

TECHNICAL REPORT | NOVEMBER 2019

PREPARING FOR THE TRANSITION OF GLOBAL FUND SUPPORTED HRH IN TB

A Sustainability Roadmap for the Philippines

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ACKNOWLEDGEMENTS

This publication was produced for review by the United States Agency for International Development (USAID). It was prepared by Open Development, a member of the HRH2030 consortium.

November 1, 2019

Cooperative Agreement No. AID-OAA-A-15-00046

Cover photo: HRH2030 Program (2018)

DISCLAIMER

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Acronyms

ACCESS TB	Advancing Client-centered Care and Expanding Sustainable Services for TB
ACF	Active Case Finding
AFB	Acid-Fast Bacillus
BHW	Barangay Health Workers
BIHC	Bureau of International Health Cooperation
BLHSD	Bureau of Local Health Systems Development
CHO	City Health Office
COE	Current Operating Expenditure
CSC	Civil Service Commission
CTRL	Cebu Tuberculosis Reference Laboratory
DALY	Disability-Adjusted Life Years
DBM	Department of Budget and Management
DIGL	Department of Interior and Local Government
DMO	Development Management Officer
DOH	Department of Health
DOTS	Directly-Observed Treatment, Short Course
DPCB	Disease Prevention and Control Bureau
DR TB	Drug Resistant Tuberculosis
DRA	Disease Reporting Advocate
DS TB	Drug Susceptible Tuberculosis
DSSM	Direct Sputum Smear Microscopy
EO	Executive Order
FY	Fiscal Year
GFATM	The Global Fund to Fight AIDS, Tuberculosis and Malaria
GIDA	Geographically Isolated and Disadvantaged Areas
HHRDB	Health Human Resource Development Bureau
HIV	Human Immunodeficiency Virus
HLMA	Health Labor Market Analysis
HPDPB	Health Policy Development and Planning Bureau
HPN	Health, Population and Nutrition
HRH	Human Resource for Health
HUC	Highly Urbanized City
ICC	Independent Component City
ICF	Intensified Case Finding
iDOTS	Integrated Directly-Observed Treatment, Short Course
IRA	Internal Revenue Allotment
ITIS	Integrated Tuberculosis Information System
JO	Job Order
KMITS	Knowledge Management and Information Technology Service
LBM	Local Budget Memorandum

LCE	Local Chief Executive
LEE	Local Economic Enterprise
LGC	Local Government Code
LGU	Local Government Unit
LIPH	Local Investment Plan for Health
LPA	Line Probe Assay
MDR TB	Multi-Drug Resistant Tuberculosis
MHO	Municipal Health Office
MOOE	Maintenance and Other Operating Expenses
MTEF	Medium-Term Expenditure Framework
MTEP	Medium-Term Expenditure Planning
NCPR	National Center for Pulmonary Research
NDP	National Deployment Program
NEP	National Expenditure Program
NHIP	National Health Insurance Program
NHWSS	National Health Workforce Support System
NOH	National Objectives for Health
NPA	Notification Project Associate
NTP	National Tuberculosis Program
NTPS	National Tuberculosis Prevalence Survey
NTRL	National Tuberculosis Reference Laboratory
PBSP	Philippine Business for Social Progress
PCR	Polymerase Chain Reaction
PHA	Public Health Associate
PHIC / PhilHealth	Philippine Health Insurance Corporation
PhilPACT	Philippine Plan of Action to Control Tuberculosis
PhilSTEP I	Philippine Strategic Tuberculosis Elimination Plan (2017-2022) Phase I
PHO	Provincial Health Office
PIDSR	Philippine Integrated Disease Surveillance and Response
PLHIV	People Living with HIV
PMDT	Programmatic Management of Drug-resistant Tuberculosis
PMTCT	Prevention of Mother-to-Child Transmission
PPM	Public Private Mix
PPP	Public-Private Partnership
PS	Personnel Services
RHU	Rural Health Unit
RN	Registered Nurse
RO	Regional Office
RRT	Registered Radiation Technologists
SG	Salary Grade
SHF	Special Health Fund
SSL	Salary Standardization Law
STC	Satellite Treatment Center

TB	Tuberculosis
TC	Treatment Center
TCP	Tuberculosis Care and Prevention
UHC	Universal Health Care
UN	United Nations
USAID	United States Agency for International Development
WHO	World Health Organization
WISN	Workload Indicator Staffing Needs

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Summary

The Global Fund to Fight AIDS, Tuberculosis and Malaria (Global Fund) is the Philippines' largest development partner for combatting tuberculosis (TB). Over the last several years, Global Fund TB grants to the Philippines have played a major role in contributing to the country's TB progress to date. In 2020, the Philippines will develop the proposal for the next Global Fund TB grant (2021-2023), with a focus on sustainability and the gradual transition of Global Fund investments to local partners. The Government of the Philippines, under the leadership of the Department of Health (DOH) and the National Tuberculosis Program (NTP), already is preparing for this eventual transition.

The current (2018-2020) Global Fund TB grant, ACCESS TB—Advancing Client-centered Care and Expanding Sustainable Services for TB—is implemented by the Philippine Business for Social Progress (PBSP), in collaboration with the DOH, NTP and other partners. The focus of the grant is on: (1) mainstreaming service delivery systems for drug resistant TB (DR-TB) cases, including support to scale up molecular-based PCR diagnostic testing, (2) finding missing cases through strategic engagement of non-rural health unit (RHU) health care facilities, especially in the private facilities, and (3) expanding TB-HIV collaboration. The grant also provides support to the NTP, the National TB Reference Lab (NTRL), the National Center for Pulmonary Research (NCPH), and Regional Offices.

One of the most critical components of the current Global Fund TB grant is to support the Government of the Philippines fill key gaps in the human resources needed to support the country's ambitious TB targets. USAID's Human Resources for Health in 2030 (HRH2030) Program was engaged to assist the DOH and NTP to better understand and analyze the HRH investments currently being supported through the Global Fund grant and to begin to lay out a roadmap for how to sustain these investments moving forward. The methodology and assumptions used by USAID's HRH2030 Program to support this activity are outlined in the Methodology section of the report.

Through a series of interviews with key informants and, through working in close collaboration with PBSP to conduct a detailed inventory of the Global Fund-supported HRH investments, HRH2030 estimates that, as of September 2019, at least 775 full-time workers were deployed throughout the country on behalf of the NTP. This does not include PBSP project staff or lay cadres, such as community volunteers or "STRiders", but rather the complement of site-based, salaried workers that provide critical functions to stand up the Government's TB response, and for whom transition planning may need to be considered, should the Global Fund reduce its resources to the Philippines.

Eighty-eight (88) percent (n=652) of the 775 professional health workers supported under the Global Fund grant primarily support service delivery across the three focus areas outlined in the grant: mainstreaming DRTB services, finding missing cases, and supporting TB-HIV collaboration. USAID's HRH2030 Program estimates that the cost to the Government to transition this subset of the Global Fund-supported health workforce through hiring new plantilla positions or 'casual' positions or DOH National Deployment Program (NDP) positions is approximately PhP262-283 million per year (US 5.0-5.4 million). However, this estimate does not include the costs to onboard, train, equip and supervise these staff. For each of the 18 different cadre types that constitute the 652 workers, HRH2030 has developed detailed "HRH Transition Pathways" to assist local stakeholders when developing detailed transition plans.

The remaining 12% (n=92) of the Global Fund-supported workforce supports critical national and regional TB policy and administration, including but not limited to financing 18 out of 23 NTP positions in the DOH's NTP Management Office. The report did not explore in detail the HRH transition pathways for these cadres, as the DOH is undergoing detailed organizational and workforce assessments of the NTP that should influence staffing functions in the future. This will have direct implications for Global Fund transition planning, including identifying the priority functions that the government will need to transition to ensure the NTP can meet its mandate and fulfill its strategic direction.

Taken together, these HRH investments represent a significant dependency on donor funding support in both the delivery of TB services and in the policy and technical expertise to guide the country's TB programming. Given the significance of TB in the Philippines – it constitutes the third highest burden of disease in the country – and its contribution to global disease burden – the Philippines is the fourth highest contributor globally to missing TB cases – the Global Fund sustainability planning activity is an important opportunity for the country to more widely consider its investments in and prioritization of TB within the health and social sectors.

While the government has made ambitious commitments to rapidly address and reduce TB burden, the financial support to meet these targets and to ensure adequate HRH remains elusive. The Philippines is undergoing major health financing reforms, in the form of the Universal Health Coverage (UHC) Law, that present a key opportunity to achieve and sustain reductions in TB burden primarily leveraging domestic resources. Where possible, this report tries to identify key opportunities for engaging in the UHC implementation to promote a health workforce to deliver on TB services, even while the rollout of UHC is still limited and many policies directly relevant to TB programming are still under development.

Further, the focus of this report is on Global Fund-supported health workers that *currently* are embedded in either health facilities or government sites. The policies, strategies and protocols that define TB service delivery expectations will continue to evolve as the DOH and NTP explore opportunities for service delivery efficiencies and integration, introduce new technologies and treatment regimens, and implement policies to reinforce engagement of the private sector. As such, the workforce needs of the country will continue to evolve, with implications for future Global Fund programming and transition planning under the next Global Fund TB grant.

As such, the sustainability analyses and HRH transition pathways outlined in this report are meant to provide a framework and comprehensive analysis to facilitate more detailed transition planning analyses and negotiations, to be led by the DOH and NTP and to include the broader Government of the Philippines and its partners, over the course of the next Global Fund TB grant proposal development. Continued analyses and technical supports will be needed to assist the DOH and NTP to develop detailed, multi-year and costed transition plans.

Methodology

USAID's Human Resources for Health in 2030 (HRH2030) Program was engaged to assist the DOH and NTP to better understand and analyze the HRH investments being supported through the Global Fund grant and to begin to lay out a roadmap for how to sustain these investments moving forward. The methodology and assumptions used by USAID's HRH2030 Program to support this activity are outlined below.

Key Analyses, Assumptions and Constraints

At the onset, USAID's HRH2030 Program held consultations with USAID/Philippines, Global Fund, the Principal Recipient of the current Global Fund TB grant (PBSP), and the DOH, (1) to clarify the 2021-2023 Global Fund TB grant proposal process and timeline, and (2) to better understand the interests and concerns of key stakeholders. USAID's HRH2030 Program agreed to support the Philippines and, specifically, the DOH and NTP to:

1. Conduct an inventory of the Global Fund's investments in facility- and community-based health workers, as well as management, technical and coordination staff that were supported under the current TB grant;
2. Develop transition pathways for each major type of Global Fund-supported health worker, from those supporting service delivery at the field level to those at the provincial, regional and national levels, including staff at the NTP;
3. Incorporate data and feedback from other analyses, such as the Workload Indicator Staffing Norms (WISN), as appropriate, to connect staffing, staffing norms and labor market dynamics to transition recommendations;
4. Estimate the HRH Mortgage—a “back of the envelope” valuation of the potential costs to the Philippines to transition the Global Fund HRH investments, and to model different transition scenarios and cost estimates that can be compared to country plans, priorities, and budgets; and
5. Develop a set of policy recommendations to inform Sustainability Roadmap for Global Fund-supported human resource to support performance targets of Objective 3 of the 2017-2022 Philippine Strategic TB Elimination Plan Phase I (PhilSTEP I), based on an analysis of the HRH Inventory data vis-à-vis WISN and other analyses, insights from interviews, and the policy context, with a view of the UHC law as a “golden opportunity” for sustainability planning.

To conduct this work within the available timeframe and budget, USAID's HRH2030 Program identified several critical assumptions:

1. The focus of the analysis would be on Global Fund-supported health workers that currently are embedded in either health facilities or government sites and play a critical role in supporting the government's TB control efforts, and therefore, reflect HRH investments that may need to be transitioned locally, as Global Fund draws down their support. The focus would be placed on identifying critical cadres that are receiving support and to focus on analysis of transition pathways for those cadres, even as the numbers of positions filled may vary between annual budgets.
2. The analysis would not consider if the current Global Fund investments in the health workforce are appropriate from a policy and programming perspective, as this would be beyond the mandate and expertise of the team; rather, the transition analysis would assume that programming efficiency and effectiveness were taken into consideration when investments were made in the existing workforce by PBSP, in consultation with the NTP, and as part of the annual joint program review.
3. Further, the analysis would not be able to consider in detail how policies not yet uniformly implemented would impact transition planning. For example, the transition analysis would not be able to model the exact staffing implications for how implementation of iDOTS would affect PBSP staffing patterns into the future.

However, the analysis would highlight how and where implementation of this policy could impact transition planning.

4. To the greatest extent possible, the analysis would consider how future HRH and health financing policies might impact the transition opportunities for Global Fund-supported positions, if and when these policies were clearly articulated and understood from an operations perspective. Most notably, there was an interest in understanding how the implementation of the UHC Law would impact TB staffing opportunities.

During the course of the exercise, USAID's HRH2030 Program did face some unexpected constraints that impacted the ability of the Program to fully realize its initial scope of work.

1. PBSP was unable to provide detailed information on lay and or community-based health workers for inclusion in the HRH inventory because the agreement was only to share those classified as their salaried employees, data that is available in the PBSP electronic payroll system. As a result, a record of investments in community volunteers and specimen transport riders (STRiders) were not included in the HRH inventory and subsequent analyses. These data could be added to the HRH Inventory by the PBSP in the future.
2. While the WISN analysis which looked into facility level service delivery level workload indicators was concluded on August 2019, the data gathered was aggregated per facility when entered into the WHO developed WISN software; hence, separating the TB related component was very challenging. Further, only nine sites that were captured in the WISN data also hosted Global Fund-supported staff. Where applicable, the relevant sub-analyses of WISN have been incorporated into this report on a cadre by cadre basis, specifically for clinic (out-patient) nurses.
3. The NTP is undertaking an organizational development review through the conduct of Administrative WISN (A-WISN). This activity will help in understanding the core activities of the NTP by reviewing its mandates and strategic directions, which will then contribute to the generation of the right staffing estimates for NTP. The report on this study is not yet available but deemed to have critical importance in discussing the NTP staffing, and, therefore transition planning.

Technical Approach

From March to October 2019, and working within the aforementioned parameters, assumptions and constraints, USAID's HRH2030 Program set out to inventory and analyze the Global Fund-supported TB workforce. Based on previous work in other countries, USAID's HRH2030 Program conducted the following critical steps:

1. Partnered with PBSP to inventory Global Fund investments in TB-dedicated staff and validate and analyze the data through a series of consultations from September to October 2019;
2. Undertook a scan of the health financing and service delivery environment in the Philippines with respect to TB staffing that included a desk review, data collection, data processing and in-depth interviews with key stakeholders at the national and local government levels from May to September 2019;
3. Defined transition pathways for key Global Fund-supported cadres, in light of sustainability considerations;
4. Estimated the financing requirements for personnel salary and benefits of the transition pathway using the salary and benefits of equivalent government position; and
5. Outlined policy recommendations to guide local stakeholders as they set out to define detailed transition plans under the next Global Fund grant, including hosting a debriefing with high-level stakeholders.

Conducted an inventory of HRH investments. To better understand the scope and nature of Global Fund investments in human resources for health (HRH), USAID's HRH2030 Program worked closely with PBSP to compile 2019 data on health workers supported by the Global Fund into the PBSP HRH Inventory. The HRH Inventory includes Global Fund support to health workers, as of August 27, 2019, that played a critical role in supporting the government's TB control efforts, and therefore, reflects HRH investments that may need to be

sustained locally, if Global Fund was to withdraw its support. PBSP staff that either coordinate or oversee Global Fund activities or provide capacity building or technical assistance to the government and local partners were not included, as these investments are unlikely to be sustained after the grant is completed. Considering that the HRH Inventory served as a major source of transition analysis for donor-assisted TB health workers, it was handed over to the NTP as the primary steward, with respective liaisons at the Health Human Resource and Development Bureau (HHRDB) and at the KMITS, to generate evidence and visualizations to inform ongoing transition and program planning investments for TB.

The following information on the Global Fund supported workforce were compiled in the HRH Inventory: the implementing partner (primary or sub-grantee), position title, cadre type, technical area, type of facility deployment, health system-level deployment, funding-level deployment, geographic deployment (region, province, city/municipality) and the related income class of the LGUs, ownership (public or private), hiring reason, and the salary (mode, minimum, and maximum). Given the limitations imposed by the Data Privacy Law and its interpretation of the prime recipient, the inventory did not include the names of the supported staff, the exact location and name of the facility, and detailed benefits on top of their basic remuneration. Cleaning and validation of the data was done through key informant interviews.

The HRH Inventory also includes a mapping of Global Fund-supported workers to Government of the Philippines plantilla positions and pay bands, based on job description and function (salary grade), to determine if these HRH investments are well positioned for local transition to public service. To map their pay scales, the 2019 tranche of increase mandated by the Salary Standardization Law (SSL) was used. To map their estimated benefits, monetary benefits itemized by the Personnel Administrative Division (PAD) were taken into account, to include allowances received by all position levels on a monthly basis, such as personnel economic relief allowance (PERA), subsistence and laundry allowance, and allowances that depend on the salary grade level, such as hazard pay. The benefits received annually, such as cash gift, bonuses, uniform allowance, and productivity enhancement incentive were translated to monthly amounts to be consistent with the other computations.

The snapshot of the HRH inventory tool and mortgage tool is attached to this Report as Annex I.

Conducted a review of the health financing and service delivery environment. In order to analyze the content of the HRH Inventory, USAID’s HRH2030 Program conducted a scan of the health financing and service

Box 1: Transition Definitions

USAID’s HRH2030 Program set out the following definitions for use in the Sustainability Roadmap:

“Transition of Functions” – This entails the transition of a sub-set of functions from a Global Fund-supported position to an existing health care worker. Rather than creating a new TB-dedicated position, the functions supported by the Global Fund would be transitioned or assigned to an existing worker. For example, a supervisory function supported by Global Fund might be transitioned to an existing government worker, with additional supports to ensure that the existing supervisory staff have adequate knowledge of the TB services under review.

“Transition of Position” – This entails the transition of an entire Global Fund-supported position locally, to either government or to another entity, such as the private sector. This would require the government or local entity to create a new fulltime position to fully transition the position currently supported by the Global Fund. For example, dedicated laboratory positions to support TB diagnostics may be required, given that the workload is sufficient enough as to require additional fulltime employees.

“Absorption of Staff” - This entails the absorption of a Global Fund-supported staff into a local entity, either government or the private sector. It is important to note that the transition of positions does not imply that the Global Fund-supported staff will be ‘absorbed’ into government. In the Philippines, as in many countries, employment opportunities in the public and private sectors are usually competitive processes, by which existing Global Fund staff can apply to open positions but may or may not be selected. This is especially challenging when the equivalent government positions are meant to recruit generalists into public service, rather than candidates with a disease or condition specific experience. When special skills are required that are not readily available in the labor market, there may be a compelling case to facilitate staff absorption, when the loss of current Global Fund staff may negatively impact TB outcomes and services.

delivery environment in the Philippines with respect to TB staffing. This began with a thorough desk review of policy, programming and budgeting documents that are critical to financing TB programs and services, and was followed by accessing, processing and analyzing up-to-date financing data on expenditures of local government units (LGUs), budget appropriations of the DOH and data on the economic costs of TB to households. In addition, USAID's HRH2030 Program interviewed 70 key informants, of which 41% were situated at the national level and 59% at the sub-national level. At the national level, the Program interviewed 29 informants from 6 bureaus within the DOH, PhilHealth, NTRL, and from key TB development partners. The informants are directly and indirectly related to the planning, budgeting and program management. At the sub-national level, the Program interviewed 41 DOH-hired and LGU-hired staff responsible for TB program implementation, as well as, facility providers, from Batangas and Cebu – provinces that represent different geographic and TB epidemiological contexts. A full list of the informants is located in Annex 2. The key informant interviews provided information on policy, planning and budgeting priorities, with respect to staffing the TB program and TB services, and context on the constraints and emerging opportunities for addressing dependencies on donor staffing supports.

Defined the HRH transition pathways for key cadres. Next, USAID's HRH2030 Program set out to define transition pathways for 18 different Global Fund-supported cadres, in light of sustainability considerations and key informant interviews. The HRH transition pathways provide a detailed discussion of why, where and how many workers are deployed with Global Fund support and define potential avenues for transitioning these functions or positions to government or other local stakeholders. To assist in defining these pathways, USAID's HRH2030 Program outlined a set of transition definitions (see Box 1). The focus of the analysis was on a sub-set of the Global Fund-supported workforce that support the three Global Fund focus areas, directly affecting service delivery, and which make up 88% of the Global Fund supported workforce. The remaining 12% of the workforce support national level policy, programming and administrative support, primarily at the NTP and regions. A deeper analysis of these cadre was not outlined in the report due to the pending results of the Administrative WISN (A-WISN), under the HRH2030-supported activity entitled, "Structure to achieve: OD institutional capacity building for NTP and FPP."

Developed the 'mortgage tool' of the HRH Inventory. To estimate the financing requirements of the transition pathway or the 'mortgage' on donor support, the HRH2030 Program expanded the HRH Inventory of the PBSP by adding the costs of salaries and benefits of PBSP cadres that will transition to Government positions according to the proposed transition pathway. From an analysis of cadre functions and PBSP salary levels, positions and salary grade of equivalent Government positions were identified, and the corresponding salaries and benefits were determined per the pay scale and benefits authorized by Law, at the lowest salary grade level (Level 1) and highest salary grade level (Level 8) and estimating a range within a salary grade. The 'mortgage tool' allows a sensitivity analysis of transition pathways by providing cost estimates for various transition scenarios. From consultations with the NTP, in addition to the transition scenario outlined in this Report, the following transition scenarios were considered as Options in the 'mortgage tool': transition of 30% or 50% of Nurses, ITIS Associates and NPAs; transition of 30% or 50% of PMDT health workers, transition only in the UHC implementation initial roll-out provinces/cities or transition in all provinces/cities excluding in UHC implementation initial roll-out sites.

Engaged with key stakeholders on recommended next steps. Finally, in addition to the HRH transition pathways, USAID's HRH2030 Program outlined policy recommendations to guide local stakeholders as they set out to define detailed transition plans under the next Global Fund grant. These recommendations focus on actions that can be taken by the DOH, specifically by the NTP, HHRDB, Health Policy Development and Planning Bureau (HPDPB), Bureau of Local Health Systems Development (BLHSD), KMITs, Regional Offices and retained hospitals, and the LGUs over the coming years to take advantage of key policies that will affect the ability of the country to responsibly transition Global Fund investments in the TB workforce locally, while accelerating progress toward TB targets. USAID's HRH2030 presented the results of the analysis and the recommendations in a debriefing activity on October 15, 2019, which was attended by high-level representatives of key stakeholders such as officials from the USAID, Global Fund, DOH, etc. (see Annex 2). Feedback from the participants and responses to clarifying questions received, are documented in this report (see Annex 7).

Understanding the TB Context

This section of the Sustainability Roadmap provides background on the TB burden in the Philippines, including the ambitious targets set forth by the Government of the Philippines to reduce that burden, and the contribution of donors, in particular, the Global Fund, to advance the achievement of the Government's targets. It is intended for stakeholders who may have to engage with the DOH on sustainability planning, under the 2021-2023 Global Fund grant proposal, but who may be less familiar with the current status of TB programming in the country.

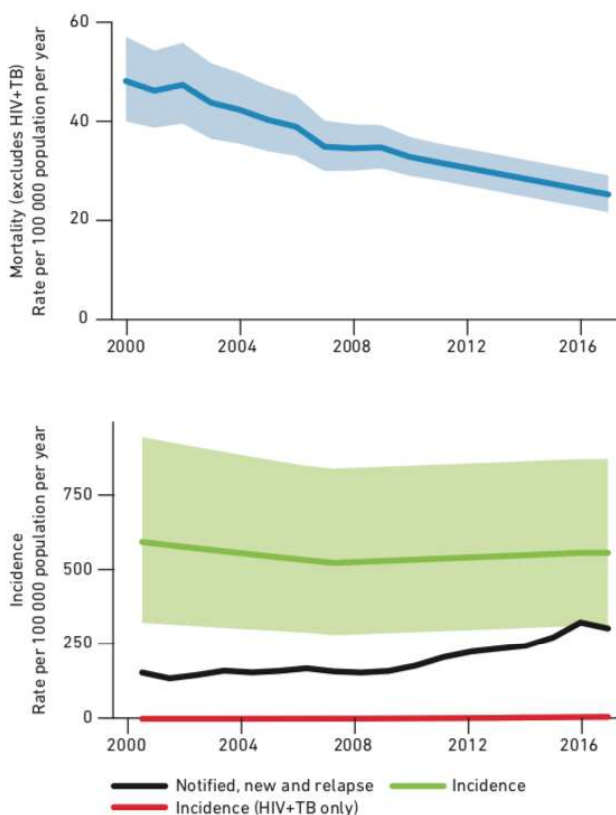
Appreciating the TB Burden in the Philippines

The Philippines is among the top 20 high-burden TB countries worldwide. Despite a steady reduction in mortality over the last 15 years, the TB incidence rate in the Philippines has remained mostly unchanged (Figure 1).¹ In 2017, over seven (7) percent of all missing TB cases globally came from the Philippines, representing the fourth highest number of cases in the world (see Figure 2).² In 2017, the Philippines DOH estimated that 77% of TB cases go undetected.³ Adding further to the overall TB burden, the Philippines has been designated by the World Health Organization as a high-burden Multi-Drug Resistant-TB (MDR TB) country.⁴

In determining the relative burden of TB, compared to other diseases in the Philippines, the Institute of Health Metrics and Evaluation of the University of Washington, using the well-established Global Burden Study, has projected that from 2015-2035, 48 diseases comprise 80% of Disease-Adjusted Life Years⁵ (Figure 3). As Figure 3 denotes, TB contributes the third highest burden of disease to overall disease in the Philippines.⁶

A 2016/2017 DOH study on the catastrophic costs of TB found that a case of drug susceptible TB (DSTB) reduces monthly income of households by an average of PhP10,901 and PhP6,290 in urban and rural areas, respectively, while a case of drug resistant TB (DRTB) results in an average monthly income loss of PhP11,410. Using the DSTB and DRTB incidence rates, the combined annual income loss from TB morbidity is estimated at PhP13.066 Billion (\$261.7 Million). TB deaths result in an estimated annual income loss of PhP3.310 Billion (\$66.3 Million). The total income loss due to TB morbidity and mortality is PhP16.376 Billion (\$328 Million), which was 0.37% of the gross domestic product of the Philippines in 2017.⁷

FIGURE 1: PHILIPPINES TB MORTALITY AND INCIDENCE RATES, 2000-2016



Source: The Philippines TB country profile. WHO Global TB Report, 2018.

¹ World Health Organization Global Tuberculosis Report, 2018.

² WHO Public-Private Mix for TB Prevention and Care, A Roadmap. World Health Organization, 2018.

³ Department of Health, 2017. National tuberculosis prevalence survey 2016, Philippines. Manila, Philippines.

⁴ Global tuberculosis report 2018. Geneva: World Health Organization; 2018

⁵ DALY is a universal metric that allows researchers and policymakers to compare very different populations and health conditions across time. DALYs equal the sum of years of life lost (YLLs) and years lived with disability (YLDs). One DALY equals one lost year of healthy life. DALYs allow us to estimate the total number of years lost due to specific causes and risk factors at the country, regional, and global levels.

⁶ Wong JQ, et al. Priority Setting for Health Service Coverage Decisions Supported by Public Spending: Experience from the Philippines, Health Systems & Reform. 2018

⁷ Calculated from data in <https://www.philcat.org/PDFFiles/TBcatastrophicpresentation.pdf>, accessed September 13, 2019.

In fact, investing in TB is one of the most cost-effective investments that a country can make. According to the Copenhagen Consensus Centre, reducing TB is considered a “best buy”, with a return of \$43 dollars for every dollar invested to reduce TB deaths by 95% and TB incidence by 90%.⁸

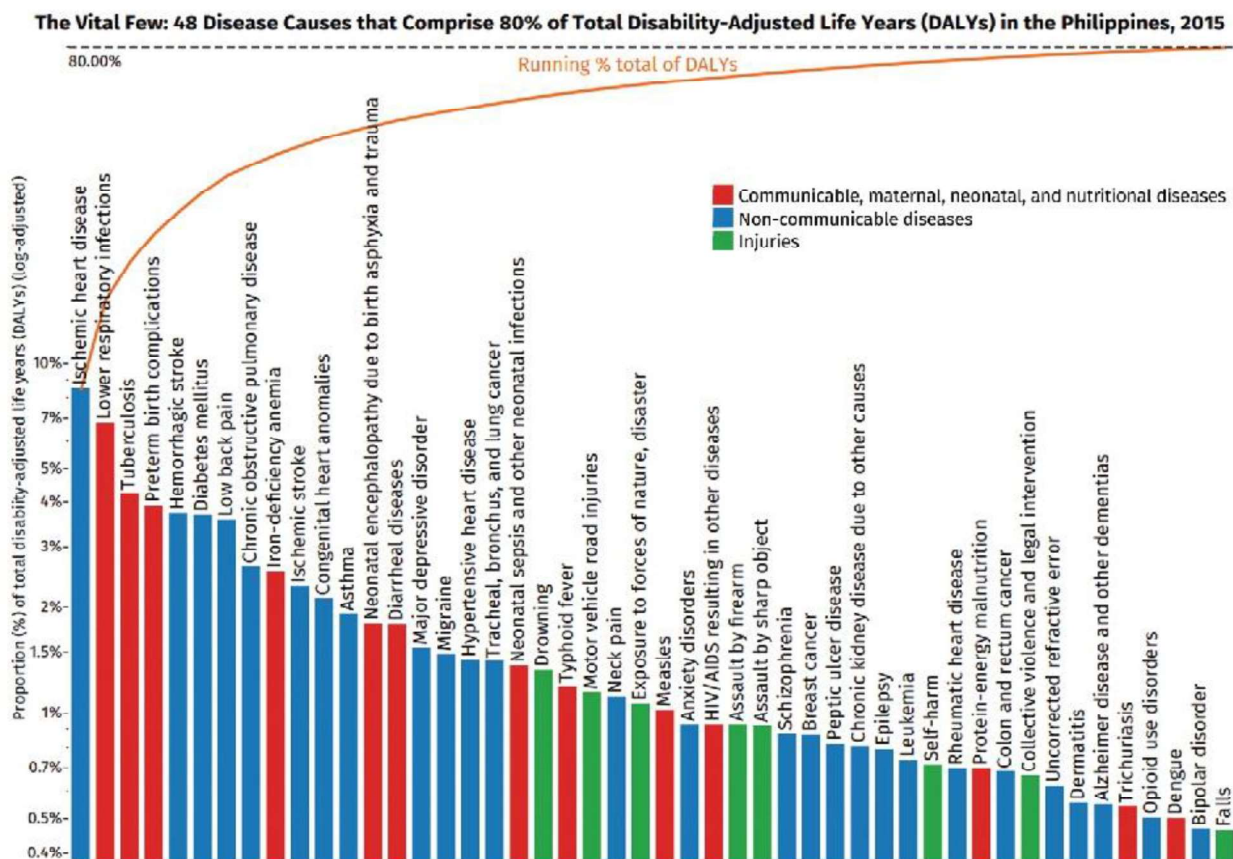
FIGURE 2: HIGH BURDEN TB COUNTRIES, RANKED BY MISSING TB CASES, 2017

Country	Population (thousands)	TB incidence rate	TB incidence (thousands)	MDR incidence (thousands)	Notifications, new and relapse (thousands)	Treatment coverage rate	Missing cases (thousands)	% global missing cases	Private share of primary care	Private share of health expenditure (thousands)
India	1340	204	2740	135	1787	65%	953	26.5%	74%	74%
Indonesia	264	319	842	23	442	53%	400	11.1%	74%	66%
Nigeria	190	219	418	24	102	24%	316	8.8%	67%	74%
Philippines	105	554	581	27	317	55%	264	7.3%	70%	68%
Pakistan	197	267	525	27	359	68%	166	4.6%	85%	69%
Bangladesh	165	221	364	8	243	67%	121	3.4%	84%	74%
China	1410	63	889	73	773	87%	116	3.2%	n/a ^a	40%
Democratic Republic of Congo	81	322	262	8	150	57%	112	31%	43%	44%
South Africa	57	567	322	14	220	68%	102	2.8%	n/a	44%
Tanzania	57	269	154	2	68	44%	86	2.4%	62%	28%
Kenya	50	319	158	3	84	53%	74	2.1%	42%	48%
Myanmar	53	358	191	14	130	68%	61	1.7%	78%	74%
Ethiopia	105	164	172	6	117	68%	55	1.5%	24%	58%
Angola	50	319	158	3	84	53%	74	1.5%	16%	50%
Thailand	69	156	108	2	36	58%	26	0.7%	40%	24%

Source: WHO Public-Private Mix for TB Prevention and Care, A Roadmap. World Health Organization, 2018.

⁸ Copenhagen Consensus Centre: <https://www.copenhagenconsensus.com/post-2015-consensus/economist>

FIGURE 3: DISABILITY-ADJUSTED LIFE YEARS IN THE PHILIPPINES, 2015



Source: Wong JQ, et al. *Priority Setting for Health Service Coverage Decisions Supported by Public Spending: Experience from the Philippines, Health Systems & Reform*. 2018

Committing to Achieving Ambitious TB Goals

Recognizing the importance of addressing TB burden in the Philippines, the Government of the Philippines, through the pronouncement of DOH Secretary in a high-level United Nations (UN) meeting in September 2018, committed to achieving ambitious TB targets. By 2022, the DOH committed to find and treat 2.5 million TB cases and to decrease TB incidence by 23% from the baseline.⁹ Specifically, the Philippines committed to:

- Detect and enroll 2.5 million Filipinos into TB treatment;
- Appropriately treat 110,083 patients with drug-resistant TB;
- Provide TB treatment to 323,548 children and adolescents with TB; and
- Provide TB prophylaxis to 1,257,555 Filipinos diagnosed with latent TB infection.¹⁰

These targets align with the PhiSTEP1, which includes the following, additional impact-level targets: 50% reduction of deaths from TB from 22,000 to 11,000; no catastrophic costs among households with an affected TB member; and at least 90% patient satisfaction with TB services.¹¹

⁹ Department of Health, 2019. World TB Day 2019: #EndTBNowNa.

¹⁰ Department of Health, National Tuberculosis Program Website, <http://www.ntp.doh.gov.ph/aboutNTP.php> (Accessed Sept. 29, 2019).

¹¹ Garfin, A.M.C., 2017. 2017-2022 Philippine Strategic TB Elimination Plan: Phase I (PhiSTEP1). Manila, Philippines.

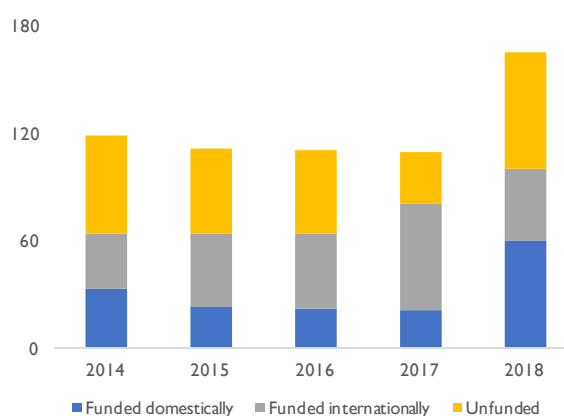
Identifying Key Strategies to Achieve TB Goals

At the April 2019 high-level UN meeting, where the DOH Secretary reaffirmed the 2018 commitment to achieve these targets by 2022, the government emphasized the following 'business-not-as-usual' strategies for combatting TB: (1) high-level commitment, (2) massive screening, testing, and treatment, and (3) mandatory notifications by the private sector.¹² Recent dialogue with the DOH to advance progress against the TB goals included the following potential pursuits: (a) the scale up of molecular-based Polymerase Chain Reaction (PCR) diagnostic testing (through GeneXpert machines) to improve the identification and treatment of MDR-TB, (b) stronger implementation of the mandatory TB notification as enshrined in the RA 10767 or the Comprehensive Plan of Action for TB Elimination Act from private providers, and (c) the creation of the national coordinating committee to focus on addressing the social determinants of TB.¹³ One of the NTP's key objectives for implementing these strategies is to ensure adequate and competent human resources for health (HRH) for TB elimination efforts.¹⁴ To date, and with the support from donors, the Philippines has realized progress on all three fronts. GeneXpert machines are being rolled-out, with increases from 260 sites at the end of 2017 to 362 sites as end of June 2019.¹⁵ Private sector TB notification has increased from 80 reported cases in 2017 to 37,501 in 2018 and to 42,304 in the first three quarters of 2019; likewise, the percentage of private practitioners reporting increased from 1% to 31% to 37% in the same period.¹⁶ Furthermore, the national coordinating committee was convened on March 5, 2019. Yet, despite this progress, the country is still not on track to meet the ambitious targets set out in the high-level UN meeting, partially due to serious and persistent financing gaps.

Resourcing the Commitment and the TB Program

Budget allocation is a concrete manifestation of political will, and as such, the DOH has increased its allocation for TB in 2018, after a progressive decline in the preceding years (Figure 4).¹⁷ This could be seen as a response to the high-level UN commitments, the PhilSTEP, and to the findings of the 2016 National TB Prevalence Survey (NTPS), published in 2017.¹⁸ Unfortunately, the dramatic increase is still largely inadequate. The 2018 national budget for TB from all sources was \$160 million, with the Government of the Philippines allocating only 37% or \$59.2 million.¹⁹ The Government of the Philippines spent less than one (1) percent of its health budget (\$2 Billion or 106 Billion Philippines Pesos) on TB.²⁰ More than half of the total TB budget is not funded domestically; donors fill some of the gap, but 41.5% goes unfunded.²¹ The Global Fund grant mechanism contributes the lion's share of donor funding for TB—US \$141 million from 2012-2017²²,

FIGURE 4: BREAKDOWN OF TB FUNDING IN THE PHILIPPINES, US MILLIONS, 2014-2018



Source: Global tuberculosis report 2018. Geneva: World Health Organization; 2018.

¹² https://www.who.int/tb/features_archive/Philippines-Department-of-Health-and-WHO-against-TB/en/

¹³ USAID/TB Innovations project documents, 2019.

¹⁴ <http://www.ntp.doh.gov.ph/aboutNTP.php> (Accessed Sept. 29, 2019).

¹⁵ Email communication from PBSP on 30 September 2019.

¹⁶ Government of Philippines, ITIS, accessed September 2019

¹⁷ Global tuberculosis report 2018. Geneva: World Health Organization; 2018

¹⁸ Philippines National Tuberculosis Prevalence Survey 2016. Department of Health Philippines 2018.

¹⁹ Global tuberculosis report 2018. Geneva: World Health Organization; 2018

²⁰ The Philippines government appropriated budget for health in 2018 was 106 Billion Philippine Pesos or \$2 Billion. <https://www.doh.gov.ph/doh-budget> (Accessed September 30, 2019)

²¹ Global tuberculosis report 2018. Geneva: World Health Organization; 2018

²² Global Fund Philippines website: <https://data.theglobalfund.org/components/PHL/Tuberculosis> (Accessed Sept. 29, 2019.) Funds of the Global Fund come from private and public contributions with the U.S.A. contributing approximately 33% of total public contributions.

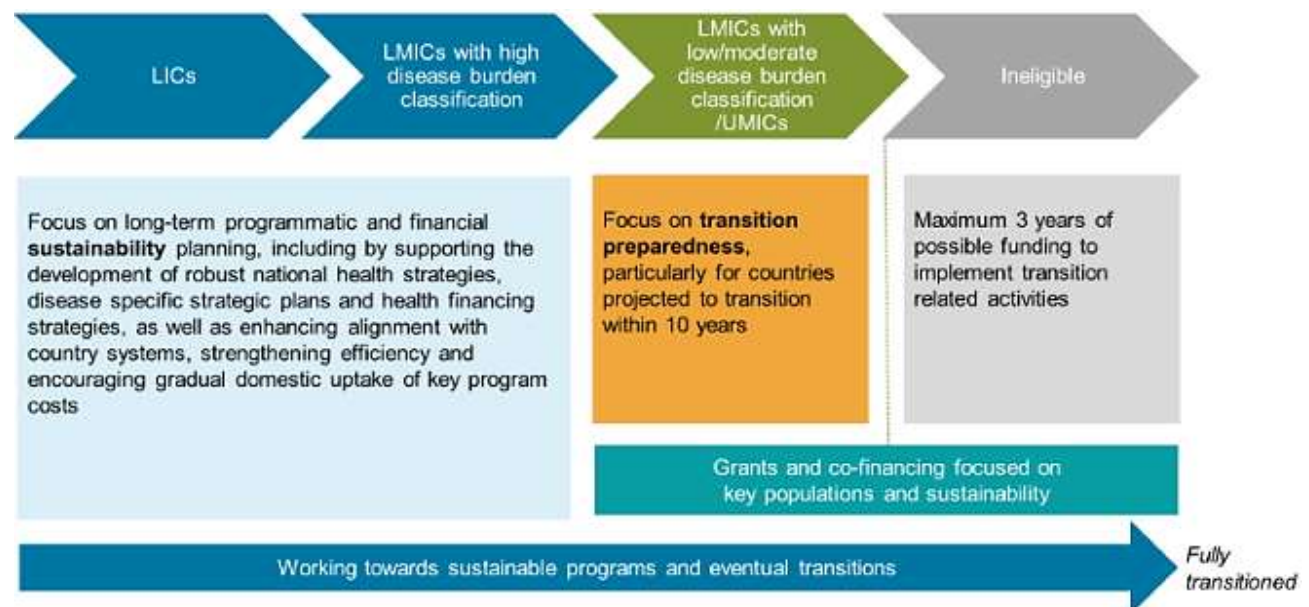
followed by USAID and other donors, including the Japanese Ministry of Foreign Affairs (1992-2007), the Japan AntiTuberculosis Association (JATA) (2008-2012), the Korean Foundation for International Healthcare (2012-ongoing), and the International Red Cross and Red Crescent Movement (2014-2018).²³ In 2018 and 2019, the Global Fund disbursed \$32 million and \$28 million (as of September 2019), respectively, to support TB programming in the Philippines.²⁴

Over the last several years, the Global Fund TB grants have played a major role in contributing to the Philippine’s TB progress to date. The current (2018-2020) Global Fund TB grant, ACCESS TB—Advancing Client-centered Care and Expanding Sustainable Services for TB—is implemented by the Philippine Business for Social Program (PBSP), in collaboration with the DOH and other partners. The focus of the grant is on: (1) mainstreaming service delivery systems for DR-TB cases, including support to scale up of molecular-based PCR diagnostic testing, (2) finding missing cases through strategic engagement of non-rural health unit (RHU) health care facilities, especially in the private facilities, and (3) expanding TB-HIV collaboration. The grant also provides significant support to the NTP, with support to the central DOH, regional offices, the National TB Reference Lab (NTRL), and the National Center for Pulmonary Research (NCPR). Stand up a health workforce to support both the NTP and the delivery of key TB strategies on a national scale has been a major contribution of the Global Fund TB grant.

Anticipating a Changing Donor Resource Landscape

While donors are committed to partnering with the DOH to continue to identify and scale effective strategies to accelerate TB targets—as evidence by the recently signed Pledge of Support to the Accelerated Response to Meet the UN High Level Commitment to End TB in the Philippines—the country’s economic growth momentum, including inclusive economic growth and poverty rate declines, suggest that the country is in a position to replace and surpass long term donor investments with domestically mobilized resources. For example, according to the

FIGURE 5: GLOBAL FUND TRANSITION PROCESS



Source: *Projected Transitions from Global Fund support by 2025 -projections by component, Global Fund, March 2018 Update.*

²³ Japanese Ministry of Foreign Affairs: <https://www.mofa.go.jp/policy/environment/wssd/2002/type2/1-1-5.html> . JATA: <https://www.ph.emb-japan.go.jp/pressandspeech/press/pressreleases/2010/13.htm> Korean Foundation for International Healthcare: <https://e-jghs.org/Synapse/Data/PDFData/9986JGHS/jghs-1-e28.pdf> International Red Cross and Red Crescent Movement: <https://www.icrc.org/en/document/philippines-fighting-tb-detention-places-0>

²⁴ Global Fund Philippines website: <https://data.theglobalfund.org/components/PHL/Tuberculosis> (Accessed Sept. 29, 2019.)

Global Fund’s Sustainability, Transition and Co-financing Policy, the next Global Fund TB grant to the Philippines is expected to focus on transition preparedness and sustainability (Figure 5). Starting in 2020, the Philippines will begin to develop the proposal for the 2021-2023 Global Fund TB grant. According to the Global Fund, the proposal will lead to the development of a detailed Transition Plan to support the gradual transition of investments locally, including support to the Government of the Philippines to fill key gaps in the human resources needed to support the country’s ambitious TB targets.

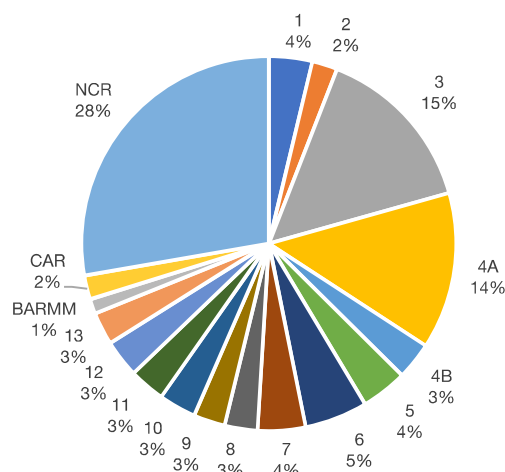
Overview of the Global Fund-supported TB workforce

According to the PBSP HRH Inventory, the current (2018-2020) TB-focused Global Fund grant supports 775 full-time health workers.²⁵ As previously noted, the current PBSP HRH Inventory does not include support for community volunteers and sputum transport riders ("STRiders") that receive Global Fund stipends or fees, as these data were not readily available from PBSP. Under the grant, PBSP hires and deploys these health workers on behalf of the NTP. The Global Fund-supported workers are unique in that they are PBSP-hired but report to at least two immediate supervisors: one from PBSP and one from a government institution, such as the NTP coordinator or a medical officer at a hospital. There are also informal lines of reporting, such as to the Provincial Health Office or the DOH Regional Office.

Ninety-eight (98) percent of the Global Fund-supported workforce is deployed to public facilities or sites (757), though some of the activities supported by health workers attached to public facilities or sites may also involve the private sector, especially for activities meant to increase TB case detection in the private sector. Fifty-six percent of the workforce is deployed in the three (3) highest TB burdened regions (3, 4A, and National Capital Region [NCR]) (Figure 6), and 75% (or 581) of the health workers are deployed at the subnational level to include: Regional Offices (ROs), Provincial Health Offices (PHOs) and Hospitals, City Health Offices (CHOs) and Hospitals, Municipal Health Offices (MHOs) and Hospitals, District and Private Hospitals, and RHUs (Figure 7).

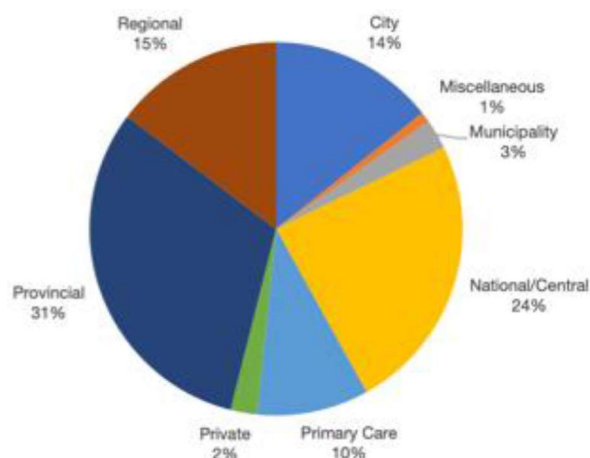
Eighty-eight (88) percent of the workforce is directly affecting service delivery, supporting one of the three main areas of focus under the Global Fund TB grant: (1) Mainstreaming service delivery systems for DR TB cases, (2) Finding missing cases through strategic engagement of non-RHU health care facilities, including private facilities, and (3) Expanding TB-HIV collaboration. The remaining 12% of the workforce provides broader policy, regulatory and administrative support to the NTP at the national and subnational levels. More than half (55%) of the workers are

FIGURE 6: DISTRIBUTION OF GLOBAL FUND-SUPPORTED WORKERS BY REGION (N=775)



Source: PBSP HRH Inventory, September 2019

FIGURE 7: DISTRIBUTION OF GF-SUPPORTED WORKERS BY HEALTH SYSTEM LEVEL



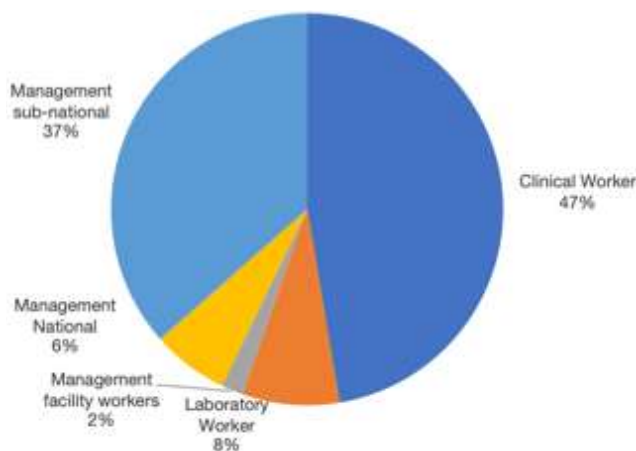
Source: PBSP HRH Inventory, September 2019

²⁵ This figure is derived from an inventory that was conducted by HRH2030 in collaboration with PBSP for the purposes of this activity. The PBSP HRH Inventory (September 2019) provides the most detailed documentation to date on the placement and compensation of 775 health workers seconded to the Government of the Philippines (and in a few small number of cases, to the private sector).

clinical or clinical support—including nurses, physicians, pharmacists, medical technologists, laboratory technicians and aides, clinical associates and TB case finders; the remainder (45%) have a range of clinical and non-clinical backgrounds but support management or administrative functions (Figure 8).

A detailed financial analysis of a sub-set of the Global Fund-supported workforce—the 652 positions that support the three Global Fund focus areas outlined below—reveals that PBSP salary support to these health workers amounts to approximately PhP 260 million (US 5 million) annually, when using the mode.²⁶ Based on estimated government equivalent positions and transition considerations,²⁷ if these positions were deployed under the plantilla for Personnel Services (PS) (as is proposed for transition), this would translate into PhP 262 – PhP 283 million (US 5.0 – US 5.4 million) in estimated annual salary and benefits (see Table I). (See Annex 3 for a breakdown of the detailed costing and assumptions and the HRH Transition Pathways section for cadre specific details.)

FIGURE 8: DISTRIBUTION OF GF-SUPPORTED WORKERS BY CADRE TYPE



Source: PBSP HRH Inventory, September 2019

While any newly created plantilla positions would be open to the general public, as per the policy of the Government of the Philippines, anecdotal evidences suggest that Global Fund-supported employees are actively looking for opportunities to move to permanent employment with their host institution and would apply to these positions. In general, salaries provided to government workers are higher than the salaries paid by PBSP. Further, a general review of the types of benefits offered suggests that the government also offers more lucrative benefits than PBSP. For example, PBSP staff do not receive 13th and 14th month pay.

TABLE I: ESTIMATED ANNUAL SALARY AND BENEFITS OF GF-SUPPORTED WORKERS IF TRANSITIONED TO GOVERNMENT EQUIVALENT POSITIONS

PBSP Position	Equivalent Government Position (Indicate position and rank)	Equivalent Govt. Salary Grade	Total Funding per Year - Step 1, PHP	Total Funding per Year - Step 8, PHP	Total Funding per Year - Step 1, USD	Total Funding per Year - Step 8, USD
A. PMDT						
STC Physician	MO IV	20	862,049.00	959,029.40	16,470.18	18,323.07
Float Nurse	Nurse II	14	27,858,655.00	30,109,353.00	532,263.18	575,264.67
Field Nurse	Nurse II	14	6,307,620.00	6,817,212.00	120,512.42	130,248.61
Clinic Nurse	Nurse II	14	114,588,430.00	123,846,018.00	2,189,308.94	2,366,183.00
Medical Technologist	Medical Technologist II	15	18,903,291.00	20,444,919.00	361,163.37	390,617.48

²⁶ PBSP did not provide actual salary data but rather provided the minimum and maximum salary scales, as well as, the mode – the value that appears most often—for each cadre type.

²⁷ Even though government employees, in general, are paid more than PBSP employees, the lower estimated cost to the government of transition includes assumptions around mainstreaming some functions currently supported by PBSP hires into existing hires within the PS. These are described in greater detail under the Transition Pathways sections below.

PBSP Position	Equivalent Government Position (Indicate position and rank)	Equivalent Govt. Salary Grade	Total Funding per Year - Step 1, PHP	Total Funding per Year - Step 8, PHP	Total Funding per Year - Step 1, USD	Total Funding per Year - Step 8, USD
Senior Medical Technologist	Medical Technologist II	I5	1,145,654.00	1,239,086.00	21,888.69	23,673.79
Laboratory Aide	Medical Laboratory Technician II	8	3,725,546.00	3,929,376.00	71,179.71	75,074.05
GeneXpert Technician	Medical Equipment Technician III	I1	5,692,652.00	6,186,502.00	108,762.93	118,198.36
LPA Technician	Medical Equipment Technician III	I1	406,618.00	441,893.00	7,768.78	8,442.74
B. Data and Information						
Project Associate (ITIS)	Public Health Associate	I1	10,572,068.00	11,489,218.00	201,988.31	219,511.23
TB Notification Project Associate	Information Systems Researcher	I0	12,565,113.00	13,212,507.00	240,067.12	252,436.13
TB Notification Project Associate	Public Health Associate	I1	13,011,776.00	14,140,576.00	248,600.99	270,167.67
TB Field Leader*	Not Applicable	N/A	N/A	N/A	N/A	N/A
TB Case Finder	Nurse II	I4	21,025,400.00	22,724,040.00	401,708.06	434,162.02
Mobile Clinic Driver	Driver Courier II	6	918,597.00	960,264.00	17,550.57	18,346.66
Mobile Clinic Nurse Coordinator	Nurse II	I4	2,102,540.00	2,272,404.00	40,170.81	43,416.20
Mobile Clinic Radiologic Technician	Radiologic Technologist III	I3	1,448,232.00	1,564,053.00	27,669.70	29,882.56
STRiders	Not Applicable					
Community Volunteer	Not Applicable					
C. TB-HIV						
TB/HIV Medical Technologist	Medical Technologist II	I5	16,437,983.00	17,792,747.00	314,061.58	339,945.49
TB/HIV Clinic Nurse	Nurse II	I4	4,676,715.00	5,058,909.00	89,352.60	96,654.74
TOTALS			262,248,939.00	283,188,106.40	5,010,487.94	5,410,548.46

* TB Field Leaders are not recommended for transition to government; functions can be transitioned to existing government positions

Anticipating Changing HRH Needs

It is important to note focus of this report is on Global Fund-supported health workers that *currently* are embedded in either health facilities or government sites. The policies, strategies and protocols that define TB service delivery expectations will continue to evolve as the DOH and NTP explore opportunities for service delivery efficiencies and integration, introduce new technologies and treatment regimens, and implement policies to reinforce engagement of the private sector. As such, the workforce needs of the country will continue to evolve, with implications for future Global Fund programming and transition planning under the next Global Fund TB grant.

The initial findings from the October 2019 Joint Program Review (JPR) point to a ramping up of TB screening and testing and DRTB services. This could mean an increased demand for laboratory personnel, STRiders and clinical staff. The envisioned opportunistic screening in all healthcare facilities and on preventive TB treatment could bring new demands for community and facility-based screeners. The expected increased claims on human resources by

the TB program will require dedicated efforts on sustainability planning covering both current and future HRH investments.

Under the UHC Law, the government is committed to rationalize the delivery of services by local governments through the province-wide and city-wide health systems and by integrating vertical or disease-specific services. Two of the three focus areas under the Global Fund TB grant—strengthening TB-HIV collaboration and mainstreaming DRTB services—will be impacted by this approach. For example, the introduction of task sharing polices may impact staffing patterns to support TB/HIV collaboration. Nurses are now allowed to perform certain TB/HIV functions that previously were solely mandated to Medical Technologists. An assessment of the impact of this policy on Global Fund-supported staffing may shift staffing norms, with longer term implications for transition planning.

In another instance, DRTB services traditionally are delivered at PMDT sites, which is reflected in the current Global Fund-supported staffing patterns. Under UHC implementation, DRTB services will be delivered through iDOTS or Integrated DOTS services and be devolved to the primary care level through upgraded RHUs. How this will affect the ease of transition planning is still to be determined. It is estimated that in the implementation of iDOTS, RHUs will add only three DRTB cases to their current TB patient workload, and that this level of workload may not require additional workforce although it may require training.²⁸ WHO treatment regimen shifts toward oral regimens and away from injections also are expected to reduce workloads. With the scale-up of iDOTS, HRH investments in the Treatment Centers and Satellite Treatment Centers likely can be reduced while taking into account increases in RHU workload and health worker's competency.

Finally, staffing to support the third focus area supported by the Global Fund grant—finding missing TB cases, especially in the private sector—also is expected to evolve with the introduction of new Public-Private Mix Models (PPM) for TB Case Notification. The NTP has discussed strategies to introduce innovations on mandatory notification of TB cases by piloting and scaling models of PPM care such as the "enhanced hospital engagement" which shall capacitate hospitals through cross-department integration and stronger linkage with the NTP, the "integrated primary care model" which shall provide vouchers to access diagnostics and medicines and shall be connected to PhilHealth and ITIS through a mobile application, and the workplace model which shall bring DOTS services at the workplace.

²⁸ Source: PBSP participant comments at the October 15, 2019 debriefing.

Considering Opportunities for Financial Sustainability

This section of the Sustainability Roadmap provides an overview and discussion of the sustainability of the Global Fund-supported HRH investments in the Philippines, with a particular focus on the opportunities and challenges for financing new plantilla positions at the National government and LGU levels. It is intended for stakeholders who may have to engage in sustainability planning discussions, under the 2021-2023 Global Fund grant proposal, but who may be less familiar with the evolving health financing environment in the Philippines. The discussion below provides greater detail to support the financial assumptions outlined in the subsequent transition pathways section.

Health financing overview and implications for sustaining TB health workers

In the Philippines, public financing for health is channeled primarily through three entities—LGUs, the National Government through the DOH, and the National Health Insurance Program (NHIP) (see Box 2). The Philippines has a largely decentralized healthcare system, in which LGUs of the Provinces, Cities and Municipalities are primarily responsible for planning, budgeting and delivering public health services, including the hiring of adequate and competent health workers. While national priorities are outlined by the DOH and “disease-oriented” programs, such as the NTP, the allocation of resources across and within sectors is primarily left to the discretion of LGUs, though decentralized decision making is also limited by national procedures, such as the Personnel Service or PS Cap. With the shift of responsibility for employing health workers to the LGUs, career pathways were disrupted. Prior to decentralization, a clear career pathway existed and qualified field health workers moved progressively to higher positions through the DOH organizational hierarchy up to the national level. To respond to the disruption, the DOH designed career pathways for LGU health workers to serve as guide to LGUs, while recognizing that hiring decisions rest on LGUs. Given the disparities in financial resources across LGUs, the DOH and “disease-oriented” programs employ mechanisms to supplement and incentivize LGU spending on health and health workers. The most notable program is the NDP, which allows the DOH to hire and distribute “surge” workers to address priority health areas. The NHIP also is a vehicle to incentivize (through reimbursement) the delivery of select services and corresponding incentives to health workers, in both public and private facilities. And, finally, new reforms are emerging that will create additional opportunities for the National government to more strongly influence health planning and budgeting at the national level, such as the introduction by the recently passed UHC Law of the Special Health Funds (SHF) which can be used for salary payments. Given the complexities of the Philippines healthcare system and the evolving health financing reforms, this report will focus on those areas that present the most critical opportunities for sustaining the health workforce that is currently being supported by the Global Fund grant.

Box 2: Three Primary Recipients of Public Health Financing and Mandates

- (1) The Local government finances the operations of primary and secondary hospitals and rural health units that provide public health programs, such as environmental sanitation, maternal and child health and tuberculosis control. The enactment of the Local Government Code (LGC) of 1991 (RA 7160) brought about the administrative and financing segmentation of the public sector’s health system whereby Provincial governments operate and finance the District and Provincial hospitals, and Municipal governments operate and finance rural health units and barangay (village) health stations. Most highly urbanized and chartered Cities fund and operate hospitals and health centers.
- (2) The National government mainly through the DOH supports national public health programs, such as immunization, family planning and tuberculosis control, and finances the operation of DOH-retained hospitals, which primarily consist of tertiary regional hospitals and a select number of reference laboratories. The Department of National Defense operates a small number of military hospitals.
- (3) The NHIP, which is administered by the Philippine Health Insurance Corporation (PHIC or PhilHealth), reimburses government and private facilities for services outlined in its inpatient and outpatient benefit packages, such as childbirth and for certain types of tuberculosis treatment.

Local government financing for health primer

Of the 775 health workers supported by the Global Fund, the majority (n=449, 58%) are seconded to facilities or sites (i.e., provinces, cities, municipalities, and primary care) that are primarily supported through LGU budgets. The ability to transition these functions to LGUs in the future will depend on the availability of LGU funding for TB services and prioritization of these positions within the PS Cap.

Local government revenue generation

In 2018, LGUs consisting of provinces, cities and municipalities reported a total of PhP 423.76 billion for the provision of services mandated by the LGC.²⁹ LGUs support these services through a combination of tax and non-tax revenues. The major source of LGU revenues is a transfer from the National government, in the form of the LGU's share in national tax collections, known as internal revenue allotment (IRA). The IRA is determined by the size of the population and land area under the LGU's administration, and a recent Supreme Court ruling may bring additional IRA resources to LGUs (see Box 3). Other tax revenues include shares from local economic enterprises (LEEs) and local tax revenues, such as those levied on real property and business. Non-tax revenues are from regulatory fees (e.g., permits and licenses), service charges, loans and grants, including those specifically earmarked for health services. In addition, LGUs generate revenue from the health sector through reimbursements by the PhilHealth and co-payments by patients.

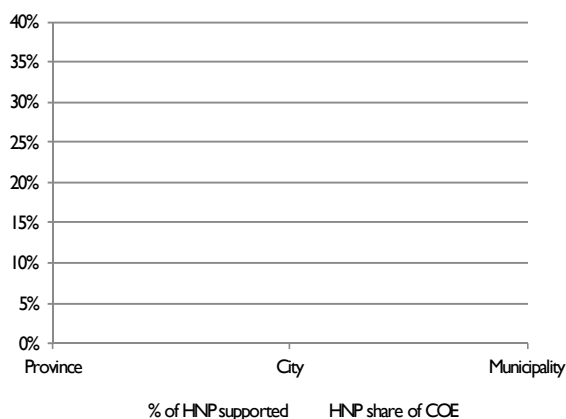
Box 3. Likely increase in IRA share for LGUs by 2022

The Philippine Supreme Court recently decided on a grievance suit filed regarding the unfair distribution of National collected revenues. The 'Mandanas ruling' of the Supreme Court increases the share of LGUs in the nationally collected revenues (i.e., IRA). By the ruling and according to the DOH HPDPB, the LGUs IRA is expected to increase 50% of its current levels by 2022. The DOH expects that with increases in financial resources, LGUs will increase its funding for health including for additional health workers so that only low-resourced LGUs (4th-6th class municipalities) may receive support from the DOH NDP. With the UHC Law, the NDP will transition to a national health workforce support system to support local public health systems in addressing their human resource needs, with the provision that deployment to Geographically Isolated and Disadvantaged Areas shall be prioritized.

Local government financing for health and TB services

In 2018, the Health, Nutrition and Population Control (HNP) Sector received the third highest LGU operating expenditure, accounting for 13% of the total budget. Further, within the Social Services Sector, HNP received the highest share at 47.5%.³⁰ Among the LGU categories, while cities spent PhP 21.38 billion on health services, accounting for 39% of the total LGU expenditure on health, health services only accounted for 13% of cities' current operating expenditure (COE) (see Table 2). Provinces, which operate provincial and district hospitals, shouldered a higher burden, with HNP expenditures accounting for 22% of their COE. Municipalities spent the least on health and had the lowest burden at only 9% of COE (see Figure 9). Unfortunately, the breakdown on LGU spending by disease or condition, including TB, was not available.

FIGURE 9: 2018 HEALTH EXPENDITURES BY LGU



Source: Calculated from Fiscal Data of the Bureau of Local Government Finance, Department of Finance. <http://blgf.gov.ph/lgu-fiscal-data/> accessed September 9, 2019.

²⁹ Source: Fiscal Data of the Bureau of Local Government Finance, Department of Finance. <http://blgf.gov.ph/lgu-fiscal-data/> accessed September 9, 2019. As of December 31, 2018, the number of LGUs by category were: 82 provinces, 145 cities, 1,478 municipalities, 41,913 barangays.

³⁰ The social sector includes the following operating units a) education, culture and manpower development; b) health, nutrition, population control; c) social security, welfare, and employment; d) housing and community development; and, e) land distribution.

TABLE 2: 2018 HEALTH EXPENDITURES BY LGU IN MILLION PESOS

LGU Level	HNP Spending	% to total HNP	HNP share to total COE
Province	20,559.56	36.99%	21.82%
City	21,378.60	38.47%	12.50%
Municipality	13,637.41	24.54%	8.60%
Total	55,575.58	100.00%	

Source: Calculated from Fiscal Data of the Bureau of Local Government Finance, Department of Finance. <http://blgf.gov.ph/lgu-fiscal/> accessed September 9, 2019

Local government prioritization of health and TB services

Local government plans and budgets should be harmonized with nationally-set goals, strategies and plans, according to guidance issued by the DBM. The LGU budgeting process is triggered by the DBM's issuance of an annual Local Budget Memorandum (LBM), addressed to all Local Chief Executives (LCEs) and others, including the Local Planning and Development Coordinators. The LBM provides comprehensive guidance to LGUs that includes indicative IRA shares for LGUs and the National government priorities in the use of IRA and other financial resources for the purposes of LGU planning. The LBM cites provisions of the LGC that states that LGU financial resources should first cover the costs of operating facilities and providing services that were devolved by the DOH to LGUs. The following TB services were designated by the LGC as the responsibility of the LGU, and therefore, are considered priority health services: TB services for suspected cases and for drug-sensitive TB (DSTB) patients, which are delivered in both hospitals and health units through the DOTS program, and a DOH Memorandum 2016-0133 dated March 26, 2016 directed Regional NTP Coordinators to implement iDOTS with community-based PMDT care in all facilities. Despite national directives, support to TB control program by the LGUs is one of the program gaps identified by PhilSTEP I, which specifically calls for LGUs to convene and maintain active multi-sectoral committees supporting TB elimination and that 100% of the provinces, highly urbanized cities (HUCs), and municipalities have clear and costed TB elimination plans.

Local government financing of health personnel

The low levels of health workforce financing at the local level and limits to LGU expansion of the health workforce is partially due to the institutional constraints in hiring imposed by the DBM. Known as the PS Cap, high-income LGUs (1st - 3rd class municipalities) and low-income LGUs (4th-6th class municipalities) can only propose a PS budget up to 45% and 55%, respectively, of the LGU's total expenditures two years prior to the budget year. Specifically, the PS budget for the HNP sector is combined with the PS budgets of all other sectors and should not be more than the above percentage set by the PS Cap. Thus, prioritization in personnel hiring for other sectors can crowd-out HPN workers. For example, the Danao and Mandaue city governments in Cebu submitted budget proposals for additional permanent health workers and are still awaiting DBM approval two years later; the health managers believe that this is because the city has hit the PS Cap as a result of hiring additional personnel, such as policemen. LGUs have resorted to hiring job order (JO) personnel to get around the PS Cap; however, JO hiring will be prohibited starting in fiscal year (FY)20, in line with the current governments policy to protect labor. Under the LGC of 1991, LGUs can create local economic enterprises (LEEs) to deliver services and some LGUs have transformed their health facilities into LEEs, which provide greater autonomy in the use of funds and excludes salaries of health workers in the PS Cap but LEEs have not gained traction in the LGUs.

Implications of the UHC Law on Local Funding for TB

The implementation of the landmark UHC Law presents an important opportunity to plan for the transition of Global Fund-supported HRH at the LGU level. The UHC Law will create a platform to harness the strategic purchasing powers of the DOH, PhilHealth and LGUs—among the largest procurers of services—with the opportunity to fundamentally alter the delivery of health services in the Philippines. Among the Global Fund-supported HRH investments, only 27% (n = 206) are deployed in one of the 33 UHC implementation sites planned for advance roll-out; however, by the Law UHC implementation will eventually span the entire country. Five of the most promising opportunities to advocate for additional resources to amplify and sustain TB resources through the UHC are discussed below.

1) Further expansion of NHIP to increase coverage in poor and disadvantaged populations. On July 30, 2019, to jump-start the UHC Law, the DBM released an amount of PhP27.7 billion to the PHIC for the payment of the one-year health insurance premiums of non-contributing or indirect members, i.e., indigent families and other qualified groups under the NHIP. This is expected to reduce the number of TB-affected households that experience catastrophic cost to zero, an objective articulated by the PhilSTEP I, by increasing PhilHealth coverage of poor and disadvantaged populations that historically have suffered disproportionately from TB burden. However, the current NHIP expansion is likely to have limited impact on TB burden for two reasons: (1) reimbursement rates for TB services under NHIP remain low, and (2) coverage of TB services is limited. Under the current guidelines [PhilHealth Circular (PC) 14 s.

2014], PhilHealth reimbursements for TB DOTS cover first-line drugs for DSTB, monitoring tests, and consultation fees, though utilization of the TB DOTS package is quite low. Currently, DRTB services are not covered by PhilHealth. PhilHealth pays in-patient rates for TB treatment and care for admitted cases and because these rates are higher than the outpatient DOTS package rates, there is an incentive for facilities with beds to provide in-patient TB care.

The low levels of TB DOTS utilization may be due to: i) the burdensome PhilHealth requirements for facility accreditation as TB DOTS provider; ii) a lack of knowledge on the availability of the package, and/or no felt need by facilities to seek reimbursement from PhilHealth. This may be due either to low reimbursement rates—a costing study estimates the cost for the package in the range of 5,000-10,000, while the fixed case reimbursement rate is 4,000 pesos (PC 14 s. 2014)—or a broader challenge that allows PhilHealth payments to accrue to the LGU treasury. Not having access to PhilHealth payments by health facilities is commonly reported. In Cebu, while the Danao CHO filed for PhilHealth TB DOTS reimbursements, they reported to have no access to the payments received by the City Treasury. On the other hand, the Mandaue City CHO receives 100% of PhilHealth payments

Box 4. Implications of the UHC Law on PhilHealth Benefits

The UHC Law provides an opportunity to mobilize new funding for individual-based TB services through PhilHealth payments to facilities providing services covered by the UHC-mandated benefits. The UHC Law defines individual-based health services as those that can be accessed within a health facility or remotely and can be definitively traced back to one recipient and with limited effect at the population level (for example, ambulatory and inpatient care, medicines, laboratory tests and procedures). The essential health benefit package is a set of individual-based health services that is guaranteed for all Filipinos. It includes primary care; medicines, diagnostics and laboratory; and preventive, curative, and rehabilitative services. The comprehensive outpatient benefit is a benefit of PhilHealth members provided in ambulatory settings and includes outpatient drugs and emergency medical services as determined from a health technology assessment. Population-based health services refer to interventions which have population groups as recipients, such as health promotion, disease surveillance, and vector control. Population-based health services will be financed by the National Government through the DOH and provided free of charge at the point of service. However, at this point, the DOH and PhilHealth have not yet identified which specific TB services would be a population-based or an individual-based service. Section 18.12 of the UHC Law's Implementing Rules and Regulations specifies that services which cannot be readily determined as population-based or individual-based, such as TB services, retain current financing subject to an assessment by the DOH aimed to determine the most efficient financing. Subsequent to the assessment, DOH and PhilHealth will issue the appropriate guidelines.

from the City. The release of payments to facilities provide incentives to health workers. The DOH NTP Manual of Procedures (2014) specifies the distribution of revenues and incentives to health workers as follows: 40% to the facility, 25% to the physician referring the patient to the TB DOTS facility (the same physician also providing services during the course of treatment), and 35% for all staff providing services in the TB DOTS facility.

The implementation of the UHC Law is an opportunity to increase reimbursements and incentives for TB DOTS as well as to introduce coverage for DRTB through iDOTS. However, to date, the DOH and PhilHealth have not identified which specific TB services would be individual-based (and therefore primarily financed through PhilHealth) versus population-based and financed by the DOH (see Box 4).

2) Creation of the SHF to increase pooling of funds and improve accountability and efficiency. Under the UHC Law, the province-wide or city-wide health system will be expected to pool and manage, through a special health fund (SHF), all resources intended for health services to finance population-based and individual-based health services, to include: health system operating costs, capital investments, remuneration of additional health workers, and incentives for all health workers. Sources for the SHF will include: (i) financial grants and subsidies from National government agencies (such as those included in the DOH LIPHs) to support population-based services³¹, (ii) income from PhilHealth payments for individual-based services, and (iii) all LGU budgets for health to cover all operations and services mandated by the Law. Other sources include financial grants and donations from NGOs, FBOs and official development assistance.

Essentially, the UHC Law will reinforce direct accountability from LGUs to support mandated health services, including guidance on allocation formulas for financing TB services, while the pooling of funds in the SHF and the efficiency gains from networks are envisioned to generate increased revenues for health facilities enabling them to eventually fully fund PS and MOOE and to increase engagement of the private sector. This sets the stage for the transfer of donor-funded HRH to local ownership, primarily through the provincial and city-wide healthcare provider networks. The ability to full staff TB services will be critical for supporting two of the Global Fund grant focus areas – mainstreaming DRTB and supporting HIV and TB collaboration—within the public sector. The other Global Fund grant focus area—to find missing TB cases—may benefit from the transition to service delivery through provincial and city-wide healthcare provider networks which can be a public-private mix (PPM) network or an all private providers network. The PhilHealth should be made cognizant of TB program strategies such as mandatory TB notification so that it can include full compliance to the mandatory TB notification and reporting system as part of the accreditation requirement for contracting provider networks.

3) Greater emphasis on HRH strategic planning and development. The UHC will require the establishment of HRH standards that will serve as the basis of staffing decisions. A tripartite cooperation among the DOH, the DBM, and the Civil Service Commission will ensure that these HRH standards are met in all healthcare facilities, even if that results in the creation of new plantillas for the public sector. Furthermore, the aim is to hire healthcare workers as permanent staff, to align province and city-wide investment plans to a National HRH Master Plan—a long term strategic plan for the management and development of HRH, to include primary care competencies in health professional and health workers' curricula—and to augment low-income LGUs through a national deployment through the National Health Workforce Support System.

4) Leveraging LIPH grants to encourage LGU investment in TB. The Local Investment Plan for Health (LIPH) is a DOH intervention, strengthened by the UHC Law, aimed to improve health and expenditure planning of the LGUs. Specifically, to improve the functionality of province-wide and city-wide health systems, the National government will make available financial and non-financial matching grants, including capital outlay, human resources and commodities, with underserved and unserved areas given priority in the allocation of grants. Program commodities such as TB drugs and supplies (e.g., cartridges for GeneXpert equipment) and HRH augmentation of the DOH NDP are incorporated in the LIPH grants. These are significant inflows of resources to

³¹ In the delivery of population- based services which are publicly financed by the National government through the DOH, the DOH will contract with province-wide and city-wide health systems that have the following minimum components: a primary care provider network, an epidemiologic surveillance system, and a health promotion program.

the LGUs. It is an opportunity to prioritize TB, but it requires advocacy by the NTP for increased budgets for commodities and TB-dedicated deployed health workers. The current LIPH HRH guidance lists cadres for full-funding by the LGUs and the NTP as the following: Physician, Nurse, Medical Technologist, and Admin Assistant/ITIS Encoder, though the UHC Law and formulation of the National Health Human Resource Master Plan will play a significant role in the prioritization of LIPH resources in the future (see Box 5).

5) **Prioritizing the NDP to support the TB workforce.**

Historically, the NDP has deployed Doctors, Nurses, Midwives, Dentists, Medical Technologists, Nutritionists, Pharmacists, and Pharmacy Assistants. Currently, the NTP is exploring the idea of deploying TB-focused health care workers through the NDP. This proposal is seen as a key intervention to reach the bold target of detecting 2.5 Million TB cases by 2022. Notable changes to the NDP in (FY)19 and (FY)20 may create a sharper instrument for rationalization of HRH deployment by the DOH, even while the overall funding for the NDP is declining (see Box 6).

Box 5. Implications of the UHC Law on HRH Planning

To support the HRH needs of local public health systems, the UHC Law institutionalizes the formulation and implementation of a National Health Human Resource Master Plan by the DOH and in collaboration with stakeholders. The Master Plan contains policies and strategies for the appropriate generation, recruitment, retraining, regulation, retention and reassessment of health workforce based on population health needs. In the development of policies and plans at the national level, the DOH intends to employ state-of-the-art HRH methods such as Health Labor Market Analysis (HLMA) and WISN. For example, the DOH is building its capacity to adapt the approaches of the HLMA and WISN in HRH planning at local levels specifically in the development of the HRH component of the LIPH. These approaches encourage integration towards improved efficiency and effectiveness of HRH. An appropriate HRH planning guidance to the LGUs will institutionalize the use of these approaches in the development of the HRH component of the LIPH.

National government financing for health primer

Of the 775 health workers supported by the Global Fund, 40% (n = 308) of PBSP supported-workers are located in sites financed by the National government, with 39% (n = 301) sitting within the central DOH or Regions, while one (1) percent (n = 7) reside in departments outside of the DOH, such as the Bureau for Corrections. The ability to transition these functions to the National government in the future will primarily depend on the availability of DOH funding for TB services and prioritization of these positions within personnel services outlined in the 2013 Rationalization Plan of the Department of Health Central and Regional Offices as mandated by Executive Order No. 366.

Box 6. Implications of the UHC Law on the NDP

From FY18 to FY19, the NDP budget was reduced by 44.5% (Php9.26 billion to Php5.14 billion). For 2019, the NDP health workers were upgraded to 'casual' status and are now entitled to benefits. The reduction in terms of the number of health workers that can be hired by the NDP is significantly reduced. The upgrading of employment category to 'casual' status is in line with the government's policy of protecting labor and may also be viewed as a transitioning into the UHC Law provision that "all health professionals and health care workers be guaranteed permanent employment and competitive salaries".

Another significant change in the FY19 budget is that the NDP was released directly to the National DOH Central Office, while previous year's NDP budgets were released to the DOH Regional Offices. The centralization of the NDP funding provides the DOH a sharper instrument for rationalization of HRH deployment and may be viewed as transitioning the NDP towards the UHC Law's provision of a national health workforce support system (NHWSS) that will "support local public health systems in addressing human resource needs".

National government financing for health and TB services

The National government's financing for health is primarily realized through annual budget allocations to the DOH.³² The total amount of new budget allocation for the DOH in FY19 was PhP97.654 Billion pesos (see Table 3). The FY19 allocation is 8% lower than the PhP106,082 Billion in FY18.³³ One-half (50%) of the FY19 allocation support the operations of DOH-owned health facilities, composed mostly of regional hospitals and a few reference laboratories, and includes financing for new construction and renovations of both DOH- and LGU-owned health facilities. Twenty-one (21) percent finances the purchase of public health commodities, such as vaccines and TB drugs, as well as the salaries and training of public health program managers at all levels including TB program management. PhP880 Million (\$16.8 Million) is allocated for the purchase of TB program commodities. This is higher than the PhP785 Million (\$14.9 Million) in FY18 but lower than the PhP1.323 Billion (\$26.5 Million) allocated in FY17.³⁴ Salaries, benefits and training of health workers deployed by the DOH to augment LGU-hired personnel makes up nine percent of the total appropriation. Approximately 11% finances the DOH's national mandate to provide health sector oversight including policy development and regulations, and nearly 10% supports a social protection program to pay for uncompensated care for poor patients at the point-of-service in both public and private hospitals. For FY2020, of the total PhP4.1 trillion national expenditure program (NEP), PhP92.2 billion (3.90%) is allocated to the DOH, a reduction of 5.5% from the FY19 appropriation.³⁵

TABLE 3: 2019 DOH NEW APPROPRIATIONS (IN THOUSAND PHILIPPINE PESOS)

Programs	Expense Classification			Total	%
	PS	MOOE	CO		
Administration, policy, regulations	8,780,735	829,862	602,811	10,213,408	10.46%
Public health HRH deployment & capacity building	5,169,283	3,559,883	0	8,729,166	8.94%
Public health other support	1,653,712	18,769,079	0	20,422,791	20.91%
Health facilities operations	27,232,230	5,456,213	16,218,015	48,906,458	50.08%
Social protection	0	9,381,810	0	9,381,810	9.61%
Total	42,835,960	37,996,847	16,820,826	97,653,633	100.00%
% to Total	43.87%	38.91%	17.22%	100.00%	

Source: Consolidation of DOH programs from the General Appropriations Act, 2019.

National government financing of health personnel

Financing salary and benefit payments of DOH PS constitutes approximately 44% of the total DOH financing for health. The share of PS in the DOH budget allocation has consistently increased over the past five years, from 12% in 2015, with an average annual growth rate of 38.4% over the 2015-2019 period. The share of PS in the DOH budget allocation is significantly higher than the government-wide share of PS (31.5%). High levels of PS in the DOH are due to higher amounts of benefits paid to DOH personnel, as mandated by the Magna Carta Law for Health Workers which does not apply to other public sector employees.

³² The Department of National Defense receive budget allocations for military hospitals.

³³ The 2019 National Expenditure Program (NEP) also called the President's Budget reports a total of PhP7.5 Billion of unused 2017 appropriations by the DOH which the DOH can still draw down on.

³⁴ Unused 2017 appropriations for TB drugs could explain the reduced recent years' allocations. Unused appropriations from previous years can be utilized in later years. The exchange rates used are end-of-year figures from the Philippine Central Bank data of 2018 and 2017 respectively.

³⁵ The NEP will be subject to review of the Philippine legislature and the Office of the President of the Philippines. The approved FY 2020 DOH allocation will be indicated in the forthcoming FY2020 General Appropriations Act (GAA).

National government prioritization of health and TB services

The annual process of developing a DOH budget starts with the issuance by the DBM of the National Budget Call in the year prior to the budget year in consideration. The Budget Call is addressed to all Heads of Departments, Agencies and Offices of the National government and contains detailed budget development guidelines. The National Objectives for Health (NOH) 2017–2022 serve as the medium-term roadmap for the Philippine health sector specifying the objectives, strategies and targets of the DOH FOURmula One Plus for Health within financing, service delivery, regulation, governance and performance accountability. TB is included as among the diseases for action in the FOURmula One Plus strategies. The NOH also serves as the basis for developing the DOH Medium-Term Expenditure Framework (MTEF).³⁶ The annual operational plans of Regional Offices, Bureaus and Programs in the DOH, and the LIPH. The MTEF, the annual operational plans and the LIPH should take the PhilSTEP1 financing plan as reference; however, the planning and budgeting system enabling such have not been established. The PhilSTEP1 financing plan calls for DOH budget support of Php32.2 billion or 48% of the total Php 66.9 billion full implementation costs of PhilSTEP1 for the period 2017 to 2022, with lower amounts planned for the earlier years.³⁷ Specifically, while only Php 1.7 billion is estimated in 2017, this increases to Php 6.1 billion by 2020, a level that is almost 5 times more than the current 2019 budget.³⁸ This points to major gap in the DOH budget support to the PhilSTEP1 budget plan in 2020. A planning and budgeting system that considers the financing plan of PhilSTEP1 will bring costed priority TB program activities into the DOH budgeting and prioritization processes. This requires NTP to actively advocate in the development of the DOH budget as the DBM and Congress conduct budget hearings with agency heads and review agency budgets and convert the NEP into a General Appropriations Bill which is deliberated on and passed jointly by both Congress and the Senate and approved by the President as the General Appropriations Act is issued. (See Annex 4 for a more detailed process map of the National government budget process.)

National government health workforce budget requests

Requests for additional personnel to support the health sector starts two (2) FYs before the intended budget year. Proposals by NTP go through an initial vetting and review process in the DPCB and then in the Office of the Undersecretary of Public Health Services. In a parallel process, proposals for additional positions by DOH Regional Offices, which may include technical and management personnel supporting the TB program, are prepared and processed without inputs from the TB program. Proposals from the DOH to use Tier 2 budget for new personnel are submitted to DBM for approval and are assessed against proposals from all other government agencies. At the DOH Central Office level, where the NTP is situated, the lack of plantilla positions for the NTP is perceived to be a result of the indicative staffing pattern as issued in the DOH Rationalization Plan or the Executive Order 366 (EO 366). The DOH Rationalization Plan contains the standard name and number of positions in DOH central and regional offices and dictates the budget allocation of the DOH for its personnel, thus restricting DOH requests for additional plantilla positions. That being said, any request for additional plantilla position and creation of a new position title shall have to undergo a process of vetting and approval from the DBM and Civil Service Commission (CSC) respectively. The request must be supported by documents providing evidence to explain and prove the requested need. Approval of past requests for additional plantilla positions were obtained by DOH programs that acquired new mandates such as from a recent Laws; for example, requests by the DOH oral health program. In the FY20 budget, that is currently under Congressional review, the NTP proposed three additional positions (i.e., Administrative Officer, Supervising Program Officer and Medical Officer). (See Annex 5 for a more detailed process map of the National government process to request health personnel.)

³⁶ The Medium-Term Expenditure Framework (MTEF) for the DOH is a five-year rolling plan aimed at aligning changes in health policies and priorities and program activities that are realizable within its fiscal resources. DOH submission of the MTEF is required by the Sin Tax Reform Law.

³⁷ Source: PhilSTEP1

³⁸ In this calculation, the 2019 TB commodities allocation was adjusted up to 2017 levels of Php1.3 Billion since unused TB appropriations can be utilized in 2019.

National government health workforce staff transfers

Unfilled positions in DOH-retained hospitals provide opportunities for hiring project staff under permanent status in the short-term. Starting in 2013, the DOH-retained hospitals were recipients of annual PS allocations from the DBM intended to meet hospital staffing standards. The DBM reports a total of 13,058 unfilled positions in the DOH in 2019, reduced from 14,278 in 2018. Some of the unfilled positions in hospitals are to cover for the forecasted new entrants to the hospital's residency program as the resident doctors move through the required residency years. There are also supply constraints indicated by low levels of applicants especially in geographically isolated locations. The DBM often cites high levels of unfilled positions as the reason for disapproving DOH requests for additional positions. To reduce the number of vacant positions, the DOH, working with hospital chiefs: (1) hire hospital staff and then assign the staff to other units within the DOH, (2) pool positions from hospitals to the DOH Central Office and then hire and assign personnel to programs, and (3) convert unfilled doctor positions to nurse and other allied medical positions.

Exploring the HRH Transition Pathways

This section of the Sustainability Roadmap analyzes the support provided by the Global Fund to assist the Government of the Philippines to fill gaps in the human resources needed to make progress toward achieving the TB targets set forth by the Government. It is intended for stakeholders who may have to engage in sustainability planning discussions, under the 2021-2023 Global Fund grant proposal, but who may be less familiar with the health workforce investments currently being supported under the Global Fund TB grant. For each major type of Global Fund-supported health worker, from those supporting service delivery at the field level to those at the provincial, regional and national levels, a discussion of the pathways toward transition are presented.

Focus Area I: Mainstreaming service delivery systems for DR-TB cases

The Programmatic Management of Drug-resistant Tuberculosis (PMDT) delivers a directly-observed treatment (DOT) model through treatment centers (TCs) and satellite treatment centers (STCs), established in key cities and municipalities, usually co-located in hospitals and government health offices or health units. Each center is run by a physician, a registered nurse, and a medical technologist, and houses a GeneXpert machine—a molecular diagnostic test that determines both presence of the bacteria and drug resistance, which is now the recommended default testing in the country. From the health centers, located at the grassroots level, suspected DR TB patients are referred to TCs/STCs for further diagnosis and subsequent management. Under the mainstreaming approach, as articulated in PhilSTEP I, the Government's objective is to provide integrated, patient-centered TB care and prevention services for both DS TB and DR TB in all DOTS facilities (iDOTS). This also is meant to transition the delivery of MDR TB diagnosis and treatment services into a regular service offering of the RHUs.

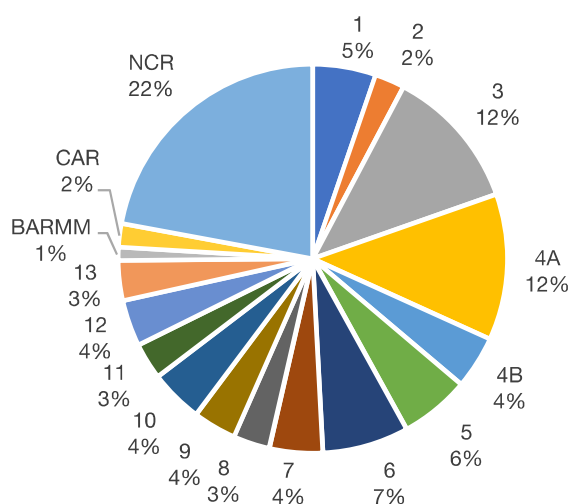
In support of this effort, the Global Fund TB grant supports the following activities:

- Purchase of additional Gene Xpert machines to improve both coverage and quality of diagnostic capacity;
- Purchase of Second Line Drugs (Shorter Standard Treatment Regimen) including support to roll out new all-oral regimens;
- Expansion of iDOTS, with community-based care and patient support;
- Quality Assurance for laboratory services;
- Support to mobilize technical assistance that may be needed by NTP to ensure inclusion of all Second Line Drugs in the National Drug Formulary; and
- Capacity building of health workers, including on active drug safety monitoring and management and drug-susceptibility testing.

In addition, PBSP has hired and deployed 362 workers to support PMDT services, spread across all 17 regions (see Figure 10). These workers are distributed across multiple cadres (see Table 4); for the purposes of transition planning, this report has focused on the transition pathways for the following cadres (which make up 95% of the support provided): PMDT Medical Technologists, Laboratory Aides, GeneXpert Technicians, Line Probe Assay (LPA) Technicians, Satellite Treatment Center (STC) Physicians, Clinical Nurses, Float Nurses and Field Nurses. Due to low numbers, the following cadres were excluded from the analysis: Clinic Associate, Clinic Pharmacist, Molecular Biologist. Drivers were also excluded.

In anticipation of a changing HRH landscape in light of the recommendations of the JPR, focus I human resources who are involved in direct service delivery for drug resistant tuberculosis are expected to be needed in the following year. These include both clinical and laboratory professionals. If the TB burden continues to worsen, these HRH complements shall be increasingly needed.

FIGURE 10: DISTRIBUTION OF GF-SUPPORTED WORKERS FOR PMDT BY REGION



Source: PBSP HRH Inventory, September 2019

TABLE 4: DISTRIBUTION OF GF-SUPPORTED WORKERS FOR PMDT BY CADRE TYPE

Position Title	Number of Staff
Clinic Associate	1
Clinic Nurse	218
Clinic Pharmacist	1
Driver	14
Field Nurse	12
Float Nurse	53
GeneXpert Technician	14
Laboratory Aide	11
LPA Technician	1
Medical Technologist	33
Molecular Biologist	1
Senior Medical Technologist	2
STC Physician	1
Grand Total	362

Source: PBSP HRH Inventory, September 2019

PMDT Medical Technologists

Donor Supported Position Title(s):

- Medical Technologist
- Senior Medical Technologist

Functions Performed: Medical technologists are responsible for performing laboratory tests at the DOTS/PMDT sites. These include sputum tests, GeneXpert RIF testing, and rapid HIV tests for all TB patients. Related to this function, they maintain the inventory of reagents, supplies, and laboratory equipment, and they perform recording and reporting of data. Moreover, they uphold quality assurance and the biosafety standards set by the NTRL.

Job Qualifications:

- Medical Technologist: Registered Medical Technologist; Graduate of BS Medical Technology or BS Medical Laboratory Sciences or BS Public Health; Prior experience working in the field of TB
- Senior Medical Technologist: On top of the qualifications of a medical technologist, s/he should possess at least 3 to 5 years' work experience in TB diagnostics.

Government Equivalent Position:

- Medical Technologist: Medical Technologist II
- Senior Medical Technologist: Medical Technologist II

Need Analysis: Laboratory professionals are indispensable for TB care, whether for drug sensitive (TB DOTS) or for drug-resistant cases (PMDTs). Possession of a license and related trainings are mandatory requirements to ensure minimum standards. Considering the high workload of running: (a) direct sputum smear microscopy (DSSM) samples (30 minutes per slide), (b) GeneXpert testing (2 hours per run which may have 4-16 samples at a

time, depending on the machine), and (c) rapid HIV testing (30-60 minutes if patient counseling is included), dedicated TB medical technologists are commonly deployed in primary health and PMDT facilities.

Number and Location of Donor Supported Positions: The Global Fund, through its grant to PBSP, hired and deploys 35 Medical Technologists. The location of these personnel varies depending on the location of the PMDT sites. They are deployed in private facilities (1), CHOs (2), regional labs (10), and DOH hospitals (22), with concentration in the last two facility types. The two Senior Medical Technologists are stationed in a DOH hospital and a regional lab. This pattern is expected given the higher workload from these facilities for TB diagnostics. Additionally, the Senior Medical Technologists are long-term serving, PBSP-hired employees from previous Global Fund grants. (See Figure 11)

Transition Pathways: Variable transition pathways are recommended depending on the level of health system deployment.

The regional DOH could absorb the Medical Technologists at regional labs (10), while the central DOH could absorb those from the DOH-retained hospitals (22). In either pathway, the National government, through the DOH, will be the accountable financing entity. While hiring these laboratory professionals as permanent employees is desirable, hiring them on a contractual basis in the coming years facilitates easier job item creation and may help respond to the immediate surge need to achieve TB targets. Budget constraints, especially if hiring laboratory staff is a low priority, could be a challenge. Between regional laboratories and hospitals, the latter could be a more logical option because they have more available permanent staff items for medical technologists, compared to non-hospital institutions such as stand-alone labs. This could maximize available Human Resources for Health (HRH) financing in retained hospitals and reduce unfilled positions which in turn mobilizes more of the DOH PS budget allocations by the Department of Budget and Management (DBM). It must be noted though that if hospitals absorb them, there is a risk of dispersed responsibilities due to the HRH taking on other hospital functions (e.g. general lab functions), since hospitals do not only operate TB-only laboratories. Of particular interest is the finding of a recent Workload Indicator Staffing Norms (WISN) analysis, which suggests that there may be opportunities to redistribute existing Medical Technologists to high TB burden sites as a possible pathway for transition (see Box 7).

Box 7: Medical Technologist Insights from WISN Analysis

A recent analysis of the Philippines health workforce using the WHO WISN methodology covering four cadres - physicians, nurses, medical technologists, and midwives - across the health system revealed some evidence that the government is underinvesting in TB. Among the four cadres analyzed, the medical laboratory technologists' staffing represents one of the most sensitive indicators for TB workload. At the RHU level, medical technologists mainly perform Acid-Fast Bacillus (AFBs) testing and a few manual urinalysis and gram staining. Compared to the other cadres, they devote majority of their time for TB services; thus, their workload potentially provides the closest estimation at least for the burden of new TB cases. Among the 40 sites analyzed, 75% registered low to extremely low workload pressure for medical technologists⁷. Twenty or half of the total study sites had extremely low workload pressure. It is important to note though that no Global Fund supported laboratory professional were among these sites; however, in Batangas Medical Center where four such professionals are dedicated solely for TB services and are donor-supported, the general hospital workload, not only specific to TB, is high representing a deficit of 13 medical technologists from the hospital pool of 57 at the time of the analysis (cite). This suggests that the government may want to explore redistribution of Medical Technologists from sites with low workload pressure to high TB burden sites, as a potential transition pathway. Within the public sector, there are nearly 5000 deployed Medical Technologists and only 35 to be transitioned from the Global Fund support.

Source: Determining staffing levels for primary care services using Workload Indicator of Staffing Need in selected Regions of the Philippines. Manila, Philippines. USAID 2019

For the CHO-based Medical Technologists (2), the local government unit (LGU) [which is considered high-income] should be responsible for transition planning. If the PS Cap is not yet limiting, the LGU can opt to create a permanent plantilla; otherwise, a job order or casual (contractual) position, charged from the maintenance and other operating expenses (MOOE), could be an interim transition solution.

For the Medical Technologist in the private facility, the private hospital should absorb the HRH of its tasks, if the function cannot be performed by existing Medical Technologists.

Financing Estimates: Considering the mode salary given by PBSP for the following cadres, a government equivalent position and salary grade have been assigned and are shown below.

- Medical Technologist (Mode Salary: PHP 28,800.00): Medical Technologist II (Salary Grade [SG] I 5: PHP 30,531 - PHP 33,279)
- Senior Medical Technologist (Mode Salary: PHP 34,600): Medical Technologist II (SG I 5: PHP 30,531 - PHP 33,279)

Factoring in the number of HRH units supported by PBSP, the government needs the following funding per cadre, per year following the minimum and maximum pay grade based on the 4th tranche of the Salary Standardization Law (SSL), which was implemented in 2019, and estimated benefits.

- Medical Technologist II: PHP 18,903,291.00 - PHP 20,444,919.00 (USD 361,163.37 - USD 390,617.48)
- Medical Technologist II for a senior position: PHP 1,145,654.00 - PHP 1,239,086.00 (USD 21,888.69 - USD 26,673.79)

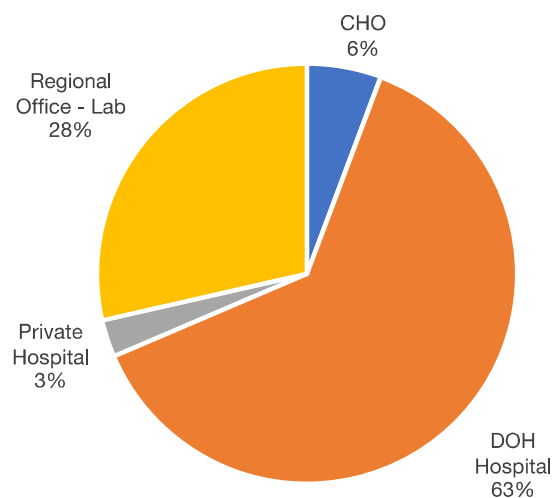
These financing estimates provide useful information on sectoral planning for HRH in terms of the response to TB, especially for DRTB. Considering that this focus area has the largest percentage of funding allotment, effective sustainability planning should include careful cost considerations. Investment in this area directly translates to service delivery, contributing to high-level target commitments of the government.

FIGURE 11: OVERVIEW OF GF-SUPPORTED PMDT MEDICAL TECHNOLOGISTS

Distribution of Personnel by Region and by Health Facility

Location	Med Tech	Sr Med Tech	Grand Total
1	1		1
DOH Hospital	1		1
2	1		1
Regional Office - Lab	1		1
3	1		1
Regional Office - Lab	1		1
5	2		2
Regional Office - Lab	2		2
6	2		2
DOH Hospital	2		2
7	1	1	2
Regional Office - Lab	1	1	2
8	1		1
DOH Hospital	1		1
9	4		4
CHO	2		2
DOH Hospital	1		1
Private Hospital	1		1
10	2		2
Regional Office - Lab	2		2
11	1		1
Regional Office - Lab	1		1
12	1		1
DOH Hospital	1		1
13	1		1
Regional Office - Lab	1		1
4A	3		3
DOH Hospital	3		3
4B	2		2
DOH Hospital	2		2
CAR	1		1
DOH Hospital	1		1
NCR	9	1	10
DOH Hospital	9	1	10
Grand Total	33	2	35

Distribution of Personnel by Health Facility



Transition Cost Estimate* by Cadre Type (in PhP)

Cadre	Low	High
Med Tech	12,090,276	13,178,484
Sr Med Tech	732,744	798,696
Grand Total	12,823,020	13,977,180

*Government equivalent salary grade; no benefits included

Source: PBSP HRH Inventory, September 2019

PMDT Laboratory Aides, GeneXpert Technician, and LPA Technicians

Donor Supported Position Title:

- GeneXpert Technician/ LPA Technician
- Laboratory Aides

Functions Performed: GeneXpert/LPA Technicians are dedicated personnel for operating the GeneXpert machines. Aside from this, they are responsible for maintaining patient records and the related reporting. Laboratory aides serve as ancillary worker to perform lower value tasks (e.g. receiving of samples, releasing of results, and cleaning of laboratory equipment) and assist the med techs in their day to day roles.

Job Qualifications:

- GeneXpert/LPA Technician: Graduate any four- or two-year college course, as long s/he can understand instructions and operate the machine and s/he has basic computer skills.
- Laboratory Aides: High school graduates with training on Biosafety 101

Government Equivalent Position:

- GeneXpert/LPA Technician: Medical Equipment Technician III
- Laboratory Aides: Medical Laboratory Technician II

Need Analysis: Because the government is underinvesting in DRTB, Global Fund has been filling this critical gap. Furthermore, as a response to the DRTB problem, newer diagnostic tests such as GeneXpert and LPA are being rolled out. Both tests are PCR-based technology that can detect drug resistance. The former can only detect Rifampicin resistance while the latter can also detect Isoniazid resistance. With new diagnostic capabilities, new functions have to be adapted. While the professional Medical Technologist are capable of doing these functions, newer cadres were created to match the increasing workload staffing needs and more sophisticated laboratory maintenance needs. For instance, running GeneXpert machines would require dedicated time for manual shaking of cartridges before it is mounted into the machine. In some LGUs, like in Batangas province, they have performed task shifting by hiring midwives who can perform this task. To date, there are no clear national professional guidelines on who can perform these newer diagnostic tests.

Number and Location of Donor Supported Positions: Currently, PBSP supports 15 GeneXpert/LPA Technicians and 11 Laboratory Aides, who are deployed in regional DOH labs (15), DOH hospitals (9), a CHO (1) and a Private hospital (1). The deployment of the LPA Technician is limited to one site, specifically in Misamis Oriental in Mindanao, where there was a prior investment of an LPA machine. The remaining ancillary lab personnel are deployed in a CHO and in a private hospital. (See Figure 12)

Transition Pathways: Recommendation for these cadres follow the same pathways as the Medical Technologists, considering that they too fall under PMDT laboratory personnel. In the short term, pursuing job order or casual (contractual) positions at DOH hospitals or regional labs, could be more feasible; however, absorption as permanent employees are ideal in the long term. Given that DOH hospitals would have more plantillas for laboratory personnel, absorption of the CTRL-based position to a nearby DOH-retained hospital, the Vicente Sotto Memorial Medical Center, in Cebu City ensures its long-term sustainability. For the GeneXpert Technicians in the private facility, the private hospital should absorb the position, if the function cannot be performed by existing technicians. If personnel budgets are constrained in the long term, task shifting of technician roles to midwives, or even high school graduates, is a potential option. With the full transition to a K to 12 system in the educational sector, Filipino high school graduates are now more job-ready and can adapt to basic lab work given the proper training.

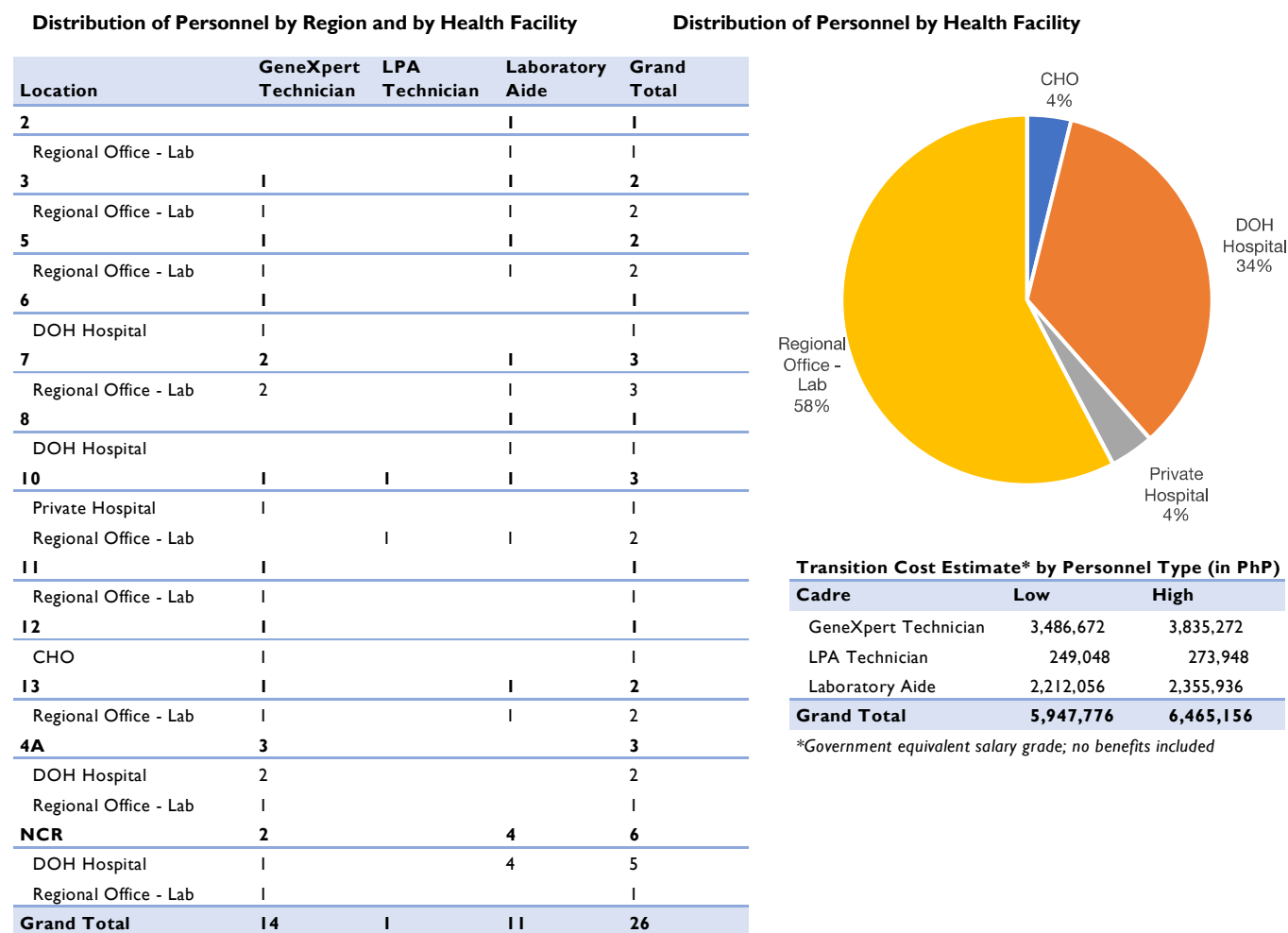
Financing Estimates: Considering the mode salary given by PBSP for the following cadres, a government equivalent position and salary grade have been assigned and are shown below.

- GeneXpert (PBSP mode salary: PHP 23,700): Medical Equipment Technician III (SG 11: PHP 20,754 - PHP 22,829)
- LPA Technician (PBSP mode salary: PHP 23,700): Medical Equipment Technician III (SG 11: PHP 20,754 - PHP 22,829)
- Laboratory Aides (PBSP mode salary: PHP 18,200): Medical Laboratory Technician II (SG 8: PHP 16,758 - PHP 17,848)

Factoring in the number of HRH units supported, the government needs the following funding per cadre per year following the minimum and maximum pay grade based on the 4th tranche of the SSL which was implemented in 2019 and estimated benefits.

- Medical Equipment Technician III (GeneXpert): PHP 5,692,652.00 - PHP 6,186,502.00 (USD 108,762.93 - USD 118,198.36)
- Medical Equipment Technician III (LPA): PHP 406,618.00 - PHP 441,893.00 (USD 7,768.78 - USD 8,442.74)
- Medical Laboratory Technician II: PHP 3,725,546.00 - PHP 3,929,376.00 (USD 71,179.71 - USD 75,074.05)

FIGURE 12: OVERVIEW OF GF-SUPPORTED PMDT LABORATORY STAFF



Source: PBSP HRH Inventory, September 2019

PMDT Clinical Personnel: The STC Physician

Donor Supported Position Title:

- Satellite Treatment Center (STC) Physician

Functions Performed: To support frontline PMDT clinical services, PBSP hires doctors to run the PMDT treatment centers (TCs) or satellite treatment centers (STCs). The PMDT Specialist is the physician in charge of running a PMDT site. This position is normally an organic staff deployed by the host institution; however, in some areas without dedicated physicians, GFATM-PBSP deploys medical officers to be the primary clinician and manager. Currently, there is only one supported STC physician who is deployed in a private facility in Sorsogon in Region 5. As an STC physician, s/he is responsible for seeing and managing patients clinically. The role also includes patient counseling and referral to other facilities as needed. Other functions include the following: Implements PMDT initiatives as directed by the NTP Manager; oversees the implementation of PMDT activities based on the Philippine Plan of Action to Control Tuberculosis (PhilPACT) and GF grant; assists in the review/development of policies and guidelines related to PMDT; and ensures that NTP-approved PMDT protocols and guidelines are implemented at the various PMDT facilities.

Job Qualifications:

- STC Physician: licensed physician, graduate of Doctor of Medicine with prior experience is preferred.

Government Equivalent Position:

- STC Physician: Medical Officer IV (SG 20)

Need Analysis: When the GFATM support for DRTB started, physicians were largely supported; however, as succeeding grant cycles were implemented, this cadre has been slowly transitioned to the facilities where they were deployed. Field visits in Batangas and Cebu LGUs revealed anecdotal evidences that some PMDT sites have employed their doctors organically. They may not be solely dedicated for PMDT because they could be also assigned to related functions, such as handling the drug-sensitive cases in TB-DOTS and pulmonology wards, to maximize their productivity.

Number and Location and Donor Supported Positions: Currently, PBSP supports 1 STC Physician located in a private hospital in Sorsogon province. (See Figure 13)

Transition Pathways: The PMDT physicians, including the STC physicians, are one of the successful cases of transition to host institutions. The fact that there is only one position left for this cadre strongly suggests that most positions supported under the Global Fund Grant were already transitioned. Currently, the lone supported personnel is stationed in a private hospital in Sorsogon City; hence, the logical transition is to the same private facility, either as a dedicated PMDT physician or as a TB-pulmonary doctor. Or the hospital can delegate the responsibilities to its existing pool of house medical officers or specialists.

FIGURE 13: OVERVIEW OF GF-SUPPORTED PMDT STC PHYSICIAN

Distribution of Personnel by Region and by Health Facility		Distribution of Personnel by Health Facility		
Location	STC Physician	Cadre	Low	High
5	1	STC Physician	613,860	687,516
Private Hospital	1			
Grand Total	1			

*Government equivalent salary grade; no benefits included

Source: PBSP HRH Inventory, September 2019

Financing Estimates: Considering the mode salary for an STC Physician of PHP 57,900, Medical Officer IV (SG 20: PHP 51,155 - PHP 57,293) is the most appropriate government equivalent position. In a year, PHP 613,860.00 to PHP 687,516.00 (USD. 11,728.31 to USD 13,135.58) is needed by the private hospital to absorb this cadre without the benefits. If the benefits are included, PHP 862,049.00 to PHP 959,029.40 shall be needed to absorb the lone STC physician in the following year.

PMDT Clinical Personnel: Nurses

Donor Supported Position Title:

- Clinic Nurse
- Float Nurse
- Field Nurse

Functions Performed: To support frontline PMDT clinical services, PBSP hired and deploys nurses to run the PMDT TCs or STCs. Currently, there are 283 nurses deployed nationally with concentration in the big three regions (3, 4A, and NCR). Considering the workload needed to manage and treat DRTB patients, nurses provide the bulk of the HR complements committed by PBSP. Clinic Nurses support clinical and administrative functions of the PMDT site. Major clinical functions include patient assessment, management, and medication administration. Key administrative functions include maintaining the patient records, mandatory reporting and registration via the ITIS, and inventory management. Float Nurses have similar functions with a clinic but s/he is not deployed permanently in a facility. S/he fills in gaps in service delivery; thus, deployment varies from time to time, usually on a per month basis. Float Nurses could either augment existing HRH to respond to surge needs or be deployed to temporarily fill in vacancies until such time that an organic employee is hired. Field Nurses, although physically stationed in PMDT facilities, are officially stationed at the DOH regional offices. They primarily track and counsel DRTB patients who are on the waitlist for enrollment and who defaulted from treatment. Among the members of the PMDT team, the nurses perform the bulk of the tasks and are considered as the most critical member of the team. Resignation or turn-over of these cadre could jeopardize the PMDT operations of a facility.

Job Qualifications:

- Clinic/Field/Float Nurse: Registered nurse, graduate of Bachelor of Nursing; professional experience in TB/infectious disease nursing is an advantage

Government Equivalent Position:

- Clinic/Field/Float Nurse: Nurse II (SG 14)

Need Analysis: Nurses are indispensable components of a PMDT site because they directly interface with the patients and deliver direct care. Considering the current DRTB service delivery network—with PMDT sites usually located in big secondary or tertiary hospitals delivering frontline care and the health centers receiving patients who are in the continuation phase—the role nurses play in PMDT is crucial. The sheer number of donor-supported nurses for DRTB is a vulnerability for the country. Without Global Fund support, majority of the PMDT sites would be paralyzed and the Philippines could succumb to an epidemic of DRTB.

Number and Location and Donor Supported Positions: The Global Fund, through its grant to PBSP, hires, trains and deploys 283 nurses across all 17 regions with the following breakdown: 218 Clinic Nurses, 53 Float Nurses, and 12 Field Nurses. The deployment varies, and they could be at any level of the health system, including special institutions such as the Bureau of Corrections and the Bureau of Jail Management and Penology. Ninety-four (94) positions fall under the National government, with 87 positions under the DOH and seven (7) under other government departments. The majority (n=180) of the nurse positions are under LGUs, and nine (9) positions are in private facilities. (See Figure 14)

Transition Pathways: Nurses deployed in higher income LGUs³⁹ (n=126), could absorb the nursing functions into facilities as contractual staff, in the short-term, and as permanent staff, in the medium-term. This will integrate well with the iDOTS strategy. For nurses deployed in lower income LGUs (n=54), the DOH may want to consider the use of the National Deployment Program (NDP) to assist LGUs to absorb these staff in the interim, until which time the LGUs can prioritize and resource plantilla positions. At the DOH level, 69 nurses are located in DOH hospitals. Given the high vacancy rates in DOH retained hospitals, an opportunity exists in the near term to swap out vacant positions for permanent nursing personnel dedicated to TB. The 17 positions located in regional health offices with one deployed at the PBSP central office may be more challenging to transition. Regional health offices with a high-TB burden, other than NCR, may want to consider absorption through contractual staff in the short-term and permanent staff in the long-term. Of particular interest is the finding of a recent WISN analysis that suggests that there may be opportunities in select sites to transition clinic, float and field nurse functions to the existing staff (see Box 8).

Box 8: Nurse Insights from WISN Analysis

A recent analysis of the Philippines health workforce using the WHO WISN methodology covering four cadres - physicians, nurses, medical technologists, and midwives - across the health system revealed some evidence that the government is underinvesting in TB in certain sites (cite). A subset analysis of outpatient nurse's workload in nine WISN facilities with matching data of Global Fund-deployed clinic nurses revealed mixed results. Five (5) sites had normal (n=3) to extremely low (n=2) workload (cite), while three (3) sites—two (2) apex hospitals and one (1) RHU—had high workload burden. Although limited in generalizability, this variable evidence suggests that the deployment of nurses in some sites does not meet the need, while others are over staffed. Further examination of these data with PBSP may be needed to determine if existing nurse deployment can accommodate some of the functions currently supported by Global Fund-supported clinic, field and float nurses.

Source: Determining staffing levels for primary care services using Workload Indicator of Staffing Need in selected Regions of the Philippines. Manila, Philippines. USAID 2019

Financing Estimates: Considering the mode salary given by PBSP for the following cadres, a government equivalent position and salary grade have been assigned and are shown below.

- Clinic/Field/Float Nurse (PBSP mode salary: PHP 28,800): Nurse II (SG 14: PHP 27,755 to PHP 30,253)

Factoring in the number of HRH units supported, the government needs the following funding per cadre per year following the minimum and maximum pay grade based on the 4th tranche of the Salary Standardization Law (SSL), which was implemented in 2019, and estimated benefits.

- Clinic Nurse: PHP 114,588,430.00 - PHP 123,846,018.00 (USD 2,189,308.94 - USD 2,366,183.00)
- Float Nurse: PHP 27,858,655.00 - PHP 30,109,353.00 (USD 532,263.18 - USD 575,264.67)
- Field Nurse: PHP 6,307,620.00 - PHP 6,817,212.00 (USD 120,512.42 - USD 130,248.61)

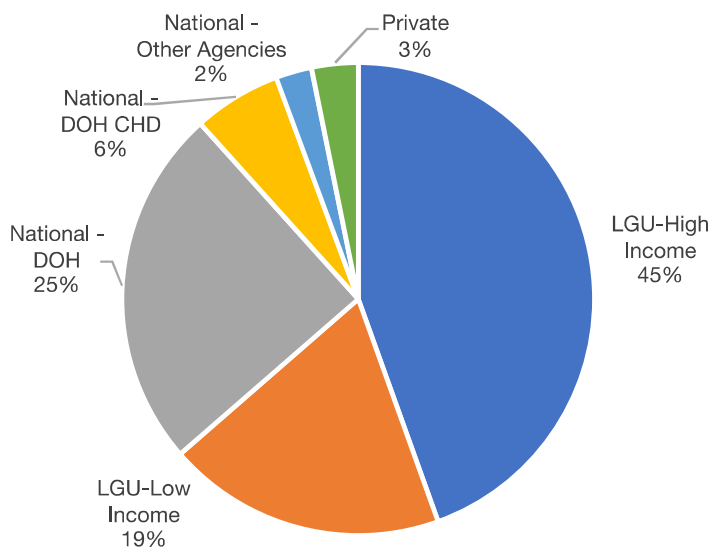
³⁹ Higher incomes LGUs include: C1-C2, M1-M2, HUC, ICC; Lower income LGUs include: C3-C6, M3-M6

FIGURE 14: OVERVIEW OF GF-SUPPORTED PMDT NURSES

Distribution of Personnel by Region and by Health Facility

Location	Grand Total
Bureau of Corrections	4
Bureau of Jail Management and Penology	2
CHO	25
City Hospital	11
Department of Defense	1
District Hospital	20
DOH Hospital	69
Health Center	38
MHO	6
PBSP	1
Private Hospital	9
Provincial Hospital	43
Regional Office	17
RHU	37
Grand Total	283

Distribution of Personnel by Health Facility



Source: PBSP HRH Inventory, September 2019

Transition Cost Estimate* by Personnel Type (in PhP)

Cadre	Low	High
Clinic Nurse	72,607,080	79,141,848
Field Nurse	17,652,180	19,240,908
Float Nurse	3,996,720	4,356,432
Grand Total	94,255,980	102,739,188

*Government equivalent salary grade; no benefits included

Focus Area 2: Finding missing TB cases

The “missing TB cases”, identified as a major program gap by PhilSTEP I, are attributed to poor health seeking behavior of patients; geographical, financial and information barriers to TB services; inadequate access to upgraded and sensitive TB diagnostic tools; and a lack of engagement of the private health care providers. About 25% of the population who seek medical attention seek it from the private sector and information on these cases are generally not captured in the DOH/NTP reporting system.

Generating timely and accurate TB information and using them for decision making are explicitly stated as a PhilSTEP I strategy. To implement the strategy, the NTP, in collaboration with the DOH Knowledge Management and Information Technology Service (KMITS), maintains the Integrated TB Information System (ITIS), a nationwide electronic case-based recording and reporting system. As mandated by the Republic Act (RA) No. 10767 or the Comprehensive Plan of Action for TB Elimination Act of 2016, public and private medical providers should notify TB cases to the government through ITIS. Before the current Global Fund grant cycle, only public healthcare providers were routinely reporting TB cases, while the private providers were not. As a response, PhilSTEP I (2017-2022) targeted that 30% of notifications should be coming from the private sector by 2022. As of 2018, ITIS reported that 33% of the 8,024 hospital-based and stand-alone private practitioners have reported at least once. This notable improvement from 1% in 2017 could be largely attributed to the efforts of the Global Fund through PBSP. Through the deployment of private sector notification workforce in the field (i.e. the TB Notification Project Associates [NPAs]) and in the hospitals (i.e. the TB Case Finders), the “missing” cases in the private sector were captured in routine reporting.

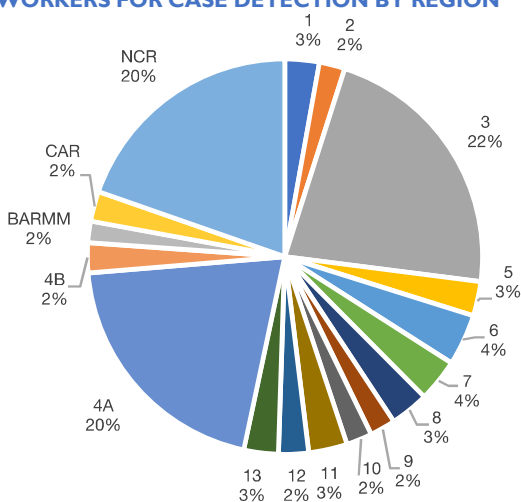
The disease impact of “missing TB cases” is that patients often receive sub-standard care potentially resulting to defaulters and/or drug-resistant cases, who are transmitting the disease in a seemingly vicious cycle. This could partly explain why the TB incidence rate has remained mostly unchanged despite the mortality reduction. To effectively halt the spread of the disease, identifying and linking these patients to effective treatment is an indispensable strategy. Additionally, beyond the individual-level consequences, non-inclusion of these patients in the NTP registry overestimates the performance and effectiveness of the TB program potentially leading to underestimated targets which is insufficient to respond to the actual disease burden.

To support the NTP’s efforts to find missing TB cases, the Global Fund TB grant supports the following activities:

- Systematic screening among high-risk groups (inmates, close contacts and urban poor);
- Engagement of community-based organizations, patients and patient organizations in case finding and case holding, and expanding private sector engagement in the NTP;
- Systematic screening in prisons aided by mobile clinics; and
- Capacity building of provincial and city health offices on private sector compliance monitoring of the mandatory case notification.

In addition, PBSP has hired and deployed 285 workers to support case detection services, spread across all 17 regions (see Figure 15). These workers are distributed across multiple cadres (see Table 5); for the purposes of transition planning, this report has focused on the transition pathways for the following cadres (which make up 94% of the support provided): TB NPAs and TB Field Leaders, Hospital TB Case Finders, ITIS Project Associates, Mobile TB Unit Professionals (Mobile Clinic Nurse Coordinators, Mobile Clinic Radiologic Technicians and Mobile Clinic Drivers), Specimen Transport Riders (STRiders) and Community Volunteers.

FIGURE 15: DISTRIBUTION OF GF-SUPPORTED WORKERS FOR CASE DETECTION BY REGION



Source: PBSP HRH Inventory, September 2019

TABLE 5: DISTRIBUTION OF GF-SUPPORTED WORKERS FOR CASE DETECTION BY CADRE

POSITION	NUMBER OF DEPLOYED HRH
Mobile Clinic Driver	3
Mobile Clinic Nurse Coordinator	4
Mobile Clinic Radiologic Technician	3
Project Associate (ITIS)	88
TB Case Finder	40
TB Field Leader	16
TB Notification Project Associate	131
Grand Total	285

Source: PBSP HRH Inventory, September 2019

TB Notification Project Associates (NPAs) and TB Field Leaders

Donor Supported Position Title(s):

- TB NPA
- TB Field Leader

Functions Performed: PBSP hired and deploys TB NPAs and TB Field Leaders to implement the Global Fund Grant’s strategic focus on finding missing TB cases. The NPAs facilitate the regular and accurate reporting of TB cases from private medical practitioners, ensuring that these cases are notified using the tools and registry developed and provided by the NTP of the DOH. They conduct field mapping and inventories of private medical practitioners and health care facilities, prepare and submit monthly and quarterly reports, and orient private healthcare providers on mandatory TB notification and platforms for reporting. While they report to supervisors who are organic to their facility of deployment, they also report to GFATM-supported TB Field Leaders who supervise a bigger catchment area with multiple NPAs. The TB Field Leaders also conduct broader activities to map and engage private medical practitioners on TB notification. NPAs are simultaneously supervised by organic staff residing in the LGU/Health Office where they are employed.

Job Qualifications: A successful NPA applicant has completed a 4-year course preferably on an allied health, business or education course. Applicants with working experience in marketing or pharmaceutical promotion are highly preferred. Experience in community mobilization, health service delivery, health education, and counseling are an advantage. The applicant is expected to be a resident of the city/municipality of assignment or in a nearby locality.

Government Equivalent Position: The NPA performs non-technical management support functions and an Information Systems Researcher is deemed an appropriate equivalent government position. It is worth noting that a Disease Reporting Advocate (DRA) of the Philippine Integrated Disease Surveillance and Response (PIDSR), implemented by the DOH’s Epidemiology Bureau for notifiable diseases other than TB, has similar functions with the NPA. The DRA can be a community leader (e.g. barangay captain, tribal leader), barangay health worker, traditional healer or private practitioner. The DRA reports notifiable diseases to the disease reporting units which

are in-charge of case detection, e.g., rural health units, LGU-owned hospitals, private clinics, etc. The PIDSR requires heads of public and private facilities to designate disease surveillance coordinators who are responsible for notification and reporting. Also, the DOH NDP has a Public Health Associate (PHA) position tasked to assist facilities in their compliance to DOH's monitoring and reporting systems. The PHA ideally is a BS Public Health graduate but due to inadequate supply, many PHAs have nursing degrees and are licensed nurses, but may have limited work experience.

Need Analysis: The NPAs were deployed to jumpstart and facilitate the implementation of the Mandatory TB Notification, specifically by private healthcare providers. Private providers were found to lack the capacity to comply with the mandatory notification. It has been shown that the records in the ITIS, DOH/NTP's electronic case-based recording and reporting system, are mostly from public facilities. All health providers and facilities that provide TB services are required to register as users of ITIS, after which the facility or provider will enter patient data and report online. Furthermore, public and private facilities at all levels, from regional and provincial/city to municipal health offices, including hospitals are required to designate a TB Notification Officer. To complement the ITIS, the NTP is developing processes, procedures and tools on notification and reporting and it has started training and orientating private providers. Preliminary recommendations from the 2019 JPR call for establishing and e-linking the whole diagnostics pathway. Once the TB notification system is in place and implemented, it is deemed that NPAs, and their TB Field Leader supervisors, will become redundant. The current NPAs enable the reporting of a project-specific coverage indicator in the grant Performance Framework: TB care and prevention (TCP)-7a: Number of notified TB cases (all forms) contributed by non-national TB program providers – private/non-governmental facilities. The target for the duration of the grant is 54,000 notified cases from the private sector.

Number and Location and Donor Supported Positions: The Global Fund, through its grant to PBSP, hires, trains and deploys 131 NPAs and 16 Field Leaders across three (3) regions (3, 4A and NCR). The positions are located in PHOs and CHOs, but primarily services the reporting needs of private healthcare providers. (See Figure 16)

Transition Pathway: With the implementation of the mandatory TB notification system, the NPA functions will transition to private facilities. Compliance with the mandatory TB notification is enabled by the recently passed UHC Law requiring that all health service providers utilize the DOH/PhilHealth-funded health information system that regularly uploads electronic health records to the National Health Data Repository through interoperable systems. With the transition, private facilities will either assign the notification functions to an existing staff or hire a new staff to perform the functions of TB notification. To ensure notification numbers continue to increase, the DOH NDP could deploy temporary PHA positions, as needed, to assist private facilities during the transition process on a temporary basis. Absorption of the TB Field Leaders is not recommended, as the supervision of the NPA function could be fully assumed by the current, organic supervisors at the LGU/Health Office who already oversee the NPAs (alongside the TB Field Leaders), and through increased engagement of province-based DOH Management Officers (DMOs) in mandatory TB notification. LGUs are expected to contribute to the implementation of the system by assigning existing staff to conduct mapping of all the health care providers and facilities that provide TB services in order to maintain a routinely updated inventory of TB health providers.

Accountable Entity for Transition: The transition should be managed by the DOH's NTP, which is accountable for: (1) implementing the roll-out of the mandatory notification system, (2) advocating for increased engagement by private providers and LGU support to mandatory reporting, (3) advocating for the enforcement of penalties for non-compliance to mandatory notification, (4) strengthening the role of the regional health office in mandatory TB notification, such as by capacitating and designating DOH Management Officers to provide technical assistance to LGUs and the private sector, and (5) advocating that the TB notification system is further strengthened in the UHC-prescribed health information system.

Financing Estimates: Most of the NPAs are paid PhP28,800 per month (mode salary). This is significantly higher than the salary range of the equivalent government position for either an Information Systems Researcher (SG10) (PhP19,233 - PhP20,387) or the or PHAs (SG11) (PhP20,754 – PhP22,829). The following estimates salary-specific

financing needs of the transition pathway described above. It assumes that 50% (66) of the current NPAs will transition their functions to a staff hired by private providers, 25% (33) will transition to s (contractual) positions hired by the Regional Office as Information Systems Researcher (SG10) and the remaining 25% (32) will transition to PHAs (SG11), under the DOH deployment program. The government financing requirement for salaries and benefits of the 65 positions that will transition to the DOH is estimated from PhP25,576,889– PhP 27,353,083

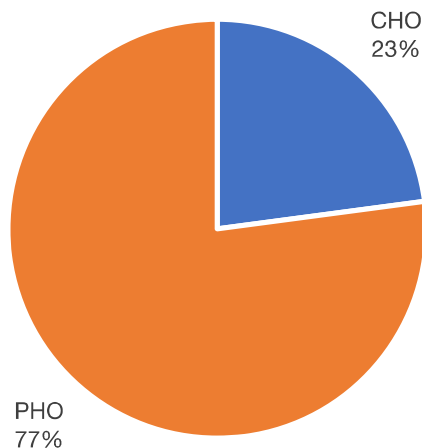
FIGURE 16: OVERVIEW OF GF-SUPPORTED TB NOTIFICATION PROJECT ASSOCIATES

Distribution of Personnel by Region and by Health Facility

Location	TB Notification Project Associate
3	52
PHO	52
4A	49
PHO	49
NCR	30
CHO	30
Grand Total	131

Source: PBSP HRH Inventory, September 2019

Distribution of Personnel by Health Facility



Transition Cost Estimate* by Personnel Type (in PhP)

Cadre	Low	High
Private Sector (66)	-	-
Information Systems Researcher (33)	7,616,268	8,073,252
PHAs (32)	7,969,536	8,766,336
Grand Total	15,585,804	16,839,588

*Government equivalent salary grade; no benefits included

(\$488,668.11 - \$522,603.80).

Hospital TB Case Finders

Donor Supported Position Title(s):

- Hospital TB Case Finder

Functions Performed:

Hospital TB Case Finders, akin to the TB NPAs, are deployed to hospitals to ensure compliance of private medical providers to the NTP's mandatory TB reporting. Specifically, they assist the TB team of private and public hospitals, which includes at least a nurse or a medical coordinator, in orienting and advocating to increase notification of cases. Also, they capacitate the coordinators to formulate policies to promote intra- and inter-hospital referral systems. They perform regular visits to hospitals with focus on all wards and other units such as laboratory, radiology and pharmacy, to make sure that all confirmed TB cases are referred via ITIS.

Job Qualifications: S/he is a licensed Registered Nurse with at least one to two years of experience in a hospital or a clinic setting; moreover, experience in health program implementation and previous work related to TB control, especially in the hospital setting, are considered advantages.

Government Equivalent Position: Nurse II (SG 14)

Need Analysis: While the TB NPAs are usually deployed at city or municipal level, Hospital TB Case Finders are also deployed in provincial health offices, and their city counterparts for city LGUs, which handle the district hospital system. Although the goal is to capacitate physicians to report for their own selves, the Hospital TB Case Finders and the NPAs usually pull out the records and perform the manual encoding for reporting. To date, very few stand-alone physicians, if there are any, are able to perform the notification themselves.

Number and Location of Donor Supported Positions: The Global Fund, through its grant to PBSP, hires, trains and deploy 40 Hospital TB Case Finders. They are deployed primarily in in city (5) and provincial (5) health offices and DOH hospitals (9), provincial hospitals (13), and private hospitals (4) as their home base to perform activities across the private to public hospital system. The remaining three (3) Hospital TB Case Finders are located in regional health offices. Interestingly, their regional distribution does not correspond to the highest burden region, dubbed as the "big three." In fact, Region 4A has only two, NCR has only one, and Region 3 has none. Regions one (1) and six (6) have the most case finders totaling five each (See Figure 17).

Transition Pathway: In an ideal set-up, hospital case finder-like HRH shall no longer be needed if related laws are being implemented properly. There is a window of opportunity for stronger implementation of the law in light of the passage of a recent "Mandatory Reporting of Notifiable Diseases and Health Events of Public Concern Act" or RA 11332 of which TB is included. This time, punitive actions such as fines ranging from USD 400 to 1000, and imprisonment from one (1) to six (6) months are to be enforced for related violations under the new law. In the long-term, the notification functions of the Hospital TB Case Finders should be transitioned to all private and public physicians and/or other allied healthcare providers. Capacity building functions shall be assumed fully by the hospital TB coordinators. Both functions are argued to be within the purview of the job description of these existing HR positions. In the short-term, PHAs, who are public health nurses deployed by the DOH through the National Deployment Program, could be used as an interim solution. More than supporting the reporting activities, PHAs should focus on capacitating the healthcare providers and TB coordinators to fully transition the functions in the future.

Accountable Entity for Transition: DOH, through its provincial arm, is the most logical accountable entity for leading the overall transition. Initially, the short-term transition could be handled by the Development Management Officers (DMOs) and the nationally-deployed PHAs. Ultimately, the hospital systems (DOH for retained hospitals, LGUs for district hospital, and private hospitals) should be accountable for long term transition.

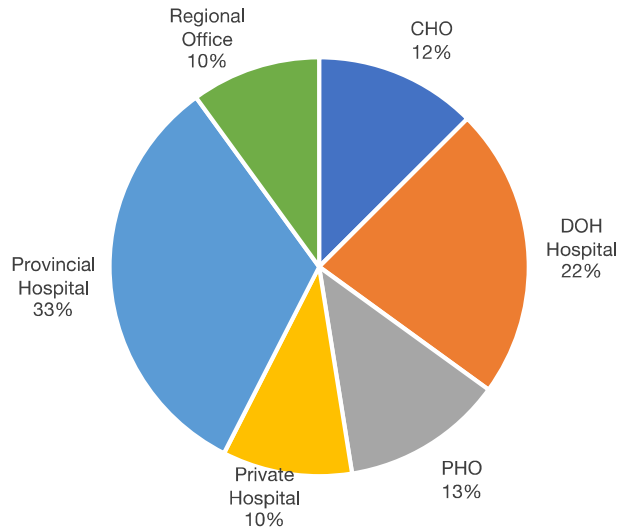
Financing Estimates: Considering the mode salary of PHP 28,800 given by PBSP to Hospital TB Case Finders, the closest government equivalent position is a Nurse II (SG 14: PHP 27,755 to PHP 30,253). Factoring in the number of HRH units supported, the government needs PHP 21,025,400.00 - PHP 22,724,040.00 (USD 401,708.06 - USD 434,162.02) every year to transition this cadre, following the minimum and maximum pay grade based on the 4th tranche of the SSL and benefits.

FIGURE 17: OVERVIEW OF GF-SUPPORTED HOSPITAL TB CASE FINDERS

Distribution of Personnel by Region and by Health Facility

Location	Hospital TB Case Finder
I	5
DOH Hospital	3
Provincial Hospital	1
Regional Office	1
2	2
PHO	2
5	3
Private Hospital	2
Provincial Hospital	1
6	5
CHO	3
Provincial Hospital	1
Regional Office	1
7	4
CHO	2
PHO	2
8	3
DOH Hospital	1
Private Hospital	1
Provincial Hospital	1
9	2
DOH Hospital	1
Provincial Hospital	1
I I	4
DOH Hospital	1
Private Hospital	1
Provincial Hospital	1
Regional Office	1
I 2	2
Provincial Hospital	2
I 3	3
Provincial Hospital	2
Regional Office	1
4A	2
PHO	1
Provincial Hospital	1
4B	2
Provincial Hospital	2
BARMM	1
DOH Hospital	1
CAR	1
DOH Hospital	1
NCR	1
DOH Hospital	1
Grand Total	40

Distribution of Personnel by Health Facility



Transition Cost Estimate* by Personnel Type (in PhP)

Cadre	Low	High
Nurse II	13,322,400	14,521,440

*Government equivalent salary grade; no benefits included

Source: PBSP HRH Inventory, September 2019

ITIS Project Associates

Donor Supported Position Title(s):

- ITIS Project Associate

Functions Performed: The Integrated Tuberculosis Information System (ITIS) Project Associate supports the use and maintenance of the ITIS in the assigned region/province. The two main functions are: (1) data entry and report generation, and (2) information technology-related support. They prepare ITIS generated reports for the NTP, in compliance with Administrative Order 2015-0024 (Implementing Guidelines on Integrated Tuberculosis Information System), and the reports for the PBSP Global Fund Quarterly Reporting. They ensure that the ITIS in their area of assignment is up-to-date and conduct troubleshooting, when needed. Lastly, they assist in the conduct of ITIS-related training.

Job Qualifications: Preferably with a bachelor's degree related to health or information technology and with encoding experience. Must have skills in coordinating, basic teaching and PC troubleshooting, and should be proficient in Microsoft Word and Excel.

Government Equivalent Position: In the provincial level, the ITIS Project Associate functions as the data encoder and report generator and is aligned to the functions of Statistician II. The Statistician II is responsible for the collection, encoding, collation, computation, and tabulation of statistical data and reports of municipalities.

Need Analysis: The establishment of ITIS addresses the need for complete, accurate, and timely records for NTP utilization. Previously, there were various information systems generating TB-related data from different levels of health service. In the aim to harmonize TB-related data and to respond efficiently to the emerging TB needs, NTP developed the ITIS for both public and private sectors. Furthermore, as stated in the AO 2015-0024, the reports that will be generated from the information system will serve as the basis for creating implementation plans and strategies for the program. In consideration of the limited plantilla positions for both health workers and IT-related positions in the province, ITIS Project Associates were deployed by PBSP to fill data entry, report generation and IT-related gaps, specifically to meet the needs of the NTP. Preliminary recommendations of the 2019 JPR calls for improvements in the ITIS to capture the whole diagnostic pathway, including the development of presumptive registers, and expanding the number of ITIS supports at both the systems development and implementation levels.

Number and Location and Donor Supported Positions: The Global Fund, through its grant to PBSP, hires, trains and deploys 88 ITIS Project Associates across all 17 regions. The positions are located primarily in provincial (59) and city (21) health offices, with the remainder in provincial hospitals (5) and regional offices (3). (See Figure 18)

Transition Pathways: Administrative Order 2015-0024 states the roles and responsibilities of different stakeholders in implementing the ITIS. Notably, the provincial and city health offices for highly urbanized cities are responsible for the provision of administrative and operational support, such as human resources. The recommended transition strategy is that the ITIS Project Associate's function to encode data and generate reports be transitioned to existing provincial/city Statistician II or personnel performing functions aligned to that of the ITIS Project Associate. Provinces and cities without existing statisticians will either need to create these positions or request that the DOH deployment program provide PHA positions to support this function. To perform the IT support function of the ITIS Project Associate, it is recommended that the regional health office deploy existing IT staff as rovers for ITIS maintenance.

Accountable Entity for Transition: The transition should be managed by the provincial health offices, in close coordination with the regional office, KMITS and NTP. This will ensure that the appropriate skill set is transferred to the LGU statistician or staff performing statistician functions. The request and funding for additional plantilla item must come from the provincial health offices, as stated at the AO 2015-0024.

Financing Estimates: It is assumed that 70% of the ITIS Project Associates (n=62) will transition their functions to an existing Statistician, and that the remaining 30% of ITIS Project Associates positions (n=26) that will not be

able to transition their functions will be supported through a DOH deployment of PHAs. The salary financing requirements for the transition is from PhP 10,572,068.00 – PhP 11,489,218.00 (USD 201, 988 - USD 219,511).

FIGURE 18: OVERVIEW OF GF-SUPPORTED PROJECT ASSOCIATES (ITIS)

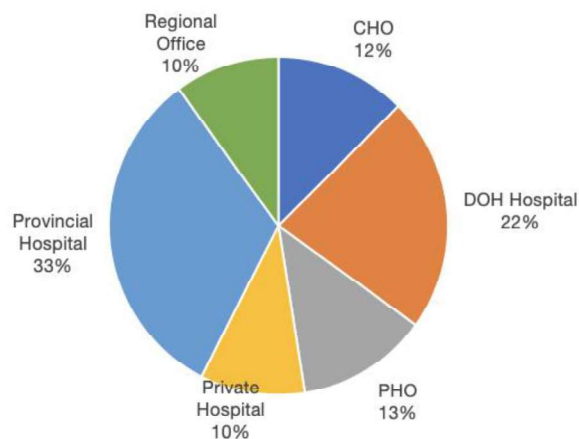
Distribution of Personnel by Region and by Health Facility

Location	Project Associates (IT IS)
1	3
PHO	2
Provincial Hospital	1
2	4
PHO	3
Regional Office	1
3	4
PHO	3
Regional Office	1
5	5
PHO	5
6	7
PHO	7
7	6
CHO	3
PHO	2
Provincial Hospital	1
8	6
CHO	1
PHO	5
9	4
CHO	1
PHO	1
Provincial Hospital	2
10	6
CHO	1
PHO	5

Location	Project Associates (IT IS)
11	5
CHO	1
PHO	4
12	5
CHO	1
PHO	4
13	5
CHO	1
PHO	4
4A	2
CHO	1
PHO	1
4B	5
PHO	4
Provincial Hospital	1
BARM	4
CHO	1
PHO	3
CAR	6
PHO	6
NCR	11
CHO	10
Regional Office	1
Grand Total	88

Source: PBSP HRH Inventory, September 2019

Distribution of personnel by facility type



Transition cost estimate by cadre type (in PHP)

Cadre	Low	High
Existing Statisticians (62)	0	0
PHAs (26)	6,475,248.00	7,122,648.00
Total	6,475,248.00	7,122,648.00

*benefits not included

Mobile TB Unit Professionals: Nurses, Radiation Technologists, and Drivers

Donor Supported Position Title:

- Mobile Clinic Nurse Coordinator
- Mobile Clinic Radiologic Technician
- Mobile Clinic Driver

Functions Performed: Aside from regular screening activities initiated by PBSP, LGUs can schedule a mobile TB unit to carry out their own intensified case finding (ICFs) to screen vulnerable populations (e.g. jails, drug rehab facilities), as opposed to active case finding (ACFs) which screens the general population. The objective is to find the missing cases among vulnerable populations such as inmates, smokers, diabetes patients, elderly, urban poor, and contacts of TB patients in the big three TB regions - the NCR, Region 3, and Region 4A.

Screening activities are carried out through the use of three (3) mobile x-ray vans equipped with artificial intelligence. Each mobile van is manned by one set of staff - a nurse, a driver, and a radiation technologist. Currently, there are 10 HRH for the mobile units. The nurse is responsible for ensuring the over-all flow of the activity. S/he is also responsible for getting the demographic profile and screening for TB symptoms among the participants before they are referred to the Radiation Technologist for x-ray screening. The driver is in charge of operating the van to reach the venue of the active case finding activity, which varies depending upon the request of the Metro Manila LGU units.

In the second year of the current Global Fund grant, additional mobile x-ray van services are being outsourced to perform ICFs in other regions in the Visayas (Regions 6, 7, and 8) and in Mindanao (Regions 9, 10, 11, and 12). Outsourcing is seen as a more cost-effective strategy to meet the targets for case detection. Instead of purchasing the mobile x-ray vans, PBSP contracts private providers which do not only provide the diagnostic infrastructure but also the manpower to perform community screenings. Also, this ensures that PBSP adequately responds to the requests and needs of the LGU without the burden of managing the mobile clinic units and ensuring its operational productivity. A notable downside would be the absence of artificial intelligence screening capabilities from these outsourced units.

Job Qualifications:

- Mobile Clinic Nurse Coordinator: Registered (Licensed) Nurse (RN), graduate of BSc Nursing degree
- Mobile Clinic Radiologic Technician: Registered Radiation Technologists (RRT), graduate of BSc Radiation Technology degree
- Mobile Clinic Driver: Possession of a professional driver's license

Government Equivalent Position:

The government does not have its own field mobile units and it relies on either the Global Fund support or from outsourced private providers.

- Mobile Clinic Nurse Coordinator: Nurse II
- Mobile Clinic Radiologic Technician: Radiologic Technologist III
- Driver: Driver Courier II

Need Analysis: Deployment of the TB mobile units is a direct response to the key strategies identified by the DOH Secretary to identify and treat 2.5 million cases by 2022. Specifically, ACF and ICF fall under mass screening to identify cases the earliest time possible and halt the spread of the disease. According to PBSP, they are able to accommodate an average of 5-10 community activities per mobile unit per month; however, recent news of looming stock outs of TB drugs discouraged implementation of ACFs to prioritize remaining drugs for DSTB cases seen at the various TB DOTS facilities. Some LGUs, like Marikina City, outsource their screening from other preferred private providers using their own funds. Preliminary recommendations from the 2019 JPR include the expansion of TB screening through mobile TB units and expansion of mobile TB unit professionals.

Number and Location of Donor Supported Positions: The three mobile units, with 10 mobile clinic personnel, are lodged under the PBSP central office to serve the needs of the big three regions. This is done to maximize the utilization of the vans by the 17 LGUs in Metro Manila and move others in the adjacent regions. (See Figure 19)

Transition Pathways: Considering the current strategy of outsourcing ACFs to private providers, this appears to be the most logical and cost-effective option for functional transition of the mobile clinic units. This frees the government of the responsibility of regular maintenance of the vans and the management burden of maximizing their productivity. For the existing vans, this could be either transitioned to the regional DOH, preferably in any of the high burden areas or they could be endorsed to a private entity through a public-private partnership (PPP) agreement. A PPP strategy would free the government from both the financial and operational responsibility of running the mobile clinics; however, the contract should specify a business model which is both sustainable for the private entity and responsive to the community screening needs of the LGU TB programs. Furthermore, ensuring quality diagnosis and services should also be considered. Striking a critical balance among these factors is an indispensable prerequisite before signing any contract. Unfortunately, as financial data on contracts with the mobile units was not made available to HRH2030, the cost to outsource this model could not be compared to the cost of using plantilla positions and government-maintained vans. As such, the estimated costs for deploying government personnel are provided below.

Accountable Entity for Transition: Considering the cross-region scope of the deployment of the PBSP vans (NCR, Region IV-A, and Region III), the DOH Central Office (national) is the most logical financing entity; however, if the vans could be delegated to the regions, the corresponding DOH Regional Office (sub-National) could be an alternative accountable entity. The additional mobile screening needs is recommended to be transitioned to the private sector through outsourced services, negotiated in bulk to leverage economies of scale, to be paid by the regional DOH.

Financing Estimates: Considering the mode salary given by PBSP for the following cadres, their government equivalent position and salary grades are shown below.

- Mobile Clinic Nurse Coordinator (PBSP mode salary: PHP 28,800): Nurse II (SG 14: PHP 27,755 to PHP 30,253)
- Mobile Clinic Radiologic Technician (PBSP mode salary: PHP 28,800): Radiologic Technologist III (SG 13: PHP 25,232 to PHP 27,503)
- Driver (PBSP mode salary: PHP 18,200): Driver Courier II (SG 6: PHP. 14,847.00 - PHP 15,664.00)

Factoring in the number of HRH units supported, the government needs the following funding per cadre per year following the minimum and maximum pay grade based on the 4th tranche of the SSL which was implemented in 2019, and estimated benefits.

- Nurse II: 2,102,540.00 - PHP 2,272,404.00 (USD 40,170.81 - USD 43,416.20)
- Radiologic Technologist III: PHP 1,448,232.00 - PHP 1,564,053.00 (USD 27,669.70 - USD 29,882.56)
- Driver Courier II: PHP 918,597.00 - PHP 960,264.00 (USD 17,550.57 - USD 18,346.66)

FIGURE 19: OVERVIEW OF GF-SUPPORTED MOBILE TB UNIT PROFESSIONALS

Distribution of Personnel by Region and by Health Facility

Location	Mobile Clinic Driver	Mobile Clinic Nurse Coordinator	Mobile Clinic Radiologic Technician	Grand Total
NCR	3	4	3	10
PBSP	3	4	3	10
Grand Total	3	4	3	10

Source: PBSP HRH Inventory, September 2019

Transition cost estimate by cadre type (in PHP)

Cadre	Low	High
Nurse II	1332240	1452144
Radiation Technologist III	908352	990108
Driver Courier II	534,492.00	563,904.00
Total	2,775,084.00	3,006,156.00

*Government salary grade; Benefits not included

Specimen Transport Riders (STRiders)

Donor Supported Position Title(s):

- STRider

Functions Performed: STRiders are engaged to transport specimen from RHUs/DOTS facilities within the catchment area of a Gene Xpert machine.

Job Qualifications: Ability to read and write, to complete training on packaging and handling infectious materials.

Government Equivalent Position: Drive Courier II

Need Analysis: The Global Fund, through the PBSP grant, engages STRiders to support the achievement of NTP targets in case detection of DSTB and DRTB cases by increasing access to Gene Xpert machines, a more sensitive testing technology than the traditional DSSM. It was observed that patients travel considerable distances and incur transportation costs to reach the Gene Xpert sites. STRiders ensure that Gene Xpert eligible cases are tested and results are released on time. They pick-up specimen from RHUs/DOTs facilities, deliver specimen to Gene Xpert sites, pick-up results from Gene Xpert sites and deliver results to RHUs/DOTS facilities. They use their personal motorbikes. The turn-around time is from 1 to 3 days. A STRider visits each RHU/DOTS up to 3 times a week depending on the distance. STRiders were fully deployed in August 2018. Preliminary recommendations from the 2019 JPR include the strengthening of TB testing and diagnosis, highlighting the need to expand the coverage and numbers of STRiders.

Number and Location of Donor Supported Positions: PBSP reports a total of 138 STRiders serving 148 Gene Xpert sites and 1,253 RHUs in 7 out of the 17 regions. Data indicating the geographic location of the STRiders is not available currently.

Transition Pathway: The expansion of the STRiders strategy is ongoing and a total of 400 STRiders are expected to be engaged by the last Quarter of 2019 through the end of the grant period in December 2020 to cover all 488 Gene Xpert machines within the NTP network including select private hospitals/physicians. This is almost a three-fold increase from the current level of 138. An ongoing assessment of the workload of STRiders is expected to inform the extension of STRiders support to community-based active case finding/screening activities to increase access to Xpert machines at community levels and thereby maintaining the STRiders cadre and expanding their numbers. An ongoing pilot activity by USAID’s TB Innovations Project investigates the use of digital

technology and standard packaging of specimen. With these developments the transition of STRiders needs further analysis and a transition pathway could not be recommended currently. Further, it is expected that the province-wide and city-wide health care provider networks under the UHC Law provide opportunities for the transition of STRiders.

Accountable Entity for Transition: The NTP in collaboration with the HHRDB will oversee the transition and sustainability planning of the STRiders.

Financing Estimates: A STRider is currently given a monthly compensation of PhP13,800 (P8,800 as a fee and P5,000 for gasoline and maintenance) and annual life and accident insurance of approximately PhP 600. The equivalent financing requirements for the 400 STRiders at the end-of-grant will be PhP 66.40 million (\$1.27 million).

Community Volunteers

Donor Supported Position Title(s):

- Community Volunteer

Functions Performed: Community volunteers are engaged to mobilize communities and lead active TB case finding, conduct TB education and provide support in sputum collection and transport.

Job Qualifications: Ability to read and write. Resident of the community of assignment.

Government Equivalent Position: Barangay health workers

Need Analysis: The Global Fund, through the PBSP grant, engages community volunteers as augmentation to barangay health workers (BHWs), who are traditionally engaged by local governments. The PBSP engages the community volunteers as augmentation to BHWs in high-TB burden regions and assigned in municipalities and barangays as recommended by the DOH regional offices TB teams, based on TB burden and the potential for finding missing persons with TB. They are engaged to mobilize communities and lead active TB case finding, conduct TB education and provide support in sputum collection and transport. Preliminary recommendations by the 2019 JPR point to increasing need for community volunteers to support expanded TB screening, scale-up of contact-tracing and preventive services as an extension of active TB case finding efforts, tracing loss-to-follow-up DRTB patients, monitoring adherence in DRTB treatment and the implementation of the X-ray voucher program.

Number and Location of Donor Supported Positions: The number and location of community volunteers are not available. The PBSP HRH Inventory, the source of data for the sustainability roadmap, does not include community volunteers and this may be explained by the fact that community volunteers are not paid salaries and thus do not get into the PBSP payroll system which is the primary data source of the PBSP HRH Inventory. Other data sources on the numbers and location of the community volunteers will be explored.

Transition Pathway: The most straightforward pathway would be to transition project-engaged community volunteer into LGU-engaged BHWs. This will benefit the TB program by maintaining human resources who have acquired capacities in active TB case finding in the community. The risk is reluctance and low uptake by community volunteers of BHW positions because BHWs are generally paid lower levels of allowances than what the community volunteers receive.

Accountable Entity for Transition: The LGUs will need to manage the transitioning of the community volunteers into BHW positions.

Financing Estimates: The project-hired community volunteers receive monthly compensation of PhP2,500 and the monthly compensation is based on performance, i.e. achieving the target number of TB cases. This monthly compensation is higher than the PhP1,500 monthly allowance that is commonly reported paid by LGUs to BHWs, although high-income LGUs pay as much as PhP8,000 per month to BHWs. Since the numbers of Community Volunteers were not available financing requirements cannot be estimated at this time.

Focus Area 3: Expanding TB-HIV Collaboration

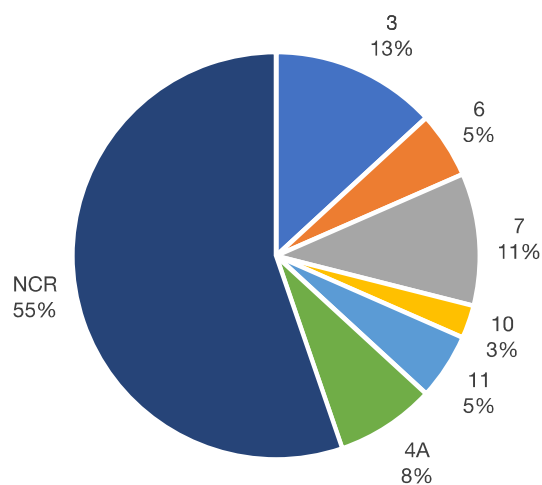
Under the current leadership of the DOH Disease Prevention and Control Bureau (DPCB), a push towards integrated delivery has been challenging the traditional vertical delivery of TB care. Specifically, TB services are to be delivered with HIV screening, diagnosis, and care. Bundled TB and HIV services shall be designed as one pathway in a bigger algorithm that would also include other basic services offered in a health unit, such as family planning, maternal and child health, immunization, and nutrition interventions. Aside from delivering more efficient care in a resource-constrained setting, such as the Philippines, this strategy is expected to ensure wider population coverage by capturing the co-infection epidemiology. Furthermore, the roll out of the new Universal Health Care (UHC) law reinforces this move from vertical to integrated care.

To support the DOH's efforts to integrate TB and HIV care, the Global Fund TB grant supports the following activities:

- Improving TB-HIV collaboration in four high burden TB and HIV regions (improving TB-HIV collaboration will be concentrated in the National Capital Region, Region 3 and Region 4A);
- Providing HIV testing among notified TB cases; and
- Providing TB screening for all people living with HIV (PLHIV).

In addition, PBSP has hired and deployed 38 workers to strengthen TB and HIV collaboration, with investments concentrated in seven (7) regions and with 76% of the workforce being invested in the National Capital Region, Region 3 and Region 4A (see Figure 20). These workers are distributed across two cadres (see Table 6); for the purposes of transition planning, this report has focused on the transition pathways for both cadres: TB/HIV Medical Technologists and TB/HIV Clinical Nurses.

FIGURE 20: DISTRIBUTION OF GF-SUPPORTED WORKERS FOR TB/HIV COLLABORATION BY REGION



Source: PBSP HRH Inventory, September 2019

TABLE 6: DISTRIBUTION OF GF-SUPPORTED WORKERS FOR TB/HIV COLLABORATION BY CADRE

Position Title	Number of Staff
TB/HIV Clinic Nurse	9
TB/HIV Medical Technologist	29
Grand Total	38

Source: PBSP HRH Inventory, September 2019

TB/HIV Medical Technologists

Donor Supported Position Title(s):

- TB/HIV Medical Technologist

Functions Performed: The TB/HIV Medical Technologist performs rapid HIV testing at the DOTS facilities in the assigned area or location. The TB/HIV Medical Technologist also performs the following: refers reactive cases to the national reference laboratories, maintains records of HIV tested TB cases, prepares and submits accurate and timely reports, participates in training and supervision, and conducts monitoring and evaluation activities of the treatment hubs.

Job Qualifications: Degree in Medical Technology and licensed as Medical Technologist, with previous experience working in the field of TB or HIV and the successful completion of the HIV Proficiency training.

Government Equivalent Position: Medical Technologist

Need Analysis: The TB/HIV Medical Technologist performs cross-cutting functions for DOTS/TB/HIV. They are either based in a DOTS facility to expand DOTS services or in a DOH Regional Office to function as a rover by conducting rapid HIV testing in facilities without a trained Medical Technologist or with a Medical Technologist on leave. Their functions directly support the following coverage indicators in the Global Fund Grant Performance Framework: TB/HIV-5: Percentage of registered new and relapse TB patients with documented HIV status and TCP-8: Percentage of new and relapse TB patients tested using WHO recommended rapid tests at the time of diagnosis. The TB/HIV Medical Technologists were engaged to fill gaps in human resources at the start of the Global Fund grant and, PBSP already has successfully planned for and gradually reduced the number of Medical Technologists supported. Preliminary recommendations of the 2019 JPR include the strengthening of the implementation of the provider-initiated counseling and testing (PICT) to all TB patients.

Number and Location and Donor Supported Positions: The Global Fund, through its grant to PBSP, hires, trains and deploys 29 TB/HIV Medical Technologists across 5 regions, with 86% located in the top three TB regions (3, 4A, NCR). The positions primarily are in regional offices (19, with four of these located in a regional lab), with the remainder in provincial (4) and city (4) health offices, a DOH hospital (1) and a provincial hospital (1). (See Figure 21)

Transition Pathway: The recommended transition pathway for TB/HIV Medical Technologists in LGU facilities is to transition their functions to existing staff. LGUs that can justify a need for augmentation may request for a Medical Technologist from the DOH deployment program. There are two options for transitioning TB/HIV Medical Technologists in the DOH Regional Offices—create a new position in the Regional Office or in the Regional Hospital. Transitioning into the Regional Office strengthens the technical and management capacities for TB/HIV integration at the regional level, supports TB/HIV integration in LGU health facilities, and maintains the rover functions of the Medical Technologists filling gaps at the LGU facilities. The risk with transitioning into the Regional Office is the difficulty in securing new plantilla positions. Additional plantilla positions will require up to 2 years forward planning within the national budget process. Hiring a contractual or casual Medical Technologist can be an interim transition arrangement. By transitioning the Regional Office-based TB/HIV Medical Technologist to the DOH-retained Regional Hospital, the DOH could use available positions that remain unfilled in hospitals. This option will strengthen the Regional Hospital's capacity in TB/HIV integration as an end-referral facility serving an apex hospital role in UHC's health care provider network. The potential risks to this transition strategy are that a Global Fund-supported Medical Technologist, with focused TB/HIV skills, may not be competitive in the selection process for hospital positions if the qualifications require skills in general laboratory; also, being located at the Regional Hospital increases the risk of dispersed responsibilities, with the Medical Technologist performing general laboratory functions.

Accountable Entity for Transition: The DOH-DPCB has management oversight of TB/HIV integration in the DOH and will oversee the transition of the TB/HIV Medical Technologists. The DPCB will lead negotiations and

facilitate discussions among regional Directors and Chiefs of DOH retained hospitals to implement the transition plan.

Financing Estimates: Assuming that the low-income LGUs⁴⁰ with Global Fund-hired TB/HIV Medical Technologists (n=3) are granted Medical Technologists positions by the DOH deployment program, that the high-income LGUs will create positions to hire Medical Technologists positions (n=7), and that all 19 regionally-based TB/HIV Medical Technologist will transition to a DOH Regional Health Office or a DOH Hospital, the estimated annual salary and benefits requirement of Medical Technologist (SG 15) for both DOH and LGUs will be in the range of PhP 16,437,983.00 - PhP 17,792,747.00 (USD 314,061.58 – USD 339,945.49).

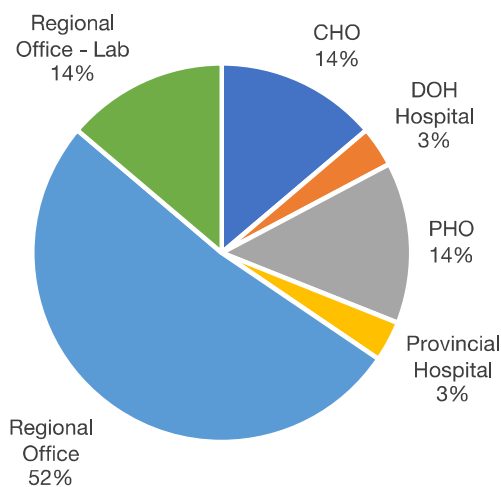
FIGURE 21: OVERVIEW OF GF-SUPPORTED TB/HIV MEDICAL TECHNOLOGISTS

Distribution of Personnel by Region and by Income Class of the LGU of Deployment

Location	Medical Technologists
3	5
CI	3
Cabanatuan - LGU	1
San Fernando City - LGU	1
Tarlac City - LGU	1
C3	1
Malolos - LGU	1
C4	1
Balanga - LGU	1
6	1
CI	1
Bacolod City - LGU	1
7	3
CI	1
Mandaue City - LGU	1
HUC	2
Cebu City - LGU	2
4A	5
CI	1
Batangas City - DOH	1
C4	1
Cavite City - Regional	1
HUC	2
Quezon City - Regional	2
MI	1
Binangonan - LGU	1
NCR	15
HUC	15
Mandaluyong City - Regional	15
Grand Total	29

Source: PBSP HRH Inventory, September 2019

Distribution of Personnel by Health Facility



Transition Cost Estimate* by Health System Level (in PhP)

Cadre	Low	High
Regional-Based Positions (19)	6,961,068	7,587,612
High Income LGU Positions (7)	2,564,604	2,795,436
DOH Deployment Program (3)	1,099,116	1,198,044
Grand Total	10,624,788	11,581,092

*Government equivalent salary grade; no benefits included

⁴⁰ Low income LGUs defined as C3-C6 and M3-M6. High income LGUs defined as C1-C2, MI-M2, HUC and ICC.

TB/HIV Clinic Nurses

Donor Supported Position Title(s):

- TB/HIV Clinical Nurse

Functions Performed: The TB/HIV Clinic Nurse assists in the implementation and daily clinical operations of the treatment hub providing HIV counseling before and after HIV testing and ensuring proper referral of HIV patients for TB screening and management. The TB/HIV Clinic Nurse is responsible for the facility's compliance to the recording and reporting requirements of TB-HIV and the timely submission of the reports while ensuring confidentiality of records of HIV/AIDS patients. She/he coordinates with the hospital pharmacy on the supply levels of anti-retroviral drugs and participates in training, supervision, monitoring and evaluation activities of the treatment hubs.

Job Qualifications: The TB/HIV Clinic Nurse has a degree in nursing and is a licensed Registered Nurse. She/has previous experience working in the field of TB or HIV and completed the training on HIV counseling and testing.

Government Equivalent Position: Nurse

Need Analysis: The TB/HIV Clinic Nurse performs cross-cutting functions for DOTS/TB/HIV in HIV/AIDS treatment hubs located in DOH-retained hospitals to expand services. At the start of the Global Fund grant, the TB/HIV Clinic Nurse was engaged to fill gaps in human resources and the project has successfully implemented gradual and planned reductions in their numbers. Their functions directly support the coverage indicator in the Global Fund Grant Performance Framework: TB/HIV-3.1: Percentage of people living with HIV in care (including Prevention of mother-to-child transmission [PMTCT]) who are screened for TB in HIV care or treatment settings.

Number and Location and Donor Supported Positions: The Global Fund, through its grant to PBSP, hires, trains and deploys 9 TB/HIV Clinic Nurses across 5 regions. The positions primarily are in DOH hospitals. (See Figure 22)

Transition Pathway: The recommended transition pathway is to transition the nine (9) remaining TB/HIV Clinical Nurses to permanent Nurse positions in the DOH-retained hospitals where they are based. Additional plantilla positions will require forward planning within the national budget process, which can take upwards of two years. Alternatively, the DOH hospitals can make use of unfilled positions. The transition will strengthen the DOH hospital's capacity in TB/HIV integration as a referral facility and technical resource supportive to LGU health facilities. The potential risks in this transition strategy are that project-hired nurses with focused TB/HIV skills may not be competitive in the selection process for hospital positions if the qualification requirement of general nursing skills remains; also, the risk of dispersed responsibilities with the TB/HIV nurse performing other functions such as ward duties.

Accountable Entity for Transition: The DOH-DPCB has management oversight of TB/HIV integration and will oversee the implementation of the transition. The DPCB will collaborate with managers of DOH retained hospitals.

Financing Estimates: Annual salaries and benefits requirement for transitioning the 9 hospital-based TB/HIV Clinic Nurse at SG 14 is in the range of PhP 4,676,715.00 - PhP 5,058,909.00 (USD 89,353 - USD 96,655).

FIGURE 22: OVERVIEW OF GF-SUPPORTED TB/HIV CLINIC NURSES

Distribution of Personnel by Region and by Health Facility

Location	TB/HIV Clinic Nurse
6	1
DOH Hospital	1
7	1
DOH Hospital	1
10	1
DOH Hospital	1
11	2
DOH Hospital	2
NCR	4
DOH Hospital	4
Grand Total	9

Source: PBSP HRH Inventory, September 2019

Transition Cost Estimate* by Health System Level (in PhP)

Cadre	Low	High
Nurse II	2,997,540	3,267,324

*Government equivalent salary grade; no benefits included

Supporting broader policy, regulatory and administrative efforts

In addition to the three focus areas, the Global Fund TB grant also provides support to enable broader policy, regulatory and administrative support to the NTP at the national and subnational levels. Approximately 12% of PBSP’s work force investment or the equivalent of 92 positions are devoted to supporting national TB efforts in the Philippines (Table 7).

Under the current Global Fund TB grant, PBSP is supporting 28 people at the DOH Central Office, of which 18 are located in the NTP and ten (10) are in KMITS. The NTP is situated in the DOH-DPCB under the Infectious Disease Office (IDO). Only 1 out of 78 plantilla positions under the DPCB is dedicated to the NTP—the Program Manager. Except for a USAID-supported technical officer and another JICA-supported personnel, the remaining NTP staff are supported by PBSP (see Annex 6 for the NTP organogram). This represents a significant vulnerability for the NTP and DOH, as the government is heavily reliant on donor funding support to provide policy and technical expertise to execute a TB-free Philippines, as envisioned by the 2017-2022 PhilSTEP.

Beyond the DOH, PBSP provides administrative, management and technical support staff to regional health offices (41), the NTRL (11), the National Center for Pulmonary Research (NCPN) (7) and DOH Hospitals (5). Investments at the regional office primarily augment the function of the core TB committee which serves as the regional extension of the DOH and provides technical expertise to the LGUs. Notable are the 16 TB/HIV technical officers hired to support the nationwide roll out of the collaborative TB-HIV services. Two centers which have national mandates for related laboratory and research standards and services, the NTRL and NCPN respectively, are also supported. The bulk of the investments for the NTRL are program officers (10), as the NTRL already has transitioned a large number of Global Fund- and JICA-supported personnel, especially the frontline lab workers, to government. In fact, the transition of the NTRL personnel is seen as a best practice (see Box 9). HRH support at the NCPN are focused on training specialists (4) to advanced TB diagnostics and care. Lastly, for the DOH Hospitals, while the majority of the Global Fund investments are to support frontline healthcare workers for these apex hospitals, there are some administrative investments including monitoring and evaluation specialists (2),

project associates (2), and a research specialist (1) who support TB program implementation. All these positions are deployed at the Lung Center of the Philippines, where the NCPR is also located.

Unlike in the previous three focus areas, USAID's HRH2030 did not drill down into the detailed transition pathways for the 93 positions residing primarily within the National government and for the purpose of policy making and administrative support. In part, this decision was due to the complexity and time needed to review individual job descriptions, rather than cadre-wide job descriptions. Further, there are a number of ongoing activities and analyses – with results that were not yet available at the writing of this report – that will have a significant impact on the HRH transition pathway considerations for these cadre. These include the ongoing work on the HRH Master Plan, as well as, a WISN analysis of the NTP and an Organizational Development activity with the NTP – both being supported by USAID's HRH2030 Program—which will provide insights into the alignment of the NTP mandate and its current strategic direction, structural and functional assessment, and workforce assessment in terms of staffing needs and workload pressure. In the end, the technical assistance aims to propose and co-design an improved NTP organizational structure that could meet the growing demands to end TB in the Philippines.

Box 9: Example of Global Fund HRH Transition in NTRL and RITM

Some agencies have shown successes in transitioning donor-funded employees to organic plantillas. Recognizing that donors exit is inevitable, this was exemplified by the NTRL at the Research Institute for Tropical Medicine. Starting as JICA-funded before Global Fund came in, half of the donor-supported staff had already been absorbed, while the remaining supported staff were distributed among various divisions doing work at the frontline level. Donor dependency is further decreased by ensuring that these staff are well distributed among their departments that no single unit is dependent on foreign support. NTRL has achieved this by employing the following best practice strategies: by actively lobbying for new plantilla positions annually with objective justifications related to their mandate, by staff engagement and participative decision-making, and by having clear role delineations and performance accountability. These resulted to good employee outcomes such as better retention, resilience, skills, and general well-being translating to organizational outcomes of higher quality, safety, and efficiency. Cognizant of their growing mandate as a national reference laboratory, the NTRL management prioritized annual lobbying for additional HRH citing the workload needs to achieve their vision and mission. However, it must be noted that when regular positions were created, these were not only opened to PBSP employees. The positions were publicized to the general public following Civil Service Commission's policies but given the experience and prior trainings of the PBSP staff, they had better chances of a successful application.

TABLE 7: OVERVIEW OF GF-SUPPORTED POLICY AND ADMINISTRATIVE WORKERS

Distribution of GFATM-supported personnel under the National Government Unit

Cadre	DOH Central Office	DOH Hospital	National Center for Pulmonary Research	NTRL PMO	Regional Office	Grand Total
Administrative	3	2	2	1	17	25
Admin Assistant	2					2
Admin Specialist			1			1
Compliance Officer			1			1
Project Associate		2			17	19
Warehouseman	1			1		2
Health Offices (HO)	15	3	5	10	21	54
Account Officer	5					5
DOTS Specialist	1					1
DSM Officer	3					3
Monitoring and Evaluation Specialist		2				2
Notification Project Associate	2					2
PMDT Specialist	1					1
PMDT Technical Staff					4	4
PMDT Training Specialist			1			1
Program Officer				10		10
Project Coordinator	3					3
Regional Project Officer					1	1
Research Specialist		1	1			2
TB/HIV Technical Staff					1	1
Technical Staff					15	15
Training Specialist			3			3
IT IS	10				3	13
Computer Programmer	2					2
Database and Network Administrator	1					1
Program Officer	4					4
Project Associate (ITIS)					3	3
Project Officer (Data Administration)	1					1
Senior Programmer	1					1
Senior Systems Analyst	1					1
Grand Total	28	5	7	11	41	92

Source: PBSP HRH Inventory, September 2019

Recommended Next Steps

The Sustainability Roadmap is intended to assist the government: (1) to identify the critical cadres that currently receive Global Fund-support and that may need to be considered in a multi-year, detailed transition plan, and (2) to consider the implications of emerging health financing, health service delivery, and HRH reforms on the transition pathways for these critical cadres. In continued preparation for the development of the next Global Fund TB grant proposal and subsequent annual grant work plans, USAID's HRH2030 Program has outlined key recommended next steps that will build on the analyses outlined in this report and shape the ongoing analysis of the data compiled in the HRH Inventory tool. Recommendations outlined below are envisioned for stakeholders in the DOH to utilize policy development and planning processes and the cross-cutting strategic information system initiatives to promote cohesive transition planning and implementation across the national and sub-national levels. For each recommendation, a page number is given to direct the reader to source information from the Sustainability Roadmap.

I. **Make a compelling, evidence-based case for investing in HRH to support TB programming:**

USAID's HRH2030 recommends that the NTP, in close collaboration with the HPDPB and HHRDB, articulate a compelling, evidence-based case for why country-wide investments in HRH to support TB services are needed and outline where these investments will be most impactful for accelerating progress toward the TB goals articulated by the government. This will provide the overarching justification and roadmap for how to prioritize the transition of Global Fund-supported workers within broader HRH staffing and health financing reforms. ["Appreciating the TB burden in the Philippines", page 15]

- a. **Take full ownership of the HRH Inventory:** While this tool could be shared with the DOH HHRDB and KMITS as related units, the findings of the recently concluded 2019 Joint Program Review (JPR) strongly suggested that the NTP should be the primary stewards of this inventory and the related mortgage tool. Recognizing the central role of HRH in achieving the country's TB targets, the JPR recommended to "embrace the work under HRH2030 project." As such, the NTP should assign a specific point person who would be in charge of safe-keeping the tool with the password access to unlock all data, and of generating results or new analysis as needed. ["Conducted an inventory of HRH investments", page 11]
- b. **Leverage the DOH commitment to staffing rationalization:** Using the investment case as evidence, the NTP should engage in the development of the National Health Human Resource Master Plan that, pursuant to PhilSTEP I objectives, will ensure adequate and competent HRH for TB services. The National Health Human Resource Master Plan will serve as the basis for HRH planning guidance to the LGUs and will be a critical opportunity to prioritize investments in TB in the HRH component of the LIPH. ["Greater emphasis on HRH strategic planning and development", page 28]
- c. **Leverage the 2019 JPR, review and formalize the TB staffing:** Appropriate HRH, with the right skill mix at the right place of deployment, is foremost in implementing the JPR recommendations. Specifically, recommendations on screening with emphasis on high risk groups, molecular based testing, and DRTB care follow on the investments of the current ACCESS TB program. This potentially entails continued hiring of laboratory professionals, STRiders, and PMDT clinical professionals. Meanwhile, the focus on opportunistic screening in all healthcare facilities and on preventive TB treatment could possibly bring in new investments such as community and healthcare facility-based screeners. A staffing needs plan will be developed, costed, vetted and approved at the appropriate level of authority in the DOH. Regular assessment of the implementation of the staffing needs plan ensures that defined HRH functions, roles and responsibilities are protected and maintained ["Anticipating Changing HRH Needs", page 22]
- d. **More clearly articulate TB mandates to prioritize HRH investments:** To strengthen the investment case, the NTP should highlight its mandates, such as the Comprehensive Plan of Action

for TB Elimination Act of 2016 to ensure that requests for plantilla positions are prioritized by the DOH and the DBM. The NTP can learn from the experience of the Oral Health Program, as an example of a program that has successfully mobilized human resources. [“National government health workforce budget requests”, page 31]

2. **Support LGU efforts to advocate for HRH investments to strengthen TB programming:** USAID’s HRH2030 recommends that the NTP advocates and works closely with key DOH units that directly support local government partners, such as the BLHSD and the ROs, to take greater advantage of existing opportunities at the LGU level to prioritize investments in HRH to address TB, especially in the context of the forthcoming increases in the LGU IRAs. This support especially is warranted in high income LGUs (C1-C2, M1-M2, HUCs and ICCs), where 75% of the Global Fund-supported workforce is deployed and where ample opportunities for financial absorption of the workforce by LGUs exist. [“Local government prioritization of health and TB services”, page 26]
 - a. **Build on the HRH Inventory and the ‘mortgage tool’ to generate LGU-specific transition pathways including financing estimates:** The NTP will mobilize internal and external partners including technical assistance providers to advance the transition pathways analysis of PBSP cadres at the province and city levels. The HRH Inventory will be routinely updated to record new cadres and update numbers including non-salaried cadres such as STRiders and Community Volunteers. Further, the analysis will now consider the appropriateness of HRH investments relative to current policy and programming perspectives including programming changes as a result of the 2019 Joint Program Review. LGUs in the high TB burden regions – Region 3, 4A and NCR will be prioritized. [“Developed the ‘mortgage tool’ of the HRH Inventory”, page 13]
 - b. **Mobilize and support TB champions in LGUs:** The BLHSD, in collaboration with the NTP and ROs, should mobilize and support local TB champions to build a strong investment case for the prioritization of TB services and staffing support in the local planning and budgeting process. The investment case should draw from the national-level investment case, but also include fiscal space and cost effectiveness analyses at the LGU level to consider the benefits and costs to address TB burden within the local fiscal environment. [“Local government prioritization of health and TB services”, page 26]
 - c. **Support LGUs to address the PS Cap:** The BLHSD, in collaboration with the NTP and ROs, should support high TB burden LGUs to analyze claims for health workers’ plantilla positions against the PS cap informed by an LGU fiscal space analysis. These analyses can be used to advocate with the DBM and the DILG on reforms to the LGU budgeting guidance and PS cap for health that takes into account HRH needs and sustainability of donor-assisted projects in high TB-burden LGUs. [“Local government financing of health personnel”, page 26]
 - d. **Incentivize LGU TB investments through LIPH grants and NDP:** To support underserved and unserved areas, the BLHSD, in collaboration with the NTP and ROs, should develop and implement strategies to better leverage DOH LIPH grants and the NDP to incentivize LGU’s investments in TB services and staffing support. [“Leveraging LIPH grants to encourage LGU investments in TB”, page 28] [“Prioritizing the NDP to support the TB workforce”, page 29]
3. **Review the critical cadres/functions needed to support TB programming moving forward:** While this report considered transition planning based on the current investments in the TB health workforce, USAID’s HRH2030 recommends that the NTP and HHRDB continue to assess the critical cadres and functions that will be needed to support TB programming into the future, both at the service delivery level and centrally. The analyses should demonstrate how the NTP is driving greater efficiencies in the deployment of human resources for TB at all levels of the health system, even while requesting greater supports for TB programming. [“Methodology”, page 10]

- a. **Assess the evolving staffing needs to support TB service delivery:** The NTP should assess the impact of new and emerging TB policies, strategies and protocols—to include the rollout of iDOTS in RHUs, strategies to incentivize private sector case reporting, and the introduction of TB-related technologies and modified treatment regimens—on the health workforce needs of the future. This might include an inventory of new skills required, and a task-based mapping and analysis of these requirements against the current staffing norms supported by the government and the Global Fund. [“Anticipating changing HRH needs,” page 22]
 - b. **Strengthen the organizational structure of NTP:** The HHRDB should determine priority staffing needs and improved organizational structure of the NTP Management Office by drawing upon the forthcoming A-WISN analysis of the NTP and the NTP Organizational Development activity—both supported by USAID’s HRH2030 Program when prioritizing requests for additional personnel. This will ensure that the NTP is staffed effectively to address the country’s significant TB burden and justify why the government must address its heavy reliance on Global Fund support to staff a program responsible for addressing the third highest disease burden in the country. While the report is due to be released by the end of the year, preliminary findings suggest that the current NTP structure is inadequate to meet its bold targets. To help achieve them, the NTP is suggested to move to a project management organizational structure and to delegate cross-cutting functions such as planning, costing, budgeting, and procurement to dedicated units at the DOH. [“Supporting broader policy, regulatory and administrative efforts,” page 60-61]
 - c. **Assess the strategic engagement of DOH Development Management Officers:** The HHRDB should engage the Regional Health Offices and LGUs in an assessment of the functions of the province/district-based DOH DMOs to determine roles supportive to TB, including helping to manage Global Fund transition at the decentralized level, and issue supporting guidance. [“TB Notification Project Associate and TB Field Leader”, page 45]
 - d. **Mobilize unfilled positions in DOH-retained hospitals:** The NTP should review successful practices utilized by other national programs to redirect unfilled, permanent positions in DOH-retained hospitals to support the TB program, including Global Fund-supported health workers, with plantilla positions. [“National government health workforce staff transfers”, page 31]
4. **Pursue involvement in the development of UHC implementation policies:** USAID’s HRH2030 recommends that the NTP actively engages the HPDPB, PhilHealth and other external partners on UHC Law implementation in order to mobilize resources to deliver both population- and individual-based TB services. The UHC Law presents an important opportunity to harness the strategic purchasing powers of LGUs, PhilHealth and the DOH through the health care provider networks and the SHF to fundamentally alter the delivery and financing of health services in the Philippines, with implications for the transition of Global Fund-supported HRH. Engagement will be critical for ensuring that service delivery approaches for PMDT, finding missing cases and TB/HIV collaboration are fully accounted for and funded under UHC implementation. [“Implications of the UHC Law on local funding for TB”, page 27]
- a. **Advocate for TB service coverage in the PhilHealth benefits packages:** As the DOH and PhilHealth have yet to identify which specific TB services would be individual-based services covered under PhilHealth, the NTP should advocate for the inclusion of TB interventions in both the guaranteed essential benefit package and the comprehensive outpatient benefit package of PhilHealth to mobilize financial and human resources for TB. [“Further expansion of NHIP to increase coverage in poor and disadvantaged populations”, page 27]
 - b. **Ensure TB service are reimbursed at appropriate levels:** The NTP also should ensure that the TB services included in individual-based services, have appropriate reimbursement rates and that the financial benefits to facilities and healthcare providers are realized fully in order to incentivize

province-wide and city-wide health provider networks to drive utilizations of these services. [“Further expansion of NHIP to increase coverage in poor and disadvantaged populations”, page 27.]

- c. **Safeguard the inclusion of TB in the SHF allocation formula:** The NTP, in collaboration with the HPDPB, should institutionalize a system for the review and implementation of the PhilSTEP I financial plan to ensure that LGU grants and the allocation formula in the SHF of the UHC Law fully address TB burden. This will ensure LGUs accountability to support mandated TB health services and health workers, using the envisioned efficiency gains realized through pooled funding and provider network contracting to fully fund PS and to increase strategic engagement of the private sector. [National government prioritization of health and TB services, page 31; “Creation of the SHF to increase pooling of funds and improve accountability and efficiency”, page 28]
- d. **Guarantee the provider networks can accommodate TB service delivery needs:** The NTP should collaborate with the HPDPB and the technical assistance providers in the UHC implementation sites on the design of the province-wide and city-wide health networks to ensure the technical skills required to support service delivery approaches for PMDT, finding missing cases and TB/HIV collaboration are taken into consideration when networks are developed. [“Creation of the SHF to increase pooling of funds and improve accountability and efficiency”, page 28]

5. **Prepare for multi-year Global Fund transition planning and implementation:** In preparation for the transition of Global Fund-supported HRH, USAID’s HRH2030 recommends that various operating units within the DOH work in close collaboration with the NTP to support analyses, guidance and system investments that will enable multi-year planning for the sustainability of the Global Fund-supported workforce at all levels of the health system. [“Anticipating a changing donor resource landscape”, page 19]

- a. **Develop detailed costing HRH transition pathways:** Building on the costing estimate or ‘mortgage’ tools provided in HRH Inventory, the NTP should advance detailed DOH transition planning for the Global Fund-supported workforce by conducting detailed costing of HRH transition pathways of prioritized cadres including introducing costs of onboarding, training, supervision and workforce supports to assess the feasibility of transition scenarios and to support the evidence-based development of detailed, costed, annual transition plans under the next Global Fund TB grant. [“Exploring the HRH Transition Pathways”, page 33]
- b. **Develop LGU guidance to plan for Global Fund transition:** The NTP, in collaboration with the BLHSD, should outline guidance for LGUs to support transition planning for the Global Fund-supported workforce. The DOH may want to engage technical assistance to develop DOH’s strategies and guidelines for the LIPH (2023-2026) to ensure that operating units will have the appropriate guidance to operationalize the commitments negotiated under the next Global Fund TB grant, especially as human resource planning must be undertaken months or even years in advance of transition deadlines. [“Leveraging LIPH grants to encourage LGU investments in TB”, page 28]
- c. **Maintain the HRH inventory of donor supports in the DOH HRIS:** The NTP should formalize a collaborative process with the HHRDB and KMITS, to routinely update the HRH Inventory turned over to the DOH by USAID’s HRH2030. The KMITS, in collaboration with the HHRDB, should incorporate a sub-system on donor-supported HRH in the forthcoming redesign of the DOH human resource information system (HRIS) by expanding the HRH Inventory to include health workers supported by other donors and deployed to other programs (e.g. HIV/AIDS). This will support Global Fund transition planning and strengthen the ability of the DOH to generate reliable and timely data for planning, management and sustainability of TB HRH investments. [“Conducted an inventory of HRH investments”, page 11]

Annex 2: Estimating the Cost of HRH Transition

Cost Estimates Assumptions/Calculations:

1. Costing is limited to health worker's salary and benefits. It does not include costs of recruitment, on-boarding, training and other related costs.
2. Use national government salary levels for positions transitioned to both the DOH and LGUs. While LGU salaries are generally lower than that of the national government which the Department of Budget and Management allows recognizing fiscal space constraints, the Magna Carta Law of health workers stipulates that the public health workers be paid national government salaries. This can justify the assumption. The alternative of using LGU salary levels is not an option at this time.
3. The equivalent government position is that position with functions as described in the DOH mandated Job Descriptions that approximate the functions performed by the PBSP-hired health worker.
4. The job title of the equivalent government position is as it appears in the Index of Occupational Services of the Philippines, DBM and specified in Executive Order 366, the DOH Rationalization Plan.
5. The Salary Grade (SG) is as specified in Executive Order 366, the DOH Rationalization Plan that defines the current DOH staffing and salary structure.
6. Salary data (monthly) are specified as a range (Step 1 - Step 8) in the SSL Tranche 4 effective January 1, 2019 for each of the SG.
7. The benefits specified by the DOH for 2019 are the following:

Particular	Amount	Given
PERA	Php 2,000.00	Monthly
Subsistence	Php 1,000.00	Monthly
Laundry Allowance	Php 150.00	Monthly
Hazard Pay	Depends on the SG level	Monthly
Cash Gift	Php 5,000.00	Annually
Mid-Year Bonus	equivalent to 1 month basic salary	Annually
Year-end Bonus	equivalent to 1 month basic salary	Annually
Uniform Allowance	Php 6,000.00	Annually
Productivity Enhancement Incentive	Php 5,000.00	Annually

8. Foreign exchange rate USD1=PhP52.34 (Reference exchange rate, Central Bank of the Philippines, August 30, 2019)
9. Present the cost estimates or Financing Estimates as a range (Step 1 - Step 8) in both Philippine Peso and US Dollar.

Steps:

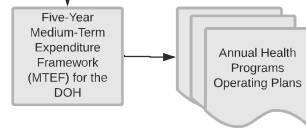
1. Refer to Equivalent Government Position in the Pathways section and use the government equivalent position you indicated.
2. Refer to the SSL Tranche 4 Salary table to determine the salary range (Step 1 – Step 8) for the government equivalent position/rank.
3. Multiply the monthly salary in Step 2 by 12 to calculate the annual salary for the (Step 1-Step 8) range to estimate annual financing estimates.
4. Divide the annual salaries in the salary range in Step 3 above by 52.34 (1 USD to PhP) and indicate these in parentheses in the annual financing estimates.

Annex 3: Process Map of National Government Budget

Policy Framework

National Objectives for Health (NOH) 2017–2022
Strategic Reform: DOH FOURmula One Plus for Health
Program Strategy and Plan (PhilSTEP) 2017-2022

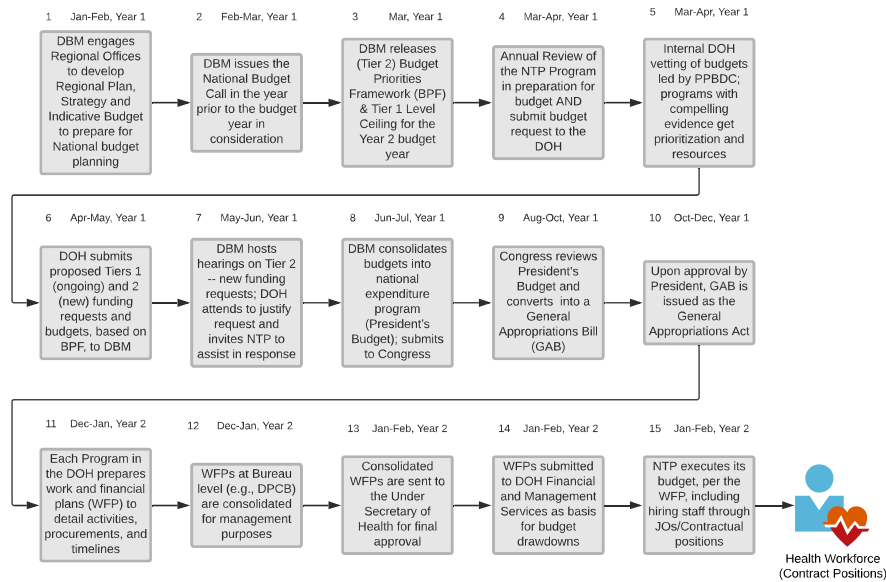
Budget Framework



The National government funds the Department of Health (DOH) and DOH-retained hospitals, which are primarily tertiary regional hospitals and a few reference laboratories. The National government also funds public health programs, such as immunization, family planning and tuberculosis control.

Plan and Budget Formulation

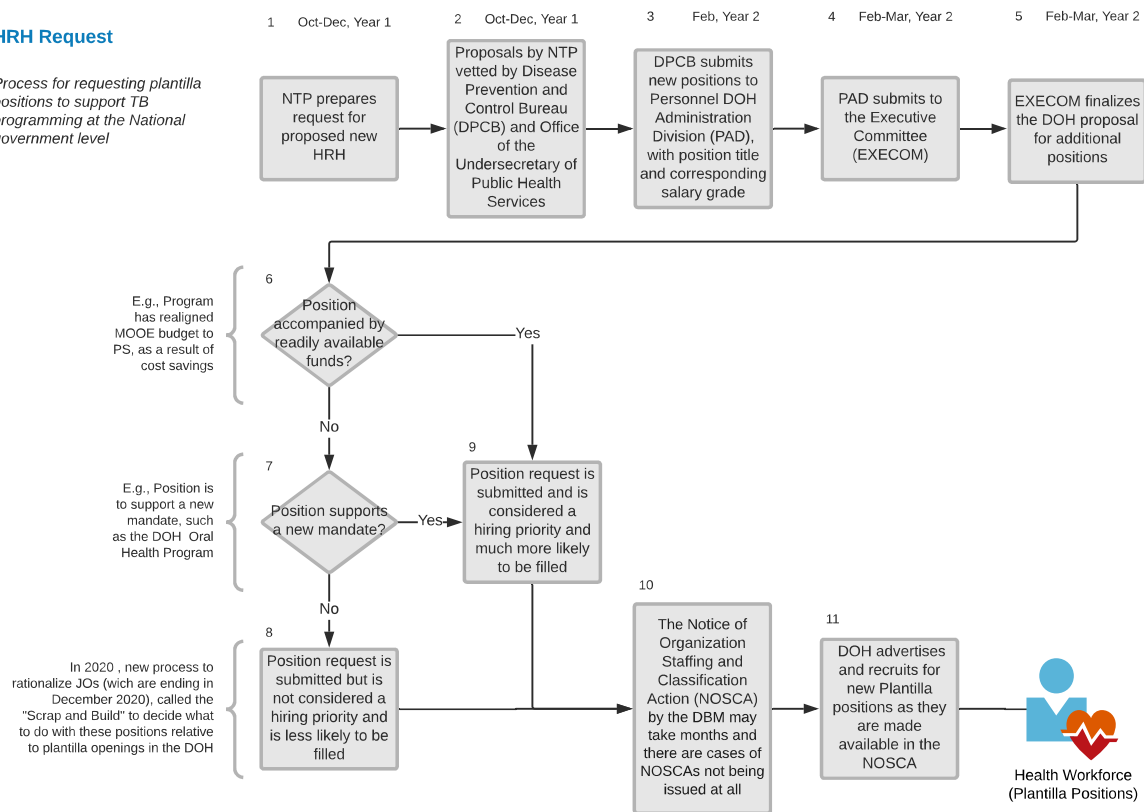
Planning and budgeting happens one year in advance of funds being released to NTP and DOH-retained Hospitals



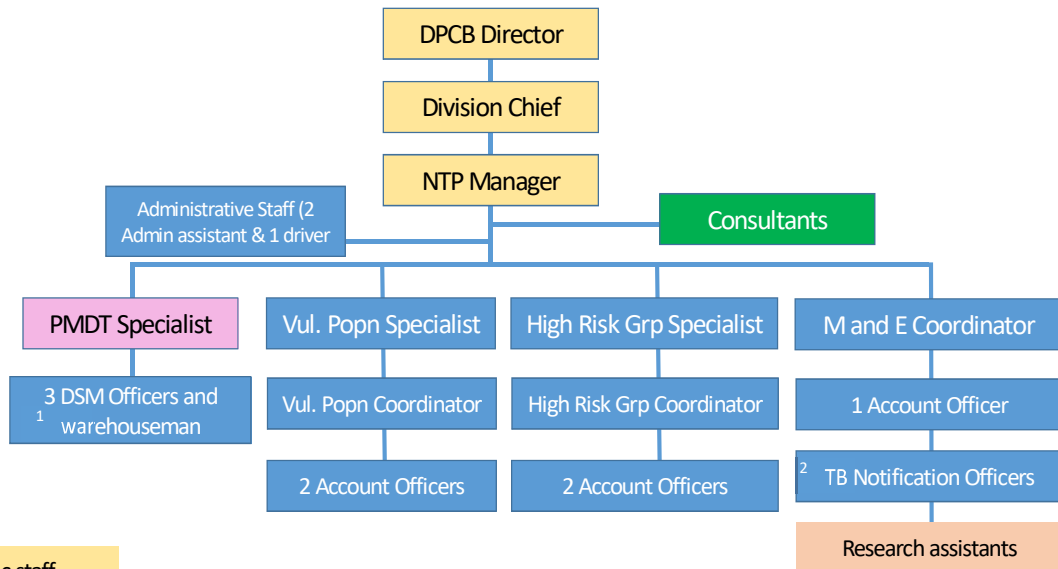
Annex 4: Process Map of National Requests for Health Personnel

HRH Request

Process for requesting plantilla positions to support TB programming at the National government level



Annex 6: NTP Organogram



Legend:

- DOH Organic staff
- Consultants – USAIS & JICA
- Hired by USAID/detailed at DOH
- Hired by GF
- Hired by Organizations with Researches

Regional Coordinators are composed of Physicians, nurses and MTs. Physicians are either working solely for TB, or cluster heads or division chiefs. Nurses are coordinators for TB and other infectious diseases as well as MTs.

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