourage the active participation of females and males and guarantee that all voices are heard and reflected in activity plans and activities.

I. PARTNERSHIP IN SUPPORTING DISASTER RESPONSE

The Philippines is vulnerable to natural hazards. Due to its geographic location, the country is one of the world’s most disaster prone countries, particularly vulnerable to tropical cyclones and floods, earthquakes, landslides and volcanic eruptions. These disasters can easily wipe-out development gains in the country.

USAID/Philippines in responding to large-scale disasters may request mobilization of implementing partners to assist in delivering humanitarian assistance. Hence, partners are encouraged to develop project implementation frameworks that have the flexibility to dispatch resources and re-align budgets to support rapid delivery of humanitarian assistance.

On a case-by-case basis, USAID/Philippines may request its implementing partners to re-align the distribution of project resources to disaster-affected areas and vulnerable populations, and to contribute to alleviate human suffering and expedite social and economic
recovery, and to assist in delivering humanitarian assistance. The scope and deliverables expected from the re-alignment of project resources will be mutually agreed upon by USAID/Philippines and the implementing partner.

J. SUSTAINABILITY AND INSTITUTIONALIZATION

This activity begins with the end in mind. USAID’s definition of sustainability is “the capacity of a host country entity to achieve long-term success and stability and to serve its clients and consumers without interruption and without reducing the quality of services after external assistance ends.” An activity contributes to sustainability when it fortifies the local system’s ability to produce valued results as well as its ability to be both resilient and adaptive in the face of changing circumstances. In this case, an intervention is considered successful if it can be incorporated into and sustained by the NTP and at lower levels of the health system.

The “TB Platforms” activity must design its technical approach to maximize the institutionalization and sustainability of all its interventions. When designing interventions, the activity must carefully consider how all aspects of the activity e.g., program design, capacity building and administrative support will be sustained at the end of the activity. The implementing partner should plan its exit strategy as part of program design including how it will transition its interventions to counterparts. The applicant should carefully consider what public, private or community institutions it will strengthen throughout the life of the activity so that by 2022, TB detection, prevention, treatment and care interventions will continue.

Equally important will be a process to constantly monitor and evaluate for sustainability. The activity will be expected to develop a sustainability plan at the outset of the award.

K. MONITORING, EVALUATION AND LEARNING

The “TB Platforms” activity will develop a robust, well-rounded Activity Monitoring, Evaluation and Learning Plan (AMELP) that will serve as the road map to determine how well project objectives are being met and monitor outcomes, results and impact of the interventions for each technical objective and sub-objective. The AMELP will include the following information, at the minimum:

1. Monitoring, Evaluation and Learning philosophy and approach including the activity’s learning agenda
2. Fully defined performance indicators using the standard USAID Performance Indicators Reference Sheet template;
3. Baseline values, annual targets and end-of-project targets for outcome, outputs, and required PPR indicators, as well as targets for gender integration and institutionalization and sustainability;
4. Objectively measurable benchmarks or milestones for performance that cannot be measured via standard performance indicators;
5. Data collection methods and frequency of data collection for each indicator;
6. Proposed plan and tools for conduct of data quality assessments;
7. Planned evaluation, learning and adaptation activities.

The AMELP will be updated annually and reported on as part of quarterly and annual reports.

Through its AMELP, the “TB Platforms” activity will monitor interventions, collect program performance data, measure progress towards results, and undertake data collection and verification strategies that provide for reliability and accuracy of progress toward expected accomplishments. Triangulation of data sources is required. The applicant must present how they will regularly analyze process, output, and outcome indicators using the appropriate methodology to improve project implementation, and document results.

In order to achieve the targets, in coordination with USAID, the activity will conduct detailed work planning with the NTP, Global Fund Principal Recipient and other implementing partners to clearly delineate technical interventions and activities by geographic area (province level). The activity recipient will be expected to collaborate in monitoring efforts with other USAID implementing partners, the DOH, and other donor/partner programs, to ensure that monitoring and evaluation systems are cost-effective and do not create parallel systems. The methodologies for collection and actual data collected may need to be harmonized for ease of aggregation or other specialized reporting needs.

Plans, design, methodology, and scopes of work of activity-initiated monitoring, evaluation and learning activities as well as evaluation reports will be reviewed and approved by USAID prior to implementation and dissemination.

The activity will track all required indicators as established by USAID’s Operational Plan and the USAID TB Implementation Approach, among others. Additional indicators may be necessary to monitor changes in the status of key indicators. Comparison of data between U.S. and non-U.S.-supported sites is desired. Indicators will be appropriately disaggregated by age, sex, and geographic region. The recipient should also include indicators on sustainability. The activity will be expected to review progress towards these targets with USAID/Philippines on at least an annual basis with quarterly progress meetings at the operational level. The recipient should be prepared for revisions in required indicators and reporting requirements during the lifetime of this activity.

The activity is expected to make an important contribution to learning, specifically around the increased access to high impact interventions and the adoption of key healthy TB-related behaviors in the Philippines. The activity should plan to conduct implementation research or other types of evaluations for select interventions in order to assess the impact of approaches and to adjust the program to bolster program results. In addition, the “TB Platforms” activity will be expected to collaborate and partner with the “Collaboration, Learning and Adapting” activity (CLA) by using CLA analytical studies and reports, providing project data information and results, and jointly conducting select operations research projects. Information generated by the CLA activity will be used to inform policy recommendations and programmatic decision-making for the USAID Health Office.
USAID may commission an independent performance evaluation during the course of the activity implementation. The “TB Platforms” activity will work closely with the evaluators to ensure successful implementation, including the identification of appropriate baseline indicators. Results of the performance evaluation may lead to modifications in the implementation of the mechanism and will be shared in a public report.

**K. ENVIRONMENTAL COMPLIANCE**

The Foreign Assistance Act of 1961, as amended, Section 117 requires that the impact of USAID’s activities on the environment be considered and that USAID include environmental sustainability as a central consideration in designing and carrying out its development programs. This mandate is codified in Federal Regulations, 22 CFR 216 (https://www.ecfr.gov/cgi-bin/text-) and in USAID’s Automated Directives System (ADS) Parts 201.5.10g and 204 (http://www.usaid.gov/policy/ads/200/) , which, in part, require that the potential environmental impacts of USAID-financed activities are identified prior to a final decision to proceed and that appropriate environmental safeguards are adopted for all activities. Recipient environmental compliance obligations under these regulations and procedures are specified in the following paragraphs of this RFA.

In addition, the Recipient must comply with host country environmental regulations unless otherwise directed in writing by USAID. In case of conflict between host country and USAID regulations, the latter shall govern.

No activity funded under this Cooperative Agreement must be implemented unless an environmental threshold determination, as defined by 22 CFR 216, has been reached for that activity, as documented in a Request for Categorical Exclusion (RCE), Initial Environmental Examination (IEE), or Environmental Assessment (EA) duly signed by the Bureau Environmental Officer (BEO). (Hereinafter, such documents are described as “approved Regulation 216 environmental documentation.”)

An IEE, Asia 17-038, has been approved for the “USAID/Philippines Health Project” that is funding this RFA. The IEE covers interventions expected to be implemented under a Cooperative Agreement. USAID has determined that a **Negative Determination with conditions** applies to one or more of the proposed interventions. This indicates that if these interventions are implemented subject to the specified conditions, they are expected to have no significant adverse effect on the environment. The Applicant shall be responsible for implementing all IEE conditions pertaining to interventions to be funded under this solicitation.

As part of its initial Implementation Plan, and all Annual Implementation Plans thereafter, the Recipient, in collaboration with the USAID Agreement Officer’s Representative (AOR) and Mission Environmental Officer or Bureau Environmental Officer, as appropriate, must review all ongoing and planned interventions under this Cooperative Agreement to determine if they are within the scope of the approved Regulation 216 environmental documentation.
If the Recipient plans any new interventions outside the scope of the approved Regulation 216 environmental documentation, it shall prepare an amendment to the documentation for USAID review and approval. No such new interventions shall be undertaken prior to receiving written USAID approval of environmental documentation amendments.

Any ongoing interventions found to be outside the scope of the approved Regulation 216 environmental documentation shall be halted until an amendment to the documentation is submitted and written approval is received from USAID.

When the approved Regulation 216 documentation is (1) an IEE that contains one or more Negative Determinations with conditions and/or (2) an EA, the Recipient shall:

1. Unless the approved Regulation 216 documentation contains a complete environmental mitigation and monitoring plan (EMMP) or a project mitigation and monitoring (M&M) plan, the Recipient shall prepare an EMMP or M&M plan describing how the Recipient will, in specific terms, implement all IEE and/or EA conditions that apply to proposed activity interventions within the scope of the award. The EMMP or M&M plan shall include monitoring the implementation of the conditions and their effectiveness. The conditions are as follows:

a. Conditions for (a) the procurement, use, storage, management and disposal of public health commodities used for delivery of services; and (b) training in health facilities and in communities that directly or indirectly result in the generation, storage, handling and disposal of hazardous medical waste, or in techniques that have a direct or indirect environmental impact;

   USAID must work with implementing partners to insure that:

   - When training professionals or community health workers in service delivery procedures that result in the generation and disposal of potentially hazardous medical waste, the curricula should cover best management practices concerning the proper handling, use and disposal of medical waste, as applicable, and that it is consistent with current DOH protocols; and

   - The medical facilities have procedures in place to properly handle, label, treat, store, transport and properly dispose of blood, placenta, sharps and other medical waste such as used sputum cups, slides, applicator sticks, syringes and cartridges for GeneXpert as well as sputum specimens, based on standards of DOH and USAID or based on guidelines developed from these standards.

At the start of each activity, the implementing partner, in consultation with the AOR, will formulate an EMMP. The implementing partner will validate the plan’s consistency with DOH and USAID guidelines as well as with internationally accepted standards for medical waste disposal. As appropriate, the implementing partner will work with facility, local, regional and/or national officials to implement and apply appropriate best management practices which incorporate appropriate health and
safety measure and environmental safeguards, including proper disposal of medical waste. The management of potential health and environmental hazards from health service delivery and health systems management may include ensuring LGUs are aware of and adhere to local standards of medical waste disposal.


b. Conditions on the use/disposal of medical equipment and supplies;

Implementing partner(s) should ensure and provide the AOR with evidence that equipment is procured from certified retailers and include environmental safety and quality certificates that conform to national and/or international standards. The recipient of the equipment should be provided with information on the proper use of and instructions on proper disposal of electronic waste. The recipient should also be provided with a list of Government of the Philippines-accredited recyclers for proper disposal of the equipment after its useful life.

c. Conditions on the use and disposal of small electric and electronic equipment, such as cellular phones, netbooks and tablets;

No special mitigation measures are needed. Normal good practices will be used. The proposed action is that the implementer should provide evidence that equipment is procured from certified retailers and include environmental safety and quality certificates that conform to national and/or international standards. The recipient of the equipment should follow all applicable national and international laws to ensure that it is used in an environmentally sound and safe manner. Equipment should be properly disposed of (when applicable) at the end of its useful life in a manner consistent with best management practices according to USG, European Union or equivalent standards acceptable to USAID.

d. Conditions and best practices for general classes of interventions involving healthcare waste;

- All interventions shall be conducted following principles for environmentally sound development, as provided in the USAID Sector Environmental Guidelines—Healthcare Waste. This document can be found at http://www.usaidgems.org/Sectors/healthcareWaste.htm.
- An EMMP shall be developed that includes the principles of the guidelines.
- Each intervention that has healthcare waste should have a sound healthcare waste management plan and system to minimize adverse health and environmental impacts caused by their wastes. A program to manage healthcare waste includes the minimum elements: (a) written plan; (b) clear responsibilities; (c) written internal rules; (d) staff training; (e) protective
clothing; (f) good hygiene practices; (g) vaccinated workers; (h) designated storage locations; (i) waste minimization; (j) waste segregation; (k) waste treatment; (l) final disposal site; and (m) periodic reviews. The format and guidance of this report will be provided by the AOR and should include the qualities of the Minimal Program Checklist and Action Plan from the abovementioned environmental guidelines.

- With interventions involving health commodities, the implementing partner should have a written plan to ensure appropriate procurement, storage, management and/or disposal of public health commodities, including pharmaceutical drugs and nutritional supplements such as established adequate procedures and capacities in place to properly manage and dispose of such commodities.
- The checklist found at the following website should be used for monitoring: http://www.usaidgems.org/Documents/VisualFieldGuides/medwastJan2010.pdf.

e. Conditions and best practices for general classes of interventions involving Healthcare Facilities:

- All interventions shall be conducted following the principles for environmentally sound development, as provided in the USAID Sector Environmental Guidelines—Health Facilities. This document could be found at: http://www.usaidgems.org/Sectors/healthcareFacilities.htm.
- Design for waste management.
- Ensure sufficient water supply and sanitary management capacity.
- Support to interventions that include healthcare waste should have a sound healthcare waste management plan and system to minimize adverse health and environmental impacts caused by their waste. See healthcare waste management guidelines found at: http://www.usaidgems.org/Sectors/healthcareWaste.htm.
- An EMMP shall be developed that includes the principles of the aforementioned guidelines.
- The checklist found at the following website can be used for monitoring: http://www.usaidgems.org/Documents/VisualFieldGuides/medwastJan2010.pdf.

Contingency Provision. Construction is not among the current planned actions under the 2017-2022 TB Platforms activity nor of this RFA. Should the need for construction arise during the period covered by this IEE, USAID will take into consideration the conditions listed below.

a. Conditions and best practices for general classes of interventions involving Small-Scale Health Facility Construction:

- All construction interventions shall be conducted following the principles for environmentally sound construction, as provided in the USAID Sector
Environmental Guidelines – Small Scale Construction, which can be found at: [http://www.usaidgems.org/Sectors/construction.htm](http://www.usaidgems.org/Sectors/construction.htm).

- For the rehabilitation of existing facilities and for construction of facilities in which the total surface area disturbed is less than 10,000 square feet, the implementing partner shall conduct and prepare a supplemental Environmental Review Checklist (ERC) documenting a site specific environmental review. A link to the ERC template is below. The ERC should include an EMMP. Construction will not begin until such a review and report is completed and approved by the AOR in consultation with the Mission Environment Officer.

- For the construction of any facilities in which the total surface area disturbed exceeds 10,000 square feet (1,000 square meters) or is considered to have a significant effect on the environment, the IEE must be amended and may need an Environmental Analysis.

- The implementing partner should design interventions to minimize vulnerability of facilities to climate change.

- A USAID Engineer is available to review all construction design.


2. Integrate a completed EMMP or M&M plan into the initial implementation plan.

3. Integrate an EMMP or M&M plan into subsequent annual implementation plans, making any necessary adjustments to activity implementation in order to minimize adverse impacts to the environment.

USAID anticipates that environmental compliance and achieving optimal development outcomes for the proposed activities will require environmental management expertise. Respondents to the RFA should therefore include as part of their application, their approach to achieving environmental compliance and management to include:

1. The respondent’s approach to developing and implementing an EMMP or M&M plan.

2. The respondent’s approach to providing necessary environmental management expertise, including examples of past experience of environmental management of similar interventions.

3. The respondent’s illustrative budget for implementing the environmental compliance interventions. For the purposes of this solicitation, applicants should reflect illustrative costs for environmental compliance implementation and monitoring in their cost application.

**L. CLIMATE RISK MANAGEMENT**
To comply with the new Agency guidance on Climate Resilient International Development as defined in ADS 201 Mandatory Reference, https://www.usaid.gov/sites/default/files/documents/1876/201mat.pdf, USAID conducted an initial climate risk assessment of all Health Activities including the Patient-Centered TB Program as evidenced in the approved IEE, Asia 17-038. The Implementing Partner should review the completed climate risk analysis prepared by USAID and describe its approach to conduct a more in-depth climate risk assessment and how it will inform activity implementation, if deemed necessary.

[END OF SECTION I]
SECTION II: FEDERAL AWARD INFORMATION

A. ESTIMATED FUNDS AVAILABLE AND NUMBER OF AWARDS CONTEMPLATED

The ceiling for this program is $20,000,000. USAID intends to provide $20,000,000 in total funding over a five year period. However, actual funding amounts are subject to availability of funds.

USAID intends to award one (1) Cooperative Agreement pursuant to this RFA. USAID reserves the right to fund any one or none of the applications received.

B. START DATE AND PERIOD OF PERFORMANCE FOR FEDERAL AWARD

The anticipated period of performance for this Activity is five (5) years. The estimated start date will be upon signature of the award, on or about May, 2018.

C. SUBSTANTIAL INVOLVEMENT

USAID will remain substantially involved over the life of the Cooperative Agreement to assist the Recipient in achieving the expected outcomes and results of the program. Substantial involvement under the proposed award shall include the following:

1. **Approval of the Recipient’s Implementation Plan.** The annual implementation plans with supporting budgets, and subsequent revisions thereto, are subject to prior written approval by USAID’s Agreement Officer’s Representative (AOR) before any substantive work for each year of the Agreement is executed.

2. **Approval of Key Personnel.** The following positions have been designated as key to the successful implementation of the program objectives of this Agreement. These personnel are subject to prior written approval by the Agreement Officer:
   a. Chief of Party
   b. TB Technical Team Leader
   c. Monitoring and Evaluation Advisor
   d. Sustainable Finance and Partnerships Manager
   e. Finance and Administration Manager.

3. **USAID and Recipient Collaboration or Joint Participation.** The Recipient's successful accomplishment of program objectives will benefit from USAID's technical knowledge;
thus, the Agreement Officer (AO) may authorize the collaboration or joint participation of USAID and the Recipient on the program. USAID involvement may include but is not limited to:

a. Geographic Targeting. Prior written USAID AOR concurrence is required on final decisions concerning the geographic targeting of the “TB Platforms” activity.

b. Approval of the Recipient's Activity Monitoring, Evaluation and Learning Plan (AMELP). In consultation with USAID through the AOR, the Recipient will develop the AMELP which will align with the monitoring and reporting framework, and other relevant reporting mechanisms required by USAID/Philippines. During the first ninety (90) days from award date, the Recipient will work closely with the AOR to establish major milestones, program monitoring indicators, as well as baseline data and performance targets which will demonstrate successful achievement of the results expected from this activity.

c. Joint participation in Steering or Technical Committees. The Recipient and USAID will jointly participate in steering or technical committees, including but not limited to NTP planning meetings, TB technical working groups and other TB-related committees.

d. Monitoring the Activity. USAID will monitor the “TB Platforms” activity to ensure activities are supporting Mission purpose, to share best practices and capture lessons learned and will authorize direction and/or redirection of interventions specified in the Program Description due to GPH and US foreign policy objectives and priorities, as well as interrelationships with other programs, including those of USAID’s. Monitoring includes but will not be limited to site visits; reviewing terms of reference, quarterly and other types of reports, deliverables and other products; and participating in technical meetings as appropriate.

e. Approval of Subawards. Per 2 CFR 200.308, all subawards (whether contracts or subgrants) not included and approved in the original cooperative agreement will require prior written Agreement Officer approval. In addition, prior written AOR concurrence with substantive provisions of subawards is required. Furthermore, USAID will participate as a member of any contracting and financing mechanism established by the “TB Platforms” activity.

4. Agency authority to immediately halt a construction activity. USAID retains the authority to immediately halt any construction that may be undertaken under this activity.

For purposes of this activity, “construction” means: construction, alteration, or repair (including dredging and excavation) of buildings, structures, or other real property and includes, without limitation, improvements, renovation, alteration and refurbishment. The term includes, without limitation, roads, power plants, buildings, bridges, water treatment facilities.

8 Except contracts for the acquisition of supplies, materials, equipment or general support services.
No construction activities are authorized under this cooperative agreement.

D. TITLE TO PROPERTY

Title to property financed by USAID under the award will vest in the Recipient, and will be subject to the USAID Standard Provisions for US Non-Governmental Organizations or Non-US Non-Governmental Organizations, whichever is applicable.

E. AUTHORIZED GEOGRAPHIC CODE

The Authorized Geographic Code for the procurement of goods and services under this activity is “937”.

F. PURPOSE OF THE AWARD

The principal purpose of the relationship with the Recipient under this activity is to transfer funds to accomplish a public purpose of support or stimulation of access to justice which is authorized by Federal statute.

The successful Recipient will be responsible for ensuring the achievement of the program objectives and the efficient and effective administration of the award through the application of sound management practices. The Recipient will assume responsibility for administering Federal funds in a manner consistent with underlying agreements, program objectives, and the terms and conditions of the Federal award. The Recipient using its own unique combination of staff, facilities, and experience, has the primary responsibility for employing whatever form of sound organization and management techniques may be necessary in order to assure proper and efficient administration of the resulting award.

[END OF SECTION II]
SECTION III: ELIGIBILITY INFORMATION

A. ELIGIBLE APPLICANTS

1. Applicants may be U.S. or non-US organizations; non-profits or for-profit organizations willing to forego their fee; nongovernmental organizations; private voluntary organizations; foundations; institutions of higher education; consortia and public international organizations. Applications from potential new partner organizations that have not previously received financial assistance from, or have not previously done business with, USAID are welcome. Individual applicants, however, are not eligible to participate.

2. To be eligible to apply under this RFA, applicant organizations are required to:
   a. Provide a valid DUNS number (http://fedgov.dnb.com/webform) in its application.
   b. Be registered in SAM (www.sam.gov) or be in the process of completing their registration in SAM.
   c. Continue to maintain an active SAM registration with current information during the time it has an application or plan under consideration by a Federal awarding agency, or during an active Federal award. USAID will not make an award to an applicant if it has not fully complied with the DUNS and SAM requirements by the time the award is ready to be made.

3. Applicants must submit complete applications that meet the requirements, including the required documentation specified in Section IV of this RFA.

4. Applicants must have established financial management, monitoring and evaluation processes, internal control systems, and policies and procedures that comply with established U.S. Government standards, laws, and regulations.

5. The Agreement Officer will subject the “apparently successful” applicant to a pre-award survey. Based on the results of the pre-award survey, the Agreement Officer will determine if the prospective recipient is a responsible entity, i.e., whether it has the necessary organization, experience, accounting and operational controls, and technical skills, or, has the ability to obtain them, in order to achieve the objectives of the program and to comply with the terms and conditions of the award.

9 USAID will not make an award to an applicant that has not fully complied with the SAM requirement by the time an award is ready to be made.
B. COST SHARE

Applicants are required to provide a cost share of up to five percent (5%) of their applications’ total estimated costs but no more than $1,000,000. Applicants that do not meet the cost share requirement will not be considered for award.


C. OTHER

Eligible organizations may submit only one (1) application under this RFA.

[END OF SECTION III]
SECTION IV: APPLICATION AND SUBMISSION INFORMATION

A. AGENCY POINT OF CONTACT

The main point of contact for this Request for Application (RFA) is:

  Name : Sandra Jansen
  Title : Agreement Officer
  Email : manila-roaa-rfa@usaid.gov

B. QUESTIONS AND ANSWERS

All questions regarding this RFA must be submitted by email to manila-roaa-rfa@usaid.gov with copies to mdela@usaid.gov and inarag@usaid.gov.

Questions regarding this RFA must be submitted by email no later than the date indicated on the cover letter of this RFA in order to allow USAID sufficient time to address the questions and to incorporate the questions and answers as an amendment to the RFA. Any information given to a prospective applicant concerning this RFA will be promptly furnished to all other prospective applicants as an amendment to this RFA if the information is necessary in submitting applications, or if the lack of it would be prejudicial to other prospective applicants. Applicants are encouraged to regularly check Grants.gov, www.grants.gov, for any amendments.

C. APPLICATION SUBMISSION

Applicants are expected to review, understand, and comply with all aspects of the RFA before submitting their applications. Applicants must ensure that all necessary documentations are complete and received by USAID on time. All applications received by the deadline will be reviewed for completeness, responsiveness and programmatic merit in accordance with the specifications contained in this RFA. Failure to do so may result in the application being considered non-responsive and will not be evaluated.

Applicants are to submit applications in both electronic and paper/hard copy. Applicants’ authorized representatives are to print and sign their names on the cover pages of their technical and cost applications as well as sign all required certifications.

For an application to be considered timely, the electronic application must be submitted by email to manila-roaa-rfa@usaid.gov and received by the USAID/Philippines internet server no later than the date and time indicated on the cover letter of this RFA. Hard copies of applications must be received no later than two (2) days after the RFA’s closing date, before 3:00pm (PST).
1. Electronic Application Submission

a. Applications submitted electronically must be no larger than 5MB per email.
   APPLICANTS MUST NOT SUBMIT ZIPPED FILES.

b. USAID’s preference is that technical application and cost application be submitted as
   single email attachments, i.e., consolidate the various parts of the technical
   application into a single document before sending it. If this is not possible to send
   either as one document, please provide instructions on how to collate the attachments.
   USAID will not be held responsible for errors in compiling submitted electronic
   applications if no instructions are provided or if instructions are unclear.

c. To facilitate the review of applications, applications must conform to the format
   described below:

   1) The Technical Application in Adobe Acrobat portable document format (.pdf). If
      necessary to comply with email size restrictions, this may be broken into separate,
      but sequential parts.

   2) The Cost Application – one (1) copy cost application in Adobe Acrobat portable
      document format (.pdf) and one (1) copy with all spreadsheets in unprotected
      Microsoft EXCEL format. The same requirement applies to all subgrantees’
      spreadsheets. If necessary to comply with email size restrictions, the cost
      application may be broken into separate, but sequential, parts.

   3) If multiple emails are needed to submit a complete application, please indicate in
      the subject line of the email whether the email relates to the technical or cost
      application, and the desired sequence of multiple emails (if more than one) and of
      attachments (e.g. "1 of 4", etc.). For example, if your technical application
      including attachments is being sent in three emails, the first email’s subject line
      will state “[organization name], Technical Application, 1of 3” and if your cost
      application is being sent in two emails, the first email must have a subject line
      which says: "[organization name], Cost Application, Part 1 of 2".

d. After submitting their applications electronically, applicants must immediately check
   their own emails to confirm that all the emails and attachments were indeed sent. If
   you discover an error in your transmission, please send the material again and
   indicate in the email’s subject line that it is a “corrected” submission. Do not send the
   same email more than once unless there has been a change, and if so, please state that
   it is a “corrected” email.

e. Faxed applications are not acceptable.
2. **Hard Copy Application Submission**

a. Applicants must submit hard copies of their applications. For the technical application, one (1) original and six (6) copies are required. For the cost application, one (1) original and one (1) copy are required.

b. Submissions may be by post, commercial courier, or hand-delivery. Please ensure the hard copy application packages are submitted in sealed envelopes and are received no later than 12noon of January 8, 2018, or five (5) days after the RFA’s closing date as indicated on the Cover Page of this RFA.

c. Hard copies of applications must be addressed as follows:

1) **Via US Postal Service**

   USAID/ROAA  
   Unit 8600 Box 1700  
   DPO AP 96515-1700

2) **Via commercial courier service or hand-delivery**

   American Embassy  
   Manila, Philippines  
   For: USAID/ROAA  
   RFA No. 72049218RFA00001  
   Tel. No. 301-6000 ext. 4923

   **Note for courier service:** Applicants are encouraged to use FEDEX. Submissions via DHL can take a longer time to delivery.

   **Note for hand deliveries:** Please call for the specific delivery address prior to making the delivery. The Embassy receives deliveries only between 8:00am and 3:00pm, Mondays to Fridays. The Embassy is closed on holidays.

d. Applications that are received late or are incomplete run the risk of not being considered in the review process. USAID’s Agreement Officer may review and consider late or incomplete applications if:

1) USAID’s treatment of the material is consistent with the terms of the RFA;  
2) All late applications are treated the same;  
3) They are evaluated before any agreements are awarded under the RFA, and  
4) The Agreement Officer consents in writing to the review of late or incomplete applications.
D. PREPARATION OF THE APPLICATION:

1. Each Applicant shall furnish the information required by the RFA. Applications shall consist of two separate parts: (a) the technical application, and (b) the cost application. These are to be submitted in both electronic and hard copies.

2. All information shall be presented in English.

3. Each applicant organization must print or type its name on the cover page of both the technical and cost applications. All applications and certifications must be signed by an authorized representative of the organization. Erasures and changes to the application must be initialed by the person signing the application. Applications signed by an agent must be accompanied by evidence of that agent’s authority, unless that evidence has been previously furnished to the Agreement Officer of this RFA.

4. Applicants who include data that they do not want disclosed to the public for any purpose or used by USAID except for evaluation purposes must:
   a. Mark the title page with the following legend:

   “This application includes data that shall not be disclosed outside the U.S. Government and shall not be duplicated, used, or disclosed—in whole or in part—for any purpose other than to evaluate this application. If, however, a grant is awarded to this Applicant as a result of, or in connection with, the submission of this data, the U.S. Government shall have the right to duplicate, use, or disclose the data to the extent provided in the resulting grant. This restriction does not limit the U.S. Government’s right to use information contained in this data if it is obtained from another source without restriction. The data subject to this restriction are contained in pages {insert page number/s};” and

   b. Mark each sheet of data it wishes to restrict with the following legend:

   “Use or disclosure of data contained on this sheet is subject to the restriction on the title page of this application.”

5. Applicants must retain for their records one copy of their application including all enclosures that accompany their application.

E. TECHNICAL APPLICATION FORMAT

The Technical Application will be the most important consideration in the selection for award of a Cooperative Agreement under this RFA.
The apparently successful Applicant’s Technical Approach, as revised during negotiations, will become the Program Description of any resulting Cooperative Agreement. It must include a clear description of the conceptual approach and the general strategy (i.e. methodology and techniques) being proposed. It must outline specific, focused activities; identify how and where (e.g. country and level: local, national, or regional) those activities will be implemented; explain how the approach is expected to achieve the proposed objectives; and describe a plan that will enable the activities to continue after the activity is completed. Applicants are encouraged to propose innovative programs designed to reach the desired outcomes/results. Creativity and innovation will be a key factor to the applicant’s success.

The technical application must be specific, complete and presented concisely. The application must demonstrate the applicant's approach, capabilities and expertise with respect to achieving the goals of this program. The application must take into account the requirements of the program and merit review criteria found in this RFA.

The Technical Application must be written in English, typed on standard 8-1/2" x 11" paper, single spaced, using Times New Roman 12-pt font, with margins no less than one inch on all sides.

The Technical Application must include the following sections:

1. **Cover Page**, which include:
   a. Program title;
   b. Request for Applications (RFA) reference number;
   c. Name of Applicant organization and business address
   d. Partnerships, if any;
   e. Technical Application contact person, title, email address, mobile and telephone numbers
   f. Cost Application contact person, title, email address, mobile and telephone numbers
   g. Name(s) and title(s) of person(s) who prepared the application and the sections they prepared,
   h. Name and signature of organization’s authorized representative
2. **Table of contents** that follows the technical application format outlined herein.
3. **List of Acronyms**
4. **Executive Summary** (2 pages maximum)
5. **Technical Application**
   a. Technical Approach and Proposed Outcomes/Results
   b. Key Personnel
   c. Management Approach and Staffing Plan
   d. Organizational Capacity
6. **Annexes.**

The Technical Application is limited to twenty-five (25) pages only. Anything more will not be included in the review process. Annexes specifically requested are not included in the page limitation. However, any information included as an annex that was not specifically requested in the RFA will not be reviewed or considered. The following are the only allowed annexes:
Case Study (5 pages maximum)
Key personnel resumes/Curriculum Vitae/Major accomplishments (maximum 7 pages per person, plus maximum of 2 pages each for major accomplishments and references
Letters of intention from key personnel
Letters of commitment from partners and/or sub-grantees
Proposed Organizational Chart
Draft Year 1 Implementation Plan
Draft Activity Monitoring, Evaluation and Learning Plan (AMELP)
Draft Sustainability Plan
Past performance summary tables and references
Draft Branding Strategy and Marking Plan (will be required only of the apparently successful applicant).
Draft Environmental Management & Monitoring Plan (EMMP)

The following pages do not count against the 25 page limit: Cover page, table of contents, acronym list, and dividers.

Graphs, charts, exhibits, tables, executive summary, etc. contained in the body of the Technical Application must be numbered and shall be included in the 25 page limit.

Applicants must include a list of all acronyms used in the application, providing both the acronym and what it stands for. Applicants are requested to spell out the first use of each acronym in the technical application.

No part of the cost application shall be included in the technical application.

F. SPECIFIC TECHNICAL APPLICATION INSTRUCTIONS

The Technical Application must address how the Applicant intends to implement the Activity Description detailed in Section I of this RFA. Applicants must briefly describe their overarching implementation strategies and how they will meet the RFA requirements, carry out the activity functions, and achieve the anticipated results. The executive summary must briefly describe the technical and managerial resources of the applicant’s organization and partners (if appropriate) and how the overall program will be managed. It should also highlight how the applicant will work with the NTP and other implementing partners to promote sustainability, and promote potential game-changing TB interventions that could be supported at all levels of the health system to bring about TB elimination.

The narrative section of the application should contain the elements outlined below:

1. Technical Approach

Applicants must address the requirements of the program description, including the objectives and sub-objectives in Section I of this RFA. The approaches presented by the
applicant for each section of the technical application selection criteria must be aligned with
the priorities of the NTP and the US Global TB strategy, and must address how the applicant
will work with the NTP and local government to strengthen capacity. Specifically:

   a. The applicant must describe its vision and the results it expects to achieve by the end of the five-year activity. In particular, the applicant should describe what the National TB Program will look like by 2022.

   b. The applicant must provide a comprehensive yet concise summary of their overall strategic and technical approach to reach the project’s objectives, and to implement and perform the three (3) objectives and nine (9) sub-objectives outlined in Section I of this RFA. There should be synergistic linkages between the approaches across the objectives and themes, and there should be a focus on complementarity and coordination with local health systems and other partners including Global Fund principal recipients and sub-recipients.

   c. The applicant must discuss the critical challenges to achieving TB elimination and should present potential game-changing TB interventions under each objective that could be supported at the provincial, facility, and community levels to bring about TB elimination. There must be an analysis of the selection of interventions to demonstrate the most cost-effective approach to achieving the objectives.

   d. The applicant must present the most optimal interventions that can be successfully implemented to encourage prompt and appropriate health-seeking behavior. The applicant should also describe how it will operationalize “patient-centered” care and indicate which interventions it will put in place in order to eliminate TB in the Philippines. The applicant should clearly articulate how they will engage people and entities into the Service Delivery Network, as well as how they will operationalize capacity building.

   e. The applicant must describe how it will institutionalize and scale-up evidence-based best practices and approaches that build on local experiences. It should also identify any partner organizations, including local community partners that will be needed to achieve the activity’s overall objectives. All approaches should include a strategy for promoting sustainability and engagement with partners beyond the life of the project.

   f. The applicant should describe how it will provide complementary wrap-around capacity building to the National TB program and how it will coordinate with partners to maximize investments for TB elimination in the Philippines and assist with transitioning external funding to sustainable community-led approaches.

   g. The applicant should demonstrate its understanding of and commitment to responding to gender issues in TB programming. The applicant must describe its gender-sensitive and gender-transformative approach to achieving expected results.
h. The applicant must describe how they will develop a strong, cost-effective, evidence-based Activity Monitoring, Evaluation and Learning Plan (AMELP) with a data quality assurance strategy. This plan should view national impact versus impact in the activity’s geographic focus areas, and should be used to monitor the quality and effectiveness of all activity interventions. The applicant must include a detailed strategic framework for evaluating performance toward achieving the outcomes of the three (3) objectives and nine (9) sub-objectives as part of the application. The plan should include how best practices and lessons learned will be disseminated, how data will be collected, and how the quality of the data will be reviewed and improved. The applicant should also identify how it would develop a system with the NTP and other partners so that the data is regularly analyzed to inform the effectiveness of interventions.

i. As part of the technical approach (to be included as an annex), the applicant must provide a case study of how TB case detection, care and treatment will be carried out to end TB at the provincial and local levels. The applicant should demonstrate how it will build the capacity of all appropriate partners to identify the 50 percent of TB cases that are not notified to the NTP, place these cases into appropriate treatment and care settings, and ensure successful completion of treatment and eventual cure. The case study is limited to five (5) pages. It must not simply repeat the concepts, elements and activities described in the 20-page technical approach but should:

(1) Explain the overarching strategy that will be used to build the capacity and sustainability of various partners and interventions to expand TB case detection, treatment and care at the local level (province/city, municipality, barangay/village, community).

(2) Describe how the activity will strengthen the TB service delivery network and bring in non-traditional partners into the mainstream strategy and activities of a decentralized TB case detection, treatment and care program.

(3) Explain how the activity will introduce or strengthen all possible financing schemes to ensure availability of resources for TB case detection, treatment, care and cure.

(4) Describe how the activity will collaborate with the Global Fund, the TB Innovations and Health Systems Strengthening activity and other partners in scaling up appropriate and relevant interventions.

(5) Describe the expected results and outcomes that will be achieved at the local level through the strategy and interventions.

2. Key Personnel
As part of the 25-page limit of the technical narrative, applicants shall provide a summary of the scope of experience, skills and expertise of its proposed Key Personnel as listed below.

As an annex, the applicant shall provide a resume of no more than seven (7) pages each for each of the five (5) required Key Personnel. In addition, for each proposed Key Personnel, the applicant shall provide a list of significant accomplishments, no more than two (2) pages each, and any relevant supporting documents to supplement the resumes. The applicant should submit no more than nine (9) pages per key personnel: seven (7) pages for the resume and two (2) pages for the significant accomplishments.

The applicant shall submit a signed letter of intention from all proposed Key Personnel stating that they understand that they have been proposed and that they intend to make themselves available to serve in the proposed position and relocate to the Philippines for the duration of the activity should the applicant receive the award.

For each of the Key Personnel, a list of three (3) professional references from the last five (5) years must be included in the annexes. Reference information must include name, current work company or organization name, address, position within company or organization, telephone number, mobile number and email address. Current and valid contact information MUST be included for each reference. Applicants may want to inform these references that they may be contacted. Applicants should validate the most suitable contact information.

Each of these five key personnel must meet or exceed the qualifications described below. These positions are expected to provide the overall technical lead and oversight of the entire activity which is expected to contribute to achieving the targets of the PhilSTEP1 and the TB strategies of the USG.

a. **Chief of Party (COP) – 100 percent level of effort**

The COP will have overall responsibility for management of all activity interventions and staff to achieve results. S/he will be responsible for managerial leadership and administrative oversight of the activity and will serve as the principal institutional liaison to USAID. S/he will manage a team of senior staff and sub-partners and guarantee quality, timeliness, and efficiency of all products and activities generated under the activity. S/he shall oversee operational procedures and policies, financial controls, and other management functions including management of subawardees, the latter with the help of the component Team Leader.

The COP is expected to have the strategic vision, leadership qualities, depth and breadth of technical expertise in infectious disease and public health service programming and delivery, the professional reputation, management experience, interpersonal skills, and written and oral presentation skills to fulfill the diverse technical and managerial requirements of the Activity Description. S/he will have principal responsibility of representing the activity to USAID. S/he will also have experience interacting with other development projects, host country governments, and international agencies. Specific experience in one or more of the main technical components of the program is required.
Required qualifications:

- An advanced degree (at least Master’s level) in medicine, public health, international development, public administration, economics, or in a closely related field is required.
- Minimum 12 years of demonstrated experience designing, executing, managing and evaluating public health programs is required.
- Minimum of 5 years of executive leadership experience implementing international (outside of the Philippines) public health -preferably infectious disease- projects or programs of a similar size and scope as “TB Platforms”.
- Demonstrated experience with strategic planning and project implementation based on evidence-driven decision making.
- Demonstrated capacity to build and maintain productive working relationships with a wide network of partners and stakeholders. Experience in interacting positively with co-workers, government agencies, host country governments and counterparts, and international donor agencies.

Desired qualifications:

- Demonstrated experience implementing health sector and health systems strengthening activities or programs
- Experience with incorporating gender and vulnerable population needs into programming.
- Strong organizational skills including people, task and time management.
- Strong communication and presentation skills particularly to GPH officials and other key stakeholders.
- Management experience with US government or other donor agency agreements is highly desirable.
- Ability to effectively communicate in oral and written English is required.

b. Tuberculosis Technical Team Leader - 100 percent level of effort

The TB Technical Team Leader will lead the design, development and dissemination of TB patient-centered care and demand generation interventions. S/he will also lead interventions on capacity building for behavior change, including the engagement of TB patients and civil society in all aspects of TB programing and monitoring. S/he is expected to spend extensive time in the field working closely with patients, providers and organizations to identify and to put in place appropriate models of detection, care and treatment.

Required qualifications:

- Advanced degree (Medical Degree, Masters, or PhD) in medicine, public health, nursing, applied clinical research, or other relevant medical or public health field.
● Minimum 10 years of progressive, focused experience in the management, design, execution, and monitoring of tuberculosis activities and projects
● Minimum 5 years of experience working (full time) in TB in at least one country, other than the Philippines, that has a high TB burden.
● Experience and demonstrated success in engaging and building capacity of health providers, institutions and organizations to deliver patient-centered care at scale.
● Experience and demonstrated success in involving patients or key affected population and civil society in project design and execution.

Desired qualifications:

● Demonstrated understanding of health-seeking behavior and patient support needs.
● Demonstrated ability to obtain, analyze, organize and interpret relevant information, education and communication (IEC)/BCC data and use this data to design, develop and deploy communication interventions for TB.
● Experience and demonstrated success in addressing gender and equity issues, as well as involving patients or key affected populations and civil society in project design and implementation.
● Strong organizational and management skills.
● Ability to communicate effectively in English, both verbally and in writing.
● Demonstrated capacity to build and maintain productive working relationships with a wide network of partners and stakeholders.

c. Sustainable Finance and Partnerships Manager - 100 percent level of effort

The Sustainable Finance and Partnerships Manager will develop systems for bringing new partners to implement TB interventions and ensure that all interventions implemented through financing mechanisms (such as contracts and grants) are in line with USAID’s TB Strategies, PhilSTEP1 and WHO Guidelines. The Sustainable Finance and Partnerships Manager will lead the selection, oversight and reporting on financing mechanisms (such as contracts and grants) with civil society (i.e. community based and non-profit organizations, private health providers, patient groups, non-NTP partners). In addition to managing recipients of financing mechanisms, the Sustainable Finance and Partnerships Manager will also support local government units and recipients to institutionalize and develop systems for sustaining financing. The Sustainable Finance and Partnerships Manager is expected to spend extensive time in the field working closely with local government units, financing recipients, community groups and other stakeholders to provide technical assistance and monitor and oversee performance.

Required qualifications:

● An advanced degree (at least Master’s level) in finance and contracting, international development, public administration, economics, public health or in a
closely related field is required.

- Minimum 10 years of demonstrated experience in managing, implementing and evaluating public health programs is required.
- Minimum 7 years developing financing mechanisms and managing contracts, grants or sub-recipients of health or other development projects is required.
- Experience working with institutions and organizations to build management, oversight and administrative systems, especially public sector entities and civil society/support groups.

Desired qualifications:

- Knowledge and experience of donor policies and guidelines for grants and grants mechanisms is highly desirable.
- Strong organizational and management skills.
- Ability to communicate effectively in English, both verbally and in writing.

d. Monitoring and Evaluation Advisor - 100 percent level of effort

The M&E Advisor will be the technical expert who will liaise with relevant advisors on health-related strategic information for activities related to bolstering the ability of health providers and institutions and community groups to monitor, document and analyze the performance of health services as a basis for accountability, advocacy and policy activities and safeguarding standards and quality of care. S/he also provides technical guidance and support to sub-awards in the design, execution, monitoring and evaluation of the effectiveness TB interventions. The M&E Advisor is expected to spend extensive time in the field working closely with project staff, health providers, community groups and other stakeholders to provide technical assistance and monitor and evaluate the project.

S/he will have primary responsibility for establishing and maintaining systems to measure, compile, analyze and report activity data at all levels and across levels; ensuring that all activity interventions are designed with M&E plans and activities; comparing performance between US and non-US sites; providing regular activity reports to USAID and for developing special reports as needed; producing analysis of program data, identifying methods and together with the relevant Team Leader, to use results and provide recommendations for program improvement; and building NTP capacity to gather and analyze data for program improvement at all levels.

S/he will review and adapt tools and create standardized tools and indicators to measure health facility and community-based interventions that capture relevant outcomes. The M&E Advisor may also be called upon to design interventions that build the capacity to buttress data collection, use and analysis of data and statistics in order to guide TB program implementation at the institution, facility and community levels. S/he must have the following qualifications, skills, and expertise:
Required qualifications:

- A Master’s degree in public health, epidemiology, monitoring & evaluation, demography, biostatistics, statistics, or a related field.
- Minimum of ten (10) years of work experience in establishing/designing M&E systems and tools and managing data-intensive health programs including use of gender-disaggregated data, for decision-making.
- Minimum four (4) years working on TB or other infectious disease programs.
- Demonstrated experience and knowledge in health programs to provide support and guidance to project staff, DoH officials, health providers, community organizations and other stakeholders on design, monitoring and evaluation and program quality management (both service and data quality).
- Experience with qualitative and quantitative M&E data collection and analysis methods, including tracking outcome indicators. Demonstrated ability to obtain, analyze, organize and interpret relevant data and use them to design or critique TB interventions. Experience building capacity of teams and stakeholders to analyze and interpret relevant data to improve program implementation.
- Demonstrated capacity to coordinate and execute evaluations and implementation/operations research, including experience developing terms of reference, recruiting, training, and managing a diverse team and analyzing and preparing data and final reports.

e. Finance and Administration Manager - 100 percent level of effort

The Finance and Administration (F&A) Manager will provide overall operational support to the “TB Platforms” activity team. S/he will be responsible for all financial and administrative functions of the Activity, including the management of accounting and financial transactions, financial reporting, and management of daily Activity administration. S/he will lead the development of administrative and operations management systems and processes required to maintain project implementation, and will guarantee that these processes are in compliance with USAID policies and regulations. The F&A Manager will assist in the development of project budgets and will oversee procurement processes.

The Finance and Administration Manager will maintain the processes for recruiting and hiring Activity staff. S/he will provide overall management support to the office, and will provide critical logistical support to the team. S/he must have the following qualifications, skills, and expertise:

Required qualifications:

- A college degree or higher, in Finance, Accounting, Business or other Management-related degree.
- Minimum of ten (10) years of professional experience in the areas of finance, accounting, operations management and/or contract management.
- Strong understanding of and demonstrated capacity to manage financial systems
and procedures of projects valued at least $15 million or more.

- Experience and knowledge of USG or other international donor policies and procedures and management of donor funding and projects.
- Strong organizational, financial reporting, management and interpersonal skills. Must have the ability to manage multiple competing priorities.
- Demonstrated integrity and fidelity
- Advanced computer skills; knowledgeable in accounting software, MS Windows, Excel, and Word.
- Fluency in oral and written English.

3. Management Approach and Staffing Plan

a. Management Plan

The Applicant must propose a management plan that will successfully achieve the objectives of the activity. The management plan must:

1) Describe how the proposed management structure will enable the applicant to successfully execute the objectives and interventions presented in the Activity Description.
2) Outline efficient and cost-effective management and administrative arrangements for the implementation of the activity.
3) Describe how the activity will develop efficient operations to secure rapid start-up and timely implementation.
4) Describe how the activity will work with the NTP and other partners to sustain and institutionalize interventions and complement and not duplicate existing interventions.
5) Describe how the activity will manage the introduction and implementation of new financing approaches.
6) Describe how the activity will build the capacity and sustain engagement of civil society organizations to implement TB interventions.
7) Describe how the activity will coordinate activities with the “TB Innovations and Health Systems Strengthening” activity at both the national and regional/provincial levels to bring technical expertise and best practices to meet activity objectives.
8) Describe how the activity will be organized to safeguard that the capabilities of all proposed partners, including local partners, is maximized, and describe the roles and responsibilities of each partner.
9) Provide the lines of authority and communication between the prime and all proposed partners to maximize efficiencies and technical expertise.
10) Describe the strategy for developing, maintaining, and operationalizing the AMELP over the life of the activity.
11) Describe policies and management on procurement of goods and services.

b. Staffing Plan
The applicant must provide a staffing plan that describes how all proposed personnel, including both key and non-key personnel, offer an appropriate balance of skills, expertise, and demonstrated experience sufficient to achieve the objectives of the activity. The plan must show the minimum number of highly qualified experienced staff needed to sufficiently manage and execute the activity. The applicant should ensure there is a focus on cost-containment and avoiding unnecessary staffing.

The applicant should provide a proposed organizational chart as an annex.

4. Organizational Capacity

The Applicant should describe its experience, institutional capability and core competencies, and those of its proposed partners/sub-awardees, to implement the activity as outlined in the Activity Description in Section I. The description should include what the organization and its proposed partners can offer in terms of their staff’s expertise, collective skills and abilities--that will lead to a reasonable assurance of success for the activity. The Applicant should highlight relevant work experience in terms of approach, magnitude and/or complexity. The Applicant may include letters (as an annex) from proposed partners/sub-awardees outlining the technical expertise they will contribute to achieving the objectives of the activity.

5. Branding Strategy and Marking Plan

It is a Federal statutory and regulatory requirement that all overseas programs, projects, activities, public communications, and commodities that USAID partially or fully funds under an assistance award or sub-award must be appropriately marked with the USAID Identity.

Pursuant to 2 CFR 700.16, USAID requires the submission of a Branding Strategy and Marking Plan from the apparently successful applicant. Therefore, applicants do not need to submit a draft Branding Strategy and Marking Plan with their initial applications. Only the apparently successful applicant will be required by the Agreement Officer to submit a draft Branding Strategy and Marking Plan prior to making an award. More information on Branding Strategy and Marking Plan are available at [http://www.usaid.gov/branding/assistance.html](http://www.usaid.gov/branding/assistance.html).

G. COST APPLICATION

The Cost or Business Application must be submitted separately from the Technical Application. There is no page limit for the Cost Application. Unnecessarily elaborate brochures or other presentations beyond those sufficient to present a complete and effective application in response to this RFA is not desired. Elaborate art work, expensive paper and bindings, and expensive visual and other presentation aids are neither necessary nor wanted.

The Cost Application is to be submitted in both electronic (in Excel, via email) and paper versions. The applicant shall submit a budget broken down by program years with an accompanying detailed
budget narrative (in Word 2000 or Word 2003 text accessible) which provides in detail the total costs for implementation of the program as further detailed below. The application must provide evidence that the funds requested are reasonable and would be used in a cost-effective manner. The review committee will assess whether the overall costs are realistic for the work to be performed, whether the costs reflect that the applicant understands the requirements, and whether the costs are consistent with the technical application. The application will also be assessed for cost effectiveness. Applications that minimize administrative costs in order to maximize program, outreach, and capacity building activities will generally be considered to be of better value.

The Agreement Officer requires from the applicant certain documents to be submitted in order for the Agreement Officer to determine the applicant’s responsibility as well as to assess USAID’s risk should an award be made.

If the applicant has established a consortium or another legal relationship among its partners, the Cost/Business application must include a copy of documents that show the legal relationship between the parties. The documents should include a full discussion of the relationship between the applicant and partners including identification of the applicant with whom USAID will work with for purposes of Agreement administration, identity of the applicant which will have accounting responsibility, how Agreement effort will be allocated and the express agreement of the principals thereto to be held jointly and severally liable for the acts or omissions of the other/s.

The following describes the documentation that applicants must submit. While there is no page limit for this portion, applicants are encouraged to be as concise as possible, but still provide the necessary details. The cost application must cover the full period of performance using the budget format in SF 424A. The budget should be expressed in US dollars using the exchange rate of $1 = P49.

1. A Cover Page containing the same information as the Technical Application cover page.
2. A summary of the budget must be submitted using Standard Form 424 and 424A. SF424B should also be submitted, duly signed. These forms can be downloaded from the grants.gov website at: https://www.grants.gov/web/grantsforms/sf-424-family.html#sortby=1

Instructions on how to complete these forms are found at https://www.grants.gov/web/grants/form-instructions.html

   a. Summary budget should have the budget categories as shown in SF424A, with costs broken down by year;
   b. Detailed/itemized budget;
   c. Budget narrative explaining costs to be incurred; and
   d. Other administrative documentation as necessary..

The forms must be signed when submitted by an authorized representative of the Applicant’s organization.

3. Detailed budgets and narrative with supporting notes and justifications that include the following:
a. The name, daily and annual salary rates, fringe benefits and expected level of effort of each person charged to the program, and salary escalation factors.
b. Specify the applicable fringe benefit rates for each category of employee, and all benefits covered by the rate.
c. The same information shall be provided for individual consultants as for regular personnel.
d. Allowances must be broken down by specific type and by person and must be in accordance with the applicant's policies. All salaries, benefits and allowances must be based on written compensation policies of the employer organization.
e. Details of all home office support to be provided.
f. Travel, per diem and other transportation expenses must be detailed in the financial plan to include number of international trips, from where to where, number of per diem days and rates. Per Diem and other travel allowances must be based on written travel policies of the employer organization. (Applicants may choose to refer to the Federal Standardized Travel Regulations for cost estimates).
g. Detail all equipment to be purchased, including the type of equipment, the manufacturer, the unit cost, the number of units to be purchased and the expected geographic source.
h. Detail all materials and supplies expected to be purchased, including type, unit cost, and number of units.
i. Detail all proposed Contractual arrangements including proposed subawards (contracts and grants).
j. Other Direct Costs such as visas, passports and Other General and Administrative costs must be presented as separate cost line items.
k. Specific budget details and narrative information, in addition to the percentage and total dollar amount of the proposed cost-share contribution.
l. Indirect costs must be supported with information (e.g., NICRA) to substantiate the calculation of the indirect cost.
m. For commercial organizations, it is USAID policy that no profit or fee shall be included in the prime award. All reasonable and allowable expenses, both direct and indirect, which are related to the agreement and are in accordance with applicable cost principles in 2 CFR Subpart E may be paid under the anticipated award.
n. Information regarding the cost share should be indicated in SF424. Cost share details (e.g., who is providing cost share, how cost share will be used, how it will contribute to the objectives, etc.) should be in narrative form and presented as budget notes.

The budget notes/narrative should explain all budget assumptions and how the costs were derived. The information will include the basis of estimate for each line item, including reference to source used to substantiate the cost estimate (e.g. organization’s policy, payroll document, vendor quotes, etc.)

4. Required “Certifications, Assurances, Other Statements of the Recipient” signed by an authorized representative of the applicant’s organization. The certifications are found at: https://www.usaid.gov/sites/default/files/documents/1868/303mav.pdf

5. Applicants shall submit any additional evidence of responsibility deemed necessary for the Agreement Officer to make a determination of responsibility. The information submitted
shall substantiate that the applicant:

a. Has adequate financial, management and personnel resources and systems or the ability to obtain such resources as required during the performance of the award.
b. Has the ability to comply with the award conditions, taking into account all existing and currently prospective commitments of the Applicant, non-governmental and governmental.
c. Has a satisfactory record of performance. Past relevant unsatisfactory performance is ordinarily sufficient to justify a finding of non-responsibility, unless there is clear evidence of subsequent satisfactory performance.
d. Has a satisfactory record of integrity and business ethics; and
e. Is otherwise qualified and eligible to receive a grant under applicable laws and regulations.

6. Applicants that have never received a grant, cooperative agreement or contract from the U.S. Government are required to submit a copy of their accounting manual.

7. Foreign Government Delegations to International Conferences will not be funded under this agreement. See Standard Provision entitled “FOREIGN GOVERNMENT DELEGATIONS TO INTERNATIONAL CONFERENCES”.

8. Dun and Bradstreet Universal Numbering System (DUNS) Number and System for Award Management (SAM). As indicated in the RFA cover letter, the Applicant, unless excepted by USAID from those requirements under 2 CFR 25.110(b) or (c), or has an exception approved by USAID under 2 CFR 25.110(d) must be registered in SAM provide a valid DUNS number and continue to maintain an active SAM registration with recent information at all times during which it has an active Federal award or an application or plan under consideration by USAID.

9. Federal awarding agencies may not make a Federal award to an applicant until the applicant has complied with all applicable DUNS and SAM requirements and, if an applicant has not fully complied with the requirements by the time the Federal awarding agency is ready to make a Federal award, the Federal awarding agency may determine that the applicant is not qualified to receive a Federal award and use that determination as a basis for making a Federal award to another applicant.

An award will be made only when the Agreement Officer makes a positive determination that the applicant possesses, or has the ability to obtain, the necessary management competence in planning and carrying out assistance programs and that it will practice mutually agreed upon methods of accountability for funds and other assets provided by USAID. For the organizations that are new to USAID, or organizations with outstanding audit findings, it may be necessary to perform a pre-award survey. The cost/business applications of all Applicants submitting a technically acceptable application will be reviewed for general reasonableness, cost realism, allowability and allocability.

Unsuccessful applications will not be returned to the Applicants.

Please note that Applicants are encouraged to ask questions about the application process or seek
technical and cost clarification/s during the open question period by submitting questions in a single document by the deadline stated on the cover letter of this RFA. Questions must be submitted to manila-roaa-rfa@usaid.gov. The answers to all questions received will be posted on www.grants.gov.

H. LIMITATION ON SUB-AWARDS

By submission of an application and execution of the award, the Applicant/Recipient agrees that at least thirty-five percent (35%) of the cost of award performance incurred for personnel must be expended for employees of the prime organization.

[END OF SECTION IV]
SECTION V: APPLICATION REVIEW INFORMATION

A. OVERVIEW OF REVIEW AND SELECTION PROCESS

USAID anticipates the award of one (1) cooperative agreement as a result of this RFA. However, USAID reserves the right to make an award, or to not make an award, if it is determined to be in the best interest of the US Government.

All applications received by the closing date stated in the RFA cover letter or amendment, if any, will be reviewed, first for eligibility, then checked for completeness and responsiveness, and finally will be evaluated against the merit review criteria set forth in this Section.

Applications received after the RFA’s closing date will be considered late and may not be evaluated. Incomplete submissions may also not be considered in the review process.

A Technical Review Committee (TRC) will conduct a technical merit review of all applications received that comply with the requirements of this RFA.

USAID may award without seeking clarifications/additional details from the applicants. However, if the Agreement Officer determines that an application or several applications can be improved, then the applicant or group of applicants will be given the opportunity to do so through verbal and/or written engagement. If necessary, the applicant or group of applicants may be invited to present their application/s to USAID. Therefore, applicants are encouraged to submit initial applications that contain their best terms from both technical and cost standpoints.

After technical evaluations have been completed, the TRC will recommend the “apparently successful” applicant to the Agreement Officer who, after considering the recommendation and the result of the cost review, will make the final selection.

Each application will be reviewed for:

1. Eligibility – Each application received before the closing date and time will be reviewed against eligibility requirements outlined in Section III., Eligibility Information. This includes the cost share requirement. Applications that do not meet the eligibility requirements will not be evaluated.

2. Responsiveness – Eligible applications will be reviewed for responsiveness. Applications not conforming to Section IV – Application and Submission Information, may be considered nonresponsive and may be eliminated from further consideration.

3. Merit Review – Eligible, responsive applications will be evaluated in accordance with the established merit review criteria. The merit review criteria are tailored to the requirements
of this particular RFA. The review will be conducted using an adjectival rating system.

Applicants must note that these criteria serve to:

a. Identify the significant matters which applicants should address in their applications, and
b. Set the standard against which all applications will be reviewed and evaluated.

To facilitate the review of applications, applicants must organize the narrative sections of their applications with the same headings and in the same order as the merit review criteria.

B. APPLICATION REVIEW INFORMATION

1. Merit Review

Technical applications will be reviewed and ranked in accordance with the following criteria shown in their order of importance:

- “Technical Approach” is the most important criterion and constitutes the highest priority in the ranking of applications.
- “Key Personnel” is the second highest priority in the ranking of applications.
- “Management and Approach and Staffing Plan” is the third highest priority in the ranking of applications.
- “Organizational Capacity” constitutes the fourth criterion for ranking applications.

a. Technical Approach: The extent to which the application proposes a Technical Approach to the “TB Platforms” activity that lays out innovative, programmatic interventions in a clear, logical and realistic manner in order to achieve program objectives efficiently. This critical review criterion will focus on three factors:

1) A clear, logical, and game-changing strategy as well as a detailed understanding of those efforts needed for effective and successful achievement of the objectives outlined in the Activity Description;

2) A comprehensive and complementary approach including wrap-around technical assistance and scaling up new approaches, to transform and expand TB Platforms, and;

3) Institutionalization and sustainability to improve the likelihood that the programs being supported will continue beyond and without USAID funding.

b. Key Personnel: The extent to which the proposed Key Personnel (Chief of Party, TB Technical Team Leader, Sustainable Finance and Partnerships Manager, Monitoring and
Evaluation Advisor, and Finance and Administration Manager) have the required qualifications and convincingly demonstrate the applicant’s ability to effectively implement proposed activities responsive to this RFA. Candidates will be considered based on the variety of their skills – and how they complement each other – and their appropriateness to the technical approach outlined in the application as well as on their academic background, expertise, including their effectiveness and success in similar positions, and years of related experience.

c. **Management Approach and Staffing Plan:** The extent to which the management and staffing plans demonstrate the applicant’s ability to effectively implement proposed activities responsive to this RFA. The application contains a sound management plan and organizational structure to convincingly manage the award and to achieve desired results and outcomes. This includes a clear and realistic description of timely plans for office establishment (locations and balance of head and field offices), staffing and mobilization (hiring of personnel, initiating communications systems and operations. If the application is from a consortium or partnership with more than one organization, or includes significant implementation sub-grantees, the management plan must identify the formal relationships, roles, and responsibilities of each consortium member, partner organization, or implementing sub-grantee. The elements of this review factor include:

1) The overall quality of the management and staffing plan to implement the “TB Platforms” activity, taking into consideration the type of interventions and roles of other partners;

2) The coherence of a supporting organizational structure that matches required skills to accomplish the full range of program objectives; and

3) Detailed explanation of any proposed consortium and/or partnerships that the applicant will participate in to carry out Activity interventions.

d. **Organizational Capacity:** The extent to which the applicant’s corporate and institutional capability demonstrates its ability to effectively implement similar activities/programs (in kind and magnitude) in the immediate past five (5) years, including activity performance and management, and client relations. Applicant’s capacity will be reviewed based on its experience and institutional technical expertise in implementing TB prevention, detection, diagnosis, treatment and care interventions in terms of approach, magnitude and complexity. The applicant’s experience managing, overseeing financing mechanisms and building capacity of civil society organizations will also be considered. Relevant information on the Applicant’s ability to attract and retain high-quality personnel will also be considered.

2. **Cost Review**

The cost application of the “apparently successful” technical applicant will be reviewed for cost reasonableness, allowability, allocability, cost effectiveness and realism, and adequacy of budget detail. The cost application must be complete with adequate budget detail and must be
USAID will assess whether the overall costs are realistic for the work to be performed, whether the costs reflect the applicant’s understanding of the requirements, and whether the costs are consistent with elements of the technical application.

Proposed costs may be adjusted based on the results of the cost review/analysis and the Agreement Officer’s assessment of cost reasonableness, completeness, and credibility.

3. Cost Share

As part of the review, the proposed cost share contribution of the “apparently successful” Applicant will be reviewed for cost realism. The cost application must demonstrate the Applicant’s plan for providing the required cost share.

Prior to acceptance of proposed contributions, USAID will verify if these meet the standards set in 2 CFR 200.306 for U.S. organizations or the Standard Provision entitle “Cost Share” for non-U.S. organizations.

[END OF SECTION V]
SECTION VI: AWARD AND ADMINISTRATION INFORMATION

A. FEDERAL AWARD NOTICE

1. USAID plans to award one (1) cooperative agreement resulting from this RFA to the apparently successful applicant whose application best meets the merit review criteria (see Section V of this RFA). The Agreement Officer will only do so after making a positive responsibility determination that the successful applicant possesses, or has the ability to obtain, the necessary management competence in planning and carrying out assistance programs and that it will practice mutually agreed upon methods of accountability for funds and other assets provided by USAID.

2. The Agreement Officer can only award the cooperative agreement after funds have been appropriated, allocated and committed through internal USAID procedures. While USAID anticipates that these procedures will be successfully completed, potential applicants are hereby notified of these requirements and conditions for the award.

3. The Agreement Officer is the only individual who may legally commit the Government to the expenditure of public funds.

4. Following the selection for award and successful negotiations, the successful applicant will receive an electronic copy of the notice of the award signed by the Agreement Officer which will serve as the authorizing document. No costs chargeable to the cooperative agreement may be incurred before receipt of either a fully executed Cooperative Agreement or a specific, written authorization from the Agreement Officer.

B. ADMINISTRATIVE AND NATIONAL POLICY REQUIREMENTS

The cooperative agreement will be administered in accordance with:


2. 2 CFR 200, Subpart E—Cost Principles, http://www.ecfr.gov/cgi-bin/text- and if applicable,


C. PRE-AWARD SURVEYS
For organizations that are new to working with USAID or for organizations with outstanding audit findings, USAID may perform a pre-award survey to assess the apparently successful applicant’s management and financial capabilities. If notified by USAID that a pre-award survey is necessary, the apparently successful applicant must prepare, in advance, the required information and documents.

The additional documents that may be requested are By-laws, constitution, articles of incorporation, organizational policies on travel, procurement, financial management, personnel, etc. When requested, the apparently successful applicant shall provide copies of the requested additional documents.

Please note that a pre-award survey does not commit USAID to make any award.

D. REPORTING REQUIREMENTS

The format of the activity performance reports, final annual work plan, financial reports and success stories will be determined in conjunction with USAID/Philippines. The applicant must meet all country-specific USG reporting requirements. Reports must be submitted in English.

1. Program Reporting –

Table 1: Program Reports and Schedule

<table>
<thead>
<tr>
<th>Report</th>
<th>Submission Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Annual implementation plan (includes Gender and Environment Risk Mitigation Plans)</td>
<td>Within 45 days(^{10}) of award</td>
</tr>
<tr>
<td>Activity Monitoring, Evaluation and Learning Plan (AMELP)</td>
<td>Within 90 days of award</td>
</tr>
<tr>
<td>Sustainability Plan</td>
<td>Within 60 days of award</td>
</tr>
<tr>
<td>Quarterly Reports (includes progress to date on sustainability, gender, and environment)</td>
<td>Within 30 days of the completion of a US fiscal quarter</td>
</tr>
<tr>
<td>Annual Reports (includes progress to date on sustainability, gender, and environment)</td>
<td>Within 30 days of the completion of a US fiscal year (September 30 of each year)</td>
</tr>
<tr>
<td>Close-out Plan</td>
<td>6 months prior to agreement end date</td>
</tr>
<tr>
<td>Final Report</td>
<td>Within 90 days of completion of agreement</td>
</tr>
</tbody>
</table>

- Annual implementation plan – The Recipient is encouraged to design innovative implementation approaches to reach the desired results. The Recipient will develop annual implementation plans in concert with other key USAID/Philippines partners, and

\(^{10}\) Days refer to calendar days.
are aligned to each USG fiscal year of the agreement. Note: The applicant will prepare a draft Year 1 implementation plan to be submitted with its application. This draft will be finalized with the AOR within 45 days of award.

The Year 2 implementation plan, and other subsequent implementation plans, will be prepared and submitted to the AOR no later than 45 days before the close of the current USG fiscal Year 1.

The implementation plan must include, at a minimum:

- Proposed accomplishments and expected progress towards achieving program results and performance measures tied to the AMELP
- Timeline for implementation of the year’s proposed interventions, including target completion dates
- Information on how interventions will be put in place
- Gender action plan that will define how gender will be integrated in the activity cycle
- Environmental Risk Mitigation Plan (EMMP) which will describe how environmental compliance and climate risk management will be integrated into activity interventions
- Personnel requirements to achieve expected outcomes
- Details of collaboration with other major partners
- An annual budget with estimates of projected monthly expenditures.

- Activity Monitoring, Evaluation and Learning Plan (AMELP) – Within 90 days of award, the Recipient will submit an Activity Monitoring, Evaluation and Learning Plan (AMELP) for the life of the activity that derives from the activities outlined in the Activity Description. The AMELP will outline key program interventions, indicators of achievement, associated annual and life-of-activity targets and the learning agenda. The plan will be reviewed and approved by the AOR. Note: The applicant will prepare a draft Year 1 AMELP to be submitted with its application. This draft will be finalized with the AOR within 90 days of award.

- Sustainability Plan – The Recipient will submit a sustainability plan for the “TB Platforms” activity within the first 60 days of the agreement. This plan should describe specific interventions that are expected to be sustained after the Cooperative Agreement ends. The sustainability plan will be updated annually and progress and updates to the implementation of the plan should be reported on quarterly and annually as part of regular reports. Note: The applicant will prepare a draft Sustainability Plan to be submitted with its application. This draft will be finalized with the AOR within 60 days of award.

- Quarterly and Annual Progress Reports –

Quarterly Reports – The Recipient will submit to the AOR and other relevant stakeholders (i.e., GPH agencies like DOH and NEDA), quarterly progress reports based on the USG fiscal quarters, i.e., Quarter 1 covers October – December; Quarter 2,
January – March; Quarter 3, April – June, and Quarter 4, July – September. The quarterly report is due within 30 days after the fiscal quarter’s end. In lieu of the fourth quarter progress report, the Recipient will submit an Annual Report that covers the fiscal year that just ended. During the final year of implementation, the Recipient will continue to submit quarterly reports except for the fourth quarter when, instead of an Annual Report, the Recipient will be required to submit a Final Report (see letter f below).

Annual Reports – The Recipient must submit the annual report no later than 30 days after the end of the fiscal year to cover annual performance from October – September of the fiscal year.

At a minimum, both quarterly and annual reports will contain:

1. Progress (interventions completed, benchmarks achieved, and performance standards completed) made since the last report by region and province as applicable
2. Problems encountered and whether they were resolved or are still outstanding
3. Proposed solutions to new or ongoing problems
4. Success stories
5. Security concerns
6. Information on new opportunities for program expansion
7. Qualitative data on program achievements and results
8. The updated AMELP, as an attachment
9. Documentation of best practices that can be taken to scale
10. Progress to date on sustainability, gender and environmental risk mitigation plans
11. Update on monthly expenditures for the quarter vis-à-vis annual budget

12. Closeout Plan – No later than six (6) months prior to the completion date of the agreement, the Recipient will submit a demobilization plan for Agreement Officer approval. The demobilization plan shall include:
   1) Draft property disposition plan,
   2) Plan for the phase-out of in-country operations,
   3) Delivery schedule for all reports or other deliverables required under the agreement, and
   4) Timetable for completing all required actions in the demobilization plan, including the submission date of the final property disposition plan to the Agreement Officer.

13. Final Report – At the end of the program period, the Recipient will prepare a final report for submission to the AOR, the Agreement Officer and other relevant stakeholders (i.e., GPH agencies like DOH and NEDA) which highlights accomplishments against implementation plans; gives the final status of the benchmarks and results; documents lessons learned during implementation and suggests ways to resolve constraints identified. The report will describe the achievements of the activity in light of the
history of USAID programming, the legacy that USAID will leave in the TB sector and the status of the operating environment.

The Final Report must contain a three-page executive summary, an index of all reports and information products produced under the agreement and a summary of the activity’s finances, disaggregated at the program area and contain, at a minimum:

- Total award budget
- Total funds awarded by USAID.

Within ninety (90) calendar days following the estimated completion date of this award, the Recipient will submit one (1) original and two (2) copies of the Final Report to the AOR and one (1) copy to the Agreement Officer. In addition, one (1) copy will be submitted to the Development Experience Clearinghouse:

- By U.S. Postal Service delivery to:

  U.S. Agency for International Development
  Development Experience Clearinghouse
  M/CIO/ITSD/KM
  Ronald Reagan Building M. 01-010
  Washington, DC 20523-6100

Note: For the Quarterly, Annual and Final Reports, the following essential bibliographic information should be included on the cover page:

- Descriptive title;
- Author/s name/s;
- Award number;
- Recipient’s name;
- Development Objective; and
- Date of publication or issuance date of the report.

2. **Financial Reporting** –

The Recipient will account for expenditures for interventions carried-out under this project to ensure funds are used for their intended purposes.

Quarterly Financial Reports – The Recipient shall submit quarterly financial reports to USAID no later than ten (10) days prior the end of each USG fiscal quarter. They should be disaggregated at the program area and contain, at a minimum:

- Total award budget;
- Total award funds obligated to date;
● Total funds previously reported as expended by applicant by main line items;
● Total funds expended in the current quarter by budget line items;
● Total funds expended (actual plus estimated accrued) towards the end of the report period;
● Total un-liquidated obligations by main line items;
● Unobligated balance of USAID funds;
● Estimated expenditures for remainder of year;
● Estimated expenditures for remainder of project;
● Estimated fund support per province; and
● Total obligated funds expended by main line items to date.

E. PROGRAM INCOME

No program income is anticipated under this award.

F. FOREIGN GOVERNMENT DELEGATION TO INTERNATIONAL CONFERENCES

Funds in the agreement may not be used to finance the travel, per diem, hotel expenses, meals, conference fees or other conference costs for any member of a foreign government’s delegation to an international conference sponsored by a public international organization, except as provided in ADS Mandatory Reference “Guidance on Funding Foreign Government Delegations to International Conferences” at http://www.info.usaid.gov/pubs/ads/300/refindx3.htm or as approved by the Agreement Officer.

G. SALARY SUPPLEMENTS FOR HOST GOVERNMENT EMPLOYEES

Any payments by the Recipient to employees at any level of any foreign government shall be subject to the USAID policy on salary supplements (dated April 1988 or as amended). If this issue arises during the period of the Agreement, the Recipient shall consult with USAID on any questions regarding the applicability of the policy.

H. BRANDING STRATEGY AND MARKING PLAN

It is a federal statutory and regulatory requirement that all USAID programs, projects, activities, public communications, and commodities that USAID partially or fully funds under a USAID grant or cooperative agreement or other assistance award or sub-award, must be marked appropriately overseas with the USAID Identity. See Section 641, Foreign Assistance Act of 1961, as amended and 2 CFR 700.16.

Under the regulation, USAID requires the submission of a Branding Strategy and a Marking Plan, but only by the “apparent successful applicant,” as defined in the regulation.

A Branding Strategy and Marking Plan must be in accordance with USAID Branding and Marking Plan as required per ADS 320 at the following link: https://www.usaid.gov/ads/policy/300/320.
The apparent successful applicant’s proposed Branding Strategy and Marking Plan may include a request for approval of one or more exceptions to marking requirements established in 2 CFR 700.16. The Agreement Officer is responsible for evaluating and approving the Branding Strategy and a Marking Plan (including any request for exceptions) of the apparently successful applicant, consistent with the provisions “Branding Strategy,” “Marking Plan,” and “Marking of USAID-funded Assistance Awards” contained in AAPD 05-11 and in 2 CFR 700.16. Please note that in contrast to “exceptions” to marking requirements, waivers based on circumstances in the host country must be approved by the Mission Director or other USAID Principal Officers, see 2 CFR 700.16(j).
SECTION VII: AGENCY CONTACTS

The USAID/Philippines contact for this RFA is:

Name : Ms. Sandra Jansen
Title : Agreement Officer
Email Address : roaa-mnl-rfa@usaid.gov

Postal Address : Ms. Sandra Jansen
Agreement Officer
Regional Office of Acquisition & Assistance
USAID/Philippines
Annex 2 Building
U.S. Embassy
1201 Roxas Boulevard
Ermita, Manila 1000.

Please note that only the abovementioned Agreement Officer is authorized to make commitments in behalf of USAID/Philippines.

[END OF SECTION VII]
SECTION VIII: OTHER INFORMATION

ANNEX A - HEALTH PROJECT 2017-2022 IMPLEMENTATION ACTIVITIES

ANNEX B – TUBERCULOSIS DATA

ANNEX C - HEALTH PROJECT 2017-2022 RESULTS FRAMEWORK

ANNEX D - DISTRIBUTION OF INTERVENTIONS – DEPARTMENT OF HEALTH, GLOBAL FUND AND USAID

ANNEX E - GENDER CONSIDERATIONS

ANNEX F – INITIAL ENVIRONMENTAL EXAMINATION

ANNEX G - LIST OF RESOURCE DOCUMENTS
ANNEX A - HEALTH PROJECT 2017-2022 IMPLEMENTATION ACTIVITIES

USAID/Philippines will implement the 2017-2022 Health Project through a combination of state-of-the-art field platforms, roll-out of innovations and system strengthening activities, along with monitoring, evaluation, learning and adapting. The suite of project activities related to tuberculosis will include:

- Five tuberculosis technical activities that transfer state-of-the-art experience in behavior change, quality improvement and equitable access to services, as well as working with the Department of Health and other stakeholders to develop and help roll out innovations in partnering, service delivery and technologies.

- Four systems strengthening activities designed to make local ownership a reality by fortifying regional health governance, central and regional health financing and resource management, supply chain management and human resources, while institutionalizing leadership and technical training, supply chain management and policy development, currently being buttressed by USAID and other donors, into the Department of Health.

- A Collaborating, Learning and Adapting activity that will assist USAID to define and report on the quantitative and qualitative progress, define a strategic research and analysis agenda in cooperation with stakeholders, evaluate data quality, conduct impact and program evaluations and develop tools and opportunities for dissemination and adaptation.

Health Activity Descriptions are below:

Tuberculosis Activities

- **“TB Platforms”** - The “TB Platforms” activity will collaborate with the Government of the Philippines to expand, scale-up and institutionalize prevention, detection, and treatment of tuberculosis and multidrug-resistant (MDR) TB. Through partnerships with regional, provincial and local governments and communities, the activity will build capacity to reduce the tuberculosis burden in selected regions, reinforcing the responsiveness of the health care delivery system, and develop approaches to reduce the catastrophic costs associated with tuberculosis treatment. The activity will focus on encouraging families and communities to adopt and foster healthy behaviors to prevent, detect and treat TB, uphold implementation at scale in regions with the highest TB burden and bolster key health systems necessary for efficient and optimal delivery of quality TB services. The activity will collaborate closely with partners to provide wrap-around technical assistance and scale-up new approaches and models developed by the “TB Innovations and Health Systems Strengthening” activity. Expected results include: improved TB health care-seeking, treatment adherence, and enrollment on treatment; robust service delivery networks with qualified health providers that offer comprehensive TB prevention, care and treatment services; and fortified systems that support governance, financing, laboratory services and data management and monitoring.
● “TB Innovations and Health Systems Strengthening” - The “TB Innovations and Health Systems Strengthening” activity to be awarded under this NFO is designed to strengthen national and regional level implementation of the National TB Strategic Plan by providing state-of-the-art capacity building and approaches to scale-up TB and MDR-TB prevention, detection and treatment. The activity will fortify policies and build the capacity of the Department of Health and regions to implement a world-class national TB program, institutionalize and sustain partnerships with the private sector for TB prevention, detection and treatment, pilot and test innovative approaches to improve the quality of care for patients with DR-TB and bolster the TB diagnostic network system. The activity will also implement activities to address human resource and supply chain barriers that prevent quality TB service delivery. The activity will collaborate closely with the DOH, the Global Fund principal recipients and subrecipients, and other USAID partners to maximize contributions and investments to the TB program. Expected results include: improved, evidence-based approaches for engaging the private sector to diagnose and treat TB patients; more comprehensive and rapid high-quality TB laboratory diagnostics systems; accelerated development and dissemination of national TB policies and guidelines that are aligned with international standards; analysis and introduction of new treatment regimens, medications and approaches for DR-TB; and consistent supply of quality health service providers and TB drugs and commodities.

● TREAT TB - TREAT TB will provide interim capacity-building and expertise to bolster scaling up the shortened TB regimen (STR) with Bedaquiline, including integration of pharmacovigilance monitoring, support operations research (OR) and other analyses for the shortened treatment regimen, develop and implement OR training courses and develop initial strategies for engaging the private sector. This activity lays the groundwork for and will complement activities conducted under the “TB Innovations and Health Systems Strengthening” mechanism. Expected results include: enhanced quality of care and pharmacovigilance for patients under the STR, realistic and focused scale up of the STR to assure quality of services, accurate and improved analysis of the STR and bedaquiline data from the OR phase, and DOH staff trained to conduct operations research.

● World Health Organization Technical Advisory Services - The World Health Organization (WHO) TB technical advisor is to provides in-house international expertise in TB to the National TB Program to assist ending the global TB epidemic by 2035. To reinforce the National TB Elimination Plan (PhilSTEP1), the technical advisor will provide state-of-the-art technical expertise to improve the patient-centered care approach, enhance private sector engagement, integrate and mainstream TB and DR-TB care and treatment with other programs and improve quality of the TB program using data, evidence-based approaches and monitoring.

● Technical Assistance and Support Contract (TASC) - The Technical Assistance and Support Contract (TASC) provides in-house TB expertise and guidance on the expansion of prevention, diagnosis and programmatic management of drug-resistant TB in the context of Global Fund grant implementation. The technical advisor to the National TB Program identifies bottlenecks and facilitates solutions through coordinated capacity building, provides assistance to the Global Fund
principal recipient to implement Global Fund grants, and assists the country to leverage resources for TB control and elimination.

**Systems Strengthening Activities**

- **Health Leadership and Governance (HLGP)** - The Health Leadership and Governance activity aims to institutionalize leadership and governance capacity building in central and regional health management systems. The activity bolsters the Department of Health’s (DOH) capacity to manage HLGP by integrating leadership and governance capabilities into the DOH’s performance competency-based framework. The activity will fortify the leadership capabilities of the DOH’s Regional Offices to influence and affect health systems strengthening at the regional and local levels. Illustrative interventions include: developing and buttressing local health systems; co-developing leadership competency standards; collaborating with DOH Regional Offices to coach and mentor chief executives in provinces, cities, and municipalities; and integrating leadership modules for different levels of local government to address adaptive leadership challenges within a service delivery network. Expected results include: enhanced leadership and management capacities of the Bureau of Local Health Systems Development to implement the Health Leadership and Governance Program; leadership and governance competencies integrated into the DOH Competency Framework; and DOH Regional Offices, local government units, civil society, and the private sector established as convergence mechanisms to bolster HLGP implementation.

- **Expanding Universal Health Care** - The goal of the “Expanding Universal Health Care” Activity is to work with national, regional and local level institutions (Department of Health (DOH), PhilHealth and local government units (LGU)) to plan for adequate and sustained financing for health programs and services. The activity aims to institutionalize policy development, monitoring and oversight within the DOH and PhilHealth; build management, analytical and financial capacity at the central and regional levels of the DOH and PhilHealth; and assist regional governments to establish trust funds and other similar mechanisms for health financing at the LGU level. Illustrative interventions include: building fiscal and financial management capacities at the national, regional and local levels; developing a monitoring mechanism to track optimal utilization of funds for health; supporting the DOH and PhilHealth to streamline accreditation and claim processes; and rationalizing zero balance billing to support implementation at the national, regional, and local levels. Expected results include: increased demand for and utilization of PhilHealth benefits and reduced out-of-pocket expenses by underserved populations; DOH and PhilHealth financing policies and guidelines translated and systematically implemented at the regional and local levels; establishment of trust funds and similar mechanisms for health financing by LGUs; and increased and effective utilization of health budgets.

- **Supply Chain Management** - The goal of the “Supply Chain Management” Activity is to provide state-of-the-art capacity-building to the Department of Health (DOH) to establish a fully functional TB supply chain management system, including but not limited to forecasting, procurement, warehousing, inventory management, distribution and use at the point of care. Illustrative interventions include: establishing procedures, training, and monitoring systems for supply chain operations at the regional, local, and facility/provider levels; assisting the DOH and other Government of Philippines Agencies with pharmacovigilance and antimicrobial resistance
monitoring. The activity will collaborate closely with the DOH, the Global Fund principal recipients and subrecipients, and other USAID partners to maximize contributions and investments to the supply chain management program. Expected results include: an established functional supply chain system at the DOH that provides adequate and timely access to a regular supply of quality commodities at the point of care and supported by an enabling policy, legal and governance framework; and a strengthened pharmacovigilance and antimicrobial resistance monitoring system.

- **Human Resources for Health** - The goal of the “Human Resources for Health” Activity is to provide capacity-building to the Department of Health (DOH), at all levels, to strengthen the deployment, training, and management of a qualified health workforce to improve access to and quality of family planning (FP), maternal and child health (MCH) and TB services for vulnerable populations. Illustrative interventions include: assisting the DOH to develop a staffing plan that delineates requirements and competencies at all levels of care; supporting the DOH to conduct training needs assessments, develop a health workforce database, and institutionalize health service provider training courses; and building the capacity of the DOH to develop HRH policies and guidelines. Expected results include: an institutionalized training system; an improved workforce deployment system for competent and qualified health providers; and the development and implementation of relevant HRH policies and guidelines.

- **Collaboration, Learning and Adapting** - The “Collaboration, Learning and Adapting” Activity (CLA) will serve as the primary monitoring, evaluation, and learning instrument for the USAID/Philippines Office of Health’s Health Project 2017-2022. The activity will provide technical assistance, advisory services and relevant logistical support to monitor project performance, design and implement performance evaluations, conduct select implementation research and impact evaluations, conduct secondary analyses of research data, and facilitate continuous collaboration, learning and adapting for all Health Project activities. Information generated by this activity will be used to inform policy recommendations and programmatic decision-making throughout the life of the Health Project. Expected results include: completion of analyses of USAID’s contributions to support achievement of select indicators of the Philippine Health Agenda which may include, reductions in TB, reductions in unmet need for FP, and reductions in teen pregnancies and neonatal deaths; collection and analysis of baseline data for required and high-level project indicators; monitoring project level performance; completion of a project performance evaluation; completion of select impact and implementation research studies; and organization of innovative learning opportunities for adaptive management.

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# ANNEX B - TUBERCULOSIS DATA

## 2015 NTP Report 3a. Case Finding of DS-TB Cases and IPT

<table>
<thead>
<tr>
<th>Region</th>
<th>P</th>
<th>EP</th>
<th>All TB Cases</th>
<th>IPT</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>New</td>
<td>Relapse</td>
<td>Prev Treated</td>
<td>New</td>
</tr>
<tr>
<td>NCR</td>
<td>11,154</td>
<td>28,371</td>
<td>1,464</td>
<td>1,701</td>
</tr>
<tr>
<td>CAR</td>
<td>856</td>
<td>2,471</td>
<td>27</td>
<td>37</td>
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<tr>
<td>Ilocos</td>
<td>4,250</td>
<td>10,545</td>
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<td>I_Cagayan_Valley</td>
<td>2,458</td>
<td>6,102</td>
<td>99</td>
<td>261</td>
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<td>I_Bicol</td>
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<td>12,140</td>
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<td>15,617</td>
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<td>7,609</td>
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<td>ARMM</td>
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<td>Philippines</td>
<td>94,627</td>
<td>181,841</td>
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## Registration Group

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<tr>
<th>Registration Group</th>
<th>Male (%)</th>
<th>Female (%)</th>
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<tr>
<td></td>
<td>185,655</td>
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<table>
<thead>
<tr>
<th>Sex</th>
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<th>Female</th>
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<tr>
<td>Private</td>
<td>41,977</td>
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<tr>
<th>M</th>
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<tbody>
<tr>
<td>F</td>
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<table>
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<tr>
<th>Total</th>
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### 2015 NTP Report 5a. Treatment Outcome of DS-TB Cases v2017

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<tr>
<th>Region</th>
<th>All TB Cases Reported in 2014</th>
<th>% Over/ Under Reporting</th>
<th>Cured</th>
<th>Completed</th>
<th>Died</th>
<th>Not Eval.</th>
<th>LTIFU</th>
<th>Total</th>
<th>Success Rate</th>
<th>Cured</th>
<th>Completed</th>
<th>Died</th>
<th>Not Eval.</th>
<th>LTFU</th>
<th>Total</th>
<th>Excluded</th>
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<td>40,301</td>
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<td>9,932</td>
<td>21,797</td>
<td>171</td>
<td>454</td>
<td>1,557</td>
<td>1,598</td>
<td>35,509</td>
<td>89%</td>
<td>77</td>
<td>16</td>
<td>2</td>
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<td>5</td>
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<td>757</td>
<td>1,943</td>
<td>277</td>
<td>2,977</td>
<td>0</td>
<td>0</td>
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<td>91%</td>
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<td>0</td>
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<tr>
<td>L. Lucos</td>
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<td>78</td>
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<td>8</td>
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<td>III_Central Luzon</td>
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</tr>
<tr>
<td>V_Bicol</td>
<td>18,087</td>
<td>-2%</td>
<td>5,280</td>
<td>10,354</td>
<td>96</td>
<td>374</td>
<td>192</td>
<td>575</td>
<td>16,871</td>
<td>93%</td>
<td>95</td>
<td>569</td>
<td>8</td>
<td>43</td>
<td>11</td>
<td>56</td>
</tr>
<tr>
<td>VI_Western Visayas</td>
<td>27,706</td>
<td>2%</td>
<td>8,085</td>
<td>18,187</td>
<td>67</td>
<td>516</td>
<td>255</td>
<td>938</td>
<td>28,048</td>
<td>94%</td>
<td>62</td>
<td>50</td>
<td>4</td>
<td>10</td>
<td>7</td>
<td>12</td>
</tr>
<tr>
<td>VII_Central Visayas</td>
<td>16,010</td>
<td>-58%</td>
<td>2,367</td>
<td>3,915</td>
<td>29</td>
<td>192</td>
<td>13</td>
<td>132</td>
<td>6,648</td>
<td>94%</td>
<td>16</td>
<td>11</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>2</td>
</tr>
<tr>
<td>VIIII_Eastern Visayas</td>
<td>9,981</td>
<td>0%</td>
<td>3,457</td>
<td>5,225</td>
<td>44</td>
<td>282</td>
<td>115</td>
<td>396</td>
<td>9,319</td>
<td>91%</td>
<td>81</td>
<td>288</td>
<td>10</td>
<td>21</td>
<td>12</td>
<td>35</td>
</tr>
<tr>
<td>IX_Zamboanga Peninsula</td>
<td>9,521</td>
<td>-2%</td>
<td>3,271</td>
<td>4,653</td>
<td>75</td>
<td>275</td>
<td>97</td>
<td>312</td>
<td>8,683</td>
<td>91%</td>
<td>218</td>
<td>289</td>
<td>10</td>
<td>17</td>
<td>3</td>
<td>27</td>
</tr>
<tr>
<td>X_Northern Mindanao</td>
<td>9,951</td>
<td>-3%</td>
<td>3,627</td>
<td>5,371</td>
<td>54</td>
<td>233</td>
<td>119</td>
<td>261</td>
<td>9,665</td>
<td>93%</td>
<td>3</td>
<td>4</td>
<td>1</td>
<td>2</td>
<td>0</td>
<td>10</td>
</tr>
<tr>
<td>XI_Davao</td>
<td>12,124</td>
<td>-11%</td>
<td>4,282</td>
<td>5,122</td>
<td>65</td>
<td>282</td>
<td>88</td>
<td>398</td>
<td>10,237</td>
<td>92%</td>
<td>116</td>
<td>374</td>
<td>13</td>
<td>22</td>
<td>5</td>
<td>30</td>
</tr>
<tr>
<td>XII_SocCSKSarGen</td>
<td>12,243</td>
<td>5%</td>
<td>4,470</td>
<td>7,110</td>
<td>52</td>
<td>270</td>
<td>99</td>
<td>577</td>
<td>12,578</td>
<td>92%</td>
<td>33</td>
<td>166</td>
<td>4</td>
<td>9</td>
<td>2</td>
<td>12</td>
</tr>
<tr>
<td>XIII_CARAGA</td>
<td>9,356</td>
<td>-7%</td>
<td>2,855</td>
<td>4,777</td>
<td>52</td>
<td>239</td>
<td>95</td>
<td>279</td>
<td>8,287</td>
<td>92%</td>
<td>60</td>
<td>249</td>
<td>3</td>
<td>23</td>
<td>8</td>
<td>19</td>
</tr>
<tr>
<td>ARMM</td>
<td>7,109</td>
<td>-6%</td>
<td>2,492</td>
<td>3,174</td>
<td>35</td>
<td>141</td>
<td>98</td>
<td>509</td>
<td>6,449</td>
<td>88%</td>
<td>27</td>
<td>126</td>
<td>2</td>
<td>6</td>
<td>24</td>
<td>55</td>
</tr>
<tr>
<td>Philippines</td>
<td>268,835</td>
<td>-6%</td>
<td>76,431</td>
<td>149,650</td>
<td>1,396</td>
<td>5,183</td>
<td>4,040</td>
<td>9,450</td>
<td>246,150</td>
<td>92%</td>
<td>1,393</td>
<td>3,959</td>
<td>91</td>
<td>282</td>
<td>146</td>
<td>514</td>
</tr>
</tbody>
</table>

ANNEX C – HEALTH PROJECT 2017-2022 RESULTS FRAMEWORK

USAID/Philippines Health Project 2017-2022

Purpose: Improved Health for Underserved Filipinos

CDCS Goal

Sub-purpose 1: Healthy Behaviors Strengthened
Partners: Families and communities, TB patient groups and other peer-to-peer organizations, CSOs, FBOs, schools, youth groups, volunteers, health facilities, POPCOM, LGUs, & existing model programs.

1.1 Improved individual adoption of healthy behavior.
1.2 Improved community ownership/participation in healthy behaviors.

Sub-purpose 2: Quality of Services Fortified
Partners: Regional & local facilities/providers (public & private), SDNs, NTP, RRPH NIT, PhilHealth, LGUs, donor partners, & experts in MDR-TB, patient-centered service delivery, supportive supervision, & operations research.

2.1 Improved quality health services through patient-centered approaches.
2.2 Innovative approaches to improving quality of care tested & rolled out.

Sub-purpose 3: Key Health Systems Bolstered and Institutionalized
Partners: Existing DOH units focused on policy and planning, logistics, training and human resources, PhilHealth, training and research institutions/experts, donor partners, LGUs and local governments.

3.1 Effective public sector supply chain for medicines, technologies, and commodities rolled out.
3.2 Critical SOTA training institutionalized and sustained by DOH.
3.3 Improved fiscal, financial and human resource management for health institutionalized at the central, regional and local level.
## ANNEX D - DISTRIBUTION OF INTERVENTIONS – DEPARTMENT OF HEALTH, GLOBAL FUND AND USAID

<table>
<thead>
<tr>
<th>Technical Area</th>
<th>DOH</th>
<th>USAID TB Platforms</th>
<th>USAID TB Innovations &amp; Health Systems Strengthening</th>
<th>Global Fund</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Total Funding</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>$132 million over 5 years (assuming no increase in budget allocation)</td>
<td>$20 million over 5 years (2017 - 2022)</td>
<td>$25 million over 5 years (2017-2022)</td>
<td>$88 million over 3 years (2018-2020)</td>
</tr>
<tr>
<td><strong>Procurement</strong></td>
<td>Procurement of 100% of DS-TB drugs/laboratory supplies for targeted 1,480,900 TB cases in 5 years</td>
<td>No procurement planned</td>
<td>No procurement planned</td>
<td>Second-line TB drugs, laboratory tests and 584 (plus 280 from Catalytic Funding) GeneXpert machines.</td>
</tr>
<tr>
<td></td>
<td>Currently no allocation for DR TB drugs but aims to procure SLD for 30% of enrolled cases by 2018, 60% by 2019 and 100% by 2020</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Case finding</strong></td>
<td>Testing of ___% of estimated 5 million presumptive TB cases in 5 years</td>
<td>Support to engage individuals and communities to foster health care-seeking and treatment adherence including interventions for stigma reduction and increased detection of new TB cases through community approaches</td>
<td>Pilot and evaluate new approaches to detect TB cases</td>
<td>Testing of 900,000 presumptive TB cases</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Detection and Treatment of 34,935 patients through systematic screening of high risk groups among urban poor (in Reg 3, 4A, NCR, 6 and 11) and in 18 jails/prisons.</td>
</tr>
<tr>
<td><strong>Diagnosis</strong></td>
<td>Develop and disseminate guidelines for scale up and expanded use of Xpert</td>
<td>Improve access to TB laboratory systems that provide rapid test results for TB at decentralized levels</td>
<td>Support to develop comprehensive strategic approach for diagnostic network, expand new diagnostic tools, improve quality assurance of diagnostics</td>
<td>Introduction of Xpert (OMNI-Organizing Medical Network Information/Single Module) as primary diagnostic tool available at point of care. Establishment of 2 LPA centers Improve systems for sputum collection/transport Improve QA for laboratory services</td>
</tr>
<tr>
<td>---</td>
<td>---</td>
<td>---</td>
<td>---</td>
<td>---</td>
</tr>
<tr>
<td><strong>Service Delivery</strong></td>
<td>Update NTP manual of procedures Capacity building of healthcare workers at all levels</td>
<td>Capacity-building to improve quality of mainstreaming DR-TB services in target regions. This includes: supportive supervision, infection control strengthening, respectful care</td>
<td>Capacity-building to develop private sector strategy for increased engagement</td>
<td>Improving infrastructure, systems, protocols and capacity building of healthcare providers Interrupter tracing, reduce LTFUs and improve treatment outcomes</td>
</tr>
<tr>
<td><strong>Private Sector</strong></td>
<td>Develops strategic plan and establishes policies, guidelines and procedures</td>
<td>Roll-out policies, procedures and guidelines in select regions</td>
<td>Develops, tests and measures new strategies and approaches</td>
<td>54,000 patients contributed by engagement of private sector</td>
</tr>
<tr>
<td>-------------------</td>
<td>------------------------------------------------------------------------------</td>
<td>------------------------------------------------------------</td>
<td>----------------------------------------------------------</td>
<td>----------------------------------------------------------</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Supports DOH to develop strategy, policies, guidelines and procedures to increase private sector engagement</td>
<td>Private sector engagement - standalone physicians, private providers, pharmacies</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Contract staff for program implementation and management, including 150 private sector “mobilizers”</td>
</tr>
<tr>
<td><strong>DR TB</strong></td>
<td>Programmatic implementation of SSTR</td>
<td>Strengthen and improve service delivery networks, engage health care providers to deliver quality patient-centered DR TB services</td>
<td>Testing of new approaches for DR TB detection, prevention and treatment</td>
<td>Detection and enrollment of 22,620 patients DRTB Cases</td>
</tr>
<tr>
<td></td>
<td>Adopt and expand the use of new drugs</td>
<td></td>
<td></td>
<td>30% of the 2,600 RHUs will be upgraded as iDOTS and Xpert Centers by 2019. The rest of the RHUs will provide community-based care for directly observed treatment for the MDR/RR TB patients in their areas.</td>
</tr>
<tr>
<td></td>
<td>Capacity building of all healthcare workers on PMDT</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### TB-HIV

<table>
<thead>
<tr>
<th>Activity</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Expand TB/HIV collaboration to cover 100% coverage by 2020</td>
<td></td>
</tr>
<tr>
<td>80% of adult TB cases provided with PICT.</td>
<td></td>
</tr>
<tr>
<td>Some assistance to foster healthy behaviors of vulnerable populations including co-infected PLHIV</td>
<td></td>
</tr>
<tr>
<td>New approaches for TB-HIV</td>
<td></td>
</tr>
<tr>
<td>Full coverage of TB-HIV collaborative services in full implementation in the National Capital Region, Region 3 and Region 4A</td>
<td>396,918 TB patients tested on HIV</td>
</tr>
</tbody>
</table>

### Policies, Guidelines and Research

<table>
<thead>
<tr>
<th>Activity</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Leads development and roll-out of policies and guidelines</td>
<td></td>
</tr>
<tr>
<td>Implementation and roll-out of policies and guidelines in target regions</td>
<td></td>
</tr>
<tr>
<td>Assistance to develop national policies and guidelines</td>
<td></td>
</tr>
<tr>
<td>Support research such as the 2018 Inventory Study, Drug Resistance Survey, 2019 JPR and Catastrophic Cost Study and Implementation Research for TB free areas/islands</td>
<td></td>
</tr>
<tr>
<td><strong>Health information Systems</strong></td>
<td>Overall management of ITIS through KMITS</td>
</tr>
<tr>
<td>-------------------------------</td>
<td>------------------------------------------</td>
</tr>
<tr>
<td></td>
<td>Conduct of Data Quality Checks</td>
</tr>
<tr>
<td></td>
<td>Development of tools for recording, reporting and monitoring</td>
</tr>
<tr>
<td></td>
<td>Implement policy and mechanisms for notifying TB cases by non-NTP providers</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Governance and Finance</strong></th>
<th>Leads negotiations to improve governance and financing of TB programs</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Works with counterparts to develop PhilHealth benefit package for DR TB</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Improving</strong></th>
<th><strong>Testing new</strong></th>
<th><strong>ITIS and support to</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>collection, analysis and use of data at regional to facility levels</td>
<td>approaches to data collection, analysis and use of data</td>
<td>improve the information system</td>
</tr>
</tbody>
</table>

| **Provides hardware and internet access** |
| **Hires programmers, system analyst and data managers** |

<table>
<thead>
<tr>
<th><strong>Build capacity of decentralized levels (LGUs and providers) to manage, finance and oversee TB programs</strong></th>
<th><strong>Build capacity of NTP and regional levels to manage, finance and oversee TB programs</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Assistance to document and analyze administrative, human resource and financial needs for TB program</strong></td>
<td><strong>Advocacy and capacity building to transition and sustain Global Fund investments</strong></td>
</tr>
</tbody>
</table>

| | | |
| | | |
| | | |
| **Supply Chain** | Procurement, storage, distribution and management of NTP logistics | Support to roll-out supply chain policies and guidelines | **USAID TB Supply Chain management activity (separate activity) - technical assistance** | Development of a national strategic plan to strengthen the current pharmaceutical management system of the DOH. Support engagement of technical assistance providers to assist in the development of a functional data management system for Procurement and Supply Chain Management (PSCM) Supply planning at facility, provincial/regional, central levels Integrating procurement mechanisms at regional/central levels through procurement framework contracts |

| | | | | |
| Human Resources for Health | Develop and implement comprehensive HRD plan for-training activities of human resources at all levels-deployment of human resources for health/rural-based health workers | Support to roll-out human resource policies and guidelines | Technical assistance to strengthen TB human resources-Pilot test new approaches for HRH |
ANNEX E - GENDER CONSIDERATIONS

USAID’s Gender Equality and Female Empowerment Policy

Gender equality and women’s empowerment are essential for achieving USAID’s development goals. The USAID Gender Policy advances equality between women and men, boys and girls, and empowers women and girls to participate fully in and benefit from development activities, through the integration of gender in the entire project cycle -- from project design and implementation to monitoring and evaluation. This integrated approach focuses on achieving three overarching outcomes: 1) Reducing gender disparities in access to, control over and benefit from resources, wealth, opportunities, and services – economic, social, political, and cultural; 2) Reducing gender based violence and mitigate its harmful effects on individuals and communities, so that all people can live healthy and productive lives; and 3) Increasing the capability of women and girls to realize their rights, determine their life outcomes, and influence decision making in households, communities, and societies.

The “TB Platforms” activity is expected to contribute to the first listed outcome by reducing gender disparities in access to and benefit from tuberculosis care and treatment services. It is also encouraged to contribute to the third listed outcome by increasing the capability of women and girls to realize their right to seek healthcare services and to influence decision-making regarding health care. Furthermore, as gender barriers often prevent men and boys from seeking services, the activity will work to transform negative masculinities that prevent men and boys from taking care of their own health as well.

Activity interventions will be implemented in a manner that promotes fair, equitable, and meaningful inclusion of both men and women in all activity interventions.

To provide greater focus on gender equality and women’s empowerment in this activity, the Activity will prepare a Gender Action Plan that will include the following considerations:

- Conduct of training for the activity staff, partners and cooperators on gender awareness, gender analysis and gender-responsive planning.
- Collection of sex-disaggregated data for use of gender analysis tools to identify potential gender gaps and constraints.
- Conduct gender-responsive consultations to encourage the active participation of women and guarantee that the baselines and monitoring of all people-level indicators and voices of women are heard and reflected in activity plans and activities.

Integration of Gender Considerations to Strengthen the TB Response

The Government of the Philippines has shown tremendous dedication and success regarding gender equality and women’s empowerment. According to the 2016 World Economic Forum’s Global Gender Gap Report, the Philippines ranks seventh of 144 countries worldwide on gender parity, higher than any other country in Asia. It is also one of four countries in the East Asia and Pacific region to close the Health and Survival gender gap and one of only two to close the Educational Attainment gap. While acknowledging these very impressive achievements, it is also necessary to remember the variation that exists among geographic regions and cultural groups. For example, the 2013 DHS found that, nationwide, 9.2 percent of women cited getting permission as a barrier to accessing health care, this ranged from 4.1 percent in CALABARZON to 30.3 percent in ARMM. Almost 48 percent of women nationwide cited money as a barrier, ranging from 31.4 percent in Davao to 90.7 percent in ARMM. Assessing and addressing the specific needs of these less-advantaged women will be necessary to achieve full gender equality.

Gender impacts how tuberculosis is experienced; to be most effective, TB programs need to take this into consideration at all stages of programming -- planning, implementation, monitoring and evaluation -- and at all points along the health/illness continuum -- risk factors, exposure, knowledge, access to services, diagnosis, treatment, support and recovery. The “TB Platforms” activity is expected to analyze these differences and design gender-sensitive or gender-transformative activities. The activity shall also assert and uphold the right of all individuals -- men, women, and transgender people -- to access quality healthcare services. Due to lack of data regarding TB and transgender individuals, this section will focus on differences between men and women.

In the Philippines, 65 percent of incident cases in 2015 were among males and 35 percent were among females, close to the global averages of 62 percent among males and 38 percent among females (WHO, Global TB Report, 2016). The 2007 Nationwide TB Prevalence Survey reports a similar disparity in prevalence: 65 percent of smear positive cases are among males and 35 percent among females, and 73 percent of culture positive cases are among males and 27 percent among females (p. 58). The National TB policy (2010–2016) reports similar findings, stating that TB cases are more than two times more common among males than females. Consequently, successful TB activities will serve approximately two times more men than women. To be effective and most efficient in bringing the TB epidemic under control, men will need to be specifically targeted by TB interventions.

Interviews conducted as part of a USAID Evaluation of the Tuberculosis Portfolio (2012) revealed that the National Tuberculosis Program and other organizations involved in TB control and prevention disaggregate patient data by gender, but have not considered gender in the planning process and resulting documents. (The Updated 2010-2016 Philippine Plan of Action
to Control TB does not mention any differences in TB rates, case notification, treatment or outcome by gender or sex.) Neither gender inequality nor lack of women’s empowerment by themselves are considered a barrier to diagnosis and treatment, and the evaluation recommended that simple operational studies could be undertaken to further analyze gender issues and possible barriers to TB care.

Men and women may also experience different risk factors and exposures to TB. For example, men may be more likely to smoke or drink alcohol, increasing risk of tuberculosis. Occupational exposures can also vary. For example, men engaged in mining activities are at much higher risk; other studies have shown that women taking care of sick relatives may be at elevated risk.

Men and women may experience stigma related to TB in different ways and may have differing levels of knowledge of the disease and treatment options — both factors that influence an individual’s health seeking behavior. For example, results from the 2007 Prevalence Survey show that fewer men (84.3 percent) than women (89.1 percent) had heard of TB (p. 74), and men were slightly less likely to identify bacteria as the cause for TB (7.2 percent) than women (9.3 percent) (p. 75). Men were also less likely than women to identify each of seven symptoms as associated with TB (p. 77).

Once an individual does decide to seek care, subsequent barriers to care also differ: women may lack the financial resources or autonomy to visit a clinic; men may be unable to miss work to attend a clinic during regular hours. Stakeholders familiar with the health system report that men do not regularly access health care because the hours of health clinics usually overlap with their work schedules. Earlier research has also documented these gender-related and service provision factors that influence men’s access to healthcare (Lee, 1999; Clark et al., 2007 as mentioned in Kiesel, et. al., 2014). More recently, the 2012 USAID Program Evaluation showed that men have difficulty accessing TB services since most facilities’ operating hours overlap with their working hours. This hinders the men from going to the facilities, since they are daily-wage earners and having check-ups has an opportunity cost. Stigma surrounding TB by communities and potential employers, as well as potential and actual patients themselves, exacerbates the problem (USAID Philippines, 2012). The Prevalence Survey found that more men took no action regarding their TB symptoms (31 percent) than women (18.5 percent) (p. 78).

Differences in preference of health care providers and in treatment completion and success also exist. When seeking care, 19.6 percent of men vs. 32.1 percent of women consulted public health care workers at a DOTS Center; 32.4 percent of men and 22 percent of women reported to a hospital or clinic (Prevalence Survey, pg. 80). A study by Tupasi et al. (2006) found that women are more likely than men to be cured following TB treatment, but the researchers could not identify any clinical variable that predicted cure. However, in the Philippine cultural norms, women are perceived to be more compliant (to treatment regimen) than men which could be the reason for higher treatment completion and cure rates.

The success of tuberculosis programs and progress toward the elimination of tuberculosis
require gender-sensitive programming. USAID expects the applicant to delve into the gender-based differences related to TB in order to thoughtfully design, implement and monitor activities that most effectively reach the targeted group while contributing to equitable access to quality care.

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INITIAL ENVIRONMENTAL EXAMINATION (IEE)

PROGRAM/ACTIVITY DATA:

Program/Activity Title: USAID/Philippines Health Project Development Objective: Improved Health for Underserved Filipinos Country/Region: Philippines/Asia

Foreign Assistance Objective: Investing in People

Program Area: 3.1. Health Program Elements: 3.1.2. Tuberculosis 3.1.6. Maternal and Child Health 3.1.7. Family Planning and Reproductive Health

Period Covered: 4/01/2017 – 12/31/2023

Life of Project (LOP) Amount: $128,250,000

IEE Prepared By: Maria Teresa Carpio, USAID/Philippines Office of Health

IEE Amendment (Y/N): No

Current Date: March 02, 2017

Expiration Date: December 31, 2023

ENVIRONMENTAL ACTION RECOMMENDED:

Categorical Exclusion: [ X ] Negative Determination with Conditions: [ X ]

Positive Determination: [ ] Deferral: [ ]
SUMMARY OF FINDINGS:

Scope: This document provides the first review of the reasonably foreseeable effects on the environment and recommends threshold decisions and conditions for proposed activities under the USAID/Philippines Health Project. In addition, this IEE sets out activity-level procedures intended to ensure that potential environmental impacts are mitigated and conditions are implemented.

Outline and Recommended Threshold Decisions:
This document consists of the following sections: I – Purpose and Scope II – Background and Description of the Health Project and Activities III – Country and Environmental Information IV - Analysis of Potential Environmental Impact V – Recommended Threshold Decisions VI – Climate Risk Management VII – Monitoring and Implementation

This IEE recommends the threshold decisions summarized in the following table.

<table>
<thead>
<tr>
<th>Implementing Mechanism (IM)</th>
<th>Categorical Exclusion</th>
<th>Negative Determination with Conditions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health Leadership &amp; Governance Program</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Collaboration, Learning &amp; Adapting</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Universal Health Care (PhilHealth/Policy)</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Tuberculosis (TB) Platforms</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>TB Innovations</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Family Planning (FP) Innovations &amp; Strengthening Service Platforms</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Family Planning/Maternal and Child Health (FP/MCH) Service Delivery in the Autonomous Region in Muslim Mindanao (ARMM)</td>
<td>☐</td>
<td>☐</td>
</tr>
</tbody>
</table>

Limitations: The Program will not undertake any activities determined to pose a significant effect on the environment under 22 CFR 216.2(d)(1). This IEE does not cover activities involving:
- indoor residual spraying of pesticides for malaria control;
- procurement, transport, use, storage, or disposal of pesticides or toxic materials;
- procurement or use and/or disposal of other hazardous/toxic materials for construction projects;
- procurement, use and/or disposal of equipment containing and/or generating low-level radioactive materials and wastes; and
- construction (other than small-scale – e.g. rehabilitation).
General Implementation and Monitoring Conditions: In addition to the specific conditions listed in Section V, the negative determinations recommended in this IEE are contingent on full implementation of a set of general monitoring and implementation requirements specified in Section VII. These include the following:

- briefings for implementing partners on environmental compliance responsibilities;
- development, integration, and implementation of an Environmental Mitigation and Monitoring Plan (EMMP) by each implementing partner;
- EMMPs for activities deemed moderate or high risk, will include appropriate measures to mitigate the impact of climate change, as discussed in Section VI;
- integration of environmental compliance responsibilities in prime and sub-contracts and grant agreements;
- assurance of sub-grantee and sub-contractor environmental compliance;
- environmental monitoring responsibility of the USAID/Philippines Office of Health; and
- amending this IEE to reflect new or substantially modified activities.

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APPROVAL OF INITIAL ENVIRONMENTAL EXAMINATION

Development Objective: Improved Health for Underserved Filipinos

Acting Office Chief
Clearance cleared 3/2/2017
Bryn Sakagawa Date

Mission Environmental Officer/
Climate Integration Lead
Clearance cleared 3/2/2017
Marian Cruz Navata Date

Regional Environmental Advisor
Clearance cleared by email 3/2/3017
Aaron Brownell Date

APPROVAL

Acting Mission Director

CONCURRENCE:
Bureau Environmental Officer

[Signatures and dates]
INITIAL ENVIRONMENTAL EXAMINATION (IEE)

PROJECT/ACTIVITY DATA:

Activity Name: USAID/Philippines Health Project  
Country/region: Philippines/Asia  
Start Date: 04/01/2017  
End Date: 12/31/2023  
Life of Project Amount ($): 128.25 million  
IEE Prepared by: Maria Teresa Carpio  
Date: 2/28/2017  
Amendment: no

ENVIRONMENTAL ACTION RECOMMENDED: (Place X where applicable)

Categorical Exclusion: [ X ]  
Negative Determination with Conditions: [ X ]  
Positive Determination: [ ]  
Deferral: [ ]

I. Purpose and Scope

The purpose of this document, in accordance with Title 22, Code of Federal Regulations, Part 216 (22CFR216), is to provide a preliminary review of the reasonably foreseeable effects on the environment, as well as recommended Threshold Decisions, for the activities detailed below. This document provides a brief statement of the factual basis for Threshold Decisions as to whether an Environmental Assessment or an Environmental Impact Statement is required for the activities managed under the scope of this document. In addition, this IEE presents activity-level implementation procedures intended to ensure that conditions in this IEE are translated into activity-specific mitigation measures, and to ensure systematic compliance with this IEE during Health Project implementation. The activities under review are recommended for the threshold decisions indicated in Table 1 below:

Table 1: Health Project Activities Covered in This IEE, 2017-2023

<table>
<thead>
<tr>
<th>Implementing Mechanism (IM)</th>
<th>Projected Life of Project Amount</th>
<th>Projected Start and End Dates</th>
<th>Recommended Determination</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health Leadership &amp; Governance Program</td>
<td>$2.0 million</td>
<td>Apr 2017 – Mar 2020</td>
<td>CE*</td>
</tr>
<tr>
<td>Collaboration, Learning &amp; Adapting</td>
<td>$7.8 million</td>
<td>Aug 2017 – Jul 2022</td>
<td>CE</td>
</tr>
<tr>
<td>Universal Health Care (PhilHealth/Policy)</td>
<td>$11.5 million</td>
<td>Feb 2018 – Jan 2023</td>
<td>CE</td>
</tr>
<tr>
<td>Tuberculosis (TB) Platforms</td>
<td>$25 million</td>
<td>Oct 2017 - Sep 2012</td>
<td>CE; NDC**</td>
</tr>
<tr>
<td>TB Innovations</td>
<td>$17 million</td>
<td>Dec 2017 – Nov 2022</td>
<td>CE; NDC</td>
</tr>
<tr>
<td>Family Planning (FP) Innovations &amp; Strengthening Service Platforms</td>
<td>$49 million</td>
<td>Feb 2018 – Jan 2023</td>
<td>CE; NDC</td>
</tr>
</tbody>
</table>
II. Background and Description of Activities

A. Background

The Philippines has made significant strides to address inequities and inefficiencies in health financing, service delivery, regulation, and demand generation. The Department of Health budget continues to rise and social insurance continues to expand to cover the indigent. Local government units fund approximately 13 percent of the total health budget. The Department of Health’s social insurance arm, PhilHealth, had reached 92 percent coverage of the projected 45 million households in 2015, of which 49 percent or 15.3 million are indigent households as of 2015. The number of PhilHealth accredited outpatient clinics providing primary care benefits, maternity care and the DOTS package for tuberculosis continued to increase with 83 percent of facilities in the local government units providing primary care benefits, maternity care and the DOTS package for tuberculosis.

Yet gaps in the continuum of care are still evident, particularly in addressing maternal and neonatal mortality, reproductive health, tuberculosis, HIV, emerging pandemic threats, malnutrition and illegal drug use. Underserved populations, especially those from the lowest income quintiles and from geographically isolated and depressed areas, continue to suffer from a high prevalence of tuberculosis, including multidrug-resistant TB (MDR-TB), and preventable maternal and newborn deaths, due to limited adoption of healthy behaviors, weak health systems and governance and inadequate service delivery. Health sector performance suffers as a result of weak logistics and pharmaceutical management, shortages of qualified health professionals in underserved areas, inadequate public sector capacity in policy development, finance and engagement of the private sector. Significant variations exist in the quality of health services and in supervision and mentoring at the national and local levels.

In 2016, the Department of Health embarked on its new Philippine Health Agenda, which focuses on financial risk protection, better health outcomes and a health system that is responsive and provides access to services. The Health Agenda will require bureaucratic systems to be effective and agile, strategic approaches to engender better health outcomes and stakeholder vigilance over policies, budgets and systems. The Health Agenda provides a platform for USAID to have an impact on the broad range of critical health problems and the underlying systems issues facing the country.

The USAID/Philippines Health Project prioritizes detecting and treating tuberculosis, especially multidrug-resistant tuberculosis and improving family planning and maternal and neonatal health. Priorities for systems strengthening include areas that demonstrate critical challenges for
the new Health Agenda and include fortifying public sector supply chain and pharmaceutical management, institutionalizing policy development and finance and technical training programs and sharpening capacity to manage and oversee human and financial resources. At the same time the Health Project will remain flexible to changing priorities within the U.S. government and the Government of the Philippines as well as new opportunities in the health sector, should additional funds become available.

B. Description of the Health Project and Activities

Project Purpose and Vision
The purpose of the Health Project is Improved Health for Underserved Filipinos. The vision is that individuals, particularly underserved populations, will gain control of their own health and will have continuous access to evidence-based information and to affordable, quality services and commodities. This translates into a focus towards fortification and institutionalization of healthy behaviors, services and systems. For the underserved, it means engaging a host of providers of information and support relevant to their age, social and cultural mores and immediate needs. For service providers it means adopting state-of-the-art approaches and technology to improve their effectiveness and reach. For systems strengthening it means deeper engagement with the local actors and the local systems that are crucial to continued achievement and sustainability of overall health outcomes.

The new Health Project is relevant to the existing Mission Strategy. USAID/Philippines’ Country Development Cooperation Strategy (CDCS) for 2012-2016, with its goal of a More Stable, Prosperous, and Well-Governed Nation, includes Development Objective 1, “Broad-Based Growth Accelerated and Sustained” with Intermediate Result (IR) 1.3: “Improving health to create a healthier workforce.” The CDCS also includes health in Development Objective 2, “Peace and Stability in Conflict-Affected Areas in Mindanao Improved” and Intermediate Result 2.1: “Local Governance Strengthened, sub IR 2.1.2: Service Delivery by Local Governments.” The CDCS makes a direct strategic link between this Development Objective and the Health Portfolio work with local government. In addition, the strategy calls for a focus on the most vulnerable, youth and male-friendly services. Consistent with the inclusive, broad-based, economic growth goal of USAID/Philippines’ Cities Development Initiative, the Health Project will adopt the urban health equity approach in selected cities with significant burden of disease and high-risk adolescent populations. Additionally, the Project’s more specific focus on targeted underserved populations will be integrated into the new Country Development Cooperation Strategy to be developed in 2018.

Sub-Purposes
Embedded in the Project purpose is a three-pronged set of sub purposes designed to: 1) strengthen individual healthy behavior; 2) fortify the quality of health services to push for more patient-centered approaches; and 3) bolster and institutionalize the key public health systems needed to support these behaviors and services.

Sub-purpose 1: Healthy behaviors strengthened
   1.1 Improved individual adoption of healthy behavior.
   1.2 Improved community ownership/participation in health behaviors.

Healthy behaviors strengthened will be achieved through providing information, activities and new local partnerships that allow individuals to make informed choices about how to protect their health, sustain the practice of healthy behavior and access health services when needed. A project emphasis will be to engage relevant community partners, (e.g., NGOs, youth groups, tuberculosis patient groups and schools) to better meet these needs.

Sub-purpose 2: Quality of service delivery fortified
   2.1 Improved quality of health services through patient-centered approaches.
   2.2 Innovative approaches to improving quality of care tested and rolled out.

The quality of services will be fortified through the use of patient-centered approaches for diagnosis, care, treatment, follow-up and mentoring, as well as through facility-based supportive supervision to ensure all aspects of quality are met. The Project will also contribute to the identification, development and roll out of innovations in the provision of quality services.

Sub-purpose 3: Key health systems bolstered and institutionalized
   3.1 Effective public sector supply chain for medicine, technologies, and commodities rolled out.
   3.2 Critical state-of-the-art training institutionalized and sustained by the Department of Health.
   3.3 Improved fiscal, financial and human resource management for health institutionalized at central, regional and local levels.

Under this sub-purpose, selected functions of the health system – training, provision of commodities, regional and local governance and financial risk planning and budgeting – that are considered critical by the Department of Health, USAID and other stakeholders will be fortified, institutionalized and sustained.

For sub-purpose 3, many activities will need to work at the central, regional and local levels of government and, at times with appropriate government agencies e.g., Food and Drug Administration for pharmaceutical management and PhilHealth for work on finance. A wide variety of public and private individuals and entities will be involved in implementation. Partners range from private sector suppliers and distributors to certified trainers in state-of-the-art technical areas from universities, civil society organizations and other donor’s projects.

Project Activities will each contain unique work plans designed to meeting some or all of the three Sub-Purposes of the Project. Activities fall into four major categories: 1) Tuberculosis and Multidrug-resistant Tuberculosis; 2) Reproductive Health and Maternal and Child Health; 3) System Strengthening; 4) Other Health Issues; and 5) Collaboration, Learning and Adaptation. As additional funding becomes available, the Health Project will take on nutrition, non-communicable diseases, community drug rehabilitation and HIV treatment and prevention.

Activities covered in this IEE by sub-purposes supported are listed in Table 2 below.


Table 2: Health Activities by Sub-Purposes 2017-2023

<table>
<thead>
<tr>
<th>Implementing Mechanism (IM)</th>
<th>Pursues Sub-Purpose</th>
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<tbody>
<tr>
<td></td>
<td>1</td>
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<tr>
<td>Health Leadership &amp; Governance Program</td>
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<tr>
<td>Collaboration, Learning &amp; Adapting</td>
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<tr>
<td>Universal Health Care (PhilHealth/Policy)</td>
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<tr>
<td>TB Platforms</td>
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<tr>
<td>TB Innovations</td>
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<tr>
<td>FP Innovations &amp; Strengthening Service Platforms</td>
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</tr>
<tr>
<td>FP/MCH Service Delivery in ARMM</td>
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*Categorical Exclusion

**Negative Determination with Conditions

The Health Project’s geographic focus will be in areas where the health burden is the greatest. Specifically for tuberculosis, concentration will be in areas where the TB disease burden is the highest, and for family planning, in areas with the highest unmet need for family planning and where there are high teenage pregnancy rates. Maternal and child health priority will be areas where the nexus for high unmet need and high teenage pregnancy rates meets with high neonatal deaths. Health systems strengthening activities will be national in nature. All funding streams will support work at the national level to develop policies and guidelines and assist the Department of Health with systematic implementation of policies and guidelines at the regional and local government unit levels. Priority among City Development Initiative cities will be where health burden is high in the technical areas that the Health Project covers.

Specific actions by sub-purpose and recommended threshold decision are listed in Table 3.

Table 3: Planned Health Actions by Sub-Purpose and Recommended Threshold Decision

<table>
<thead>
<tr>
<th>Sub-Purpose 1: Healthy Behavior Strengthened</th>
<th>Recommended Threshold Decision*</th>
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<tbody>
<tr>
<td>• Engagement with new partners to reach community members, empower and reinforce adoption of (a) TB healthy behaviors and (b) healthy behaviors with family planning, age appropriate reproductive health and maternal and neonatal health messages</td>
<td>□ CatEx: 216.2(c)(2)</td>
</tr>
<tr>
<td>• Raise awareness about TB and provide skills for healthy behavior, recognizing symptoms and seeking care</td>
<td>□ CatEx: 216.2(c)(2)</td>
</tr>
<tr>
<td>Strengthen adoption of healthy behavior/lifestyle and infection control measures among the communities and families</td>
<td>CatEx: 216.2(c)(2)</td>
</tr>
</tbody>
</table>
- Address stigma and discrimination surrounding TB in workplace and schools  
  CatEx: 216.2(c)(2)
- Develop information and skill building activities, events, materials and products for diagnosis, treatment completion and infection  
  CatEx: 216.2(c)(2)iii
- Expand the establishment and availability of local TB patient support groups  
  CatEx: 216.2(c)(2)i, iii, viii
- Support FP and TB service outreach to hard-to-reach communities  
  CatEx: 216.2(c)(2)ii; NDC
- Work with civil society organizations, community groups, non-governmental organizations, government entities and the private sector to  
  (a) develop approaches to detect, prevent and treat TB and MDR-TB and  
  (b) to develop state-of-the-art age-appropriate, culturally respectful and  
  CatEx: 216.2(c)(2)i; NDC
- Conduct operations research on new behavior change approaches for adolescents and youth, women of reproductive age groups and FP “influencers”  
  CatEx: 216.2(c)(2)ii, viii
- Identify and test new approaches to (a) increase enrollment in treatment, reduce default rates, and reduce stigma and discrimination for MDR-TB;  
  (b) mobilize communities to identify TB suspects, refer for treatment and support patients to complete treatment; (c) create TB patient support groups and work with political leaders and other civil society organizations; and (d) reduce teen pregnancies and increase access to and utilization of family planning services, including involving men in  
  CatEx: 216.2(c)(2)ii, iii, viii

### Sub-Purpose 2: Quality of Service Delivery Fortified

<table>
<thead>
<tr>
<th>Recommended Threshold Decision</th>
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</table>
| • Support TB Law implementation and development and implementation of policies on TB, family planning and maternal and  
  CatEx: 216.2(c)(2)i, iii, viii; |
| • Support National TB Program to scale up MDR-TB diagnosis, prevention and treatment and roll out of TB innovations  
  NDC |
| • Strengthen patient-centered approaches to provide TB diagnosis and treatment and family planning, maternal and neonatal health service delivery with a particular focus on respectful care  
  CatEx: 216.2(c)(2)viii; NDC |
| • Improve and develop interpersonal communication and counseling for patient-centered care among midwives  
  CatEx: 216.2(c)(2)i |
| • Improve patient skill-sets for infection safety for families and communities  
  CatEx: 216.2(c)(2)ii; NDC |
| • Improve quality of care by (a) training public and private providers on high-impact reproductive health and critical neo-natal procedures; (b) strengthening facility-based supportive supervision, follow-up and mentoring for both the public and private sectors; (c) mentoring and monitoring midwives to improve the quality of reproductive health and maternal and newborn care; and (d) strengthening adolescent friendly care with age-appropriate information  
  CatEx: 216.2(c)(2)ii; NDC |

Sub-Purpose 2: Quality of Service Delivery Fortified
- Encourage the DOH and other agencies, including private providers, to introduce innovative and state-of-the-art approaches to improve the quality of reproductive, maternal and neonatal health services

- Provide assistance to accelerate DOH licensing and PhilHealth accreditation of facilities for TB, family planning and maternal and neonatal health services

- Support the DOH, regional offices and local government units in the establishment of appropriate Service Delivery Networks (SDN) to address the health needs of affected populations, in particular (a) support development and strengthening of functional TB referral networks (and document and apply lessons learned); (b) intensify participation of private midwives and provincial hospitals in SDNs or similar community efforts; and (c) support implementation research to document lessons learned for functional service delivery

- Bolster the quality of practice of midwives through adoption of standards for complete pre-natal care, safe attendance of deliveries and post-partum and newborn care

- Support, test and document new approaches and innovations, including through operations research, for shorter TB treatment regimens and improved family planning, maternal and neonatal health services delivery and test and support national scale-up of strategic and targeted high-impact family planning, maternal and

- Catalyze civil societies, non-government organizations and academia through innovation grants to demonstrate state-of-the-art local solutions to increase health service utilization among underserved populations

- Strengthen communication to inform public and private providers of PhilHealth TB, family planning, maternal and child health requirements and procedures and other health policies

- Fill service delivery gaps of DOH-ARMM and the local government, including the provision of adolescent and reproductive health services

- Establish approaches and support service outreach to hard-to-reach communities for FP and TB interventions

**Sub-Purpose 3: Key Health Systems Bolstered and Institutionalized**

- Support system strengthening activities to institutionalize facility-based and health provider training programs, including follow-up and mentoring

- Support policy development to add TB patient support group costs to normal facility-based operational expenses

- Assist with TB, FP/MCH and related health systems strengthening policy development and implementation

- Work with PhilHealth, the National TB Program, and local government units to implement and roll-out key TB guidance and

- Build capacity of regional offices and local government units to assist with flow-down and implementation of key TB policies

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<table>
<thead>
<tr>
<th>Thematic Area</th>
<th>Action</th>
<th>Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>216.2(c)(2)i, iii, viii; NDC</td>
<td><strong>CatEx:</strong></td>
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<thead>
<tr>
<th>Threshold Decision</th>
<th>Code</th>
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<tbody>
<tr>
<td>216.2(c)(2)i, iii, viii; NDC</td>
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<th>Action</th>
<th>Code</th>
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<tr>
<td>216.2(c)(2)ii, viii, xiv; NDC</td>
<td><strong>CatEx:</strong></td>
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<th>Recommended</th>
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<tbody>
<tr>
<td>216.2(c)(2)i, iii, viii; NDC</td>
<td><strong>CatEx:</strong></td>
</tr>
</tbody>
</table>
• Participate in working groups such as the National TB Program Technical Working Group and the National Implementation Team for the Responsible Parenthood and Reproductive Health Law

• Collect and document evidence and data to update and change MDR-TB prevention, care and treatment policies

• Work with PopCom, PhilHealth, the DOH Family Health Office, the Department of Education and local government units to implement and roll-out reproductive health guidance and reforms

• Provide information and evidence to inform program and policy decisions and support processes that facilitate the use of the best information and evidence in program and policy development surrounding the Responsible Parenthood and Reproductive Health

• Strengthen and build capacity of local health systems to manage and use information, logistics and commodities and human resource

CatEx:

216.2(c)(2)i, iii, v

216.2(c)(2)i, ii, v, viii

216.2(c)(2)i, ii, v, viii; NDC

216.2(c)(2)i, iii, v

*Reg 216 section reference corresponds with the classes of actions identified in section V.A. below.

III. Country and Environmental Information

The Government of the Philippines (GPH) is a signatory to several international environmental agreements such as the Agenda 21 (on Sustainable Development), the Rio Declaration on Environment and Development, the United Nations Framework Convention on Climate Change, the Hyogo Framework of Action, the 1987 Montreal Protocol, the Basel Convention, and the Stockholm Convention. As a signatory to these agreements, the Philippines commits itself to the principles of sustainable development, climate change adaptation, disaster risk reduction and management, protection of human health and the environment. International commitments are supported by national efforts to enact environmental laws and policies. Foremost of these is the Climate Change Act (CCA) of 2009, which promotes the principles of subsidiarity local government units (LGUs) to serve as frontline agencies to address climate change at the local level) and multi-stakeholder participation and partnerships.

Several Philippine statutes provide guidelines on proper waste management. The 1965 Republic Act (RA) 4226 or the Hospital Licensure Act (HLA), as enunciated in the Department of Health’s AO 1965-01 Rules and Regulations Implementing RA 4226, provides that healthcare facilities shall provide for the “maintenance of sanitary standards, including approved water supply and sewage disposal systems…throughout hospital buildings and premises for the purpose of ensuring cleanliness and as a protection against the spread of infectious and contagious diseases”. It further provides that hospitals and other health facilities shall provide approved methods for the disposal of contaminated dressings, surgical and obstetrical wastes and other similar materials.

Republic Act (RA) 6969 or the Toxic Substances and Hazardous and Nuclear Waste Act of
19904 and RA 9003 or the *Ecological Solid Waste Management Act of 2001*5 provides the over-all framework for managing hazardous and infectious waste. RA 6969 provides guidance on managing hazardous and infectious wastes in such a manner as not to cause or potentially cause: (a) pollution; (b) state of danger to public health, welfare and safety; (b) harm to animals, birds, wildlife, fish or other aquatic life, plants and vegetation; and (d) limitation on the beneficial use of a segment of the environment. RA 6969 further provides that the waste generator shall be responsible for the proper management and disposal of the hazardous waste, and shall bear the costs for the proper storage, treatment and disposal of their hazardous wastes. RA 9003 identifies the short-term and long-term adverse impacts of improper use and management of toxic substances on people and on the environment6, and emphasizes recycling, re-use and composting as methods to minimize and eventually manage the waste problem. The law assigns to LGUs the responsibility to collect waste at 100% efficiency, and encourages collaboration between LGUs and waste generators to reduce and efficiently manage waste.

Other Philippine laws, policies and specific administrative requirements related to health care waste management provide for any or a combination of the following: (a) regulation of the sale and use of equipment and devices in treating sharps, pathological and infectious waste; (b) promotion of environmentally sound and safe non-burn technologies for the handling, treatment, thermal destruction, utilization and disposal of biomedical and hazardous wastes; (c) waste segregation; (d) phase-out the use of mercury containing devices and equipment such as mercury thermometers and sphygmomanometers in the healthcare facility; (e) patient safety; and (f) health care facilities should have a health care waste management policy, plan, and written procedures for the proper disposal of healthcare waste and other hazardous substances and required written policy guidelines on bio-safety and bio-security.

While no comprehensive baseline environmental information is available for the Philippine health sector, guidelines on medical waste management and infection prevention protocols exist in the Philippines. Among the most relevant policies and regulations governing health care waste management are the joint issuance of the Department of Environment and Natural Resources (DENR) and the Department of Health governing health care waste management and the Department of Health Healthcare Waste Management Manual.

The DOH-DENR Joint Administrative Order No. 02 series of 2005 *Policies and Guidelines on Effective and Proper Handling, Collection, Transport, Treatment, Storage and Disposal of Healthcare Wastes*7 aims to: (a) provide guidelines to generators, transporters and operators/owners on proper handling, collection, transport, storage, treatment and disposal of healthcare waste; (b) clarify the jurisdiction, authority and responsibility of the DENR and DOH.

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6 RA 9003 identifies ‘Short-term acute hazards include acute toxicity by ingestion, inhalation or skin absorption, corrosivity or other skin or eye contact hazards or the risk of fire or explosion, and ‘Long-term hazards, including chronic toxicity upon repeated exposure, carcinogenicity (from acute exposure but with a long latent period), resistance to detoxification process such as biodegradation, the potential to pollute underground or surface waters, or aesthetically objectionable properties such as offensive odors.’
with regard to healthcare waste management; and (c) harmonize the efforts of the DENR and the DOH on healthcare waste management.

The DOH “Healthcare Waste Management Manual” of 2004, 2nd edition aims to: (a) improve regulatory compliance; (b) protect human health by reducing the exposure of workers, patients, watchers, and entire community to hazardous HCW in the work environment; (c) enhance community relations by demonstrating a commitment to environmental protection; (d) gain economic benefits resulting from pollution prevention, products that reduce and recycle waste; (e) avoid long-term liability; and (f) increase workers’ morale resulting from a healthier and safer work environment. The Healthcare Waste Management Manual 3rd edition aims to make the guidelines, practices and techniques compliant with policies and legislation enacted in the last seven years and be at par with international best practices. A national roadmap that defines medium-term strategic directions and a training module to keep health workers informed are two other complementary efforts of the DOH to enhance national capacities in managing healthcare waste. The Manual emphasizes the need for every healthcare facility to minimize, properly segregate, treat and dispose of the waste generated to prevent the spread of disease, occurrence of accidents and environmental degradation.

Health care facilities as generators of health care waste are responsible for the collection, handling, segregation, transport, treatment and disposal of the wastes they produce. The DOH AO 2012-0012 updates the RA 4226 classification of hospitals and other health facilities to consider differences in ownership, scope of services and specialization. This is aimed to upgrade the services offered in health facilities and come up with a more homogeneous category for health facilities with similar services. The new classification of health facilities will simplify licensing systems and processes and make the regulatory scheme more effective and efficient.

The DOH licensing requirements ensure that health care facilities comply with minimum standards for environmental protection, proper waste disposal and infection prevention. The DOH license qualifies health facilities for PhilHealth accreditation. Most LGUs, which are decentralized, have their own local regulations on waste disposal. However compliance monitoring is not conducted uniformly or regularly.


8 http://www.pcij.org/blog/wpdocs/ hcmw.pdf
11 Ibid, DOH AO 2012-0012 Annex C
PhilHealth or the Philippine Health Insurance Corporation is a national government owned- and controlled health insurance corporation (GOCC). The law mandates universal coverage with PhilHealth. Accreditation by PhilHealth allows facilities and health providers to charge or reimburse for services provided to members.
IV. **Analysis of Potential Environmental Impact**

While development activities are intended to provide benefits for targeted recipients, when managed ineffectively they may cause adverse impacts that can offset or eliminate these intended benefits. Impacts can be direct, indirect, or cumulative. They can also be beneficial or negative. The USAID Sector environmental guidelines at [http://www.usaidgems.org/sectorGuidelines.htm](http://www.usaidgems.org/sectorGuidelines.htm) are good resources for finding more information on potential impacts for various sectors.

Healthcare waste generation is inevitable in the provision of health services. If not managed appropriately, healthcare waste can have hazardous impacts on the environment and the general public. Transmission of disease through infectious waste is the greatest and most immediate threat from healthcare waste. If waste is not treated in a way that destroys the pathogenic organisms, dangerous quantities of microscopic disease-causing agent such as viruses, bacteria, parasites or fungi will be present in the waste. These agents can enter the body through punctures and other breaks in the skin, mucous membranes in the mouth, by being inhaled into the lungs, being swallowed, or being transmitted by a vector organism.

Chemical and pharmaceutical waste, especially in large quantities, can be a threat to the environment and human health. Since hazardous chemical waste may be toxic, corrosive, flammable, reactive and/or explosive, they can harm people who touch, inhale or are in close proximity to them. If burned, they may explode or produce toxic fumes. Some pharmaceuticals are toxic as well.

Some Health Project activities involve actions that may generate healthcare waste, or in other ways, indirectly or indirectly affect the community and the environment adversely, such as:

1. Procurement, use, storage, management and disposal of public health commodities used for delivery of services in family planning, tuberculosis treatment and prevention, maternal and neonatal health, such as the following:
   - medical supplies, pharmaceuticals, including over-the-counter and prescription drugs and medications; and
   - catheters, bandages, sutures, syringes, scalpels, sharps and other health supplies.

2. Clinical training in health facilities and communities that directly or indirectly result in the generation, storage, handling and disposal of hazardous medical waste or in techniques that have a direct or indirect environmental impact such as:
   - training and application of essential intrapartum and neonatal care, including neonatal resuscitation, as necessary;
   - training of midwives on emergency obstetric care and essential newborn care;
   - training on family planning methods such as administration of injectable contraceptives, intra-uterine device (IUD) insertion and removal of intra-uterine devices, removal of implant and permanent methods (bilateral tubal ligation and non-scalpel vasectomy);
   - support for deployment of itinerant teams that provide family planning services particularly short, long-acting and permanent methods; and
• training of health care workers as part of strategies to intensify TB case finding and treatment in indigenous populations, plantation and mining populations, geographically isolated and depressed areas, congregate settings of the urban poor, and population groups at risk for TB or multi-drug resistant TB (MDR-TB).

3. Improper use of equipment may reduce its useful life and the disposal of electronic waste might negatively impact the environment if not properly handled. Health activities may involve the use and disposal of healthcare equipment such as:
   • general medical equipment, infant monitors, breastmilk pumps, and other equipment and fixtures used for FP/MCH service delivery;
   • cartridges to be used with GeneXpert, the technology for rapid diagnosis of drug resistant TB; and
   • minor laboratory equipment support for expanding access to TB diagnostic services.

4. Improper use of electric and electronic equipment may reduce its useful life and the disposal of electronic waste might negatively impact the environment if not properly handled. Health activities may involve limited procurement and distribution of small electric and electronic equipment, such as cellular phones, netbooks and tablets, in support of the following:
   • FP/MCH health services monitoring, logistics management, health information systems management and other related purposes;
   • strengthening TB logistics management tracking and scaling up TB case-holding and treatment at the community level to reduce rates of drop-outs of TB patients and other related purposes

V. Recommended Threshold Decisions

A. Justification for Categorical Exclusion Request

Implementing mechanisms covered in this IEE for which all the actions are recommended for Categorical Exclusion are listed in Table 4.

Table 4: Health Activities Recommended for Categorical Exclusion

<table>
<thead>
<tr>
<th>Activity Name</th>
<th>Goals</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Health Leadership &amp; Governance Program</strong></td>
<td>Institutionalize leadership and governance training and lessons learned into central and selected regional government systems. The leadership and governance training program strengthens the knowledge and skills of government leaders at the provincial, city, and municipal levels to improve and manage the health programs under their jurisdiction.</td>
</tr>
<tr>
<td><strong>Collaboration, Learning &amp; Adapting</strong></td>
<td>Serve as the primary monitoring, evaluation and learning instrument of the Office of Health. Provides the Office of Health with technical assistance and expertise to convene stakeholders to define how best to monitor, evaluate and adapt the Project in an evidence-based, participatory manner. This activity will focus on support to Office of Health monitoring, evaluation and learning activities.</td>
</tr>
</tbody>
</table>
All planned actions in the above health implementing mechanisms and certain actions in all implementing mechanisms covered in this IEE do not have foreseeable direct adverse environmental impacts. Specifically, pursuant to 22 CFR 216.2 (c)(1) and (2), the activities that fall into the following classes of action are recommended for Categorical Exclusion:

- education, technical assistance, or training programs except to the extent such programs include activities directly affecting the environment (such as construction of facilities, etc.), per 22 CFR 216.2 (c)(2)(i);
- controlled experimentation exclusively for the purpose of research and field evaluation which are confined to small areas and carefully monitored per 22 CFR 216.2 (c)(2)ii;
- analyses, studies, academic or research workshops and meetings per 22 CFR 216.2 (c)(2)iii;
- document and information transfers per 22 CFR 216.2(c)(2)v;
- programs involving nutrition, health care or population and family planning services except to the extent designed to include activities directly affecting the environment (such as construction of facilities, water supply systems, waste water treatment and treatment of water in the households), per 22 CFR 216.2(c)(2)viii; and
- studies, projects or programs intended to develop the capability of recipient countries to engage in development planning, except to the extent designed to result in activities directly affecting the environment (such as construction of facilities, etc.) 22 CFR 216.2(c)(2)xiv.

The actions under review that justify Categorical Exclusion are detailed in Table 3. In general, they are technical assistance and capacity-building activities that involve education, training, workshops, research, studies and transfer of information.

**B. Negative Determination with Conditions**

Implementing mechanisms in Table 5 below are ones that (in addition to categorically excluded actions) have actions that are recommended for Negative Determination with Conditions per 22 CFR 216.3(2) (iii).

<table>
<thead>
<tr>
<th><strong>Table 5: Health Activities</strong> that include actions Recommended for Negative Determination with Conditions</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Universal Health Care (PhilHealth/Policy)</strong></td>
</tr>
<tr>
<td>Enable national, regional and local level institutions to ensure adequate and sustained financing for health programs and activities. The major objectives of this activity are to: 1) institutionalize policy development, monitoring and support within Department of Health; and PhilHealth; 2) build capacity for financial and resource analysis and management at the central and regional levels of the Department of Health and PhilHealth; and 3) assist regional governments to establish trust funds and other similar mechanisms for health financing at the LGU level.</td>
</tr>
</tbody>
</table>
**Activity Name and Goal/s**

<table>
<thead>
<tr>
<th>Activity Name and Goal/s</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>TB Platforms</td>
<td>will support the Government of the Philippines to expand and scale up prevention, detection, and treatment of tuberculosis and multidrug-resistant TB. The Platforms project will aim to increase TB case detection rates, decrease default rates, increase treatment success and cure rates. The activity will fortify local platforms to support the expansion of TB activities at the regional and provincial levels.</td>
</tr>
<tr>
<td>TB Innovations</td>
<td>will support the Department of Health and other partners to significantly reduce cases of multidrug-resistant TB through the introduction of state-of-the-art technologies and approaches to scale up MDR-TB diagnosis, prevention and treatment.</td>
</tr>
<tr>
<td>FP Innovations and Strengthening Service Platforms</td>
<td>will endeavor, in close collaboration with key counterparts, to: (a) strengthen adoption of FP and MCH healthy behaviors among youth, women and men; (b) fortify the quality of reproductive health services with a focus on patient-friendly service delivery and improved supervision and mentoring for public and private sector providers; (c) build capacity to test and introduce state-of-the-art technologies and new approaches to strengthen reproductive health and maternal and newborn care; and (d) enhance local platforms to support scale-up of FP/MCH services.</td>
</tr>
<tr>
<td>FP/MCH Service Delivery in Autonomous Region of Muslim Mindanao</td>
<td>will improve and support family planning and maternal and child health service delivery in ARMM.</td>
</tr>
</tbody>
</table>

Planned actions recommended for Negative Determination with Conditions in the health activities listed in Table 3 are assessed to have the potential for directly or indirectly affecting the environment and fall under the following classes of actions:

1. Activities involving treatment in health facilities and in communities that directly or indirectly result in the generation and disposal of hazardous medical waste or in techniques that have a direct or indirect environmental impact.
2. Activities that directly or indirectly cause the procurement, storage, management and disposal of public health commodities,
3. Limited procurement and distribution of small electric and electronic equipment in support of FP/MCH and TB health services and commodities, monitoring, and health information systems management and other related purposes.

The following are specific conditions to mitigate the potential negative impacts discussed in Section IV.

Conditions for (a) the procurement, use, storage, management and disposal of public health commodities used for delivery of services; and (b) training in health facilities and in communities that directly or indirectly result in the generation, storage, handling and disposal of hazardous medical waste, or in techniques that have a direct or indirect environmental impact:

USAID must work with implementing partners to ensure that:

- when training professionals or community health workers in service delivery procedures that result in the generation and disposal of potentially hazardous medical waste, the curricula should cover best management practices concerning the proper handling, use, and disposal of medical waste, as applicable, and that it is consistent with current DOH protocols; and
- the medical facilities have procedures in place to properly handle, label, treat, store, transport and properly dispose of blood, placenta, sharps and other medical waste such as
used sputum cups, slides, applicator sticks, syringes and cartridges for GeneXpert as well as sputum specimens, based on standards of DOH and USAID or based on guidelines developed from these standards.

At the start of each activity, the implementing partner, in consultation with the Assistance Officer’s Representative (AOR) or Contracting Officer’s Representative (COR) will formulate an Environmental Monitoring and Mitigation Plan. The IP will validate the plan’s consistency with DOH and USAID guidelines as well as with internationally accepted standards for medical waste disposal. As appropriate, the implementing partner will work with facility, local, regional and/or national officials to implement and apply appropriate best management practices which incorporate appropriate health and safety measures and environmental safeguards, including proper disposal of medical waste. The management of potential health and environmental hazards from health service delivery and health systems management may include ensuring LGUs are aware of and adhere to local standards of medical waste disposal.

Implementing partners may require selected medical facilities to complete a Healthcare Waste Management Minimum Program Checklist and Action Plan (Annex 1) as part of monitoring.

**Conditions on the use/disposal of medical equipment and supplies:**
Implementing partner(s) should ensure and provide the AOR/COR with evidence that equipment is procured from certified retailers and include environmental safety and quality certificates that conform to national and/or international standards. The recipient of the equipment should be provided with information on the proper use of and instructions on proper disposal of electronic waste. The recipient should also be provided with a list of Government of the Philippines-accredited recyclers for proper disposal of the equipment after its useful life.

**Conditions on the use and disposal of small electric and electronic equipment, such as cellular phones, netbooks and tablets:**
No special mitigation measures are needed. Normal good practices will be used. The proposed action is that the implementer should provide evidence that equipment is procured from certified retailers and include environmental safety and quality certificates that conform to national and/or international standards. The recipient of the equipment should follow all applicable national and international laws to ensure that it is used in an environmentally sound and safe manner. Equipment should be properly disposed of (when applicable) at the end of its useful life in a manner consistent with best management practices according to USG, European Union or equivalent standards acceptable to USAID.

**Conditions and best practices for general classes of activities involving healthcare waste:**
- All activities shall be conducted following principles for environmentally sound development, as provided in the USAID Sector Environmental Guidelines – Healthcare Waste. This document can be found at: [http://www.usaidgems.org/Sectors/healthcareWaste.htm](http://www.usaidgems.org/Sectors/healthcareWaste.htm).
- An Environmental Monitoring and Mitigation Plan shall be developed that includes the principles of the guidelines.
- Each activity that has healthcare waste should have a sound healthcare waste
management plan and system to minimize adverse health and environmental impacts caused by their wastes. A program to manage healthcare waste includes the minimum elements: (1) written plan; (2) clear responsibilities; (3) written internal rules; (4) staff training; (5) protective clothing; (6) good hygiene practices; (7) vaccinated workers; (8) designated storage locations; (9) waste minimization; (10) waste segregation; (11) waste treatment; (12) final disposal site; and (13) periodic reviews. The format and guidance of this report will be provided by the AOR/COR and should include the qualities of the Minimal Program Checklist And Action Plan in Annex 1, from the above mentioned environmental guidelines.

- With activities involving health commodities, the implementing partner should have a written plan to ensure appropriate procurement, storage, management and/or disposal of public health commodities, including pharmaceutical drugs and nutritional supplements such as established adequate procedures and capacities in place to properly manage and dispose of such commodities.
- The checklist found at the following website should be used for monitoring: [http://www.usaidgems.org/Documents/VisualFieldGuides/medwastJan2010.pdf](http://www.usaidgems.org/Documents/VisualFieldGuides/medwastJan2010.pdf)

**Conditions and best practices for general classes of activities involving Healthcare Facilities:**

- All activities shall be conducted following the principles for environmentally sound development, as provided in the USAID Sector Environmental Guidelines – Health Facilities. This document can be found at: [http://www.usaidgems.org/Sectors/healthcareFacilities.htm](http://www.usaidgems.org/Sectors/healthcareFacilities.htm).
- Design for waste management.
- Ensure sufficient water supply and sanitary management capacity.
- Support to activities that include healthcare waste should have a sound healthcare waste management plan and system to minimize adverse health and environmental impacts caused by their waste. See healthcare waste management guidelines found at: [http://www.usaidgems.org/Sectors/healthcareWaste.htm](http://www.usaidgems.org/Sectors/healthcareWaste.htm).
- An Environmental Monitoring and Mitigation Plan shall be developed that includes the principles of the aforementioned guidelines.
- The checklist found at the following website can be used for monitoring: [http://www.usaidgems.org/Documents/VisualFieldGuides/medwastJan2010.pdf](http://www.usaidgems.org/Documents/VisualFieldGuides/medwastJan2010.pdf)

**Contingency Provision.** Construction is not among the current planned actions of the Health Project. Should the need for construction arise during the period covered by this IEE, USAID will take into consideration the conditions listed below.

**Conditions and best practices for general classes of activities involving Small-Scale Health Facility Construction:**

- All construction activities shall be conducted following the principles for environmentally sound construction, as provided in the USAID Sector Environmental Guidelines - Small Scale Construction, which can be found at: [http://www.usaidgems.org/Sectors/construction.htm](http://www.usaidgems.org/Sectors/construction.htm).
- For the rehabilitation of existing facilities and for construction of facilities in which the total surface area disturbed is less than 10,000 square feet, the implementing partner shall conduct and prepare a supplemental Environmental Review Checklist (ERC) documenting a site specific environmental review. A link to the ERC template is below. The ERC should include an Environmental Monitoring and Mitigation Plan. Construction will not begin until such a review and
report is completed and approved by the AOR/COR in consultation with Mission Environment Officer.

- For the construction of any facilities in which the total surface area disturbed exceeds 10,000 square feet (1,000 square meters) or is considered to have a significant effect on the environment, the IEE must be amended and may need an Environmental Analysis.
- The implementing partner should design activities to minimize vulnerability of facilities to climate change.
- A USAID Engineer is available to review all construction designs.
- A template for the ERC can be found under the Asia section at the following website: http://www.usaidgems.org/compliance.htm. The checklist at http://www.usaidgems.org/Documents/VisualFieldGuides/ENCAP_VslFldGuide--Construction_22Dec2011.pdf should be used to monitor activities.
ANNEX G – List of Reference Documents


[END OF ANNEXES]

[END OF SECTION VIII]