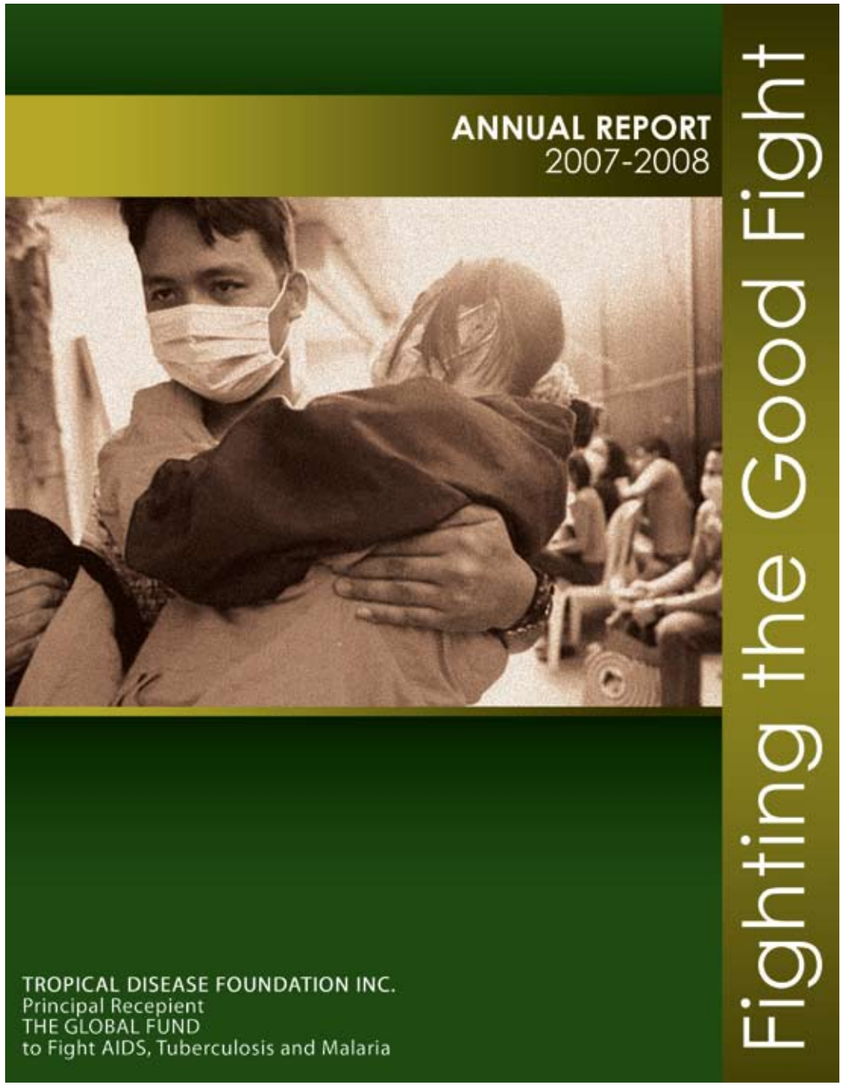
ANNUAL REPORT
2007-2008

Fighting the Good Fight

TROPICAL DISEASE FOUNDATION INC.
Principal Recepient
THE GLOBAL FUND
to Fight AIDS, Tuberculosis and Malaria



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tropical disease foundation inc.

Investing in our future
The Global Fund
To Fight AIDS, Tuberculosis and Malaria

Foreword

As Chairman of the Board, and I have sat in more than 17 Boards in the past several years, the many faceted activities of the Tropical Disease Foundation leave me with no dull moments.

From a very small NGO, the Tropical Disease Foundation has grown in stature both nationally and internationally. We have gone through a series of growth spurts that has seen a broadening of partnerships with organizations with similar goals. The strengthening of collaboration with the health ministry and allied local government health facilities have been a great boost in the realization of our vision of the universal and equitable access to health as a vehicle for national productivity. The critical role of the Foundation as the Principal Recipient of the projects of the Global Fund to fight AIDS, Tuberculosis and Malaria has further catalyzed this collaboration and has lead to the further realization of this vision in a national scale.

The pioneering work of the young and committed staff of the Foundation has been given due recognition and appreciation by the international community. The World Health Organization has deemed it fit to approve it as the first facility to be approved to provide treatment for Multi-drug Resistant Tuberculosis by the Green Light Committee. From thereon, this pilot project is poised to support the nationwide scale up of the program in the Philippines to becoming an important player in the region to accelerate the response to the crisis of multi-drug resistant tuberculosis. The International Union against TB and Lung Disease has stewarded the growth of the Foundation to attain potential international stature. The US Centers of Disease Control and Prevention, the Case Western Reserve University TB Research Unit have considered the potential for more innovative undertakings of the Foundation as an important organization for collaborative undertakings. Strong partnerships have also been forged with other regional organizations including the Korea Institute of Tuberculosis, the Foundation for Innovative New Diagnostics, and the Global Alliance for TB Drug Development in the transfer of technology to improve local capabilities.

With meager resources, the Foundation has been deemed worthy to receive endowments from philanthropists nationally as well as internationally. The Foundation is grateful for the generous endowments from the Ayala Corporation, the Angelo King Foundation, and the World Lung Organization and other generous donors that have allowed the establishment of the facility to house the Philippine Institute of Tuberculosis which was the highlight of the World TB Day Celebration of the Foundation in 2007.

Ambassador Bienvenido Tan, Jr, LlB
Chairman of the Board

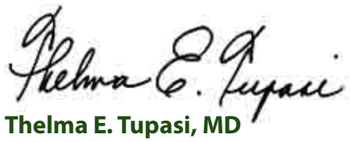
President's Report

From 1986 until April 2007, the Tropical Disease Foundation has been hosted by the Makati Medical Center. This was through the generosity and strong social responsibility of the MMC led by its founding Chairman, the late Dr. Constantino P. Manahan, and carried on by his successor as Medical Director, Dr. Raul G. Fores.

Through the generosity of the Ayala Corporation, a property appropriate for the construction of a new headquarters for the Foundation was donated in 2007 through the intercession of the Board of Trustees, notably Board Chairman, Ambassador Bienvenido Tan, Jr. This paved the way for the construction of what is now hailed as an architectural feat by Architect Pablo Antonio, Jr, of creating more than 1000 square meters of space from a real estate of 297 square meters. Construction was made possible through the generosity of benefactors including Angelo King Foundation, World Lung Foundation, private philanthropists including Mr. Alex Fu, Dr. Roberta C. Romero and Class 1964 UP Medicine, and countless others that prefer not to be named. To all these generous benefactors and patrons, the Foundation owes so much to be able to serve more patients and we are all eternally grateful.

The Global Fund projects have now been running for five years. Much impact in all three disease components are now evident. Which are chronicled in this annual report. The first two projects approved in Round 2 of the Grant Proposals cycle have come to an end. These two grants have been extended through the new system of funding referred to as Rolling Continuation Channel to commence in 2009. The Round 3 and 5 HIV projects have made outstanding inputs in HIV control, albeit in the limited focal points addressed by them.

This outstanding performance is to the credit of the public private partnership, spearheaded by the Department of Health, National Centers for Disease Prevention and Control, Infectious Disease Office and the implementing units under the Local Government Units, and their partners from the private sector and the Non-Government Organization. These are the Philippine Coalition against Tuberculosis, the World Vision Development Foundation Inc., the Holistic Community Development Inc, and the Kilusan Ligtas Malaria. It is to the credit of the Department of Health, that they have embraced public private partnership and has collaborated with The Tropical Disease Foundation, in its twin role as the Principal Recipient of these two grants and as implementing sub-recipient of the Programmatic Management of Drug-Resistant Tuberculosis and the Malaria Project. Technical assistance and oversight function have been provided by Technical Working Groups and the Country Coordinating Mechanism. (CCM)



Thelma E. Tupasi, MD
President/Executive Director

"...A World Where Everyone Enjoys the Right to Health and Economic Productivity..."

History Of The Tropical Disease Foundation

The Tropical Disease Foundation (TDF) is a private, non-stock, non-profit, non-government organization founded in 1984 by a group of physicians in the Research Institute for Tropical Medicine. The founding chairman was Dr. Jesus Azurin, then the Secretary of Health.

The vision of the TDF is a world where everyone enjoys the right to health and economic productivity. The mission of the TDF is the control and prevention of infectious diseases of public health importance through research, training and service. It views its mission not only as a clinical but also as a developmental strategy.

The TDF's thrusts are 1) to conduct research, training and service in infectious diseases of public health importance; 2) to enter into partnership with public and private agencies in the implementation of programs in the control of infectious diseases; 3) to enter into partnership with national and international institutions involved in research to ensure technology transfer; 4) to enter into a multi-sectoral partnership with other disciplines to ensure that cured patients are socio-economically productive; 5) to serve as a national and international training center for infectious diseases. Tuberculosis has been the main focus of the research and training initiatives of the TDF.

Linkage with the Makati Medical Center

Through a Memorandum of Agreement with the Makati Medical Center (MMC) in 1987, the TDF transferred to the MMC and Dr. Constantino P. Manahan was elected as the Chairman of the TDF Board of Trustees, The Makati Medical Center was founded by a group of distinguished health professionals headed by Dr. Constantino P. Manahan, who was the first Chairman of the Board and concurrent Medical Director. It is owned and operated by the Medical Doctors, Inc. and was formally inaugurated on 31 May 1969.

The MMC, because of its belief in the sanctity of human life, renders equal standards of medical services to all patients regardless of their socio-economic status. Its efforts are geared toward meeting the health needs of the patients by maintaining highly qualified staff and by constantly updating its medical technology.

Through the generosity of donors and friends, the Foundation inaugurated its research laboratory on mycobacteriology including fluorescent sputum smear microscopy, TB culture and drug sensitivity testing. 2 February 1988 graced by the presence of Professor Calvin M. Kunin and Dr. Constantino P. Manahan. With these laboratory facilities, the TDF was able to pursue its activities in training and research in tropical infectious diseases. The TDF established an Institutional Review Board which also served the other clinical staff of the MMC that were involved in clinical trials. The TDF has undertaken research projects in accordance with the provisions of the Helsinki Declaration.

Supporting the Public Health Programmes

The 1997 National Tuberculosis Prevalence Survey was undertaken by the TDF on behalf of the Department of Health (DOH). It also initiated the close collaboration between the TDF and the National TB Control Program (NTP) of the Department of Health in TB Control through the initiation of the DOTS Clinic at the Makati Medical Center. This private-public collaboration between the TDF, the Makati Medical Center (MMC) the NTP and the local government unit, the Barangay San Lorenzo, has provided free service in the management of TB patients since 1999. It later became the very first DOTS-Plus pilot project approved in 2000 by the Green Light Committee (GLC), a technical subgroup of the Working Group on Drug-Resistant TB of the Stop TB Partnership. This is considered unique that a privately initiated DOTS facility in a developing country was the first facility to be approved to provide MDR-TB management by the GLC. It has established a satellite DOTS-Plus and housing facility, Kabalikat sa Kalusugan, in partnership with the Philippine Tuberculosis Society, Inc at the Quezon Institute In recognition of its outstanding pioneering work, this pilot-project has been recommended as a center of excellence in MDR-TB management.

In its search for support of patients with MDR-TB, the TDF was directed to apply for resources from the Global Fund to fight AIDS, Tuberculosis and Malaria, which was established in 2000. The TDF was nominated by the Department of Health and elected by the Country Coordinating Mechanism. as the Principal Recipient for the Global Fund Projects in 2003. As such, it has since been the Principal Recipient of six of the eight grants: two each on Tuberculosis, Malaria, and HIV. Resources for the management of MDR-TB was thus provided, first for a cohort of 500 patients, then expansion to 2,500 patients, and more recently to a nationwide scale-up of the intervention and to treat a total of more than 10,000. Resources for the management and control fo Malaria was likewise made available first for 25 provinces, then an additional four provinces, and more recently for a total of 40 provinces nationwide. HIV projects have initially focused on 11 sites, then augmented to 18 more sites, with the establishment of six more treatment hubs to augment the original five treatment hubs.

A Program Management Unit headquarters at the Montepino Building was thus established to administer the Global Fund projects, through the generosity of the United Laboratories. Presently, this unit now supervises six grants in total of the GFATM projects in the Philippines.

In the implementation of projects, strategic linkages have been established both in the international and national front.

Strategic Linkages with International Institutions:

- World Health Organizaiton
- STOP TB Partnership, MDR-TB Working Group, Green Light Committee
- Korea Institute of Tuberculosis
- Global Fund to Fight AIDS, Tuberculosis and Malaria
- Centers for Disease Prevention and Control, US Public Health System
- Case Western Research University Tuberculosis Research Unit (TBRU)
- Foundation for Innovative New Diagnostics (FIND)

Strategic Linkages with National Institutions:

- Department of Health,
- National TB Program
- Malaria Control Service
- National AIDS/STD Prevention and Control
- Centers for Health Development
- National TB Research Laboratory
- Lung Center of the Philppines
- Department of Local Government
- Local Government Units
- Philippine Coaltion against Tuberculosis
- Philippine Tuberculosis Society, Inc
- World Vision Development Foundation
- Holistic Community Development Inc.
- Kilusan Ligtas Malaria
- Pilipinas Shell Foundation
- Philippine NGO Council on Population Health and Welfare

> "Each Sector is represented on the Board that Promotes Partnership between Districts to Combat Diseases."

Philippine Global Fund Projects

The Philippine Partnership to Fight TB, Malaria and AIDS is committed. The partnership strives for the prevention and control of these diseases to make the world a healthier, better place.

As a public-private partnership based in the Philippines, the PPTMA holds an annual forum to focus on how the organization can impact the people who need it most. The first forum was held in conjunction with the International Congress of Chemotherapy on June 5th, 2005 in Manila. Kicking off the event was the new Secretary of Health, Dr. Francisco T. Duque III, as the forum's keynote speaker.

A spotlight of the event was feedback on the implementation of the Philippine projects on TB, Malaria and AIDS, funded by the Global Fund since July 2003.

The Global Fund to Fight AIDS, TB and Malaria was established in January 2002 to combat the severe problems of these diseases. It is a partnership of national governments from donor and developing countries, private organizations, affected communities, and other concerned parties. The GFATM provides financial needs to improve health care systems and overall well-being through prevention and control of the diseases.

The Country Coordinating Mechanism was established on March 5th, 2002 through the National Infectious Diseases Advisory Committee. Each sector is represented on the board that promotes partnership between districts to combat diseases. Members are from several types of organizations that work together to oversee all GFATM applications and programs in the Philippines.

The formal nomination of the members of the Country Coordinating Mechanism also took place at the June 2005 event.

The Philippine Launch of the Global Plan to Stop TB (2006-2015)

The Tropical Disease Foundation plans to eliminate TB by 2015. The Foundation works closely with the Department of Health, the Philippine Coalition Against Tuberculosis, the Quezon City Local Government, the World Health Organization, and other partners. TDF launched the Global Plan to Stop TB on March 24, 2006, as part of World TB Day. Over 500 people from more than 80 agencies and organizations packed the Philippine International Convention Center for the event.

Francisco T. Duque III formally started the day as the guest of honor. Dr. Giorgio Rosciigno, the CEO of the Foundation for Innovative New Diagnostics and a member of the Stop TB Partnership, formally launched the Global Plan to Stop TB. Four Chairs of the Working Groups of the Stop TB Partnership attended, including Dr. Giorgio Roscigno, WG on Diagnostics; Dr. Thelma E. Tupasi, WB on Drug-resistant TB; Dr. Maria Freire, WG on New TB Drugs; and Dr. Gijs Elzinga, WG on TB/HIV. The Global Plan outlines the organization's mission and resources to implement the new six-point strategies used in Stop TB.

Stakeholders' participation

The launch's main goal was to gain committed advocates and support for the Call to Action to Stop TB. Dr. Duque led the highlight of the event, a symbolic signing of the Call to Stop TB. Heads of organizations attending the committee endorsed the overall plan as well as the national and regional plans to control tuberculosis. Over 85 heads of organizations attended, including some from the United Nations.

The Global Fund to Fight AIDS, TB and Malaria

The CCM applications to the GFATM Round 2 Proposals in November 2002 were approved in July 2003 for TB and Malaria and August 2004 for HIV/AIDS. The Tropical Disease Foundation became the principal recipient for the Global Fund for its projects regarding TB, Malaria and AIDS. The program was called Accelerating the National Response to TB, Malaria and AIDS.

TDF is the voice of these projects, working around the Philippines to give quality care to its patients. TDF is a legal entity with transparent financial systems and the ability to let its partners carry out proposed activities. TDF receives and organizes the funds on behalf of GFATM.

Financial management and administration, including receiving and dispersing the funds to sub-recipients,

overseeing the propose procurement and submitting reports to the GFATM and CCM falls to the Tropical Disease Foundation.

Everyone works together to better the world. That's why many sub-recipients implementing Global Fund projects include the Department of Health, the National TB Program, the Malaria Control Program and the National AIDS/ STD Prevention and Control Program. Additionally, local government units work with partners from the private sector to make the world a better place. Partners include the Philippine Coalition Against Tuberculosis, the world Vision Development Foundation, Inc., for TB, and the Philippine NGO Council on Population, Health and Welfare, Inc. for AIDS.

In August 2005, the Global Fund projects on TB and Malaria were approved for Phase II and years 3-5. In August 2006, the Phase II of the HIV/AIDS project was also approved. The Philippine CCM applications to the GFATM Found 5 Call for the three diseases were all approved. The Tropical Disease Foundation was elected principal recipient for the AIDS and TB projects, called:

- **Upscaling the National Response to HIV-AIDS through the Delivery of Services and Information to Populations at Risk and People Living with HIV and AIDS**
- **Scaling up and Enhancement of NTP in the Philippines**

World TB Day is an annual event celebrated every 24th day of March that intends to orient, inform and enlighten the general public about the burden of TB in the country.

The Pilipinas Shell Foundation, Inc. was the elected PR of the Round 5 Malaria project: **Bolstering and Sustaining Proven and Innovative Interventions in Malaria Control through Corporate-Public Partnership**.

Responding to the GFATM Round 6 Call for Proposals, the applications for Malaria and AIDS were approved and are presently under negotiation for signing. TDF and the Department of Health were appointed as PR for the two projects, respectively, entitled:

- **An Intensified Strengthening of Local Response and Health Systems to Consolidate the Gains in Malaria Control in Rural Philippines through Public Private Partnership**
- **Scaling Up HIV Prevention, Treatment, Care and Support through Enhanced Voluntary Counseling and Testing and Improved Blood Safety**

The PR coordinates with the GFATM Portfolio Manager. It was originally with Ms. Sandii Lwin from 2003-2005 and has been with Mr. Oren Ginzburg since 2005. The Local Fund Agent for the GFATM-supported projects in the Philippines is the Isla Liipana & Co., a member firm of the PricewaterhouseCoopers.

> “Accelerating the Response to Malaria among the Philippines’ Rural Poor.”

Malaria Projects
Global Fund Rounds 2 and 6

Accelerating the Response to Malaria among the Philippines’ Rural Poor

The period of August 1, 2007, to July 31, 2008, saw the end of the Round 2 grant and the inception of the Round 6 grant. Both grants are in support of the efforts to bring down the burden of malaria to a level that it will no longer be a socio-economic problem.

The Round 2 grant, “Accelerating the Response to Malaria among the Philippines’ Rural Poor”, was implemented in the 26 most highly endemic provinces (see Map). The goals to be reached by the end of 2007 are: 1) to decrease malaria morbidity by 70%, and 2) to decrease malaria mortality by 50%. Major objectives include:

1. To increase the proportion of febrile patients given prompt diagnosis and appropriate treatment
2. To control malaria transmission through appropriate vector control methods
3. To strengthen the capacity for the implementation of a sustainable community-based malaria control program

These objectives are in accordance with the major strategies of the national Malaria Control Program of early diagnosis and prompt treatment, vector control and social mobilization which are aligned with the Philippines’ Millennium Development Goals

The first strategy focuses on early diagnosis and prompt treatment.

The project has provided support to the local service providers to capacitate them to render malaria diagnostic and treatment services to communities at risk.

Hospital physicians became the focus of capacity building activities in the last year of grant implementation. Activities included a formal

three-day course on the management of severe malaria with a half-day Doctor's Forum. The latter proved to be more effective as a venue to impart updates on the treatment protocol for malaria and facilitated the participation of private practitioners.

The training on the use of Rapid Diagnostic Tests (RDTs) pushed through with the decision of the Malaria Management Committee to use the Paracheck RDTs. This was due to the field study results on the use of combination type of RDTs which showed poor overall performance. Additional Barangay Health Workers (BHWs) and midwives were trained in the four remaining provinces that had earlier postponed the trainings due to the problem with the combination RDT.

Drugs, laboratory supplies and RDT kits continued to be provided to the health facilities during this period. At the end of Round 2 implementation, a total of 2,015 health facilities were supported resulting in the provision of diagnostic and treatment services to malaria suspects and allowing for confirmation of malaria patients. Of all these service points supported, the Barangay Malaria Microscopy Centers (BMMCs) have the highest proportion (89%) that have remained functional (continue to provide diagnostic and treatment facilities), followed by Rural Health Units (87%) and hospitals (85%). RDT sites have the lowest proportion at 55%. This may be due to the difficulty in retaining the services of barangay health workers because of their need to look for better sources of income for their families.

The use of Artemisinin Combination Therapy (ACT) remained low possibly due to the perceived effectiveness of the first-line drugs. The policy on the management of malaria has been revised and is awaiting approval and official issuance by the Department of Health. Once this is underway, the ACT, particularly Artemisinin Lumefantrine, will be the first line antimalarial drug of choice.

School promotes the use of insecticide retreated nets.

People Reached

- 1.09 million patients (approx.) tested for malaria from start of project to end of year 5,
- with around 93,072 patients tested and patients diagnosed and treated for year 5

Commodities Distributed

- 537 microscopes
- 10,422 RDT kits (Paracheck and ICT)
- Chloroquine
- Sulfadoxine Pyrimethamine
- Primaquine
- Coartem
- Various laboratory supplies

People Trained

- 2,095 trained on malaria diagnosis:
- 390/348 medical technologists,
- 268/249 barangay microscopists
- 1,437 Rapid Diagnostic Test
- (RDT) volunteers – 1002/486 (Paracheck), 435/497 (combination RDT)
- 1,053/998 RHU and hospital doctors

Service Points Supported

- 1934 health facilities
  - 309 rural health units
  - 501 barangay microscopy centers
  - 966 RDT sites
  - 158 hospitals

Outcome

The investments in early diagnosis and prompt treatment have resulted in the improvement of services to detect and manage malaria cases. Based on the health facility survey, 97% of uncomplicated malaria patients were correctly diagnosed and treated in the field health facilities (RHUs, BMMCs and RDT sites).

Management of malaria patients admitted in hospitals, however, is an area for improvement. According to the survey, 66% of the 1,307 patients admitted in 79 hospitals and diagnosed to have malaria were correctly treated (correctly given anti-malarial drugs according to national malaria treatment policy).

Challenges and Recommendations

An external evaluation was conducted by the World Health Organization (WHO) and identified several areas of strength. A wide network of microscopists and diagnostic centers has already been established which has contributed to increased access to services by underserved and remote populations. Momentum has been maintained with the absorption of medical technologists and barangay malaria microscopists under the local government unit. It was recommended that sustained support for these service providers be pursued.

It was also pointed out that there was good quality assurance for malaria microscopy and first line antimalarial drugs were available and free in all facilities visited. Pre-hospital treatment was observed to be generally good and that there was correct treatment and prompt referral when malaria was diagnosed.

It was pointed out however, that there were instances when the recognition of severe or complicated malaria was slow. Definitive diagnosis was delayed after admission resulting in late commencement of treatment and sometimes even led to death. The practice of some physicians in pushing first-line drugs resulted in low utilization of a better drug (Coartem) despite its availability.

To address these identified challenges, it was recommended that the adoption of ACTs as first line be accelerated. This should include the use of Artesunate suppositories for pre-referral treatment by workers in remote areas. Directly observed treatment strategy (DOTS) was also recommended for the three-day Coartem and the 14-day primaquine treatment to increase compliance. A communication strategy to encourage hospital doctors to use the new ACT-based regimen should be developed.

The second strategy focuses on vector control.

The use of insecticide-treated nets is the major vector control method promoted by the Round 2 grant. Retreatment of nets given in the previous cycles of distribution as well as those actually owned by community members was a major strategy to increase the coverage of the population protected by insecticide-treated nets (ITN coverage).

A total of 755,114 nets were treated and distributed as part of the last cycle of distribution. Health promotion activities were conducted complementary to the net retreatment and distribution to ensure that the key message on the importance of regular ITN use is imparted to the target audience.

The Bednet Utilization Survey (BUS) showed that 66% of children under five years old use ITN. This is below the 80% target but still an improvement from the previous 54 %. Bednet ownership was assessed at 84%. The Principal Recipient, in coordination with the Management Committee, has programmed the procurement of more than a million nets in the Round 6 grant, in order to address this gap.

A total of Php 15,598,375 ($ 389,959) was collected from the Cost Recovery Scheme. Out of this amount, Php 9,735,001.75 ($ 243,375) was used to procure nets, insecticides, and spraycans. The remaining balance will be spent to fund community-based activities as determined by the RHU staff and community leaders.

Indoor residual spraying was done in more barangays this year in response to outbreaks and to complement ITN distribution in areas that have consistently high malaria cases. Spraymen from among the community and the field staff of the Malaria Control Program were equipped on the proper use of the spraying equipment and the conduct of spraying. A total of houses were sprayed resulting in a coverage of %.

People Trained

Community volunteers and Malaria Control program personnel were trained on Indoor Residual Spraying.

Commodities Distributed

- By the fifth of year of the project, a total of 755,114 nets were distributed to target beneficiaries of the 26 provinces.
- KO tabs were likewise provided for retreatment of nets provided by the project and those previously owned by the households.

Service points supported

Nine Zonal stockpiles for epidemic response are being supported with commodities for outbreak response. These are lodged at the Department of Health-Centers for Health Development II, III, IV-A, IV-B, IX, X, XI, CARAGA, Insecticides for spraying, spraycans, first to third-line drugs and RDT kits are maintained in these stockpiles which can be easily accessed by provinces in their respective regions.

People reached:

- 84 % coverage for bednet distribution to target families.
- A total of 71,164 houses were sprayed in selected target provinces.

Challenges and Recommendations

The retreatment rate needs to be improved. There is much difficulty in motivating people to have their nets retreated because people's behavior still put them at risk. For example, forest work, evening social activities and other pre-bedtime activities often lead people to be exposed to infective mosquitoes.

It is recommended that a national LLIN replacement campaign be implemented that will also focus on modifying community acceptance of LLINs, promote correct use and improve compliance. There should also be greater efforts and innovative strategies to target indigenous people's (IP) households, internally displaced populations (due to civil unrest) and other mobile populations.

The third strategy is social mobilization.

Strengthening of the local capacity to implement and sustain a community-based malaria control program is the focus of the social mobiization strategy of the project. Organizational principles were put into play as Action Committees or Malaria Control Teams were established at the provincial, municipal and barangay levels. These organized groups were intended to take the lead in the identification of key problems in malaria control and in the formulation of plans and their subsequent implementations. These committees and teams have played major roles during the net distribution and retreatment, in the conduct of indoor residual spraying and in responding to malaria outbreaks.

Parallel to organizing efforts was the implementation of the health promotion component of the project. Teachers in schools of endemic barangays were taught on how to use the Malaria modules in the different subjects in both the elementary and secondary level. Other complementary school-based activities were also conducted like games, quizbowls, symposia and even net retreatment programs among the students.

IEC materials like flipcharts, posters and other teaching aids were developed and distributed to disseminate the key messages of regular bednet use, seeking consult early and treatment compliance once found to be positive for malaria.

People Trained

- 202 school teachers trained on the use of the malaria modules
- 1810 personal sellers or malaria advocates were trained on interpersonal communication skills so they can "sell" the key messages on malaria prevention and control

Commodities Distributed

Various IC materials distributed

Malaria control is an important issue discussed by leaders of indigenous communities.

Service Points Supported

2661 partnerships were established from project start

Impact of the Round 2 Grant

On the national level, malaria cases and deaths show a downward trend. In 2006, there were 33,852 cases and 89 deaths, representing a 30% reduction in morbidity compared to the baseline figures of the average cases from 1997-2001; and a 50% reduction in deaths compared to baseline mortality in 1998. When compared to 2005 figures (46,342 cases and 150 deaths), these data represent 27% reduction in malaria cases and 40% in malaria deaths.

In particular, with the Global Fund support, the 26 Category A provinces showed a downward trend of cases, with a 20.53% reduction of cases (2007). This has resulted in the re-categorization of the 26 project provinces that were originally Category A provinces. Only 8 project areas remain as Category A, 16 are now in Category B and 2 in category C. When comparing the 5-year average number of malaria cases (2001-2005) to the previous 5-year average from 1995-2000 of the different provinces, the number of Category A provinces has decreased from 26 to 9 (65% reduction), while the Category B provinces has increased by 4% (from 22 to 23 provinces respectively) and Category C provinces has likewise increased by 72% (from 18 to 31 provinces respectively). Likewise, Malaria free provinces have increased by 23% (from 13 to 16 provinces).

In the second batch of 15 provinces which started implementation in year 2 of the project (August 2004 to July 2005), the number of cases have shown an actual increase in nine provinces and this was brought about by better diagnosis with the deployment of trained microscopists and the RDT diagnostic staff in the hard to reach areas. In most of these provinces, the actual status of malaria has been difficult to assess prior to project implementation due to the absence of personnel and facilities equipped to diagnose the disease. With the Global Fund support, active case finding was made possible, hence the increased trend in several provinces. However, with adequate and continuous supply of antimalarial drugs and support for the facilities as well as adequate coverage of ITN, these trends improved in the 4th year of the project like those in the first batch of provinces.

Access to and availability of quality diagnostic services, free anti-malarial drugs for treatment and the distribution of insecticide-treated mosquito nets have had a synergistic effect in bringing the malaria cases down. However, in 2005 and 2006, there were several outbreaks in the project provinces that occurred and resulted in the increase of cases in an otherwise declining trend. These are the areas that require intensive surveillance, together with investigation of cases in the neighboring provinces and municipalities that border these affected areas.

In 2006, the Philippine Country Coordinating Mechanism (CCM) heeded the Global Fund's sixth call for proposals. The project is entitled, 'An Intensified Strengthening of Local Response and Health Systems to Consolidate the Gains in Malaria Control in Rural Philippines through Public Private Partnership'

The goals, objectives, strategies and activities of this proposal are consistent with the National Objectives of Health (Annex 16) and those of the national Malaria Control Program strategies and with those of the two projects currently being supported by the GF. The goal is the reduction of malaria morbidity by 70% in the 21 provinces under Round 22 and the four emerging provinces and the achievement of zero mortality by year 2011-2012 relative to 2005.

1. To consolidate, expand and sustain high coverage of early diagnostic and treatment services for malaria through health systems strengthening and public private partnership

Round 6 intends to maintain the momentum achieved in Round 2 and expand access to these services in the four new provinces. The first year of project implementation focused on preparing for the capacity building activities. An evaluation of the training courses conducted in Round 2 facilitated the improvement of the curriculum for clinical management and diagnosis.

Municipal Health Officers of Rural Health Units and resident physicians of hospitals in the four new provinces were trained on Basic Malaria Management Course and Management of Severe Malaria, respectively.

Rapid Diagnostic Test (RDT) sites were established in 56 barangays in the four new project provinces. The first batch of medical technologists in Zamboanga del Norte also underwent the two-week course on Basic Malaria Microscopy.

Partnership with FBOs and NGOs in the area of service delivery will be purused in this grant. Hence, upcoming trainings will involve staff and volunteers of FBO and NGO partners.

2. To upscale vector control methods to interrupt malaria transmission

The first year of implementation was spent in preparation for the actual distribution of LLINs. Municipalities and barangays were ranked according to level of endemicity in order to identify the priority recipients of the LLINs and to ensure maximum impact in the shortest time possible in view of

a staggered delivery of the nets. Initial negotiations with the community leaders and local official are also being undertaken to ensure their support.

3. To strengthen local capacity through community systems strengthening for sustainable community-based malaria control and management.

Public-private partnership with FBOs and NGOs will be pursued. Utilizing their infrastructure, diagnostic and curative services as well as distribution of commodities for vector control will reach more people. Service delivery through establishment of referral system between community-based microscopy centers and RDT sites to referral level hospital, in both public and private health sectors; integration of malaria and TB microscopy services and dispensing of treatment, and monitoring and evaluation of the project will ensure that goals and targets are attained.

Behavior change communication using IEC tools and methods that are culturally sensitive and acceptable will be undertaken to promote social mobilization focusing on core messages to encourage 1) early diagnosis by knowing and using malaria diagnostic and treatment services available within 24 hours of onset of fever 2) compliance to treatment, and 3) the use of insecticide treated nets. Proven strategies used in Round 2 shall be applied such as Malaria School–On-Air, school-based malaria education activities and the mobilization of malaria advocates.

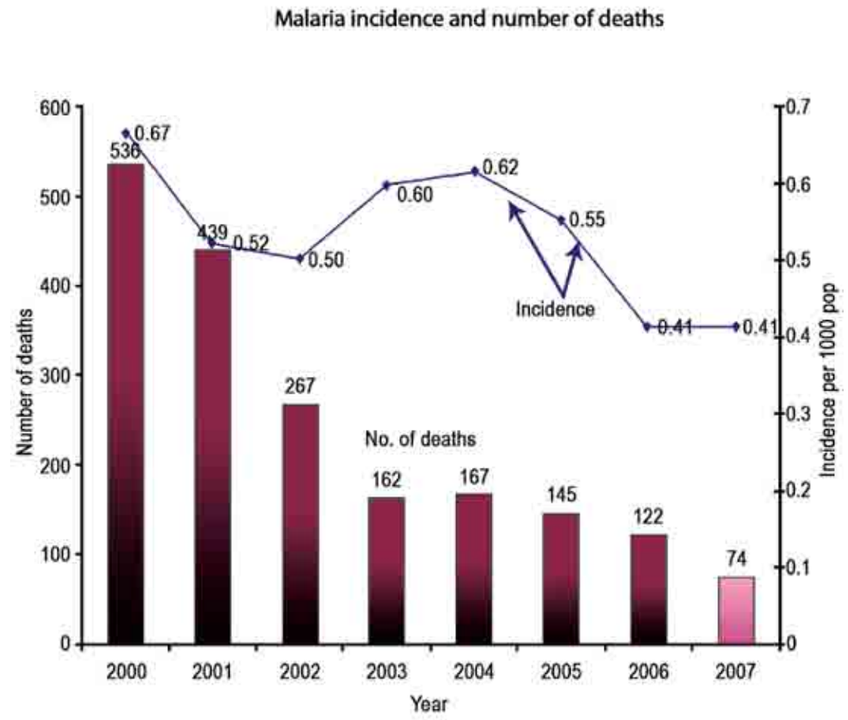
Based on results of the evaluation of health promotion strategies employed in Round 2, health promotion plans were developed for implementation in Round 6. The school-based malaria education strategies will be a major undertaking for this grant with standardized modules and teaching aides.

Indoor residual spraying in Palawan.

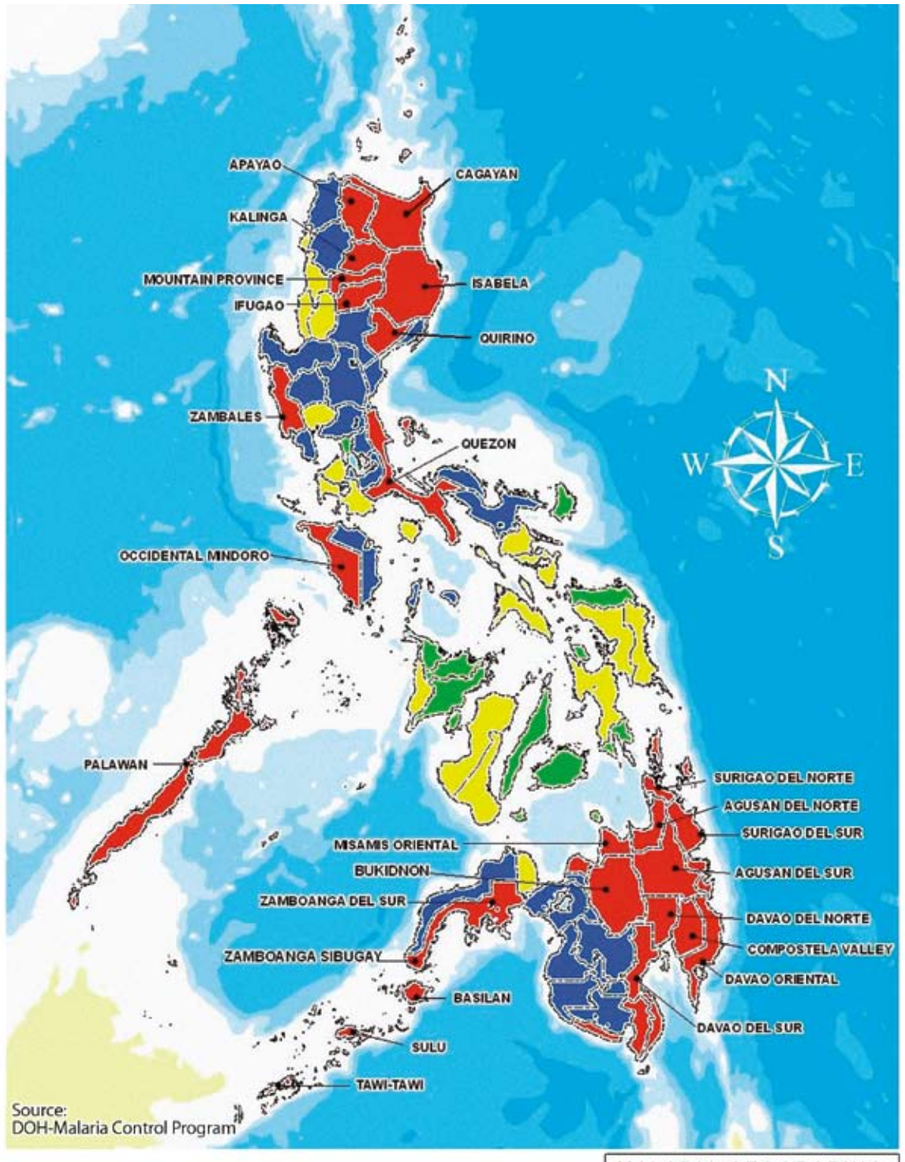
Malaria in the Philippines In 2007

Malaria is the 8th leading cause of morbidity in the Philippines (FHSIS, 2000). It is the most common and most persistent mosquito-borne infection in the rural areas of the country. The 2003 DOH / WHO data on malaria show that there were 588,836 suspected malaria cases in the country with 48,441 confirmed cases and 162 deaths. 94.0% of the cases nationwide are found in 26 (of the 59 endemic provinces) provinces in the Philippines currently addressed by GFATM project round 2. Year-round transmission occurs in all these provinces, with peaks mainly during and after the rainy season (June-Sept). The population groups affected by malaria are those living near breeding sites, mobile rural poor people dependent on forest products, subsistence farmers seeking livelihood and indigenous peoples (ethnic minorities). Vulnerability is basically due to financial, socio-cultural, linguistics and topographical barriers that hinder them from immediately seeking health services. These vulnerable groups are being covered by this project particularly in terms of orientation on malaria and in making malaria prevention, diagnosis and effective treatment available to them in far flung area.

Since 2003 till end of 2007, the number of confirmed malaria cases has declined by 24.65% and the number of deaths due to malaria has declined by 54.32%. The reduction in malaria mortality since 2000 is 86%. The graph below represents this decline in morbidity and mortality:



The maps in this spread clearly shows the decline of malaria from 2000 to 2006 in the Philippines with the number of provinces with over 1000 cases per year declining from 26 to 9 (red colored areas) and over 22 provinces (from 13) are malaria free (green colored).

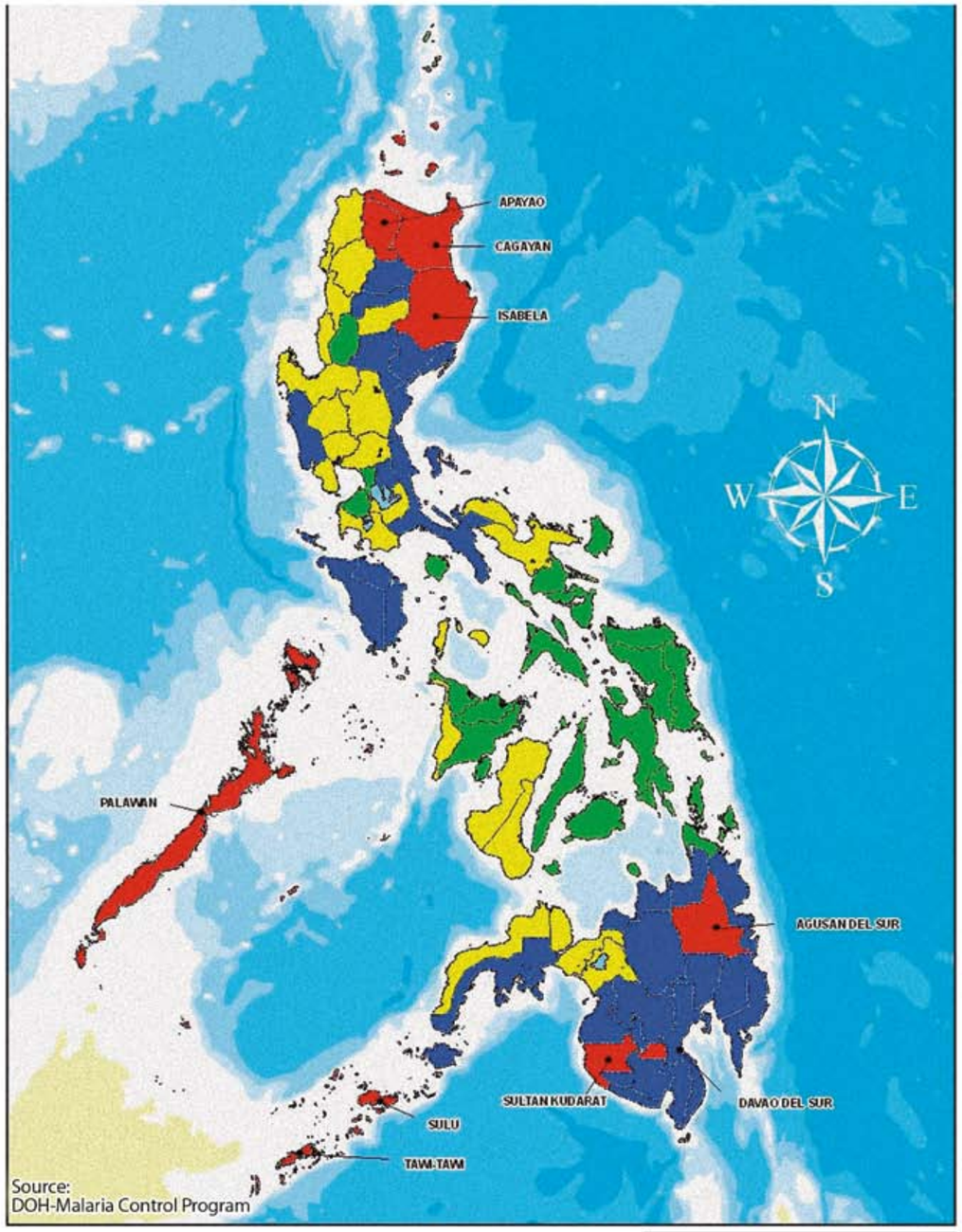


GEOGRAPHICAL DISTRIBUTION OF MALARIA CASES (1991 - 2000)

Legend

Malaria Free | 100 to 1000 cases per year | No Data
<100 Cases per year | >1000 Cases per year

MALARIA GEOGRAPHIC INFORMATION SYSTEM
Malaria Study Group
Research Institute for Tropical Medicine
Filinvest, Alabang, Muntinlupa
(+632) 807-2028 loc. 227



GEOGRAPHICAL DISTRIBUTION OF MALARIA CASES (2001 - 2006)

Legend

Malaria Free | 100 to 1000 cases per year | No Data
<100 Cases per year | >1000 Cases per year

MALARIA GEOGRAPHIC INFORMATION SYSTEM
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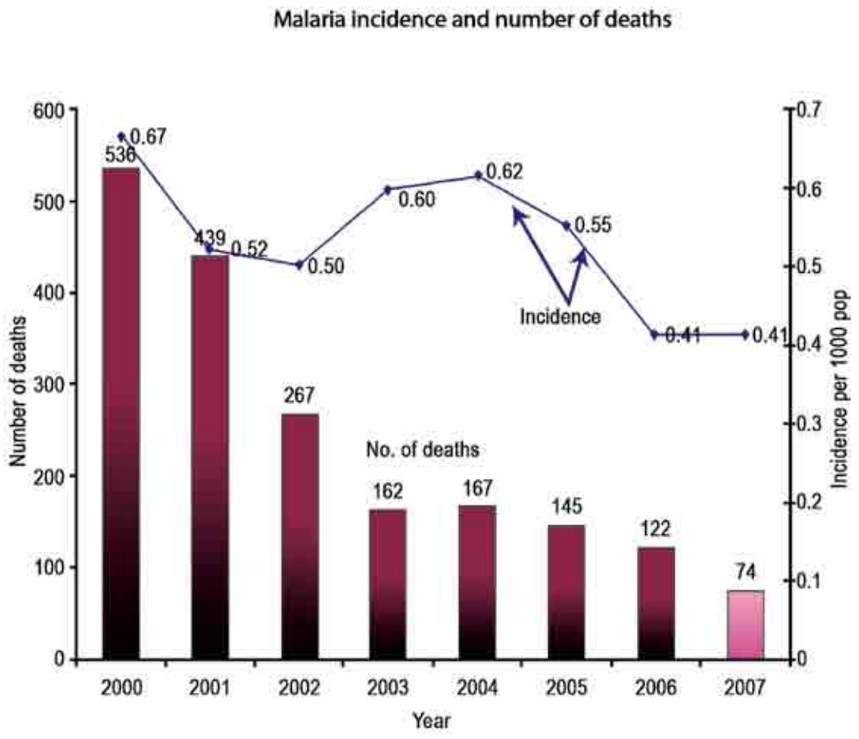
Estimation of Malaria

The global malaria report (2008) has estimated the burden of malaria and the graph below represents its estimates in Asia:-



Estimates of the number of malaria cases and fever suspected of being malaria have been made:

By adjusting the reported malaria cases for reporting completeness, the extent of health service utilization and the likelihood that cases are parasite-positive; where data permit, this is generally the preferred method and it was used for countries outside the African region and selected countries.

Estimates of the number of malaria deaths were also made:

By multiplying the estimated number of *P. falciparum* malaria cases by a fixed case fatality rate for each country. This method was used in countries where malaria accounts for a relatively small proportion of all deaths, and where reasonably robust estimates of case incidence could be made. Method was used primarily for countries outside the African region.

Barangay Health Workers promote malaria prevention in Sarangani.

According to these estimates the burden of malaria in the Philippines could range from 89,066 to 172, 978 (124,152 mid point) and the estimate number of deaths range from 222 to 332 (130 mid point)1. This includes all the endemic provinces some of which are not covered.

CONCLUSION:

Philippines will achieve the MDG goals and is well on course to eliminate malaria by 2020 as per the goals of the Government. In the next few years sporadic outbreaks of malaria can be expected in low endemic areas due to the movement of populations.

> Improving behavior change communication and STI management among the most at risk and vulnerable population

HIV/AIDS Projects
Global Fund Rounds 3 and 5

Accelerating STI and HIV Prevention… Upscaling the National Response…

The Global Fund HIV and AIDS projects approved in Rounds 3 and 5 aim to contribute to the national goal of preventing the further spread of HIV and reduce its impact on those infected and affected. Specifically, it aims to improve behavior change communication and STI management among the most-at-risk and vulnerable populations, i.e., people in prostitution (PIP), males having sex with males (MSM), injecting drug users (IDU), and migrant workers (MW); and to scale up voluntary counseling and testing (VCT), and treatment, care and support for people living with HIV (PLHIV) and their families. Towards this end, the projects have two major components:

A.Prevention

The project implemented HIV prevention activities through behavior change communication campaigns and STI management among the most-at-risk and vulnerable populations in thirty two (32) risk sites all over the country. Activities included:

- Social mobilization and advocacy campaigns to key stakeholders for prevention of STI and HIV transmission;
- Outreach and education;
- Capacity building of service providers and at-risk and vulnerable groups; and
- Improvement of STI services.

B.Treatment, Care and Support

Treatment, care and support activities, on the other hand, included:

- Improvement and expansion of voluntary counseling and testing;

- Development of partnership mechanisms for care, treatment and support involving the positive community, service providers and key stakeholders;
- Clinical services for HIV and AIDS care and treatment in health facilities were also improved and expanded at the same time with the establishment of home-based and community care for PLHIVs. Furthermore, operational researches were also conducted among selected study populations such as the out-of-school youth, seafarers and the informal workforce.

The Rounds 3 and 5 projects were faced with a lot of challenges in the fourth and second year, respectively, of their implementations. Several adjustments and catching up activities need to be made to conform to the emerging needs of the HIV and AIDS program and situation in the Philippines. Nevertheless, through the leadership of the Tropical Disease Foundation's Management Team, its effective partnership with the Department of Health, its NGO implementers and the local government units (LGUs) in the thirty-two project sites all over the country, and with support from the HIV Technical Working Group, both grants successfully achieved their programmatic targets, for which they were both accorded a highly commendable rating of "A" or EXCELLENT by the Global Fund.

People trained:

- **343** Community Health Outreach Workers (CHOWs) and Peer Educators (PEs) completed the training on Behavior Change Communication (BCC)
- **46** NGO Representatives trained on Project Monitoring and Evaluation
- **74** Social Hygiene Clinic and Treatment Hub Personnel, NGO Representatives and private practitioners trained on HIV Voluntary Counseling and Testing
- **21** Social Hygiene Clinic Personnel trained on Comprehensive Management of Sexually Transmitted Infections (STIs)
- **57** DOH STI Coordinators, DILG and DSWD Representatives trained as Regional AIDS Assistance Teams (RAATs)
- **8** HIV and AIDS Core Teams (HACT) Members from the Treatment Hubs were trained in the use of HIV and AIDS Electronic Medical Records (EMR) to record patients' data

People reached:

- **Prevention**
  - **1,923** People who Inject Drugs

    800 (100%) Round 3 and 1,123 (126%) Round 5
  - **29,218** Migrant Workers

    18,330 (134%) Round 3 and 10,888 (272%) Round 5
  - **24,563** Males who have Sex with Males

    16,592 (116%) Round 3 and 7,971 (159%) Round 5
  - **24,797** People in Prostitution

    16,825 (110%) Round 3 and 7,972 (166%) Round 5
- **Treatment, Care and Support**
  - **532** AIDS Patients: 170 (100%) Round 3 and 362 (259%)
  - **88** (88%) received prophylaxis for opportunistic infections
  - **111** (185%) treated for opportunistic infections (OIs)
  - **28** (117%) patients provided with INH prophylaxis
  - **1,921** (%) People living with HIV (PLHIV), Affected Family Members and Significant Others who received care and support

    1,146 (134%) Round 3 and 775 (129%) Round 5

Commodities Distributed

- **3,776,903** Condoms distributed: 3,008,424 (82%)Round 3 and 768,479 (170%)Round 5
- Gram Stain Kits and Syphilis Diagnostic Kits, HIV Test Kits and Antibiotics for STI to Social Hygiene Clinics in thirty-two prevention sites
- **Anti-retroviral Drugs (ARVs)**, including first-line, second-line drugs and drugs for opportunistic infections (OIs) in the eleven Treatment Hubs
- **Laboratory Supplies** including reagents used to determine CD4 Count and Viral Load of People Living with HIV (PLHIVs) on ARVs

Service points supported:

- 44 Service points have been strengthened including 32 Social Hygiene Clinics and 11 Treatment, Care and Support sites throughout the Philippines
- 16 Regional Epidemiology and Surveillance Units (RESU)/STI/HIV/AIDS Units provided with computers and printers for monitoring and evaluation purposes
- 19 Sub-recipient Non-Government Organizations (NGOs) provided with the appropriate capacity building through enhancement trainings on Behavior Change Communication, Voluntary Counseling and Testing, Financial Management and Project Monitoring and Evaluation

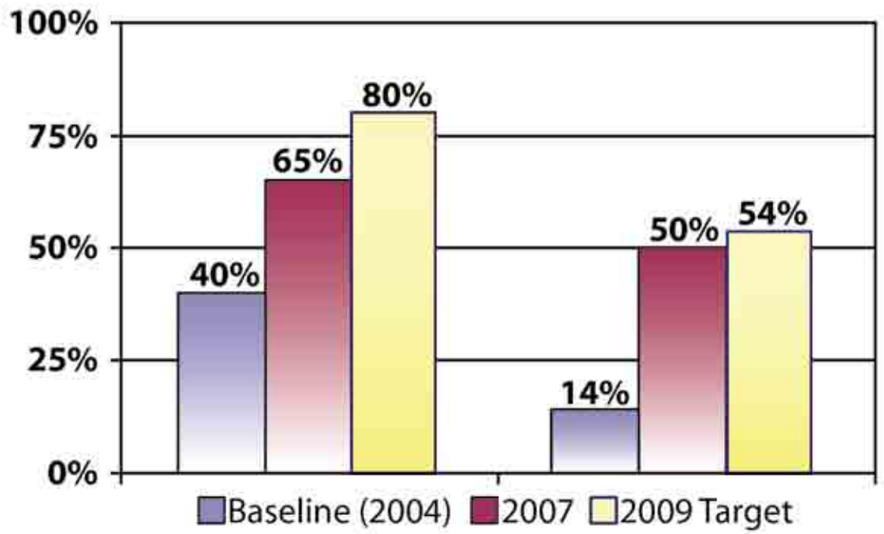
For 2008, the HIV and AIDS Round 3 and 5 projects demonstrated behavior change among the most-at-risk and vulnerable populations, signs of sustainability, outcomes as well as impact, which are as follow:

1. HIV Prevalence remains at <0.1%
2. Increased Condom Use among the Most-At-Risk Populations
3. Decreased Unsafe Injecting Practice among Injecting Drug Users
4. Decreasing STI Cases in the 11 Prevention Sites
5. Universal Access to Anti-retroviral Drugs
6. Meaningful Involvement of PLHIVs
7. Local Government Units Complying with the AIDS Law (RA 8504)

HIV Prevalence remains at <1%

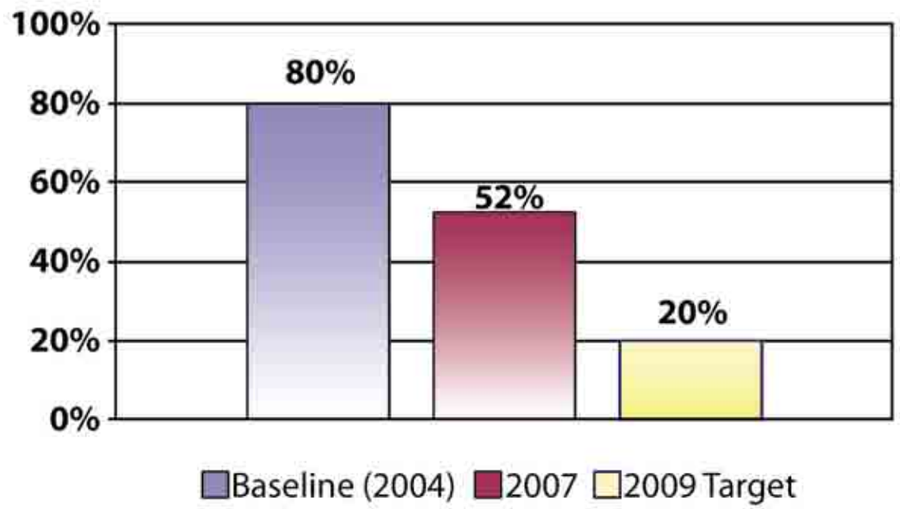
The national adult HIV prevalence remains at <0.1%, with a 0.08% rate among the most-at-risk populations (MARPs), as reported in the 2007 Integrated HIV Behavioral and Serologic Surveillance (IHBSS).

Increased Condom Use among Most-At-Risk-Populations



In 2004, the % of Condom Use among Female Sex Workers (FSWs) was at 40% and 14% among Males having sex with males (MSMs). The % increased to 65% and 50% respectively on the third year of project implementation. Although it still falls below the universal access target of 80%, the increase in the % of condom use for both MARPs are already very close to the 2009 (Year 5) target of 80% and 54% respectively.

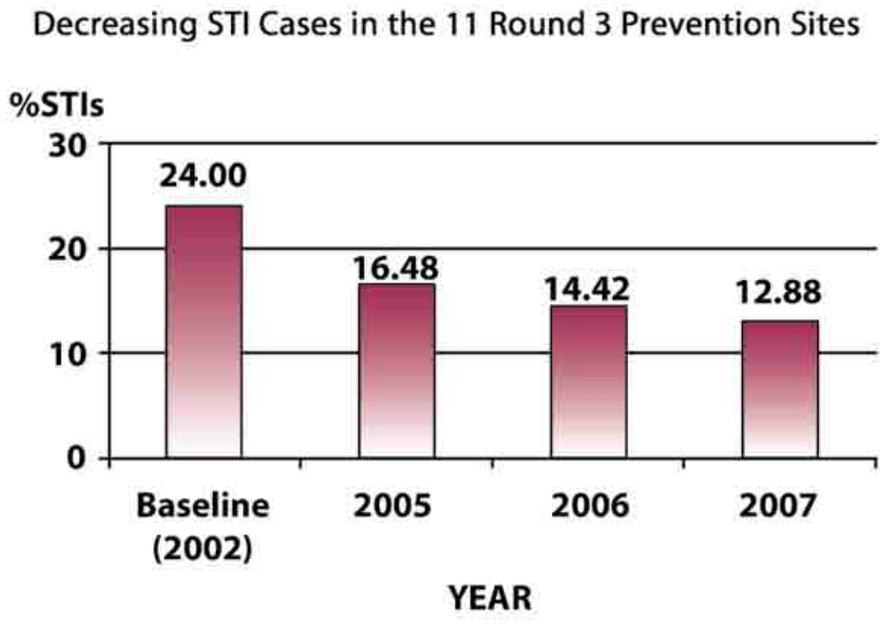
Decreased Unsafe Injecting Practice among Injecting Drug Users



In 2004, the % of Injecting Drug Users with unsafe injecting practice was at 80%. Three years after the project implementation, the % of unsafe injecting practice among IDUs had decreased to 52% nearing the 2009 (Year 5) target of 20% for the Round 3 Project.

Decreasing STI Cases in the 11 Round 3 Prevention Sites

When the project started in 2004, the baseline value for STI cases was at 24%. Since then, there is an increasing trend among total visits in Social Hygiene Clinics for consultation/ check up from 2006-2007. The general trend of Sexually Transmitted Infections from 2005-2007 in the eleven (11) project sites is slowly decreasing with a rate of about 2% per year. The expected outcome is to reduce the STI cases by 50% on the fifth year of the project. Following the trend, the projected % of STI cases by the year 2009 (Year 5) will be at 8%, which clearly shows achievement of the project outcome.



Universal Access to Anti-retroviral Drugs

The greatest achievement of the GFATM-HIV Round 3 and 5 Projects is the establishment of a system so that there is universal access to anti-retroviral drugs in the Philippines. This was made possible through the strengthened treatment hubs and the capacitated physicians so that the ARVs are made available to all who are in need. Although no comparative numbers can be shown as proof of this impact due to lack of baseline data, sequential analysis of the data at hand shows the increasing numbers of patients being enrolled to ARVs through the project life remains to be the proof of increased access to ARVs. This is further complemented by the increasing survival rate of patients on ARVs at 12 months (95%) and 24 months (86%) after initiation of ARVs.

Meaningful Involvement of PLHIVs

As the project has sown its seeds through trainings and capacity building of service providers at all levels of the health delivery system, it also fostered a tight NGO-GO partnership and meaningful involvement of PLHIVs as advocates which complements in the delivery of services for HIV and AIDS. PLHIV organizations are conducting regular activities such as counseling, home based care, and learning group sessions to the infected and affected family members and significant others as part of the care and support component of the project.

Local Government Units Complying with HIV and AIDS Law (RA 8504)

Although Global Fund remains to be the single largest contributor of funds to the Philippine National HIV and AIDS Response, local government units (LGUs), civil society and regional stakeholders also played active roles in ensuring the sustainability of the HIV and AIDS response. Inspired by the Philippine HIV and AIDS Prevention and Control Act of 1998, also known as Republic Act 8504, Local Chief Executives (LCEs) in the project sites realized the need for a local policy anchored on RA 8504. To date, 21 of the 32 project sites have HIV and AIDS Ordinances and functional Local AIDS Councils (LACs). Of which, around 10 (50%) are utilizing their budget allocation from the LGUs to support their respective HIV and AIDS local responses.

Furthermore, at the National level, the National AIDS/STI Prevention and Control Program (NASPCP) of the Department of Health which has been a major partner in the implementation of the project has also shown its willingness to complement the project's initial efforts by providing stop gap measures on the areas where the project could not address the problem in the hope that given enough time and appropriate resources by the government, they can continue on what the project has shown to be an effective response. NASPCP has increased its budget to PhP8 million per year in support to the National Response to HIV.

Nevertheless, while HIV prevalence among the most-at-risk-populations (MARPs) remains low at 0.08%, there is no reason to be complacent; sustaining behaviour change among the MARPs and vulnerable populations continue to be a challenge. Gains must be sustained, and concerted efforts of government agencies, civil society groups and donors must be strengthened and geared towards instituting measures in governance, prevention and treatment, care and support to avert the likely possibility of having a full-blown HIV epidemic in the Philippines.

Success Stories

Community Post for Prevention Services

Leyte Family Development Organization (LEFADO)
Project Sites: Allen, Calbayog, Catbalogan, Isabel, Kananga, Tacloban (PIP, MSM, MW)

A community setting "tambayan" (outreach post) was established primarily to bring in new clients for learning group sessions intended to improve knowledge on STI and HIV prevention. Cooperation with staff from social hygiene clinic also enabled the post to provide STI diagnosis and treatment – a stop-gap arrangement that addressed clients' availability beyond the clinic's operating hours, as well as some clients' "trust issues" with location of (including proximity to law enforcement agencies) and client-provider confidentiality in the clinic.

Mobilization of Internet Social Networks for MSM Outreach

TLF SHARE Collective (TLF)
Project Sites: Makati, Mandaluyong, Marikina, Pasig and Batangas City

MSM have increasingly used online social networks for peer and sexual networking –have become less frequent, and peer groups formed from within the Internet sites. TLF SHARE Collective promoted the project's prevention services from within social networks through casual sexual encounters negotiated online and face-to-face cruising, and arranged among groups access to the services (interpersonal and group learning sessions, condom distribution, STI referrals), when and where groups met offline (a.k.a. "eye-balls" or EB).

Driving Clients Towards Repeat Contact Sessions

Health Development and Empowerment Services (HDES)
Poject Sites: Zamboanga City (IDU)

HDES clearly rationalized its prevention services: after establishing initial contact with target clients, outreach personnel exert best efforts for intensifying repeat contact sessions, encouraging clients to deepen appreciation on HIV and Hepatitis prevention, including involving them in risk reduction counseling. In what may be the clearest demonstration of case working of clients, sub-recipient was able to identify among particular clients their respective individual behavioral change support needs.

Success Stories

Mobilization with Village Leaders for IDU Outreach

Social Health, Environment and Development Foundation (SHED)
Project Sites: General Santos City (IDU)

Renewed campaigns from the national drug enforcement agency presaged formidable challenges in conducting outreach among IDU in the site. Building on a call for responsiveness to the local HIV prevention ordinance, the sub-recipient sought discreet cooperation among some barangay and purok leaders (village and neighborhood leaders) in delivering prevention services, when and where potential and existing clients were situated in relative safety from apparent risk to their persons.

Multi-faceted Advocacy for Migrant Workers

Kanlungan Center Foundation
Project Sites: San Fernando, La Union (PIP, MSM, MW)

To address the challenge of improving reach among migrant workers, Kanlungan Centre Foundation aggressively embarked on different forms of advocacy actions to open opportunity channels for outreach. In the project site, the sub-recipient provided HIV/AIDS orientation sessions among organizations and agencies that function as stakeholders and gatekeepers of local migration processes. Negotiations were made with agencies involved with the third round GFATM – HIV and AIDS project. Participation in local events that catered to prospective migrant workers was utilized to improve public visibility of the prevention services.

Continuing Advocacy with Local Health Board

Bicol Reproductive Health Information Network (BRHIN)
Project Sites: Daraga (PIP, MSM, MW)

Continuing participation of sub-recipients' officers in meetings of the local health board and the local AIDS council enabled stakeholders to be updated with project implementation – the information they learned helped them in analyzing how to carry project gains towards further development of local HIV prevention responses. Some initiatives of community volunteers also get implemented through networking available resources among these stakeholders. Sub-recipient's participation in these bodies enabled them to advocate on operational issues such as improving social hygiene clinic's facilities and ensuring appropriate allocation for the local response.

Success Stories

Maximizing Facilitation for the Local AIDS Ordinance

H.O.P.E. Volunteers Foundation (H.O.P.E.)
Project Sites: Bacolod City (PIP, MSM, MW)

At the end of the second phase, through the sub-recipient's diligence in ensuring close follow-through, the proposed local AIDS ordinance passed on its third reading. The sub-recipient maintained close working relationships with its key government counterpart in the advocacy, the social hygiene clinic. It provided technical expertise and resources to enable the project site to develop and propose related measures detailed "to the letter" as well as ensure multi-sector involvement from planning to participation of implementing advocacy activities to participatory evaluation of experiences in collaboration.

Joint Partners' Monitoring Activities

Remedios AIDS Foundation (RAF)
Project Sites: Metro Manila – Makati, Mandaluyong, Marikina, Pasig (PIP, MW)

Face-to-face monitoring meetings between project implementing partners occur at two levels – for every individual project site and for all project sites. The first level resolves coordination work issues per site, the second provides opportunity for sharing experiences across the cluster. Towards end-phase, assessment and planning cluster-wide synthesized gains of collaboration work as well as set the stage for joint partner-initiated advocacy to local government officials.

Facilitation to Increase Community Stake-holding

Family Planning Organization of the Philippines – Surigao Chapter (FPOP)
Project Sites: Surigao City (PIP, MSM, MW)

Building upon its opportune position of good working relations with local government, including the execution of a memorandum of agreement as regards the project, the sub-recipient was thoroughly involved in evolving dynamics of the technical working group and local AIDS council. In a drive to ensure wider, multiple sector stake-holding on HIV and AIDS in the site, the sub-recipient also complements local governance gains with facilitation for improving awareness and interest from other civil society organizations.

Success Stories

Ligaya Center for Healing… creating an environment to soften stigma to HIV and AIDS

Zamboanga City Medical Center (ZCMC)

Having faced the dilemma of encouraging patients with sexually transmitted infections to submit for HIV testing, ZCMC, in closed coordination with various agencies such as Human Development and Empowerment Services (HDES), Zamboanga City Multi-Sectoral AIDS Council (ZCMSAC), and Zamboanga City Health Office, created the LIGAYA CENTER FOR HEALING (LCH) -- an office that provides an environment that shall soften the stigma brought about by misconceptions on HIV and AIDS.

With a vision to become a resource facility for the nurturance of the spiritual, emotional, psychological, social, and medical well-being of people, the center also cater to patients with other chronic or debilitating medical conditions, aside from HIV and AIDS. The message that LCH wishes to inculcate to the cultural psyche of the community is that HIV infection is similar to other chronic conditions that require holistic healing. For this, the community needs to look at PLHIV in the same way as it sees people with heart failure, cancer, etc., i.e., to see HIV infection with compassion. (By Dr. Jejunee Rivera, HACT Physician, ZCMC)

John*: from a depressive state to active advocacy and volunteerism…

Human Development and Empowerment Services (HDES)
Project Sites: Zamboanga City (Care and Support)

John, a PLHIV in Zamboanga City, was provided with care and support by HDES in 2007. Having found difficulties in accepting his condition, he developed insomnia, anxiety disorders and depression which even caused him to commit suicide. This prompted the HDES staffs to continue provide a series of counseling sessions to him. Because of the emotional support of the committed project staff and also for the continuing support of the Zamboanga City Health Office and the HACT Physician, eventually John was able to cope with his situation.

At present, John is an active PLHIV advocate in Zamboanga City. He is now enjoying his privileges as a volunteer for the Zamboanga City Health Office which also extends their assistance to his affected family members.

**Name changed to protect client's identity*

Success Stories

Ordinance No. 8, Series of 2005

Bauang, La Union Social Hygiene Clinic

Monthly inspection of entertainment establishments and videoke bars is being implemented in Bauang, La Union as part of the prevention and control of STI and HIV in the municipality as mandated by Ordinance No. 8 (Ordinance promulgating policies and prescribing measures for the prevention and control of HIV/AIDS). The ordinance states that all operators / managers of tourist-oriented / entertainment establishments shall attend seminars on STI/HIV/AIDS prevention; not allow entertainers to report without presenting health certificate & make available in the establishment condom and information materials.

Social Hygiene Clinic Nurse convinced a Bishop to Support LGU HIV/AIDS Program

A Social Hygiene Clinic nurse was able to convince a Bishop not to push for the closure of entertainment establishments in one of the GF Round 3 Project sites. The religious authority has been lobbying for the closure of establishments for years –one mayor after the other. The dedicated nurse visited the Bishop and presented to him the STI situation and realities in the said project site as well as the ongoing national response for STI/HIV/AIDS. After a long discussion, the Bishop was finally convinced and gave his much awaited blessing for the STI/HIV prevention activities on the condition that there will be no addition to the existing establishments in the project site.

Mindanao Advocates – A Peer Support Organization

Alliance Against AIDS in Mindanao (ALAGAD)
Project Sites: Mindanao (Care and Support)

A Peer Support organization, Mindanao Advocates was organized through the initiative of ALAGAD. The group intends to increase PLHIV involvement in advocacy activities and in providing support systems among them in Mindanao. Protection of the rights of the PLHIV is topmost concern of this group.

Success Stories

Each One, Reach One, Teach One: Leadership Innovation of PLHIV in Western Visayas

Kabataang Gabay sa Positibong Pamumuhay (KGPP)
Project Sites: Iloilo (Care and Support)

A support group in Iloilo conducts regular treatment, care, and support activities including TV and radio appearances, PLHIV-led campaigns, self-initiated income generating opportunities and proactive participation in local AIDS Councils to discuss concerns surrounding HIV and AIDS in Western Visayas.

The group's goals are to provide the people living with HIV (PLHIV) in Western Visayas with a sense of community and direction as a thriving and striving members of society; to transform their HIV positive status into an opportunity; to take the lead in reaching out those who were tested positive of HIV; and communicate with their affected family members and significant others.

**Kabataang Gabay sa Positibong Pamumuhay was awarded as the National Champion during the 6th Search for Ten Accomplished Youth Organization (TAYO).*

Other Reports

GFATM HIV Round 5 Evaluation

As the HIV Round 5 of the Global Fund Project gets into the eighteenth month of Phase 1 implementation, the need for an external evaluation came as a natural process in preparation for the invitation for continued funding for Phase 2.

The 2008 External Evaluation for Round 5 was a collaborative effort of the Technical Support Facility (TSF), who provided the funds for the External Evaluation Consultant, who chaired the evaluation team. The assistance was made possible through the UNAIDS Country Office; the World Health Organization (WHO) WPRO Office through the WHO Country Office, who provided technical assistance by providing two foreign consultants as part of the Evaluation Team; and the Tropical Disease Foundation who provided the administrative and coordinative support for the evaluation team while in the country.

Dr. Angela Chauduri chaired the Evaluation Team, with Dr. Wang Xiachun and Dr. Gerard Belimac as members. Due to the wide scope of the terms of reference of the evaluation, two evaluation teams had to be created to which local consultants were provided also by UNAIDS and WHO Country Offices in the person of Dr. Peter Mosende, Dr. Madeline Salva, and Ms Malou Quintos to form the second team of evaluators.

The External Evaluation was an almost one month activity from 3 to 30 March 2008. It began with a three-day Team Preparation where the objectives and schedules were set; evaluation tools were developed, checked and distributed; criteria for site selection as well as actual selection was done in a very transparent way; and the roles of all involved in the external evaluation, whether as consultant, support staff or as the PR, were clarified. The evaluation ended in a presentation of the evaluation report to the PR and the Technical Working Group which was eventually approved for presentation to the Country Coordinating Mechanism on 14 April 2008.

Highlights

- The Global Fund Project can only cover a small part of the most at risk population in the Philippines considering that the Philippine HIV Round 5 had to cover 21 sites with a small grant fund of $6.5 million over a 5 year implementation.
- It was quite evident that there was some degree of change in the health seeking behavior of the MARPs specifically the PIPs as shown by the sharp rise in the consultations at the SHCs and the consequent treatment of STIs once diagnosed to be infected.
- Moreover, there were some data indicating project impact that have been noted as an offshoot of the Round 3 Project in terms of accessibility of ARVs to the positive individuals resulting in higher percentages of survival rates at 12 months on ARVs.

“Looking back and moving forward”

Program Implementation Review: GFATM-AIDS Component, Rounds 3 and 5 Projects

The Tropical Disease Foundation, in partnership with the Department of Health conducted two batches of Program Implementation Review (PIR) for the Rounds 3 and 5 Global Fund HIV and AIDS project.

The first batch was held in Best Western Astor Hotel in Manila from 12 to16 May 2008, and the second batch was held in Sarossa International Hotel in Cebu City last 26 to 30 May 2008. The PIR was attended by project partners, both from government and nongovernment organizations, members of the HIV Technical Working Group, and, most importantly, representatives from the People Living with HIV (PLHIV) groups.

The Program Implementation Review was aimed at assessing the implementation of HIV and AIDS programs for both Rounds 3 and 5. It covered prevention and treatment, care and support and looked into the quantitative and qualitative aspects of project implementation.

During the PIR, participants showcased their accomplishments as well as the issues and challenges they encountered in the first phase of the project. Participants from the City and Municipal Health Offices and partner NGOs gladly shared their success stories and inspired each other to continue on with what everyone has started during Phase 1. Partners from the Centers for Health Development (CHDs) who were represented by the Assistant Regional Directors (ARDs) and STI Coordinators also expressed their sincere intentions of becoming actively involved in the project for Phase 2.

The two batches of the PIR were ended by the Candle Light Memorial Celebration to commemorate those who passed away due to the dreaded disease. Everyone realized the role and importance of people’s participation and committed to contribute further in moving towards sustainability.

Other Reports

Treatment Hubs' Pharmacists Training and HACT Clinical Case Conference Held

HIV and AIDS Core Team (HACT) physicians and pharmacists from the 11 Global Fund-supported treatment hubs gathered for a pharmacist training and HACT clinical case conference at Sulo Hotel, Quezon City from 14 to 15 February 2008. Pharmacists from the Research Institute of Tropical Medicine (RITM) and San Lazaro Hospital (SLH), the two biggest treatment hubs in the Philippines, and the Procurement and Supply Management (PSM) team of the Tropical Disease Foundation (TDF) presented tools that can be used by the different treatment hubs to ensure accurate monitoring and timely reporting of antiretroviral (ARV) stocks. This training was aimed at minimizing risk for expiration of the drugs and preventing drug interruption among patients on ARVs. Physicians from the RITM, SLH, the Philippine General Hospital (PGH), and TDF presented cases of HIV patients currently being managed at the treatment hubs. The participants discussed a number of topics, among which are (1) management issues related to ARV treatment; (2) common adverse drug reactions to ARVs; (3) pediatric HIV; (4) prevention of parent-to-child transmission; (5) common opportunistic infections; (6) HIV and TB co-infection; and (7) HIV and drug-resistant tuberculosis. *(Mary Joy A. Morin)*

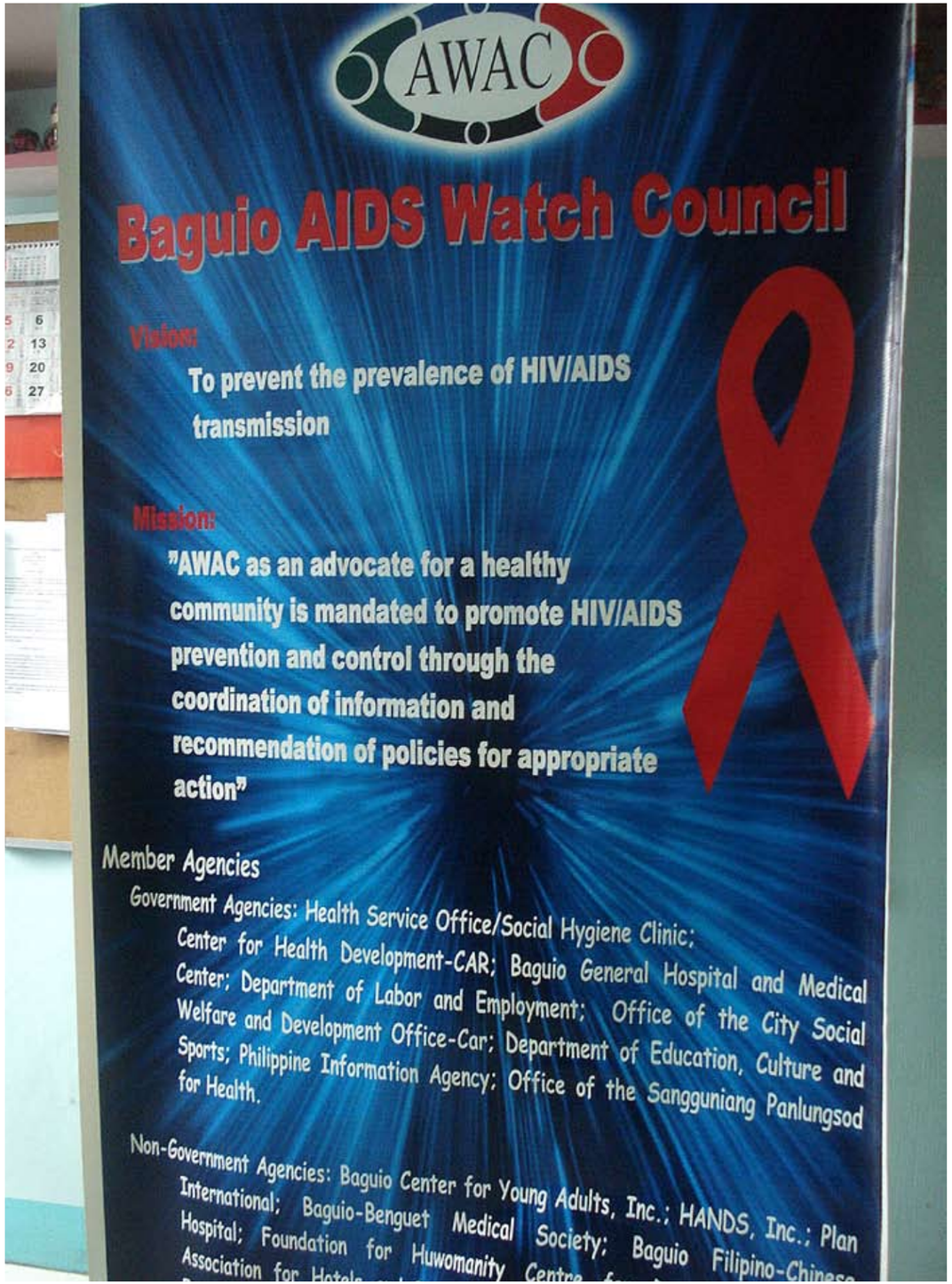
Amie: an affected family member volunteering as peer educator

The active involvement of the affected family members to several trainings immensely contributed not only in terms of understanding the situation of the people living with HIV, but also towards appreciating their own role in providing care and support services.

This is the case of Amelita Alvarado, 42 years old, and a sister of a PLHIV. She started as a caregiver for two months to her brother during his confinement at San Lazaro Hospital. Among other things, she realized the importance of family support for the patient to recover from his situation. Their family also received moral support from other family members present in the hospital by giving them comfort, sharing their experiences and insights, and oftentimes, offering them food.

After his brother's recovery, she volunteered to be part of Remedios AIDS Foundation's TCS team in August 2007 as peer educator to affected family members and significant others. She motivates her peers for greater involvement in the provision of care and support activities. In some activities, she was also tasked as a facilitator.

Acknowledging the fact that she needs further training and exposure in the field, she strives to expand her learning and enhance her skills to improve the quality of her services. *(RAF Report)*



> Reducing the prevalence and mortality of TB

TB Projects

Global Fund Rounds 2 and 5

Scaling up and Enhancement of the National Tuberculosis Program in the Philippines

The Philippines Global Fund TB Round 2 project was approved in 2003 and another in Round 5 in 2006. With the impact demonstrated by the Round 2 TB project, a Rolling Continuation Channel (RCC) was approved for implementation, consolidated with Round 5 for implementation in 2009.

The over-all goal of the TB GF projects is to reduce the prevalence and mortality of TB by half from a baseline established in 2000 and reverse the incidence by 2010 in support of the Millennium Development Goals for poverty alleviation. Four strategies to attain these goals include Quality DOTS Expansion, Private-public Mix DOTS to engage private practicing physicians and other care givers, Advocacy, communication, and social mobilization for TB, and addressing challenges including Programmatic Management of MDR-TB and integration of HIV/TB services.

During the year 2007-2008, the cumulative coverage were:

People trained:

- **14,708** doctors, nurses, medical technologists, midwives, barangay health workers trained on NTP policies and guidelines
- **2,507** community support group members and public health workers trained in DOTS
- **1,746** service deliverers trained in diagnosis and treatment of MDR-TB

People reached:

- 9,433 TB symptomatic referred to DOTS centers through social mobilization
- 18,256 New smear positive TB cases detected thru all initiatives
- 2,379 MDRTB cases detected
- 1,270 MDR-TB patients enrolled for treatment

Service point Supported

- 1 National Coordinating Committee supported
- 16 Regional Coordinating Committees supported
- 169 PPMD units installed
- 344 community support groups formed
- 6 MDRTB treatment centers established

TB Round 5 Grant: Data Quality Assured

A Data Quality Audit (DQA) by THE KNCV Tuberculosis Foundation of the Netherlands, commissioned to do the DQA for the TB round 5 Grant was undertaken in September 2008. The DQA was grounded in the components of data quality, namely, that Programs and projects need accurate, reliable, precise, complete and timely data reports that managers can use to effectively direct available resources and to evaluate progress toward established goals. The purposes of the DQA were specifically for the Global Fund Round 5 TB proposal in The Philippines to:

- Verify the quality of the reported data for key indicators at selected sites; and
- Assess the ability of data management systems to collect and report quality data

The indicators selected for the DQA were:

1. Number of new sputum smear-positive patients registered during the period July-December 2007
2. Number of patients successfully treated (cure and treatment completed) of the cohort of patients registered during the period April-June 2007

Verification and review of data started in the national level and later to selected sites including Regions III, VI and VII. This was a pilot study in implementing the DQA by the Global Fund. The Philippines' TB round 5 Grant passed the data quality assurance with flying colors as shown in the table below.

The availability, completeness and timeless of reports for the two indicators for the M&E, intermediate and service delivery site levels combined is listed below.

Indicator	% Available Reports	% Timely Reports	% Complete Reports
Number new smear-positive patients detected	97%	92%	97%
Number new smear-positive patients successfully treated	80%	93%	93%

The quantitative results for the trace and verify exercise, based on the GF Protocol 2 tool, were limited due to small numbers and sampling issues. Nonetheless, in both quantitative and qualitative terms, only minor issues were detected which would require some limited interventions to improve the data quality for this project for the two indicators. The trend seemed to indicate that fewer reported cases for both indicators were found on the national level than at the service delivery sites; thus, the national system seems to be slightly under-reporting cases. Overall, the results of the audit, with GF Protocol 2, suggested that the project is running quite well.

Mayor Vilma Santos participates in the fight against TB.

A Committed Strategy Materialize: ACSM's Task Forces commitment unwavering

In the interim period, we faced the problem of continuity of function of the task force groups, the members of whom are volunteers from the barangays. One of the effects of consolidating the grant is the adjustment of the time period of implementation which affected 270 Task forces. Support had to be temporarily cut off in financial and monitoring terms. In spite of this setback, the Task Forces proved their resiliency by continuing to refer TB suspects to the health units, proof that they wanted their communities to be free from TB. They reported an additional 299 new smear positive patients, an increase of 42% over the last reporting period. In the paradigm of community development employed by the implementing agency and the Global Fund, it appears that the Task Forces could be a sustainable endeavor.

Public-Private Mix Dots (PPMD) Implementation

Local TB Coalition (LTBC) Building and Strengthening

A Local TB Coalition (LTBC) is a group of individuals within a community representing different organizations who agree to work together to address the TB problem at the local level. Its objective is to expand TB advocacy activities in the various provinces of the country. A guidebook was published to standardize the basic processes of local coalition building and organizing. These organizations represent about 38.5 million population. As of February 2009, there are 27 existing LTBCs (6 regional, 11 provincial, 9 city, 1 municipality) while 4 LTBCs are still currently being organized.

Social Mobilization Approach in Social Health Insurance: "Medicare sa Masa Benefits"

This was designed and implemented by the City Health Office of Bislig City with the objective of attaining 100% coverage of health care financing for the indigent families of theCity by year 2008. It involves a tripartite scheme – the indigent family, the sponsoring NGOs, business entrepreneurs, local political leaders, individual families, and the national PHIC. Families without PHIC coverage are matched with an NGO, GO or entrepreneurs willing to subsidize part of the payment for PHIC. Sponsors are enlisted through advocacy and Social Mobilization (SOCMOB) approach. The client is expected to enjoy the the LGU for capitation funds.

Tool for Monitoring and Evaluating PPMD Sustainability

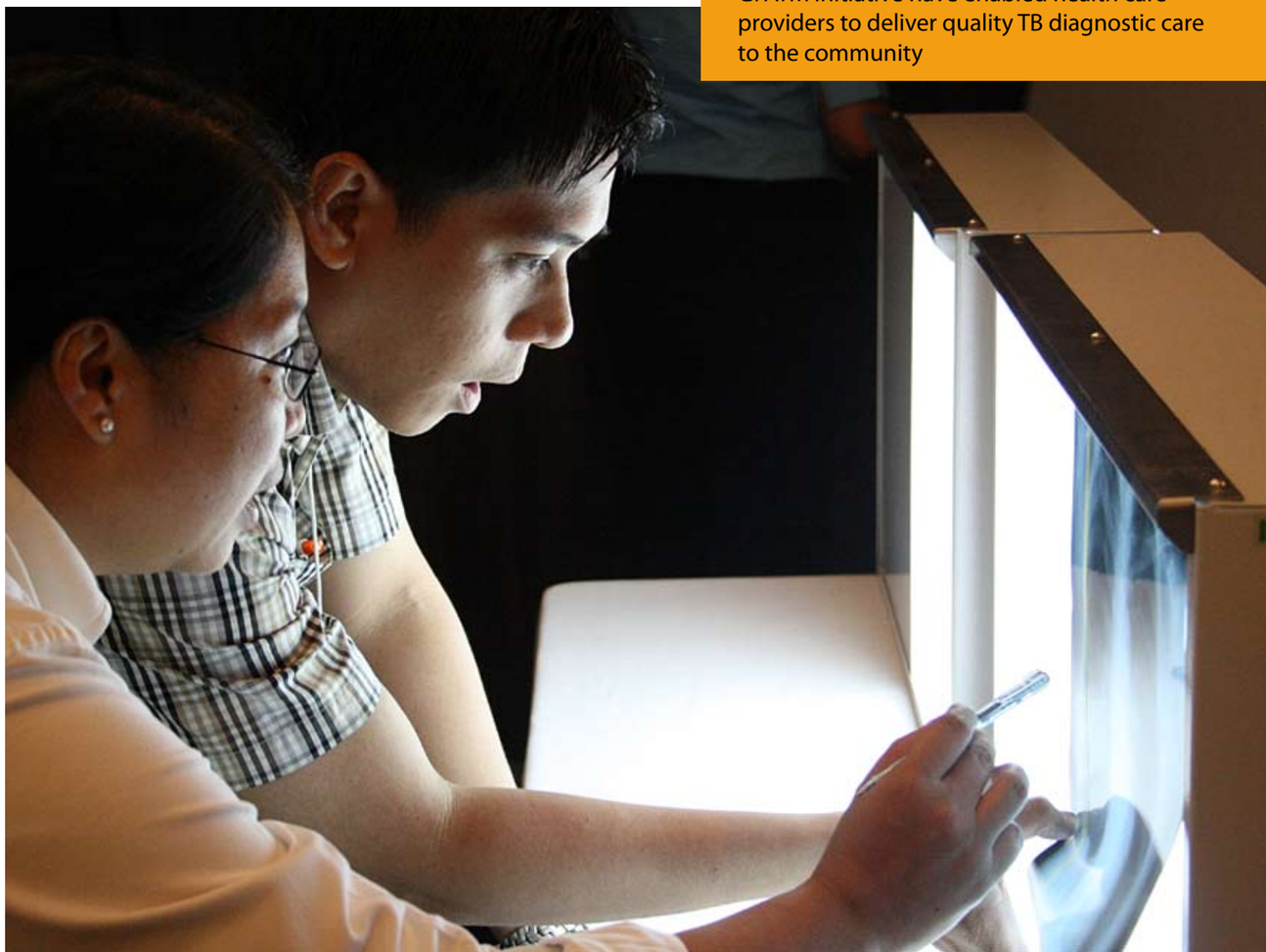
A Sustainability Monitoring Tool (SMT) was developed to monitor the progress using the PPMD sustainability element and five-year strategic direction as guide. It measures the extent by which the targets were met for all 13 sustainability indicators based on year of operation. To evaluate the sustainability of a PPMD unit, a Questionnaire (SSAQ- Sustainability Self-Assessment Questionnaire) was used with 13 questions each corresponding to the sustainability indicators. Scores generated determines the level of accomplishments of PPMD units relative to sustainability targets.

PPMD Evaluation Wheel

This is a graphical representation of PPMD units' level of accomplishments to help them visualize their current sustainability performance based on the 4 domains: technological, sociocultural, political, and financial. Out of 220 PPMD units that utilized the tool:

- 3 units are sustainable (40 pts.)
- 92 units have high potential for sustainability (28-39 pts.)

Capacity Building activities supported by the GFATM initiative have enabled health care providers to deliver quality TB diagnostic care to the community



- 95 units have moderate potential for sustainability (16-27 pts.)
- 15 units have low potential for sustainability (4-15 pts.)
- 15 units did not utilize the tool

The national performance score is 26.9 out of a total 40 points. This translates to moderate potential for sustainability of PPMD units. PPMD units' strengths are in the Technological and Socio-cultural domains. Financial and Political domains still need further development.

Regional Coordinating Committees (RCC) in PPMD Implementation

RCCs were set-up nationwide to serve as the overall coordinating body at the regional level. They selected areas where PPMD units could be installed and provide technical assistance in the conduct of advocacy symposia to generate commitment, training of private physicians for establishing and operating these units. They facilitated the installation of 169 PPMD units with a total of 5086 private physicians engaged in DOTS. Efforts to attract support from private physicians and other non-NTP providers have resulted in 20,879 TB patients enrolled for treatment. New smear positive cases from PPMD units contributed 14% to CDR in areas where PPMDs are operating and 5% to the National CDR in 2007. Of the 2,223 smear positive cases in 2006, 91% were successfully treated.

Developing Local Polices for DOTS

Generating support through local policies for both public and private initiated PPMD units is seen as one of the strategies to ensure political viability of PPMD units. This Policy signifies program ownership of the LGU and the private-initiated PPMD units. A total of 186 policies are in place while 74 are still in progress. These policies define support for PPMD operations, drug supply, BHW and treatment partner, TBDC meetings, advocacy, PhilHealth packages, etc.

Community support is essential to the success of anti-TB efforts.

> “Integrating with the government services in Training, Drug Management and Laboratory”

Service

Programmatic Management of Drug Resistant TB (PMDT)

Mainstreaming PMDT in the National TB Control Program (NTP)

Programmatic Management of Drug-resistant TB (PMDT) has a full coverage in the National Capital Region which has a population of 13 million. This was formally initiated in 2006 through a Memorandum of Understanding (MOU) with the Center for Health Development (CHD)–NCR and its local government units (LGUs), the National Center for Disease Prevention and Control (NCDPC) of the Department of Health (DOH), the National TB Reference Laboratory (NTRL), the Lung Center of the Philippines (LCP), and the Tropical Disease Foundation (TDF). This expression of political commitment was followed by the Issuance of Administrative Order (AO) 2008-0018, *the National Implementing Guidelines for PMDT* by the Secretary of Health setting the mandate for nationwide support for the management of multidrug-resistant TB (MDR-TB) cases in the context of the National TB Control Program. PMDT services have then been integrated to the government services in the aspects of Training, Drug management, and laboratory.

Expanding regionwide to Metro Manila and to another region

In March 2008, one MDR-TB Treatment Center (MTC) was established in the Jose N. Rodriguez Memorial Hospital (JNRMH), a private-public Mix DOTS unit (PPMD) in Caloocan City. With an outpatient facility done outdoor and a few hospital beds, this facility is able to accommodate many MDR-TB patients. In September 2008, the fifth MDR-TB Treatment Center (TC) was set up at the Philippine Tuberculosis Society, Inc. in Tayuman, Manila with an indoor facility. All these five TCs are strategically located to accommodate the patients

from different parts of the region. As of December 2008, a total of 1,207 drug-resistant TB patients have been enrolled in the different treatment centers.

Expansion to the first region outside Metro Manila occurred in September 2009. A Memorandum of Understanding was signed by the key partners The MTC of the South within the Eversley Compound in Mandaue City, Cebu was launched formally signifying the availability of MDR-TB services in the region in November 2008.

Patient Empowerment

As TB/MDR-TB is an illness that goes beyond the medical aspect, the psychosocial care program for patients that began in KASAKA led by a Clinical Psychologist in 2005 has been replicated in all MTCs established. Addressing the emotional problems that go with such a chronic illness, psychosocial care through focus group discussions and one-on-one counselling, has become integral to the management overall management of drug-resistant TB. Group outings, general assemblies and peer counselling activities participated by most patients.. Capacity building to facilitate group discussions has been done for the Treatment Center social workers and other staff.

Skills training, livelihood projects such as making beaded slippers, purses Christmas decorations, other crafts, gardening, poultry-raising and cooking, are some of the activities in MTCs done to alleviate homesickness, to provide patient empowerment. MDRpTB patients have spoken about their experience with MDR-TB during special occasions.

PMDT Training

Competency-based Training Modules for PMDT have been developed with technical assistance from the World Health Organization (WHO) – Headquarters, and with the input from partners in the NTP. These modules were finalized after undergoing the WHO-recommended ten-step process of training material development that began in September 2006 . A Final Editing Workshop on January14-18, 2008 facilitated by the core PMDT Team of TDF with the guidance of K. Bergstrom and J. Creswell, WHO-HQ consultants, and participated by the NTP, CHD-NCR and WHO. These were pilot tested on April 31-May 4 to CHD-NCR NTP during the Training of Trainers for CHD-NCR NTP Coordinator.

The PMDT set of Modules consist of 8 modules namely: A) Detect cases of MDR-TB, B) Treat MDR-TB Patients, C) Inform Patients about MDR-TB D) Ensure Continuation of MDR-TB Treatment, F) Manage Drugs and Supplies for MDR-TB, G) Monitor MDR-TB Case Detection and Treatment with two Monitoring Workbooks for both Participant and Facilitator, and H)Field Exercises: Observe MDR-TB Management. The Reference Booklet is a compilation of all the forms that are used in the programmatic management of drug-resistant suspects and cases. The Facilitator's Guide functions as an easy step-by-step accompaniment to the modules for the facilitator.

A pool of Master Trainers have been created in the TDF and the NTP, and a core of Trainers for the Metro Manila Region coming from the CHD-NCR and selected LGUs through a Training of Trainers in April 2009. Following this, a five-day modular course for Treatment Site doctors and nurses has been conducted regularly May-August 2009 facilitated by the regional core of trainers initially under close supervision by the Master Trainers in TDF and DOH. By September 2008, CHD-NCR trainers started conducting the course on their own to Treatment Site staff.

This first edition is currently pulling together comments from its end-users and new developments from the new WHO guidelines on PMDT and from the literature in preparation for a future revised edition.

PMDT Modules used to train health workers.

Patient Decentralization

Patient decentralization is a systematic process of endorsing patient care from the specialized MTC to the peripheral Treatment Site thereby improving access to MDR-TB services by bringing them nearer to where patients live. This is done when the patient has converted to sputum culture- and DSSM negative, and if the patient is not experiencing uncontrolled adverse drug reactions. This is also done after the facility has undergone PMDT training. As of December 2008, a total of 195 (40%) public DOTS facilities and 13 NGOs, faith based organizations, and self installed PPMD.

Patient decentralization started in 2003 as a project-based activity and was shifted to a program-based process in a phased manner in July 2007 involving the cities of Caloocan, Quezon, Pasay and Pasig, followed by Phase 2 (Marikina, Malabon, Mandaluyong, Navotas, San Juan and Valenzuela) in Novemebr 2007, and Phase 3 (Las Pinas, Manila, Makati, Muntinlupa, Taguig, Paranaque and Pateros). This program-based patient decentralization is a highly coordinated activity which entails a series of procedures starting with a social preparation for the eligible patients at the Treatment Center coordinator with the CHD for the training of the corresponding Treatment Sites.

PMDT staff regularly train health workers on the management of drug-resistant TB.

Drug management

Second-line drugs (SLDs) used to be managed centrally by the Tropical Disease Foundation. Through the GFATM, the regional warehouse of the Metro Manila was renovated in April 2007. In May, storage of drugs was transferred to this warehouse. In December, the CHD-MM Warehouse started to take on the responsibility of delivering the drugs to the Treatment Centers. While the project-based procedure utilized individual packets of daily drugs in a "push" system to Treatment Sites directly from Treatment Centers, starting September 2008, the "pull" system was used wherein Treatment Sites determined their own drugs needs and requested these to the Treatment Centers through their respective City Health Offices.

The PMDT team in TDF monitors the drugs in the warehouse and in Treatment Centers and still handles the procurement of SLDs. These functions will be slowly mainstreamed to the DOH through its Materials Management Division (MMD).

Laboratory

From 1999 to early 2007, all cultures and drug susceptibility testing (DST) was done at the TDF Laboratory. Through capacity building by the TDF lab staff, the LCP lab has been doing culture since October 2007; and the PTSI Lab in September 2008. The National TB Reference Laboratory (NTRL) started to do routine culture for PMDT in late 2007 and satisfactorily passed the proficiency test for DST in February 2008 after which it has been doing routine DSTs for the program together with TDF. At the moment, capacity building is ongoing for the Cebu TB Reference Laboratory which is anticipated to start services by the second quarter of 2009.

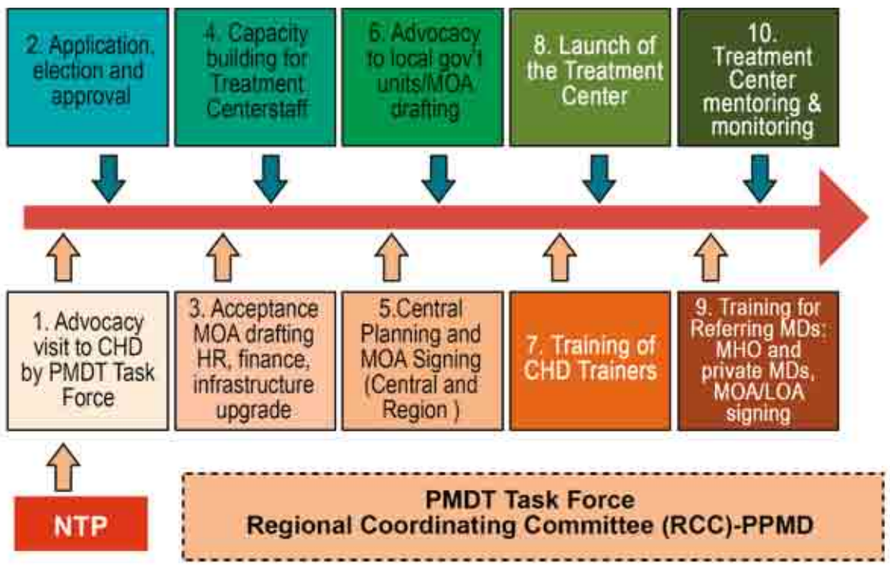
Infection Control:

Infection control has become an important aspect in MDR-TB care both in the laboratory setting. The three controls in hierarchical order namely administrative, engineering controls and personal protective equipment are observed in both Treatment Centers and the laboratories. Treatment facilities have popularly used the tent in an outdoor area providing the most cost-effective setup for supervised therapy particularly in the early intensive phase in a tropical country like the Philippines. Cohorting, assigning time slots to bacteriologically positive and negative patients have been used. Patients are required to wear surgical masks at all times, while health workers are required to wear fit tested respirators. An infection control team of laboratory technologists led by a well-trained specialist conducts visits to the different facilities from time to time. Staff surveillance is also ongoing to ensure that staff are examined regularly.

The scale up

In preparation for the nationwide scale up through the Consolidated GFATM Grant (2009-2014), a 10-step series of activities have been initiated to engage regions in the country.

10-step approach to engaging regions



The first step in this approach is an invitation letter from the DOH to the Regional Director to participate in the MDR-TB control efforts of the NTP. The letter also requests the CHD to identify potential Treatment Centers from well-performing DOTS facilities and non-regional laboratories in the region to support regional laboratories that have been earlier engaged by the NTRL. A PMDT Task Force led by the NTP, with members from TDF, PhilCAT, World Vision, LCP-PMDT, and WHO visit the region to hold consultative meetings and do ocular visits to the nominated facilities. A call for application is made and the facilities are given one month to apply to become a treatment center. The Task Force reviews applications and selects the best one. The NTP informs the facility and the process of project-based human resource, financial and infrastructure upgrade begins. A memorandum draft is also passed for comments by involved parties. Once personnel for the facility are hired, capacity building can begin at the TDF center and its satellites. A Central Planning Workshop is then conducted participated in by the CHDs, the NTP, TDF, the selected facilities, PhilCAT and partners. The MOA is signed during this three-day activity. Capacity building is also done during this workshop to train regions on how to conduct advocacy activities with their LGUs and local training activities to the referring physicians such as the municipal health officers, the private and hospital doctors. After the Central Planning, the CHD now starts conducting advocacy activities with their respective LGUs. This is followed by a Training of Trainers. After the infrastructure has been upgraded, the Treatment Center will then be launched. Training of referring physicians follow together with a Signing of an MOA between the CHD, the LGus and the treatment and laboratory facilities.

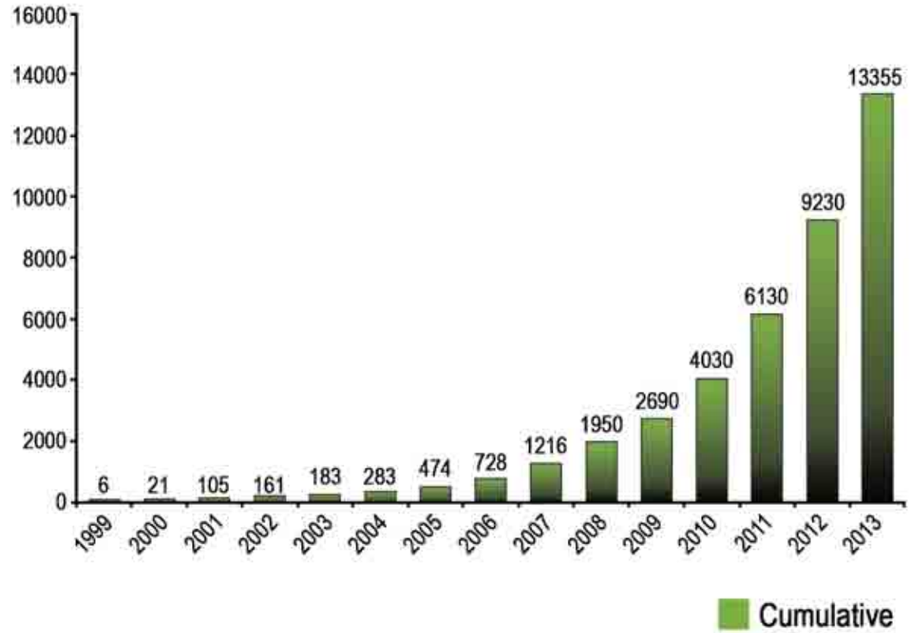
The schedule below reflects the timeline for the engagement of regions in the country anticipating a nationwide coverage by the second quarter of 2010. From the baseline of two regions now implementing PMDT, another 10 regions will be engaged in 2009 and the remaining 5 in 2010. A total of 37 more treatment centers will be set up in the different regions by 2014.

Timeline for CHD engagement in the Philippines during the GFATM Scale up (2009-2014)

Baseline (2)	Quarter	Year 1: 2009 (10)	Year 2: 2010 (5) - not in order	Year 3: 2011 (0)
1. NCR 2. CHD 7	**Quarter 1**	1. CHD 10 2. CHD 11	1. CHD 2 2. CARAGA	
	Quarter 2	3. CHD 1 4. CHD 5	3. CHD 8 4. CHD 4B 5. ARMM	
	Quarter 3	5. CHD 4A 6. CHD 6 7. CAR		
	Quarter 4	8. CHD 5 9. CHD 3 10. CHD 12		

A total of 13,355 patient will have been initiated on treated by 1013 by th 43 treatment Centers in the country.

Patient enrolment during the scale up (2009-2014)

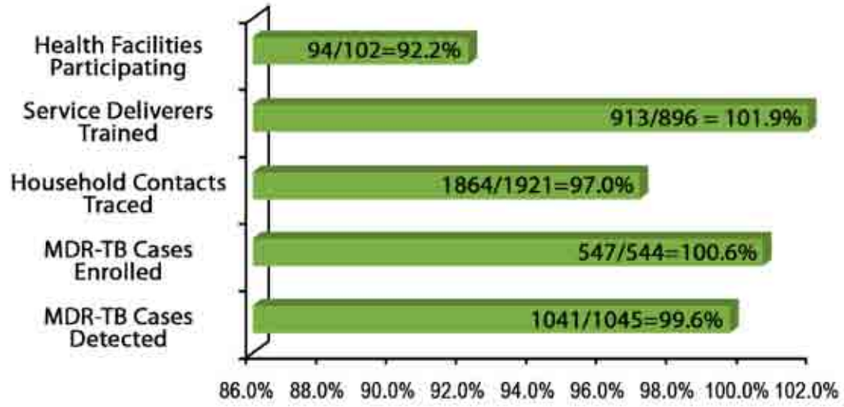


PMDT targets and accomplishments of Round 2 (2003-2008) and Round 5 (2006-2008)

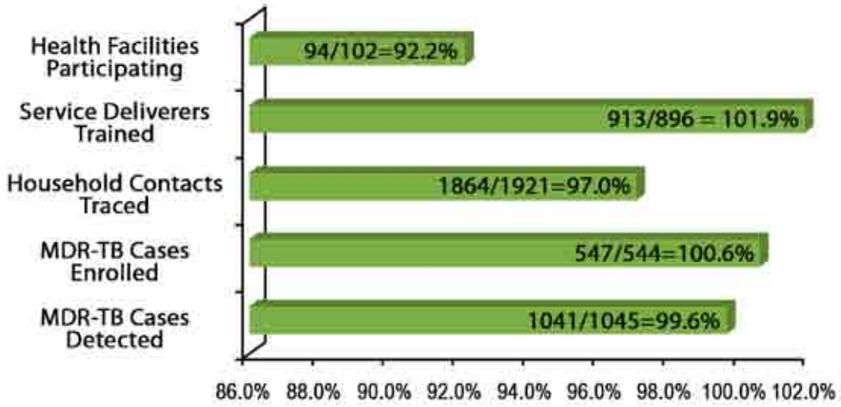
Indicator	Round 2 (June '03 - July '08)		Round 5 (October '06 - December '08)	
	Target	Accomplishment	Target	Accomplishment
People Reached				
MDR-and DR-TB cases detected	1045	1041 (99.6%)	1274	1328 (104.2%)
MDR- AND DR-TB cases enrolled	544	547 (100.6%)	660	723 (109.5%)
Household contacts traced	1921	1864 (97.0%)	1686	2216 (131.4%)
People Trained				
Service deliverers trained in PMDT	896	913 (101.9%)	757	833 (110.0%)
Service Points Supported				
Health facilities participating in PMDT	102	94 (92.2%)	40	101 (252.5%)

Indicator	Round 2 (June '03 - July '08)		Round 5 (October '06 - December '08)	
MDR-TB treatment centers established	N/A		6	6 (100.0%)
Service Points Supported				
MDR-TB patients successfully treated	62.41% (83/133)	75.94% (101/133)	Not yet applicable	
MDR-TB patients who defaulted	11.28% (15/133)	10.53% (14/133)	Not yet applicable	

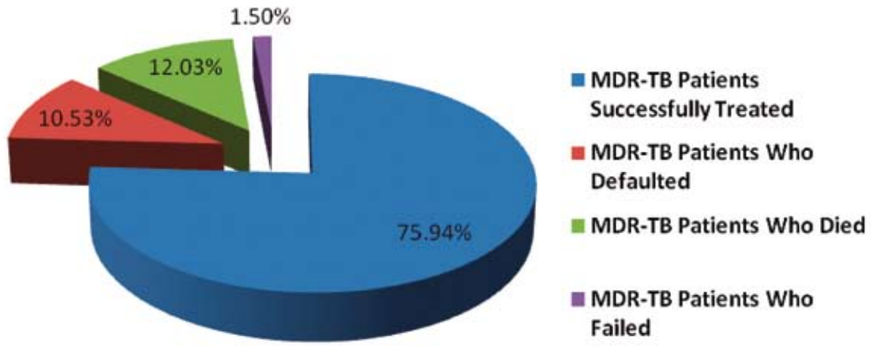
Targets and accomplishments: GFATM Round 2 June 2003 – July 2008



PMDT targets and accomplishments GFATM Round 5: October 2006 – December 2008



Treatment Outcomes
GFATM Round 2: August 2004 – July 2005 Cohort



Trainees are actively engaged in the fight against TB.

I am stopping TB! and Images from PMDT

The Philippines ranks 9th among the 22 high TB burden countries of the world and 2nd in the Western Pacific Region (WHO Global Report, Western Pacific Report, 2008). Seventy-five Filipinos die of TB every day. For every thousand patients, there are about 5 who have culture-positive disease (2007 National TB Prevalence Survey., 2008). Globally, almost 500,000 patients with multidrug-resistant TB emerge (Drug-resistant TB Surveillance, 2008); in the Philippines, an estimated 11,000 MDR-TB cases develop…. We can talk endlessly of figures and statistics but … behind these numbers are human voices and faces, and individuals deeply affected by TB.

"*I am stopping TB*" are living quotes from both patients and health providers who have encountered TB one way or another. Each has a message on how s/he is stopping TB.

"Interesado akong ikuwento ang aking karanasan sa sakit na TB hindi lang para sa sarili ko, kundi sa pagnanais ko ring makatulong sa sambayanang Pilipino. Kung may dinaramdam sila, ay huwag silang mahiyang magpagamot para masugpo ang sakit na ito. Hinihiling ko ang inyong kooperasyon. Tulungan natin ang ating sarili. Para matulungan din natin ang ating bansa at sambayanang Pilipino."

– Arnold T. Ferrer, LCP

"Ngayong magaling na ako, I'm free to do the things I want to do. Yung mga bagay na pinangarap kong magkaroon ako ay natupad na. Nakakapagtrabaho na ako, at higit sa lahat isang magandang trabaho ang binigay nya sa'kin. Since November of 2007 I am working at The Tropical Disease Foundation as part of the team in-charge of Programmatic Management of Drug-resistant TB. Alam ko kung anong mga hirap ang pinagdadaanan nang isang MDR-TB patient as I've been there. And for me, napaka-noble ng trabaho ko dahil alam ko na ang pinagseserbisyuhan ko ay mga pasyenteng magiging maayos din ang buhay tulad ko sa paggaling nila. God is so good. There is always a purpose why things do not happen and why things happen. Alam nya kung kailan dapat at hindi dapat. And I was a witness. He will use people in answering your prayers. You just have to be patient.

- Mildred Fernando, MMC DOTS Clinic

I am stopping TB! and Images from PMDT

"Simula nung una akong matapos gamutin, hanggang ngayon, patuloy akong nagkukusang-loob na makatulong sa paggagamot at pagpapayo sa ibang mga pasyente. "

– Toto del Rosario, cured patient, volunteer health worker, LCP

"Hindi kailangang sumuko sa buhay. Hangga't ika'y nabubuhay, kasama ang pamilya, mga kaibigan at ang Panginoon, andiyan sila upang tayo'y damayan kung ano man ang mga problemang dumarating sa 'tin. Kaya kailangan lang ay lumaban dahil kapag ito'y iyong nalampasan, ay may magandang kalalabasan ang lahat ng paghihirap natin. Kailangan lamang magsumikap. Parte ito ng pamumuhay natin, kaya huwag kayong magpatalo."

– Al N. Bognot, LCP

WHO/Dominic Chavez

Leo Vincant Jawili carries his wife, Decere Lai Jawili, to a waiting taxi outside the International Center for Tuberculosis in Manila, Philippines. Every day for several months, he has carried his wife into the centre where she takes her daily regimen for MDR-TB.

I am stopping TB! and Images from PMDT

WHO/Dominic Chavez

Christopher Alabado receives his daily injection of capreomycin at the International Center for Tuberculosis in Manila, Philippines. A few hundred patients arrive six days a week at the centre to receive their treatment. Many of the patients have formed close bonds because of the daily visits.

"… I spend most of my time facilitating group discussions, individual counseling and other therapy sessions with TB patients. I have found listening and speaking with people who have almost given up hope in life as a great learning experience. Teaching them to cope with their feelings of rejection, abandonment, discrimination, and the stigma associated with TB has been very rewarding. To coach them to eventually accept life in its own terms is the step towards the ultimate realization of their own self worth and the beginning of the will to live. I feel glad that by doing this, I became part and instrument of God in healing patients with MDR-TB. "

– Rod Lopiga, psychologist

I am stopping TB! and Images from PMDT

Dennis Atibula, an MDR-TB patient, prays during a church service in Manila, Philippines. Atibula works as a realtor in the city, selling commercial and residential properties. He says he has relied on his faith to help him take the second-line drugs for his infection and to keep his thoughts positive.

"I could have had the walk of fame in Hollywood, or the walk along the London Bridge, or any other walk in some green pastures that most of my countrymen dream of. All it takes is a nursing profession, hospital experience and stamina of youth, which I all have. but I chose to be a TB worker, embracing new challenges because with this I realize the relevance of my existence and social contribution I can make for the progress of society. "

- Virgil Belen, Health, nurse

"… tiis at tatag lang ng loob upang makatapos sa paggagamot. Determinasyon na kung kaya ng iba, kaya ko rin. At higit sa lahat, dasal at pasasalamat na na-extend pa ang pananatili sa earth."

- Ydnar E. Mangiralas, LCP

I am stopping TB! and Images from PMDT

"Akala ko nung una, dapat mahiya kapag may TB. Hindi pala dapat. Kung inuna namin ang hiya dahil l'ang marami kami sa pamilya na may TB, baka hindi na kami umabot sa ganito. Napatunayan ko na pag magkakaramay ang pamilya, kayang-kaya… Hindi ako dapat mawalan ng pag-asa. At last, matatapos na rin ako sa gamutan ko. Actually, masaya na ako, kasi alam ko na kaya namin 'to. Kaya ko 'to. "

– Joanne Mancilla, KASAKA

"So tuloy lang ang laban. Tuloy at di papalya sa gamutan. After all, itong pagkakaroon ko ng sakit na TB made me a stronger and better person. No regrets, no more question na bakit ako pa? Hindi kailangang mag-senti dahil hangga't may programa para sa ganitong sakit at mga health workers na dedicated sa layunin nilang makatulong, buhay ang pag-asa sa mga kagaya kong may TB."

– Ruben Marasagian, LCP

Arnold Sillote (left) and his mother Luzminda Sillote (centre) wait nervously for her MDR-TB test results at the International Center for Tuberculosis in Manila, Philippines. If she is found to have MDR-TB, she will need to take second-line drugs daily for the next 18 months.

I am stopping TB! and Images from PMDT

"Nalaman ko na nahawa ang nag-iisa kong kapatid sa akin. Awang-awa ako sa kanya lalo't nag-aaral pa siya. Gusto kong magsilbing inspirasyon sa aking kapatid na huwag siyang mawalan ng pag-asa, tulad ko, sa tulong ng Panginoon. Naniniwala ako na ang kagalingan at kalakasan ay ibinigay na niya sa amin."

- Mark Jerrome Lero, MMC DOTS

"…I believe that God has put me here for a reason; all I need to do is to continue to pray that all the patients waiting for treatment will be put on treatment, that all patients suffering from adverse drug reactions will be soothed. I pray that I wouldn't have to ask payment from patients nor ask them to buy their own drugs to be cured. I pray that I could be someone who can treat patients without asking for payment, and can contribute to the greater good of society."

– Ruth Orillaza-Chi, physician

WHO/Dominic Chavez

"I want to be a nurse and help others who are sick," said Charlene Laguinday. "I want to give back what was given to me." She recently lost her mother to MDR-TB. She is now undergoing treatment for the same disease, and her health is improving every week.

"A Hundred Percent Coverage of all Examinations….through Mountains and Fields, Rain or Shine…"

Research Division

Epidemiology

The TDF as one of its main thrusts undertakes field research in epidemiology, operational researches, laboratory-based studies, and clinical trials. Ten years after the launch of the DOTS strategy, the Department of Health deemed in appropriate to undertake the 3rd nationwide TB prevalence survey. The Tropical Disease Foundation was once again commissioned to undertake the study.

The 2007 Nationwide Tuberculosis Prevalence Survey: Significant Decline in the Tuberculosis Burden in the Philippines Ten Years after Launching DOTS

Four teams comprising 12 members including doctors, nurses, medical technologists, radiographers, and field data editors undertook the survey of 50 clusters all over the country from 27 July 2007-12 December 2007. The total population surveyed was 30,667 individuals of all ages.

The objectives of the NTPS were:

- To measure the national prevalence of TB disease, among those >10 y/o
- To assess trends of prevalence of TB disease
- To determine the drug resistance patterns of TB bacilli isolated
- To determine the health seeking behavior of TB symptomatics and patients
- To assess the risk factors of TB, including demographic and socio-economic determinants

The marching order was nothing but a hundred percent coverage for all examinations. And in rural and urban communities, through mountains, fields, and rain or shine, the team went on relentlessly.

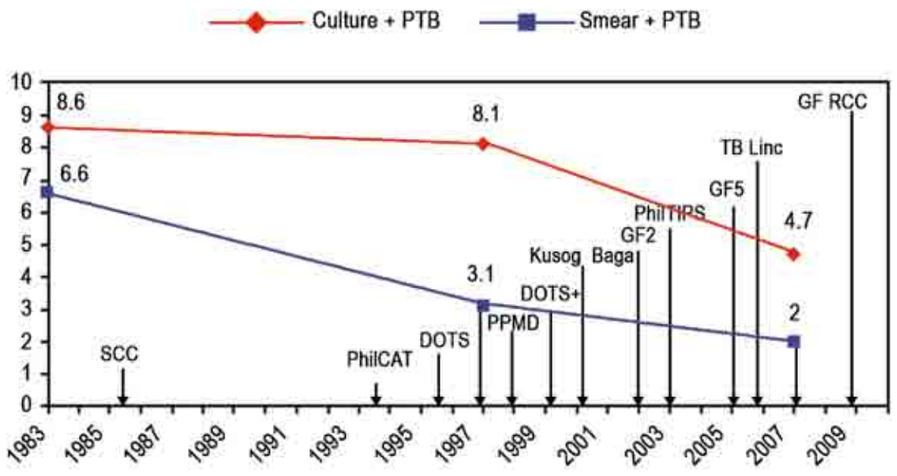
They reached impressive coverage of 90% chest x-rays and 96% of all sputum examinations, 96% interview. With such rates of coverage a post survey audit done in the London School of Hygiene and Tropical Medicine deemed that the data was of high quality with a high level of internal consistency. Few TB cases, if any, would have been missed.

The prevalence of culture-positive pulmonary tuberculosis (PTB) was 6.3 per thousand (95% CI: 4.9-7.8) and sputum acid fast smear positive (AFS+) PTB was 2.6 per thousand (95% CI: 1.7-3.6). For the total population of all ages, the estimates were 4.7 per thousand and 2.0 per thousand, respectively.

Comparing the prevalence rates in the first two nationwide TB prevalence survey (NTPS) in 1981-83 and that in 1997 NTPS, the disease burden then had only minimally declined in terms of culture-positive PTB. However, the prevalence rates in 2007 showed a 36% reduction in culture-positive PTB and 28% in AFS+ PTB compared to 1997.

This significant decline in the TB burden 10 years after the initiation of directly-observed treatment short-course (DOTS) strategy has been attributed to the various initiatives implemented in the past decade. In 1994, the Philippine Coalition against TB (PhilCAT) was established and became the umbrella organization of private and public stakeholders in support of the vision of a TB-Free Philippines.

Disease trends of TB and Interventions implemented from past 25 years



Health workers were deployed all over the Philippines for the Nationwide Tuberculosis Prevalence Survey.

DOTS strategy was subsequently launched in the latter part of 1996, immediately before the 1997 NTPS. Private public mix DOTS (PPMD) initiatives were undertaken in 1998 where private institutions organized DOTS centers within their own facilities in partnership with the National TB Program (NTP). In one of these PPMDs established by the Tropical Disease Foundation in the Makati Medical Center was approved as the first DOTS-Plus pilot project by the Green Light Committee in August 2000. By 2007, a total of 1,207 MDR-TB patients had been put on treatment. In 2001, a community-based program on social mobilization for TB (SMT) was undertaken by the World Vision Development Foundation to increase demand for TB services. Then Global Fund against AIDS, Tuberculosis and Malaria (GFATM) was approved in 2003 for round 2, another in 2007 for round 5, and a rolling countinuation channel funding has likewise been approved for implementation in 2009. USAID projects on TB were likewise implemented; PhilTIPS in 2002 and TB Linc in 2007.

A field nurse administers a tuberculin skin test.

Clinical Trial

DMID Protocol Number 01-009: Prospective Study of Shortening the Duration of Standard Short Course Chemotherapy from 6 Months to 4 Months in HIV-non-infrected Patients with Fully Drug Susceptible, Non-cavitary Pulmonary Tuberculosis with Negative Sputum Cultures after 2 months of anti-TB treatment.

The Philippines participated as one of three international treatment sites in 2004 of the Case Western Reserve University School of Medicine, Cleveland, Ohio, USA, (CWRU) TB Research Unit. The other international treatment sites were Núcleo de Doenças Infecciosas (NDI); Universidade Federal do Espírito Santo, Vitória, Brazil and Makerere Medical School; Uganda-CWRU Research Collaboration; Kampala, Uganda

This is a phase III trial involving 2339 subjects screened from April 2002 to August 2006. The TDF screened 787 patients, pre-enrolled 358 and randomized 95 patients out of a total of 2323, 850, and 395 patients, respectively, from all sites. Two of the 95 patients were withdrawn and four were lost to follow. Due to an apparent increase in the proportion of subjects who relapsed in the 4 month arm, the study DSMB recommended stopping study enrollment on August 30, 2007. All subjects being screened and those awaiting enrollment were treated with 6 months of standard short course chemotherapy. All randomized subjects continued up to 30 months follow-up.

Patients screened, enrolled, and successfully treated in Study DMID Protocol 01-009

Patient Recruitment	Philippines	All Sites
Screened	787	2323
Pre-enrolled	358	850
Randomized	95	394
Protocol withdrawal	2	6
Successful completion	89	370
TB relapse	0	18
Death	0	4
Lost to follow up	4	8

Preserving the Effectiveness of Tuberculosis Treatment with Second Line Anti-TB Drugs (PETTS)

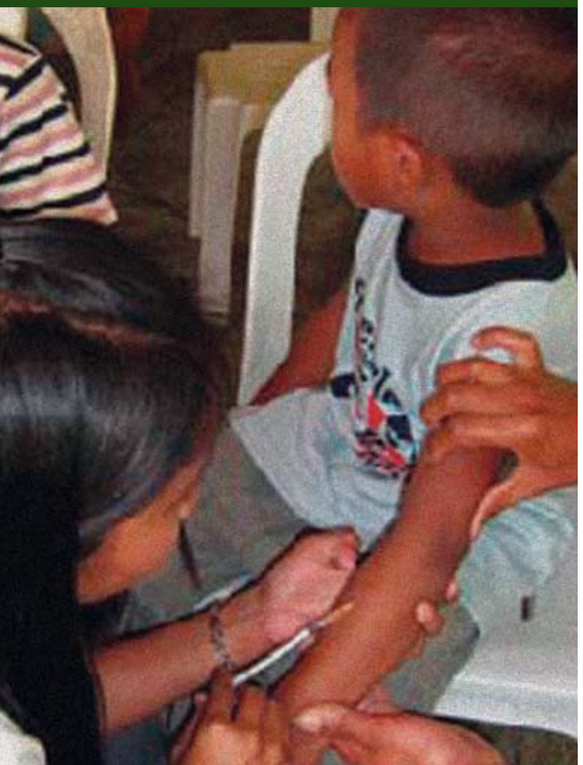
August 2007 to July 2008

Preserving Effective Tuberculosis Treatment Study (PETTS) is on its fifth year of implementation at Tropical Disease Foundation (TDF). The study is being conducted by the US Centers for Disease Control and Prevention (CDC) in collaboration with MDR TB centers in Estonia, Latvia, Peru, Philippines, Russia, South Africa, South Korea, Taiwan and Thailand. The study aims to determine the frequency of, risk factors for and consequences of acquired resistance to second-line TB drugs (SLD). Patients who are diagnosed to have MDR TB and started on SLD are enrolled and followed up until they

have reached an outcome. Baseline and monthly follow-up isolates are shipped to CDC for drug susceptibility testing and genotyping. The frequency and timing of acquired drug resistance will be compared between GLC and non-GLC sites.

In June 2008, the PETTS team and composed of representatives of the Programmatic Management of Drug Resistant TB (PMDT) treatment centers, TB laboratory and data management unit, completed patient enrollment for the study. The team enrolled 482 patients or 109% of the planned number of patients for enrollment. Of the 482 patients enrolled, 174 (36%) have a baseline and at least one follow up isolate. The team is now following up patients who are still on treatment to identify more patients with follow up isolates to complete the 222 cases needed to enable the team to determine site-specific amplification of resistance to the SLDs. The team collects programmatic, clinical and laboratory data on a monthly basis using a standardized data collection tool. Data are encoded in the PETTS database which is uploaded regularly to the CDC Global Coordinating Center in Atlanta. The team has complied with all requirements of the study as stated in the protocol and the CDC Institutional Review Board.

A nurse administers a tuberculin skin test.



The TDF PETTS team participated in the 4th Annual Investigators Meeting last November 13, 2007 held at Atlantic Imbizo Conference Studio at Cape Town, South Africa. The Team also contributed data to the UNION/CDC Late-breaker presentation; *Preserving Effective TB Treatment with Second-line drugs (PETTS): Prevalence of XDR-TB and other Second-line Drug Resistance among MDR-TB patients in 6 countries, 2005-2007*, presented during the 38th Union World Conference on Lung Health in Cape Town, South Africa from November 8-12, 2007. Dr. Janice Campos Caoili and Dr. Maricelle Gler participated in the evaluation visit to Jose Pearson TB Hospital in Port Elizabeth, South Africa.

TDF is the office for the Regional Coordinator for Asia, Dr. Janice Campos Caoili, who is in charge of coordinating PETTS in Thailand, South Korea and Taiwan. The CDC Global Coordinating Center will continue to provide technical and budgetary assistance to TDF until the completion of the study.

PETTS Activities at TDF:

- Presented the revised PETTS protocol (Revised Protocol, May 6, 2007) to the TDF IRB last August 22, 2007. The protocol was approved.
- Attended the 38th Union World Conference on Lung Health in Cape Town, South Africa from November 8-12, 2007.
- Provided data for the UNION/CDC late breaker session presentation; Preserving Effective TB Treatment with Second-line drugs (PETTS): Prevalence of XDR-TB and other Second-line Drug Resistance among MDR-TB patients in 6 countries, 2005-2007.
- Participated in the 4th Annual Investigators Meeting last November 13, 2007 held at Atlantic Imbizo Conference Studio at Cape Town, South Africa.
- Presented the annual review of PETTS to TDF IRB last March 31, 2008. The study was approved to continue enrollment and follow-up of patients.
- Completed enrollment for PETTS in June 30, 2008.
- Enrolled 482 patients of which 174 (36%) have a baseline and at least one follow up isolate. The team is continuing follow up of 330 patients.
- Shipped 590 isolates of which 291 are baseline isolates.

Foundation for Innovative New Diagnostics

FIND Demonstration Project

The TDF laboratory is one of the demonstration sites of the Foundations for Innovative New Diagnostics (FIND), a Swiss-based non-profit organization dedicated to the development of rapid, accurate and affordable diagnostic tests through public-private partnerships. The BD MGIT 960 an automated system of rapid liquid culture and drug susceptibility testing (DST) for Tuberculosis was initially implemented in four FIND demonstration sites which included Russia, Uzbekistan, Nepal and the TDF lab for the Philippines. With this system, DST results are available in less than one month in contrast with two to three months required for standard culture and DST on solid media. This report covers the period from Aug 2006 – Aug 2007.

A MGIT 960 machine and supplies of MGIT reagents were provided. Bench training at the Borstel Mycobacteriology Laboratory in Hamburg Germany was undertaken by Grace Egos under the direct supervision of Dr. Sabine Ruesch-Gerde.

Annual consultancy visits by FIND experts and meetings with other projects sites were also undertaken.

There were three phases of the project. First, the validation of culture took from September– November 2006. The contamination rate to be acceptable should be 3-8%. Phase 2 of the project involved inclusion of the patients' data in the Case Report Forms for FIND data analysis and phase 3 were data analysis and dissemination of results by FIND to technical bodies such as the WHO to enable them to recommend test in NTPs with the focus on improved detection of MDR-TB patients.

Tauns' Capilia, a rapid immunochemistry test for TB species identification was also evaluated at the TDF laboratory. Using Capilia, specie identification of positive culture isolates from MGIT cultures were done. By Sept 2007, TDF lab was approved to use Capilia as confirmatory test without parallel Niacin.

Comparison of Capilia TB test for rapid species identification with the conventional method

Capilia	Biochem M.Tb	Biochem MOTT	Total
Positive	718	8	726
Negative	2	72	74
Total	720	80	800

Sensitivity: 99%, **Specificity**: 90%

Positive Predictive Value: 99%

Negative Predictive Value: 97%

Based on the smear positivity of the specimen, the Table below shows the isolation of MTB from MGIT cultures. There was a 14.9% isolation of MTB from specimens with 0 AFS. Thereafter, there was an increasing positive from 77% in 1+ smear positive specimen to 99.7% in those with 4+ AFS specimens.

Isolation of MTB in sputum specimens according to AFS smear positivity

AFB	MOTT	Negative	TB	Total
0	85	921	178	1184
%	7.1	77.3	14.9	100
1+	29	27	189	245
%	11.8	11	77.1	100
2+	23	9	278	310
%	7.4	2.9	89.7	100
3+	16	5	389	410
%	3.9	1.2	94.9	100
4+	8	1	385	394
%	2	0.3	97.7	100
Total	161	963	1419	2550
%	6.3	37.8	55.6	100

DST validation then followed which involved parallel testing with the conventional Middlebrook MH10 solid media DST method and passing the proficiency testing with the same isolates used for the annual DST proficiency testing of the laboratory. By February 1, 2007 and 2 months after MGIT DST validation was started. TDF lab was officially allowed to use MGIT DST routinely for MDR-TB diagnosis.

The MGIT culture combined with Capilia TB for species identification reduced turn-around time from 12-16 weeks down to 1- 4 weeks. When DST was done on MGIT, total diagnostic turn around time was reduced from 16-20 to 3-6 weeks . Hence, with these rapid methods, diagnostic delays was diminished, allowing prompt treatment and enabling the MDR-TB program to treat more patients.

On World TB Day 2006, the Chief Executive Officer of the Foundation for Innovative New Diagnostics (FIND) and the Tropical Disease Foundation signed a memorandum of agreement for a demonstration project to be undertaken by the Tropical Disease Foundation for rapid diagnostic methods for the culture, identification, and drugs sensitivity tests for *Mycobacterium tuberculosis*.

> ...to conduct research, training, and service in infectious diseases of public health importance and to serve as a national and international training center for infectious diseases...

Training Division

By the nature of its mission and vision, the Tropical Disease Foundation provides for the opportunity through linkages with national and international organizations to enhance human resource capability through training in various aspects of research and service in the control of infectious diseases. There are two programs that it undertakes: the intramural program, which enhances the capacity of its own human resources in its staff and members of the organization; and through extramural programs that provides for health personnel outside the organization. The latter includes fellowship training in infectious diseases and training for health workers in the implementation of the DOTS-Plus programs.

Intramural Training Program

The intramural training participants are shown in Table 1, which includes all national and international training programs undertaken from 2007-2008 to enhance laboratory and program implementation of the projects it undertakes in research and service on TB, malaria, and HIV/AIDS.

The Extramural Training Program

The extramural training program is shown in Table 2, which includes all national and international training programs led by TDF staff and undertaken from 2007-2008.

Intramural

Participants	Course	Dates	Location
Grace Egos, MSPH	Engineering Methods for the Control of Airborne Infections	July 14-25, 2008	Harvard School of Public Health, Boston, Massachusetts, U.S.A.
Janice Campos Caoili, MD	Voluntary Counseling and Testing	July 7-11, 2008	Makati City
Richard Vito	Supply Chain Governance	July to September 2008	De La Salle Professional Schools -RCBC Campus, Makati City
Jerard Peter Vargas	Introduction to Supply Chain Management	July to September 2008	De La Salle Professional Schools -RCBC Campus, Makati City
Rita Cucio	GMS Consultancy for Monitoring and Evaluation	July 2008	APMC Building, Tropical Disease Foundation, Makati City
Dominador Cabugayan	Malaria Management for Field Operation for Provincial Malaria Coordinator	June 27, 2008	Davao City
Rita Cucio Adrian Badiable Gloria Rebecca Navarro Vina Vanessa Ulat Albert Eugenio	Participatory Monitoring and Evaluation	June 23-27, 2008	University of the Philippines Diliman, Quezon City
Dr. Luz Escubil	GFATM CCM Strengthening Workshop	May 21-22, 2008	Kuala Lumpur, Malaysia
Rita Cucio	GMS Consultancy for Monitoring and Evaluation	May 2008	APMC Building, Tropical Disease Foundation, Makati City
Ruth Orillaza, MD Ma. Imelda D. Quelapio, MD Lualhati Macalintal, MD	Effective Project Management for an NGO or Foundation Seminar	April 16, 2008	Legend Villas, Pioneer, Mandaluyong City
Virginia Ferrera, RMT	Training on Basic TB Laboratory Services, including Drug Susceptibility Testing	April 14 – May 23, 2008	Korean Institute of Tuberculosis, Seoul, Republic of Korea
Leilani Naval	Consultancy with the Grant Management Solutions on Procurement and Supply Management: GFATM regulations guidelines specification for pharmaceuticals. Cat. A,B,C pharmaceuticals	April 2008	Montepino Building, Tropical Disease Foundation, Makati City
Marilou Ortiz	Strengthening Pharmaceutical Systems	April 2008	De La Salle Professional Schools -RCBC Campus, Makati City
Katrina Gonzales	Training on Drug Management Information System for Second-line Anti-Tuberculosis Medicines	April 2008	De La Salle Professional Schools -RCBC Campus, Makati City
Leilani Naval	Consultancy with the Grant Management Solutions on Procurement and Supply Management: GFATM regulations/guidelines specification for LLINs	April 2008	Montepino Building, Tropical Disease Foundation, Makati City
Procurement and Supply Management Unit	Technical Support to the Tropical Disease Foundation as Principal Recipient of HIV/AIDS, Malaria and TB Grants in the Philippines: Procurement and Supply Management Activities	March 24 to April 6, 2008	Montepino Building, Tropical Disease Foundation, Makati City

Participants	Course	Dates	Location
Maria Luz A. Alvaro Willie Cabauatan, Jr., MD Gail Delas Alas Ma. Tarcela Gler, MD Mary Joy Morin Amalia Palisoc Kristine Rose Pua Maree France Supnet Dave Anthony Vergara, MD Richard Vito	IUALTD HR Consultancy Racing Ahead: Change Agents Workshop	March 10 to 13, 2008	Tiara Oriental Hotel, Makati City
Therese Chongko Perez	Training Workshop on Good Clinical Practice and Research Ethics for Investigators and Ethics Committee Members	March 10-12, 2008	University of the Philippines College of Public Health Annex II, Manila
All TDF Department Heads and next in line team members	IUALTD HR Consultancy Role Clarity Workshop	March 8, 2008	Wyeth Swaco, Makati City
Maria Luz A. Alvaro Norma G. Miranda Nellie V. Mangubat Ruth Orillaza-Chi, MD Luz Escubil, MD Janice Caoili, MD Grace Egos Jojo Merilles Rhandy Rowan Leilani Naval Ma. Rita Cucio Carlito Miranda Tomdion Julian Raymund Boy	IUATLD HR Consultancy Role Clarity Workshop	March 6 to 8, 2008	Wyeth Swaco, Makati City

Participants	Course	Dates	Location
Leilani Naval	Consultancy with the Grant Management Solutions on Procurement and Supply Management: GFATM procurement regulations	March 2008	Montepino Building,Tropical Disease Foundation, Makati City
Macario M. Velo II Hilario Umali Marilou Ortiz Katrina Gonzales Dominador Cabugayan Wilson Suiza George Tomas Leilani Naval	GMS Procurement and Supply Management Training (Forecasting, Quantification, Inventory, Distribution, Tech. Specs., Monitoring)	March 2-6, 2008 February 2-6, 2008 November 12-16, 2007	Montepino Building,Tropical Disease Foundation, Makati City
Grace Egos, MSPH	TB Infection Control Training for International Consultants	February 18-22, 2008	Gaborone Sun Hotel, Gaborone, Botswana
Vina Vanessa Ulat Dominador Cabugayan	Malaria Management for Field Operation for Project Coordinator	February 13, 2008	Legaspi City
Aida S. Ladaga Carolyn L. Bautista Romuel Flores Albert Eugenio Adrian Badiable Gloria Rebecca Navarro Vina Vanessa Ulat Lourdes L. Pambid	Malaria Management for Field Operations For Field Coordinators - Phase II	February 11-16, 2008	Legaspi City
Procurement and Supply Management Unit	Technical Support to the Tropical Disease Foundation as Principal Recipient of HIV/AIDS, Malaria and TB Grants in the Philippines: Procurement and Supply Management Activities	February 10, 2008	Montepino Building, Tropical Disease Foundation, Makati City

Participants	Course	Dates	Location
Rita Cucio	GMS Consultancy for Monitoring and Evalution	February 2008	Montepino Building, Tropical Disease Foundation, Makati City
Procurement and Supply Management Unit	GMS Consultancy Procurement and Supply Management	January 23, 2008	Montepino Building, Tropical Disease Foundation, Makati City
Rita Cucio Anthia Aberia	Preparation to Round 7 Grant Signing	January 22-25, 2008	World Health Organization-WPRO
Marilyn de Chavez Raquel Baylon	Payroll Taxes and Documentation	December 4-6, 2007	Holiday Inn Galleria, Pasig City
Grace Egos, MSPH	Advanced Course on MDR-TB for the Western Pacific	December 3-7, 2007	Korean Institute of Tuberculosis, Seoul, Republic of Korea
Dominador Cabugayan	Pharmaceutical Management and Quantification for Malaria Commodities	December 1, 2007	Hanoi, Vietnam
Richard Vito	Inventory Planning and Control	November 2007 to January 2008	De La Salle Professional School, RCBC Plaza, Makati City
Macario M. Velo II Hilario Umali Marilou Ortiz Katrina Gonzales	Strategic Purchasing & Procurement Management	November 2007 – January 2008	De La Salle Professional School, RCBC Plaza, Makati City
Dominador Cabugayan	Quantification and Pharmaceutical Management for Malaria	November 27 to December 1, 2007	Vietnam
Amy Miraña Samual Rasalan	Expanded Withholding Tax and Allowable Deductions	November 27-29, 2007	Holiday Inn Galleria, Pasig City
Wilson Suiza	Inventory Planning	Nov 24, 2007 to Jan 19, 2008	Makati City

Participants	Course	Dates	Location
Ruth Orillaza, MD	International Course on Human Resource Development	November 19 to 30, 2007	Bangkok, Thailand
Janice Campos Caoili, MD	4th Annual Investigators Meeting	November 13, 2007	Cape Town, South Africa
Procurement and Supply Management Unit	GMS Consultancy Procurement and Supply Management	November 10 to 17, 2007	Montepino Building, Tropical Disease Foundation, Makati City
Janice Campos Caoili, MD	Strategies for TB and HIV Co-Infection Postgraduate Course	November 9, 2007	Cape Town, South Africa
Grace Egos, MSPH Janice Campos Caoili, MD	38th IUATLD World Conference on Lung Health	November 8 to 12, 2007	Cape Town, South Africa
Kristine Rose Pua, RMT Christopher Romano, RMT	Basic Training on Direct Sputum Smear Microscopy	October 22-26, 2007	Quezon Institute, Quezon City
All TDF Employees	IUATLD HR Consultancy Racing Ahead Workshop	October 8 to 13, 2007	Wyeth Swaco, Makati City
Michael Evangelista, RMT	Regional Workshop on Strengthening Laboratory Services for TB Control	September 10 to 14, 2007	Bangkok, Thailand
Albert Angelo L. Concepcion	International Course on Budget Planning and Project Management for Tuberculosis Control	September 3 – 15, 2007	Bangkok, Thailand

Extramural

Facilitators	Course	Dates	Location
Janice Campos Caoili, MD	PETTS Monitoring Visits to the Office of Disease Control and Prevention 7th	July 28-30, 2008	Ubon Ratchathani, Thailand
Janice Campos Caoili, MD	PETTS Monitoring Visit – Korean Institute of Tuberculosis	July 15-17, 2008	Seoul, Korea
PMDT Staff	TB 303: 21 day competency based programmatic MDR-TB Management for TC staff	July 2008	De La Salle Treatment Center, Cavite
PMDT Staff	TB 303: 21 day competency based programmatic MDR-TB Management for TC staff	July 2008	Eversley Hospital, Cebu
Thelma E. Tupasi, MD Nerizza Munez	Follow-on Course on the Management of Second-Line Anti-TB Drugs	June 2-5, 2008	Philippine International Center for Tuberculosis, Makati City
Ma. Imelda D. Quelapio, MD Nerizza Munez	IUATLD Clinical Management of Drug-resistant TB	May 5-9, 2008	Philippine International Center for Tuberculosis, Makati City
Maria Luz A. Alvaro Willie Cabauatan, Jr., MD Gail Delas Alas Ma. Tarcela Gler, MD Mary Joy Morin Amalia Palisoc Kristine Rose Pua Maree France Supnet Dave Anthony Vergara, MD Richard Vito	TDF Three-Month Workshop Series "The Foundation"	April to June 2008	Tiara Oriental Hotel, Bristol Myers Philippines, Wyeth Learning Center

Facilitators	Course	Dates	Location
Janice Campos Caoili, MD Mary Joy Morin Gelza Mae Zabat, MD Hilario Umali	Treatment Hubs' Pharmacists Training and HACT Clinical Case Conference	February 14-15, 2008	Sulo Hotel, Quezon City
PMDT Staff	TB 303: 21 day competency based programmatic MDR-TB Management for TC staff	February 2008	Tala Treatment Center, Caloocan
Janice Campos Caoili, MD	PETTS Taiwan Centers for Disease Control Site Training	January 22-25, 2008	Taipei, Taiwan
Janice Campos Caoili, MD	PETTS Korean Institute of Tuberculosis Site Training	January 9-12, 2008	Seoul, South Korea
Janice Campos Caoili, MD	PETTS Monitoring Visits to the Office of Disease Control and Prevention 7th	December 18-21, 2007	Ubon Ratchathani, Thailand
TDF-PMDT	DOTS and PMDT Orientation for Patients	December 7, 2007	Wyeth Swaco, Makati City
PMDT Staff	Advanced Course for TB/MDR-TB in the Western Pacific Region	December 2007	South Korea
Janice Campos Caoili, MD Ma. Tarcela Gler, MD	PETTS evaluation visit to Jose Pearson TB Hospital	November 14-17, 2007	Port Elizabeth, South Africa
PMDT Staff	Training for Second-Line Drug Management	November 2007	Manila
TDF-PMDT	DOTS and PMDT Orientation for Patients	September 21, 2007	Wyeth Swaco, Makati City

Facilitators	Course	Dates	Location
Janice Campos Caoili, MD	PETTS Monitoring Visits to the Office of Disease Control and Prevention 7th	September 16-22, 2007	Ubon Ratchathani, Thailand
Claire Macugay, RMT	Training on Basic TB Laboratory Services	August to October 2007	Makati Medical Center, Makati City
Thelma E. Tupasi, MD Ruth Orillaza-Chi, MD Nona Mira Albert Angelo L.Concepcion Nerizza Munez Virgil Belen Grace Egos, et al.	Training on Programmatic Ambulatory MDR-TB Management	August 2007	Tropical Disease Foundation, Makati City
Ma. Imelda D. Quelapio, MD	MDR-TB Course for Referring Physicians (PhilCAT Convention)	August 17, 2007	Mandaluyong City
PMDT Staff	Applying Infection Control Principles in the Local Setting	August 15 to 17, 2007	14th Annual PhilCAT Convention, Crowne Plaze Galleria, Pasig City
Grace Egos, MSPH	Applying Infection Control Principles in the Local Setting	August 15 to 17, 2007	14th Annual PhilCAT Convention, Crowne Plaze Galleria, Pasig City
PMDT Staff	5-Day Training Course for International Delegates	August 9-11, 2007	Metro Manila
PMDT Staff	Advanced Course for PMDT in South East Asia	August 2007	Faridabad, India
PMDT Staff	Course for referring Physicians for DR-TB	August 2007	Metro Manila

Dr. Sang Jae Kim of South Korea gives a lecture during The Union International Course on the Clinical Management of Drug-resistant TB, held at the Philippine Institute of Tuberculosis.

> The Tropical Disease Foundation (TDF) is a private, non-stock, non-profit, non-government organization founded in 1984 by a group of physicians in the Research Institute for Tropical Medicine.

Financial Reports

Consolidated Statement of Cash Receipts and Disbursements of TDF as Principal Recipient of Global Fund-Supported Programs

and

Consolidated Statement of Cash Receipts and Disbursements of the General Fund

with accompanying Notes to Financial Statements

For the year ended July 31, 2008 and 2007

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SEC Accreditation No. 0012-FR-1

INDEPENDENT AUDITORS' REPORT

The Board of Trustees
Tropical Disease Foundation, Inc.
2 Amorsolo St. C. P. Manahan Memorial Annex
Makati Medical Center
Makati City

We have audited the accompanying financial statements of Tropical Disease Foundation, Inc. (a nonstock, nonprofit organization), which comprise the statements of assets, liabilities and fund balance as at July 31, 2008 and 2007, and the statements of income and expenses, statements of changes in fund balance and statements of cash flows for the years then ended and a summary of significant accounting policies and other explanatory notes.

Management's Responsibility for the Financial Statements

Management is responsible for the preparation and fair presentation of these financial statements in accordance with accounting principles generally accepted in the Philippines for non-publicly accountable entities as described in Note 2 to the financial statements. This responsibility includes: designing, implementing and maintaining internal control relevant to the preparation and fair presentation of financial statements that are free from material misstatement, whether due to fraud or error; selecting and applying appropriate accounting policies; and making accounting estimates that are reasonable in the circumstances.

Auditors' Responsibility

Our responsibility is to express an opinion on these financial statements based on our audits. Except as discussed in the sixth paragraph, we conducted our audits in accordance with Philippine Standards on Auditing. Those standards require that we comply with ethical requirements and plan and perform the audit to obtain reasonable assurance whether the financial statements are free from material misstatement.

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the financial statements. The procedures selected depend on the auditor's judgment, including the assessment of the risks of material misstatement of the financial statements, whether due to fraud or error. In making those risk assessments, the auditor considers internal control relevant to the entity's preparation and fair presentation of the financial statements in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the entity's internal control. An audit also includes evaluating the appropriateness of accounting policies used and the reasonableness of accounting estimates made by management, as well as evaluating the overall presentation of the financial statements.

We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinion.

Opinion

As discussed in Notes 5 and 11 to the financial statements, the Foundation changed its method of accounting for acquisitions of property and equipment using the grant received from Global Fund to fight AIDS, Tuberculosis and Malaria (Global Fund). These acquisitions were previously capitalized as part of the assets reported in the financial statements. In 2008, the Foundation accounted for the acquisitions as outright expense since management believes that it will be able to properly account for the grant received from Global Fund if the acquisition costs of property and equipment are expensed outright. The Foundation restated the prior year's financial statements to give retroactive effect to the change in the method of accounting for such acquisitions. Accounting principles generally accepted in the Philippines, however, provides that the cost incurred in the acquisition of property and equipment should be capitalized as part of the assets of the Foundation. Had the acquisitions been capitalized, property and equipment should have increased by about ₱3.4 million and about ₱2.1 million as of July 31, 2008 and 2007, respectively. On the other hand, all other acquisitions of property and equipment arising from sources other than from Global Fund are capitalized as part of the Foundation's assets.

In our report dated November 14, 2007, our opinion on the July 31, 2007 financial statements was unqualified. However, because of the restatement of these financial statements discussed in Notes 5 and 11 to the financial statements, our opinion on the 2007 financial statements, as presented herein, is no longer unqualified.

In our opinion, except for the effects of the matter discussed in the preceding paragraph, the financial statements present fairly in all material respects, the financial position of Tropical Disease Foundation, Inc. as of July 31, 2008 and 2007, and its financial performance and cash flows for the years then ended in accordance with accounting principles generally accepted in the Philippines for non-publicly accountable entity as described in Note 2 to the financial statements.

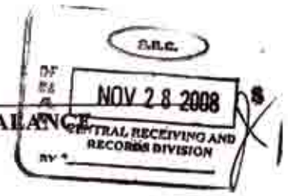
SYCIP GORRES VELAYO & CO.

Jose Pepito E. Zabat

Jose Pepito E. Zabat III
Partner
CPA Certificate No. 85501
SEC Accreditation No. 0328-A
Tax Identification No. 102-100-830
PTR No. 0015800, January 3, 2008, Makati City

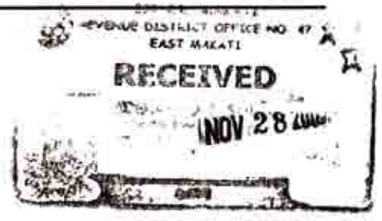
November 14, 2008

TROPICAL DISEASE FOUNDATION, INC.
(A Nonstock, Nonprofit Corporation)
STATEMENTS OF ASSETS, LIABILITIES AND FUND BALANCE



	July 31			
	Unrestricted Funds	Restricted Funds	2008 Total	2007 (As restated, Notes 5 and 11)
ASSETS				
Current Assets				
Cash and cash equivalents (Note 3)	₱29,940,434	₱759,738,947	₱789,679,381	₱349,406,945
Marketable equity securities	3,000	–	3,000	3,000
Short-term investments	3,258,636	–	3,258,636	3,346,468
Advances and other receivables (Note 4)	2,126,749	8,095,546	10,222,295	5,441,257
Total Current Assets	35,328,819	767,834,493	803,163,312	358,197,670
Noncurrent Assets				
Property and equipment - net (Note 5)	105,379,850	–	105,379,850	30,041,255
Refundable deposits (Note 9)	1,722,239	1,629,037	3,351,276	1,358,145
Total Noncurrent Assets	107,102,089	1,629,037	108,731,126	31,399,400
TOTAL ASSETS	₱142,430,908	₱769,463,530	₱911,894,438	₱389,597,070
LIABILITIES AND FUND BALANCE				
Current Liabilities				
Accounts and other payables (Note 6)	₱11,890,840	₱10,470,721	₱22,361,561	₱16,121,012
Loan payable (Note 7)	15,000,000	–	15,000,000	2,000,000
Funds held in trust (Note 11)	–	756,560,204	756,560,204	307,617,381
Total Current Liabilities	26,890,840	767,030,925	793,921,765	325,738,393
Fund Balance				
Members' contributions	70,000	–	70,000	70,000
Fund Balance	115,470,068	2,432,605	117,902,673	63,788,677
Total Fund Balance	115,540,068	2,432,605	117,972,673	63,858,677
TOTAL LIABILITIES AND FUND BALANCE	₱142,430,908	₱769,463,530	₱911,894,438	₱389,597,070

See accompanying Notes to Financial Statements.



TROPICAL DISEASE FOUNDATION, INC.
(A Nonstock, Nonprofit Corporation)
STATEMENTS OF INCOME AND EXPENSES
FOR THE YEARS ENDED JULY 31, 2008 AND 2007

		RESTRICTED				2007 (As restated, Notes 5 and 11)
	UNRESTRICTED	Global Fund	CDC	TOTAL	2008	
INCOME						
Donations and contributions (Note 5)	₱80,005,456	₱–	₱–	₱–	₱80,005,456	₱18,334,662
Grants (Note 11):						
Global Fund	–	62,798,801	–	62,798,801	62,798,801	41,265,600
Centers for Disease Control and Prevention (CDC)	–	–	3,128,921	3,128,921	3,128,921	3,927,778
General	3,044,798	–	–	–	3,044,798	5,684,056
Interest	303,682	–	–	–	303,682	80,892
Others	170,295	–	–	–	170,295	627,079
	83,524,231	62,798,801	3,128,921	65,927,722	149,451,953	69,920,067
EXPENSES						
Personnel costs (Note 8)	4,661,051	27,462,592	1,755,020	29,217,612	33,878,663	16,342,972
Honorarium	2,181,989	13,346,148	–	13,346,148	15,528,137	13,321,296
Laboratory and office supplies	8,730,824	1,381,949	30,110	1,412,059	10,142,883	5,242,739
Professional fees	3,455,995	3,281,662	1,421,683	4,703,345	8,159,340	1,603,761
Depreciation (Note 5)	5,470,769	–	–	–	5,470,769	3,870,258
Capital expenditures (Note 5)	–	3,379,418	–	3,379,418	3,379,418	2,107,884
Transportation and travel	47,510	2,432,669	808,917	3,241,586	3,289,096	272,461
Utilities	346,244	2,026,304	56,780	2,083,084	2,429,328	1,268,573
Leases (Note 9)	4,768	2,102,573	47,705	2,150,278	2,155,046	314,399
Repairs and maintenance	101,581	1,901,098	14,000	1,915,098	2,016,679	672,371
Communication	216,945	917,638	29,464	947,102	1,164,047	768,939
Interest expense (Note 7)	1,108,363	–	–	–	1,108,363	–
Insurance	151,685	492,778	35,182	527,960	679,645	471,031
Medicines	345,342	8,067	309,541	317,608	662,950	62,475
Entertainment, amusement and recreation	25,438	248,050	–	248,050	273,488	568,863
Unrealized foreign exchange losses	247,234	–	–	–	247,234	1,486,637
Taxes and licenses	65,839	111,436	58,086	169,522	235,361	132,431
Program management and administration	–	–	–	–	–	13,920,051
Others	582,910	3,706,419	228,181	3,934,600	4,517,510	1,765,138
	27,744,487	62,798,801	4,794,669	67,593,470	95,337,957	64,192,279
EXCESS OF INCOME OVER EXPENSES	₱55,779,744	₱–	(₱1,665,748)	(₱1,665,748)	₱54,113,996	₱5,727,788

See accompanying Notes to Financial Statements.

TROPICAL DISEASE FOUNDATION, INC.
(A Nonstock, Nonprofit Corporation)

STATEMENTS OF CHANGES IN FUND BALANCE
FOR THE YEARS ENDED JULY 31, 2008 AND 2007

	Members' Contributions	Fund Balance		Total
		Unrestricted	Restricted	
Balances at July 31, 2006, as previously reported	₱70,000	₱54,632,176	₱11,551,370	₱66,253,546
Adjustments from changes in method of accounting for:				
Revenue (Note 11)	–	–	(1,234,489)	(1,234,489)
Property and equipment (Notes 5 and 11)	–	–	(6,888,168)	(6,888,168)
Balances at July 31, 2006, as restated	70,000	54,632,176	3,428,713	58,130,889
Excess of income over expenses for the period, as restated	–	5,058,148	669,640	5,727,788
Balances at July 31, 2007, as restated	₱70,000	₱59,690,324	₱4,098,353	₱63,858,677
Balances at July 31, 2007, as previously reported	₱70,000	₱59,690,324	₱4,098,353	₱84,126,704
Adjustments from changes in method of accounting for:				
Revenue (Note 11)	–	–	(13,856,298)	(13,856,298)
Property and equipment (Notes 5 and 11)	–	–	(6,411,729)	(6,411,729)
Balances at July 31, 2007, as restated	70,000	59,690,324	4,098,353	63,858,677
Excess of income over expenses for the period	–	55,779,744	(1,665,748)	54,113,996
Balances at July 31, 2008	₱70,000	₱115,470,068	₱2,432,605	₱117,972,673

See accompanying Notes to Financial Statements.

TROPICAL DISEASE FOUNDATION, INC.
(A Nonstock, Nonprofit Corporation)

STATEMENTS OF CASH FLOWS
FOR THE YEARS ENDED JULY 31, 2008 AND 2007

	2008	2007 (As restated, Notes 5 and 11)
CASH FLOWS FROM OPERATING ACTIVITIES		
Excess of income over expenses	₱54,113,996	₱5,727,788
Adjustments for:		
Depreciation	5,470,769	3,870,258
Interest expense (Note 7)	1,108,363	–
Unrealized foreign exchange loss - net	247,234	1,486,637
Interest income	(303,682)	(80,892)
Donation of land (Note 5)	(32,373,000)	–
Operating income before working capital changes	28,263,680	11,003,791
Decrease (increase) in advances and other receivables	(4,781,038)	902,145
Increase in accounts and other payables	6,240,549	5,637,347
Net cash generated from operations	29,723,191	17,543,283
Interest received	303,682	80,892
Interest paid	(1,108,363)	–
Net cash flows from operating activities	28,918,510	17,624,175
CASH FLOWS FROM INVESTING ACTIVITIES		
Additions to property and equipment (Note 5)	(48,436,364)	(2,540,146)
Increase in refundable deposits	(1,993,131)	(520,782)
Cash flows used in investing activities	(50,429,495)	(3,060,928)
CASH FLOWS FROM FINANCING ACTIVITIES		
Increase in funds held in trust (Note 11)	448,942,823	258,771,626
Net proceeds from bank loan (Note 7)	13,000,000	2,000,000
Cash flows from financing activities	461,942,823	260,771,626
NET INCREASE IN CASH AND CASH EQUIVALENTS	440,431,838	275,334,873
EFFECT OF EXCHANGE RATE CHANGES ON CASH AND CASH EQUIVALENTS	(159,402)	(1,033,454)
CASH AND CASH EQUIVALENTS AT BEGINNING OF PERIOD	349,406,945	75,105,526
CASH AND CASH EQUIVALENTS AT END OF PERIOD	₱789,679,381	₱349,406,945

See accompanying Notes to Financial Statements.

TROPICAL DISEASE FOUNDATION, INC.
(A Nonstock, Nonprofit Corporation)
NOTES TO FINANCIAL STATEMENTS

1. Corporate Information

Tropical Disease Foundation, Inc. (the Foundation) was registered with the Philippine Securities and Exchange Commission (SEC) on November 5, 1984 as a nonstock, nonprofit corporation committed to undertake biological research and provide training and service in the control and management of tropical and infectious diseases, including therapeutic and preventive measures.

As a nonstock, nonprofit corporation, the Foundation is exempt from payment of income tax with respect to receipts received in accordance with the provision of Section 30 (e) of RA No. 8424 entitled "An Act Amending the National Internal Revenue Code, As Amended, and For Other Purposes". The income from activities conducted in pursuit of the objectives for which the Foundation was established is exempt from tax. However, any income on any of its properties, real or personal, or from any activity conducted for profit, regardless of the disposition of such income, is subject to tax. Also, the Foundation is an accredited donee institution by the Philippine Council for NGO Certification. As such, its donors are entitled to full or limited deduction and exemption from donor's tax.

The Foundation's registered office is at 2 Amorsolo St. C. P. Manahan Memorial Annex, Makati Medical Center, Makati City.

The financial statements of the Foundation as of and for the years ended July 31, 2008 and 2007 were authorized for issue by the Executive Committee, appointed by the Board of Trustees, on November 14, 2008.

2. Summary of Significant Accounting Policies

Basis of Preparation
The financial statements of the Foundation are prepared on a historical cost basis and are presented in Philippine peso.

Statement of Compliance
The financial statements of the Foundation have been prepared in compliance with accounting principles generally accepted in the Philippines applicable to a non-publicly accountable entities (NPAE). The Foundation qualifies as an NPAE under Philippine Accounting Standard 101 *Financial Reporting Standards for Non-Publicly Accountable Entities* and, as permitted under that standard, prepared its financial statements on the basis of Statements of Financial Accounting Standards (SFAS) and SFAS/International Accounting Standards (SFAS/IAS) effective as of December 31, 2004.

Cash and Cash Equivalents
Cash includes cash on hand and with banks. Cash equivalents are short-term, highly liquid investments that are readily convertible to known amounts of cash with original maturities of three months or less and that are subject to an insignificant risk of changes in value.

Marketable Equity Securities and Short-term Investments
Investments are carried at the lower of aggregate cost or market value based on the quoted market price determined at the statement of assets, liabilities and fund balance date. The amount by which aggregate cost exceeds market value is accounted for as a valuation allowance and changes in the valuation allowance are included in the statement of income and expenses. Realized gains and losses from the sale of current investments are included in the statement of income and expenses. When the investments are sold or otherwise disposed of, the difference between the net disposal proceeds and the carrying amount is included in the statement of income and expenses.

Advances and Other Receivables
Advances and other receivables are recognized and carried at face value less allowance for any doubtful accounts. An allowance for doubtful accounts is made when collection of the full amount is no longer probable.

Property and Equipment

a) Property and equipment acquired from sources other than Global Fund

Property and equipment are carried at cost less accumulated depreciation and any impairment in value, except for land which is stated at appraised value as determined by an independent firm of appraisers.

The initial cost of property and equipment consists of its purchase price, including import duties, taxes and any directly attributable costs of bringing the property and equipment to its working condition and location for its intended use. Expenditures incurred after the property and equipment have been put into operation, such as repairs and maintenance are normally charged to income in the period in which the costs are incurred. In situations where it can be clearly demonstrated that the expenditures have resulted in an increase in the future economic benefits expected to be obtained from the use of an item of property and equipment beyond its originally assessed standard of performance, the expenditures are capitalized as an additional cost of property and equipment.

Depreciation is computed on a straight-line basis over the estimated useful lives of the property and equipment as follows:

	Years
Condominium units	20
Office furniture, fixtures, and equipment	5
Laboratory equipment	5
Transportation equipment	5

Leasehold improvements are amortized over their estimated useful life of 5 years or the term of the lease, whichever is shorter.

Construction in progress is stated at cost. This includes cost of construction and other direct costs. Construction in progress is not depreciated until such time as the relevant assets are completed and available for use.

The useful lives and depreciation method are reviewed periodically to ensure that the periods and method of depreciation are consistent with the expected pattern of economic benefits from items of property and equipment.

When assets are retired or otherwise disposed of, the cost and the related accumulated depreciation and any impairment in value are removed from the accounts and any resulting gain or loss is credited to or charged against current operations.

b) Property and equipment acquired from Global Fund

The Foundation accounts for acquisition of property and equipment and other capital expenditures using the grant received from the Global Fund as period cost and are presented as part of expenses under the Restricted Fund "Global Fund" portion in the statement of income and expenses.

The acquisition costs are accounted for as an outright expense in the year the costs are incurred since management believes that it will be able to properly account for the grant received from Global Fund if the acquisition costs of property and equipment are expensed outright.

Impairment of Assets
The carrying values of property and equipment are reviewed for impairment when events or changes in circumstances indicate that the carrying values may not be recoverable. If any such indication exists and where the carrying values exceed the estimated recoverable amount, the assets or cash-generating units are written down to their estimated recoverable amounts. The estimated recoverable amount of property and equipment is the greater of its net selling price and value in use. The net selling price is the amount obtainable from the sale of an asset in an arm's-length transaction less the costs of disposal. In assessing value in use, the estimated future cash flows are discounted to their present value using a pre-tax discount rate that reflects current market assessments of the time value of money and the risks specific to the asset. For an asset that does not generate largely independent cash inflows, the estimated recoverable amount is determined for the cash-generating unit to which the asset belongs. Impairment losses, if any, are recognized in the statement of income and expenses.

Income
Income is recognized to the extent that it is probable that the economic benefits will flow to the Foundation and the amount of income can be reliably measured. The following specific recognition criteria must also be met before income is recognized:

Grants, Contributions and Donations
Income is recognized upon receipt of the grants, contributions and donations. Grants received for specific purposes and which are covered by contracts or agreements to implement specific projects and are required by donors to be accounted for separately are accounted for separately and recorded under "Funds Held in Trust" account in the statement of assets, liabilities and fund balance. Contributions-in-kind are recorded at fair market value on the date of contribution.

Where discounting is used, the increase in the provision due to the passage of time is recognized as an interest expense.

Contingencies
Contingent liabilities are not recognized in the financial statements. These are disclosed unless the possibility of an outflow of resources embodying economic benefits is remote. Contingent assets are not recognized in the financial statements but disclosed in the notes to financial statements when an inflow of economic benefits is probable.

Subsequent Events
Post year-end events that provide additional information about the Foundation's financial position at the statement of assets, liabilities and fund balance date (adjusting events) are reflected in the financial statements. Post year-end events that are not adjusting events are disclosed in the notes to financial statements when material.

3. Cash and Cash Equivalents

	Unrestricted	Restricted	2008	2007
Cash on hand and with banks	₱24,794,132	₱196,005,893	₱220,800,025	₱121,100,950
Cash equivalents	5,146,302	563,733,054	568,879,356	228,305,995
	₱29,940,434	₱759,738,947	₱789,679,381	₱349,406,945

Unrestricted Funds
These represent funds held by the Foundation without donor or grantor imposed restrictions.

Restricted Funds
The Foundation is the principal recipient of grants from Global Fund. These funds should be used only for the implementation of the specific programs agreed upon by the Foundation and Global Fund (see Note 11).

Cash on hand and with banks amounting to about ₱196.0 million and about ₱109.2 million in 2008 and 2007, respectively and cash equivalents amounting to about ₱563.7 million and about ₱223.2 million as of July 31, 2008 and 2007, respectively represent restricted funds held for the implementation of specific programs entered into by the Foundation (see Note 11).

Cash with banks earn interest at the respective bank deposit rates. Cash equivalents are made for varying periods of up to three months depending on the immediate cash requirements of the Foundation. These cash equivalents earn interest at the short-term investment rates.

4. Advances and Other Receivables

	Unrestricted	Restricted	2008	2007
Officers and employees	**₱1,699,164**	**₱5,379,133**	**₱7,078,297**	₱3,141,352
Suppliers	**94,026**	**–**	**94,026**	475,650
Philippine Lung Center	**–**	**–**	**–**	575,480
Others	**333,559**	**2,716,413**	**3,049,972**	1,248,775
	₱2,126,749	**₱8,095,546**	**₱10,222,295**	₱5,441,257

5. Property and Equipment

As of July 31, 2008

	Condominium Units	Office Furniture, Fixtures and Equipment	Leasehold Improvements	Laboratory Equipment	Transportation Equipment	Construction In Progress	Land	Total
Cost:								
Beginning balances	₱25,486,628	₱5,577,585	₱980,734	₱8,744,227	₱1,964,800	₱2,404,285	₱-	₱45,158,259
Additions	–	3,889,388	291,881	2,373,174	–	41,881,921	32,373,000	80,809,364
Reclassification	44,286,206	–	–	–	–	(44,286,206)	–	–
Ending balances	69,772,834	9,466,973	1,272,615	11,117,401	1,964,800	–	32,373,000	125,967,623
Accumulated depreciation:								
Beginning balances	3,115,377	3,119,767	876,720	6,643,597	1,361,543	–	–	15,117,004
Depreciation for the period	1,798,186	1,360,184	254,523	1,664,916	392,960	–	–	5,470,769
Ending balances	4,913,563	4,479,951	1,131,243	8,308,513	1,754,503	–	–	20,587,773
Net book value	₱64,859,271	₱ 4,987,022	₱141,372	₱2,808,888	₱210,297	₱-	₱32,373,000	₱105,379,850

As of July 31, 2007 (As restated, see Note 11)

	Condominium Units	Office Furniture, Fixtures and Equipment	Leasehold Improvements	Laboratory Equipment	Transportation Equipment	Construction In Progress	Total
Cost:							
Beginning balances	₱25,409,132	₱5,577,585	₱980,734	₱8,685,862	₱1,964,800	₱-	₱42,618,113
Additions	77,496	–	–	58,365	–	2,404,285	2,540,146
Ending balances	25,486,628	5,577,585	980,734	8,744,227	1,964,800	2,404,285	45,158,259
Accumulated depreciation:							
Beginning balances	1,839,361	1,961,163	629,530	5,848,109	968,583	–	11,246,746
Depreciation for the period	1,276,016	1,158,604	247,190	795,488	392,960	–	3,870,258
Ending balances	3,115,377	3,119,767	876,720	6,643,597	1,361,543	–	15,117,004
Net book value	₱22,371,251	₱2,457,818	₱104,014	₱2,100,630	₱603,257	₱2,404,285	₱30,041,255

a) All the property and equipment above represent acquisitions from sources other than Global Fund (see paragraph (d) below).

b) Construction in progress refers to a building constructed by the Foundation on the land donated by Ayala Corporation. The construction was completed in March 2008.

c) On August 14, 2006, Ayala Corporation donated a parcel of land located in Makati City to the Foundation. On January 7, 2008, the title of the land was transferred to the Foundation.

d) In 2008, the Foundation changed its accounting policy retroactively for acquisitions of property and equipment using the grant received from Global Fund. The acquisition costs were no longer capitalized in the financial statements. These are accounted for as an outright expense in the year the costs are incurred (see Note 11). The accounting principles generally accepted in

the Philippines under SFAS/IAS 16, *Property, Plant and Equipment*, requires that costs incurred in the acquisition of property and equipment should be capitalized and depreciated over the estimated useful lives of the property and equipment. The Foundation, however, believes that it will be able to properly account for the grant received from Global Fund if the acquisition costs of property and equipment are expensed outright.

6. Accounts and Other Payables

	Unrestricted	Restricted	2008	2007
Accounts payable	**₱9,931,528**	**₱10,245,483**	**₱20,177,011**	₱14,799,794
Accrued expenses	**52,233**	**–**	**52,233**	83,901
Others	**1,907,079**	**225,238**	**2,132,317**	1,237,317
	₱11,890,840	**₱10,470,721**	**₱22,361,561**	₱16,121,012

7. Loan Payable

On June 14, 2007, the Foundation obtained a loan amounting to ₱2.0 million with an interest of 8.75% per annum to finance the construction of its new building (see Note 5). The principal is payable on demand and in lump sum, while interest is payable monthly in arrears. This is collateralized by the Foundation's condominium unit at the Montepino Building. The loan was settled on August 22, 2007.

On August 22, 2007, the Foundation obtained a medium-term loan amounting to ₱15.0 million from a local bank which is payable on demand with interest rate at 9.25% per annum. The principal is payable on demand and in lump sum, while interest is payable quarterly. The purpose of the loan is to finance the construction of the Foundation's new building (see Note 5). This is collateralized by the Foundation's condominium unit at the Montepino Building and at the Makati Medical Plaza (see Note 5).

8. Personnel Costs

	Unrestricted	Restricted	2008	2007
Salaries and wages	**₱1,919,745**	**₱19,694,971**	**₱21,614,716**	₱10,860,624
Other benefits	**2,741,306**	**9,522,641**	**12,263,947**	5,482,348
	₱4,661,051	**₱29,217,612**	**₱33,878,663**	₱16,342,972

9. Leases

The Foundation leases two condominium units at the Medical Plaza Makati Building for its clinical activities and two units at the Atlas Marketing and Promotion Corporation (APMC) Building for its operational activities. In 2008, the Foundation leases additional three units at the APMC Building for administrative and accounting department. The lease terms cover varying periods of up to two years.

10. Retirement Plan

Pending the adoption of a formal retirement plan, the Foundation provides for the retirement benefits of qualified employees as required under RA 7641. Based on the latest actuarial valuation report dated July 31, 2006 the present value of retirement obligations amounted to about ₱1.2 million while the fund balance amounted to about ₱3.6 million. The principal assumptions used to determine retirement benefits were an interest rate and average salary increase rate of 10% per annum. No retirement cost was recognized in 2008 and 2007 because the annual amortization of the excess of plan assets over the present value of retirement obligations exceeds the current service cost.

11. Contracts and Agreements

Global Fund
The Foundation entered into program grant agreements with Global Fund for the implementation or overseeing the implementation of six programs as follows:

Programs	Grant No.	Start Date	Phase 1 End Date	Proposed Completion Date
Accelerating the Response to Tuberculosis	PHL-202-G02-T-00	August 1, 2003	July 31, 2005	July 31, 2008
Accelerating the Response to Malaria	PHL-202-G01-M-00	August 1, 2003	July 31, 2005	July 31, 2008
Accelerating STI and HIV Prevention and Care Through Intensified Delivery of Services to Vulnerable Groups and People Living with HIV in Strategic Areas in the Philippines	PHL-304-G03-H	August 1, 2004	July 31, 2007	July 31, 2009
Upscaling the National Response to HIV/AIDS Through the Delivery of Services and Information to Populations at Risk and People Living with HIV/AIDS	PHL-506-G04-H	October 1, 2006	September 30, 2008	September 30, 2011
Scaling up and Enhancement of the National Tuberculosis Program in the Philippines	PHL-506-G06-T	October 1, 2006	September 30, 2008	September 30, 2011
An Intensified Strengthening of Local Response and Health Systems to Consolidate the Gains in Malaria Control in Rural Philippines Through Public Private Partnership	PHL-607-G07-M	November 1, 2007	October 31, 2009	October 31, 2012

Grant agreements for Tuberculosis Round 2 and Malaria Round 2 with grant numbers PHL-202-G02-T-00 and PHL-202-G01-M-00, respectively, were completed on July 31, 2008. The Foundation is currently applying for the continuance of the programs.

In 2008, the Foundation changed its method in accounting for the grants received from Global Fund to properly account and comply with the requirements of the latter. As such, (a) the acquisition costs of property and equipment will be recognized as expense in the year the costs are incurred (see Note 5), and (b) grants received will be reflected in the statement of income and expenses as and when the related cost and expenses are actually incurred.

The effect of the change in accounting for the grants received from Global Fund has been accounted for retroactively in conformity with the provisions of SFAS 13 (revised 2000), *Net Income or Loss for the Period, Fundamental Errors and Changes in Accounting Policies*, and as a result, the 2007 financial statements were restated. The Foundation adjusted its property and equipment and funds held in trust by about ₱6.4 million and about ₱13.9 million, respectively, to correct the balances as of July 31, 2007. The resulting change decreased fund balance as of July 31, 2007 and 2006 by about ₱20.3 million and about ₱8.1 million, respectively, and decreased the excess of income over expenses by about ₱12.1 million in 2007.

Case Western Reserve University (CWRU)
The Research Consortium Agreement between CWRU and the Foundation which is sponsored by the National Institutes of Health under project title: "Tuberculosis Research Unit" is a collaborative effort between the two organizations wherein the Foundation agreed to use its personnel and facilities in the performance of work in exchange for costs reimbursement based on an agreed budget. The program started on November 15, 2003 and was completed in April 2008.

Centers for Disease Control and Prevention (CDC)
The Foundation entered into a cooperative agreement with CDC under the project title "Improving the Effectiveness of the Diagnosis of Tuberculosis in the Philippines" under Program Announcement Number 04259. The program started on September 15, 2004 with expected completion date of September 14, 2009.

Otsuka Pharmaceutical Development & Commercialization, Inc. (OPDC)
The agreement between the Foundation and OPDC is contracted through Parexel APEX International Clinical Research Co., Ltd., who acts as the independent contractor. OPDC engaged the Foundation to carry out clinical trials in accordance with the protocol dated February 13, 2008 and entitled "A Multi-center, Randomized, Double-Blind, Placebo-controlled Phase 2 Trial to Evaluate the Safety, Efficacy and Pharmacokinetics of Multiple Doses of OPC-67683 in Patients with Pulmonary Sputum Culture-Positive, Multidrug-resistant Tuberculosis". The period of performance of the study began in June 2008 and shall continue until April 2009. In consideration for the performance of the study, the Foundation is compensated in accordance with the budget and payment schedule attached in the agreement.

INDEPENDENT AUDITORS' REPORT

The Board of Trustees
Tropical Disease Foundation, Inc.
(Principal Recipient of Global Fund - Supported Programs)

We have audited the accompanying consolidated statement of cash receipts and disbursements in US dollar of Tropical Disease Foundation, Inc. (Principal Recipient of Global Fund - Supported Programs) for the period ended July 31, 2008. This statement and the supplementary schedules of cash receipts and disbursements are the responsibility of the Principal Recipient's management. Our responsibility is to express an opinion on the statement based on our audits. The statement for the period ended July 31, 2005 were audited by other auditors whose report thereon, dated May 15, 2006, expressed an unqualified opinion on those statements.

Except as discussed in the fourth paragraph, we conducted our audits in accordance with Philippine Standards on Auditing. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the financial statements are free of material misstatement. An audit includes examining, on a test basis, evidence supporting the amounts and disclosures in the financial statements. An audit also includes assessing the accounting principles used and significant estimates made by management, as well as evaluating the overall financial statement presentation. We believe that our audits provide a reasonable basis for our opinion.

As described in Note 2 to the consolidated statement of cash receipts and disbursements, the consolidated statement of cash receipts and disbursements was prepared on the basis of cash received and disbursements made, which is a comprehensive basis of accounting other than the accounting principles generally accepted in the Philippines.

We were not able to perform audit procedures for the statements of cash receipts and disbursements of certain implementers for the periods ended July 31, 2008 and 2007; the total receipts and disbursements based on the records of these implementers amounted to about $4.4 million and about $3.3 million, respectively. We were unable to satisfy ourselves as to the reasonableness of these amounts by other audit procedures.

In our opinion, except for the effects of such adjustments, if any, as might have been determined to be necessary had we been able to satisfy ourselves as to reasonableness of the amounts of the total receipts and disbursements of the unaudited implementers, the accompanying statement referred to above present fairly, in all material respects, the cash receipts and disbursements of the program for the period ended July 31, 2008 on the basis of accounting described in Note 2 to the consolidated statement of cash receipts and disbursements.

Our audits were made for the purpose of forming an opinion on the consolidated statement of cash receipts and disbursements for the period ended July 31, 2008. The accompanying supplementary schedules of cash receipts and disbursements of HIV/AIDS Rounds 3 and 5, Tuberculosis Rounds 2 and 5, and Malaria Round 2 and 6 for the periods ended July 31, 2008, 2007 and 2006 are presented for purposes of additional analysis and are not required part of the consolidated statement of cash receipts and disbursements and, in our opinion, except for the effects of such adjustments, if any, as might have been determined to be necessary had we been able to satisfy ourselves as to reasonableness of the amounts of the total receipts and disbursements of the unaudited implementers, are fairly stated in all material respects in relation to the consolidated statement of cash receipts and disbursements taken as a whole.

This report is intended solely for the information and use of the Global Fund to Fight AIDS, Tuberculosis and Malaria as funding agency of the Tropical Disease Foundation, Inc. (Principal Recipient of Global Fund - Supported Programs) and for submission to this funding agency and should not be used for any other purpose.

SYCIP GORRES VELAYO & CO.

Jose Pepito E. Zabat

Jose Pepito E. Zabat III
Partner
CPA Certificate No. 85501
SEC Accreditation No. 0328-A
Tax Identification No. 102-100-830
PTR No. 0015800, January 3, 2008, Makati City

December 23, 2008

TROPICAL DISEASE FOUNDATION, INC.
(PRINCIPAL RECIPIENT OF GLOBAL FUND - SUPPORTED PROGRAMS)
CONSOLIDATED STATEMENT OF CASH RECEIPTS AND DISBURSEMENTS
FOR THE PERIOD ENDED JULY 31, 2008
(In US Dollar)

	HIV/AIDS		Tuberculosis		Malaria	
	Round 3 2005-2008	Round 5 2007-2008	Round 2 2004-2008	Round 5 2007-2008	Round 2 2004-2008	Round 6 2008
RECEIPTS (Notes 2 and 3)						
Funds received from Global Fund	$4,996,473	$2,800,614	$11,438,065	$16,607,711	$11,828,150	$10,078,023
Interest income	27,485	25,090	48,337	109,415	55,045	191,778
Others	100	171	114,564	8,490	417,932	–
	5,024,418	2,825,875	11,600,966	16,725,616	12,301,127	10,269,801
DISBURSEMENTS (Notes 2 and 3)						
Human resources	1,264,149	689,441	1,920,089	1,247,009	2,424,864	607,287
Training	1,149,559	313,067	1,094,158	1,635,789	1,529,770	235,906
Commodities and products	311,559	63,450	–	158,217	3,501,176	–
Program management and administration	327,650	257,811	986,512	1,683,787	770,047	–
Planning and administration	332,227	113,304	1,015,649	652,839	817,677	90,661
Monitoring and evaluation	266,254	167,592	773,471	851,806	886,200	34,985
Drugs	237,270	184,664	1,114,650	265,550	244,655	–
Infrastructure and other equipment	227,513	120,908	223,783	534,140	560,106	122,557
Medicines and pharmaceutical products	–	111,935	641,412	1,499,841	33,715	5,398
Health products and health equipment	64,741	52,943	81,761	479,080	232,933	69,567
Cost of installation	–	–	842,379	–	–	–
Planned training course and seminar	–	–	234,874	244,767	–	–
Social marketing and advocacy	–	–	410,485	–	–	–
Communications materials	–	10,121	66,144	87,905	91,145	13,241
Information Education and Communication (IEC) materials	–	–	265,803	–	–	–
Overheads	402	77,591	151,555	174,009	33,468	44,398
Screening (Laboratory test)	–	–	237,086	–	–	–
Technical and management assistance	661	80,174	5,008	–	11,200	118,784
Cohort expansion	–	–	209,480	–	–	–
Enablers	–	–	196,262	–	–	–
Living support to clients/ target population	39,378	8,415	63,954	84,509	–	–
Updates, workshops and technical supports	–	–	172,794	–	–	–
Bacteriologic monitoring	–	–	126,744	–	–	–
Procurement and supply management costs	11,051	17,880	52,977	93,088	31,662	2,397
Community empowerment	–	–	89,525	–	–	–
Household contacts tracing	–	–	21,419	–	–	–
Infection control upgrading	–	–	5,414	–	–	–
Networking activities	–	–	1,799	–	–	–
Surveillance and proficiency testing	–	–	1,634	–	–	–
Proficiency testing	–	–	1,071	–	–	–
Others	–	–	–	–	147,014	–
	4,232,414	2,269,296	11,007,892	9,692,336	11,315,632	1,345,181
EXCESS OF RECEIPTS OVER DISBURSEMENTS	$792,004	$556,579	$593,074	$7,033,280	$985,495	$8,924,620

See accompanying Notes to Consolidated Statement of Cash Receipts and Disbursements.

TROPICAL DISEASE FOUNDATION, INC.
(PRINCIPAL RECIPIENT OF GLOBAL FUND - SUPPORTED PROGRAMS)
SCHEDULES OF CASH RECEIPTS AND DISBURSEMENTS
FOR HIV/AIDS ROUND 3
FOR THE PERIODS ENDED JULY 31, 2008, 2007 AND 2006
(With Comparative Figures for 2005 and 2004)
(In US Dollar)

	2008	2007	2006	2005	2004	Total
RECEIPTS (Notes 2 and 3)						
Funds received from Global Fund	$586,553	$913,103	$1,225,802	$764,973	$1,506,042	$4,996,473
Interest income	21,764	2,628	2,680	773	–	27,845
Others	–	100	–	–	–	100
	608,317	915,831	1,228,482	765,746	1,506,042	5,024,418
DISBURSEMENTS (Notes 2 and 3)						
Human resources	213,922	199,887	489,668	360,672	–	1,264,149
Training	66,682	135,484	614,544	332,849	–	1,149,559
Drugs	–	130,791	86,898	199,590	–	417,279
Planning and administration	32,927	66,029	136,566	96,705	–	332,227
Program management and administration	101,802	85,954	67,137	72,741	16	327,650
Commodities and products	–	96,890	103,066	111,603	–	311,559
Monitoring and evaluation	26,001	11,906	154,426	73,921	–	266,254
Infrastructure and other equipment	28	101,894	53,168	72,423	–	227,513
Health products and health equipment	64,741	–	–	–	–	64,741
Living support to clients/ target population	39,378	–	–	–	–	39,378
Procurement and supply management costs	11,051	–	–	–	–	11,051
Technical and management assistance	661	–	–	–	–	661
Overheads	402	–	–	–	–	402
Medicines and pharmaceutical products	(180,009)*	–	–	–	–	(180,009)
	377,586	828,835	1,705,473	1,320,504	16	4,232,414
EXCESS (DEFICIENCY) OF RECEIPTS OVER DISBURSEMENTS	$230,731	$86,996	($476,991)	($554,758)	$1,506,026	$792,004

**The negative balance pertains to refund from WHO for the procurement of drugs paid in advance at an amount higher than the actual cost.*

TROPICAL DISEASE FOUNDATION, INC.
(PRINCIPAL RECIPIENT OF GLOBAL FUND - SUPPORTED PROGRAMS)

SCHEDULES OF CASH RECEIPTS AND DISBURSEMENTS FOR HIV/AIDS ROUND 5
FOR THE PERIODS ENDED JULY 31, 2008 AND 2007
(In US Dollar)

	2008	2007	Total
RECEIPTS (Notes 2 and 3)			
Funds received from Global Fund	$1,720,756	$1,079,858	$2,800,614
Interest income	6,469	18,621	25,090
Others	171	–	171
	1,727,396	1,098,479	2,825,875
DISBURSEMENTS (Notes 2 and 3)			
Human resources	479,314	210,127	689,441
Training	154,370	158,697	313,067
Program management and administration	119,300	138,511	257,811
Drugs	–	184,664	184,664
Monitoring and evaluation	167,592	–	167,592
Infrastructure and other equipment	32,040	88,868	120,908
Planning and administration	7,463	105,841	113,304
Medicines and pharmaceutical products	111,935	–	111,935
Technical and management assistance	80,174	–	80,174
Overheads	77,591	–	77,591
Commodities and products	–	63,450	63,450
Health products and health equipment	52,943	–	52,943
Procurement and supply management costs	17,880	–	17,880
Communications materials	10,121	–	10,121
Living support to clients/ target population	8,415	–	8,415
	1,319,138	950,158	2,269,296
EXCESS OF RECEIPTS OVER DISBURSEMENTS	$408,258	$148,321	$556,579

TROPICAL DISEASE FOUNDATION, INC.
(PRINCIPAL RECIPIENT OF GLOBAL FUND - SUPPORTED PROGRAMS)

SCHEDULES OF CASH RECEIPTS AND DISBURSEMENTS FOR TUBERCULOSIS ROUND 2
FOR THE PERIODS ENDED JULY 31, 2008, 2007 AND 2006
(With Comparative Figures for 2005 and 2004)
(In US Dollar)

	2008	2007	2006	2005	2004	Total
RECEIPTS (Notes 2 and 3)						
Funds received from Global Fund	$1,301,353	$3,642,844	$3,059,381	$2,101,589	$1,332,898	$11,438,065
Interest income	16,306	24,341	3,321	2,836	1,533	48,337
Others	113,010	990	564	–	–	114,564
	1,430,669	3,668,175	3,063,266	2,104,425	1,334,431	11,600,966
DISBURSEMENTS (Notes 2 and 3)						
Human resources	708,001	401,114	342,764	376,879	91,331	1,920,089
Drugs	–	176,710	290,117	270,287	377,536	1,114,650
Training	361,349	409,106	122,453	151,825	49,425	1,094,158
Planning and administration	103,721	336,085	291,365	235,205	49,273	1,015,649
Program management and administration	260,879	121,007	337,172	146,432	121,022	986,512
Cost of installation	–	11,545	557,076	196,935	76,823	842,379
Monitoring and evaluation	313,871	295,678	128,466	25,352	10,104	773,471
Medicines and pharmaceutical products	250,424	390,988	–	–	–	641,412
Social marketing and advocacy	–	37,354	61,135	298,143	13,853	410,485
IEC materials	–	153,493	33,482	48,125	30,703	265,803
Screening (Laboratory test)	–	63,001	146,701	27,384	–	237,086
Planned training course and seminar	–	50,791	70,133	49,611	64,339	234,874
Infrastructure and other equipment	(11,650)*	8,591	68,054	108,776	50,012	223,783
Cohort expansion	–	93,963	63,905	42,451	9,161	209,480
Enablers	–	68,585	68,118	49,076	10,483	196,262
Updates, workshops and technical supports	–	167,939	–	–	4,855	172,794
Overheads	151,555	–	–	–	–	151,555
Bacteriologic monitoring	–	63,743	–	48,388	14,613	126,744
Community empowerment	–	89,525	–	–	–	89,525
Health products and health equipment	81,761	–	–	–	–	81,761
Communication materials	66,144	–	–	–	–	66,144
Living support to clients/ target population	63,954	–	–	–	–	63,954
Procurement and supply management costs	52,977	–	–	–	–	52,977
Household contacts tracing	–	6,166	8,049	6,275	929	21,419
Infection control upgrading	–	4,413	1,001	–	–	5,414
Technical and management assistance	5,008	–	–	–	–	5,008
Networking activities	–	–	–	1,252	547	1,799
Surveillance and proficiency testing	–	35	39	1,422	138	1,634
Proficiency testing	–	–	–	1,071	–	1,071
	2,407,994	2,949,832	2,590,030	2,084,889	975,147	11,007,892
EXCESS (DEFICIENCY) OF RECEIPTS OVER DISBURSEMENTS	($977,325)	$718,343	$473,236	$19,536	$359,284	$593,074

**The negative balance pertains to refund from TDFI for disbursements disallowed by the GFATM on the planned construction of a clinic at Montepino Building since the unit was subsequently used as an administrative office after the owners of the said building did not approve the construction of the clinic.*

TROPICAL DISEASE FOUNDATION, INC.
(PRINCIPAL RECIPIENT OF GLOBAL FUND - SUPPORTED PROGRAMS)
SCHEDULES OF CASH RECEIPTS AND DISBURSEMENTS
FOR TUBERCULOSIS ROUND 5
FOR THE PERIODS ENDED JULY 31, 2008 AND 2007
(In US dollar)

	2008	2007	Total
RECEIPTS (Notes 2 and 3)			
Funds received from Global Fund	$10,381,117	$6,226,594	$16,607,711
Interest income	68,644	40,771	109,415
Others	17	8,473	8,490
	10,449,778	6,275,838	16,725,616
DISBURSEMENTS (Notes 2 and 3)			
Program management and administration	1,218,424	465,363	1,683,787
Training	1,419,742	216,047	1,635,789
Medicines and pharmaceutical products	1,499,841	–	1,499,841
Human resources	936,811	310,198	1,247,009
Monitoring and evaluation	763,076	88,730	851,806
Planning and administration	115,897	536,942	652,839
Infrastructure and other equipment	165,136	369,004	534,140
Health products and health equipment	479,080	–	479,080
Drugs	–	265,550	265,550
Planned training course and seminar	–	244,767	244,767
Overheads	174,009	–	174,009
Commodities and products	–	158,217	158,217
Procurement and supply management costs	93,088	–	93,088
Communications materials	87,905	–	87,905
Living support to clients/ target population	84,509	–	84,509
	7,037,518	2,654,818	9,692,336
EXCESS OF RECEIPTS OVER DISBURSEMENTS	$3,412,260	$3,621,020	$7,033,280

TROPICAL DISEASE FOUNDATION, INC.
(PRINCIPAL RECIPIENT OF GLOBAL FUND - SUPPORTED PROGRAMS)
SCHEDULES OF CASH RECEIPTS AND DISBURSEMENTS
FOR MALARIA ROUND 2
FOR THE PERIODS ENDED JULY 31, 2008, 2007 AND 2006
(With Comparative Figures for 2005 and 2004)
(In US Dollar)

	2008	2007	2006	2005	2004	Total
RECEIPTS (Notes 2 and 3)						
Funds received from Global Fund	$211,581	$1,815,679	$2,556,128	$2,520,750	$4,724,012	$11,828,150
Interest income	24,187	20,811	1,451	5,627	2,969	55,045
Others	89,422	235,888	92,622	–	–	417,932
	325,190	2,072,378	2,650,201	2,526,377	4,726,981	12,301,127
DISBURSEMENTS (Notes 2 and 3)						
Commodities and products	–	(160,899)*	1,550,035	813,143	1,298,897	3,501,176
Human resources	242,127	446,301	763,477	785,217	187,742	2,424,864
Training	102,263	256,801	328,042	662,516	180,148	1,529,770
Monitoring and evaluation	373,090	98,653	223,794	179,984	10,679	886,200
Planning and administration	23,311	240,502	206,399	191,050	156,415	817,677
Program management and administration	–	–	–	317,409	452,638	770,047
Infrastructure and other equipment	922	–	77,380	131,766	350,038	560,106
Drugs	–	(552)**	12,305	102,023	130,879	244,655
Health products and health equipment	232,933	–	–	–	–	232,933
Communications materials	91,145	–	–	–	–	91,145
Medicines and pharmaceutical products	33,715	–	–	–	–	33,715
Overheads	33,468	–	–	–	–	33,468
Procurement and supply management costs	31,662	–	–	–	–	31,662
Technical and management assistance	11,200	–	–	–	–	11,200
Others	107,417	39,597	–	–	–	147,014
	1,283,253	920,403	3,161,432	3,183,108	2,767,436	11,315,632
EXCESS (DEFICIENCY) OF RECEIPTS OVER DISBURSEMENTS	($958,063)	$1,151,975	($511,231)	($656,731)	$1,959,545	$985,495

**The negative balance is attributed to collections received under the Malaria Cost Recovery Program from laboratory supplies previously purchased and released to Project Management Teams.*

***The negative balance pertains to refund from WHO for the procurement of drugs paid in advance at an amount higher than the actual cost.*

TROPICAL DISEASE FOUNDATION, INC.
(PRINCIPAL RECIPIENT OF GLOBAL FUND - SUPPORTED PROGRAMS)

SCHEDULES OF CASH RECEIPTS AND DISBURSEMENTS FOR MALARIA ROUND 6

FOR THE PERIOD ENDED JULY 31, 2008

(In US Dollar)

RECEIPTS (Notes 2 and 3)	
Funds received from Global Fund	$10,078,023
Interest income	191,778
Others	–
	10,269,801
DISBURSEMENTS (Notes 2 and 3)	
Human resources	607,287
Training	235,906
Infrastructure and other equipment	122,557
Technical and management assistance	118,784
Planning and administration	90,661
Health products and health equipment	69,567
Overheads	44,398
Monitoring and evaluation	34,985
Communications materials	13,241
Medicines and pharmaceutical products	5,398
Procurement and supply management costs	2,397
	1,345,181
EXCESS OF RECEIPTS OVER DISBURSEMENTS	$8,924,620

TROPICAL DISEASE FOUNDATION, INC.
(PRINCIPAL RECIPIENT OF GLOBAL FUND - SUPPORTED PROGRAMS)

NOTES TO CONSOLIDATED STATEMENT OF CASH RECEIPTS AND DISBURSEMENTS

1. **Program Profile**

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

Tropical Disease Foundation, Inc. (TDFI) was nominated and elected to be the Principal Recipient (PR) for the GFATM programs in the Philippines in November 2002. The PR must be a legal entity that can receive the grant funds and manage these on behalf of the GFATM. The PR is responsible for the financial management and administration of the programs, including receiving and disbursing the grant funds to the program implementers, overseeing and managing the proposed procurement, and submitting regular financial and programmatic progress reports to the GFATM and to the Country Coordinating Committee Mechanism. Also, the PR shall ensure that all grant funds are prudently managed and shall take all necessary action to ensure that grant funds are used solely for the program purposes and consistent with the terms of the Program Grant Agreement (the Agreements). The Agreements define the terms and conditions under which the GFATM may provide funding to the PR to implement the programs in the Philippines.

The Agreements entered into by TDFI, as PR, with GFATM for the implementation or overseeing of the implementation of the programs are as follows:

Programs	Round	Grant No.	Grant Fund	Start Date	End Date
HIV/AIDS					
Accelerating STI and HIV Prevention and Care through Intensified Delivery of Services to Vulnerable Groups and People with HIV in Strategic Areas in the Philippines	3	PHL-304-G03-H	$5,528,825	August 1, 2004	July 31, 2009
Upscaling the National Response to HIV/AIDS through the Delivery of Services and Information to Populations at Risk and People Living with HIV/AIDS	5	PHL-506-G04-H	$3,011,919	October 1, 2006	September 30, 2011
TB					
Accelerating the Response to TB	2	PHL-202-G02-T-00	$11,438,064	August 1, 2003	July 31, 2008
Scaling up and Enhancement of the National Tuberculosis Program in the Philippines	5	PHL-506-G06-T	€11,709,434	October 1, 2006	September 30, 2011
Malaria					
Accelerating the Response to Malaria	2	PHL-202-G01-M-00	$11,829,545	August 1, 2003	July 31, 2008
An Intensified Strengthening of Local Response and Health Systems to Consolidate the Gains in Malaria Control in Rural Philippines through Public Private Partnership	6	PHL-607-G07-M	$16,285,198	October 1, 2007	September 30, 2012

TDFI shall be responsible to the GFATM for the overall implementation of the programs.

As amended by the Implementation Letter issued by the GFATM, agreed and signed by the PR, the starting and ending dates for the TB Round 2 and Malaria Round 2 programs have been moved from July 1, 2003 to August 1, 2003 and from June 30, 2008 to July 31, 2008, respectively.

Under the agreements, the PR may provide grant funds to other entities (Sub-recipients) to carry out activities contemplated under the programs (see Note 3).

The consolidated statement of cash receipts and disbursements for the period ended July 31, 2008 was approved and authorized for issue on December 23, 2008 by the Chief Financial Officer, who has been authorized to do so by the Board of Trustees.

2. Basis of Preparation

The PR fund accounted for in the consolidated statement of cash receipts and disbursements pertains to the grants received from the GFATM only. The PR and its implementers maintain US dollar, Euro and Philippine peso bank accounts. Remittances from the GFATM are coursed through the US dollar and Euro bank accounts. Disbursements for the programs are made from either the US dollar or Philippine peso bank accounts.

The PR's consolidated statement of cash receipts and disbursements in US dollar has been prepared on the basis of cash received and disbursements made, which is a comprehensive basis of accounting other than the accounting principles generally accepted in the Philippines. Consequently, receipts from grants are recognized when received rather than at the time of commitment of the grantor and disbursements are recognized when paid rather than when incurred. Accordingly, the consolidated statement of cash receipts and disbursements is not intended to present financial position and results of operations in conformity with accounting principles generally accepted in the Philippines.

For reporting purposes, the Philippine peso and Euro amounts were translated into US dollar using the closing exchange rate on the transaction date.

3. Program Goals and Objectives

The goals and objectives of the programs as detailed in the Agreements are as follows:

Malaria Component

Round 2:

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

Objective 1: To increase the proportion of fever patients receiving early diagnosis and prompt and effective treatments.

Objective 2: To reduce malaria transmission.

Objective 3: To strengthen local capacity for sustained implementation of community-based malaria control programs.

Philippine Rural Reconstruction Movement (PRRM) is the implementer, as approved by TDFI (see Note 1), of all Malaria Round 2 activities until July 31, 2005. Thereafter, TDFI assumed the sub-recipiency and implementation of all malaria activities from PRRM. As of July 31, 2008, the PRRM still has unliquidated advances amounting to US$151,209. As of December 15, 2008, such advances were fully liquidated.

Round 6:

Goal: To reduce malaria morbidity by 70% starting in 2008 until achieving zero mortality by 2011 in 21 covered provinces.

Objective 1: To consolidate, expand and sustain the coverage of early diagnostic and treatment services for malaria through the strengthening of health systems and establishment of public private partnership.

Objective 2: To upscale vector control methods to interrupt malaria transmission.

Objective 3: To strengthen local capacities to handle malaria cases through the strengthening of community systems designed for sustainable community based malaria control and management.

TDFI handles the implementation of all Malaria Round 6 activities.

TB Component

Round 2:

Goal: To halve the prevalence, incidence and mortality of TB by 2010 in concordance with the National TB Control Program plan. By the end of 2008, it shall have detected 85% of all TB cases and cured at least 85% of them.

Objective 1: To increase the case detection rate of the estimated TB cases from 58% in 2003 to 85% in 2008 through (a) Nationwide establishment of Public-Private Mix Directly Observed Treatment, Short Course (DOTS) being implemented by the Philippine Coalition Against Tuberculosis, Inc. (PhilCAT); and (b) enhancement of DOTS in the public sector which is implemented by the (i) Department of Health (DOH), specifically by improving the service side of TB control through trainings, and the (ii) World Vision Development Foundation, Inc. (WVDFI), by improving the demand side through social mobilization.

Objective 2: To utilize the Green Light Committee approved DOTSPlus project in addressing Multi-drug Resistant TB (MDR-TB) cases. The Implementer of this objective is the TDFI-DOTSPlus Clinic.

The program implementers, as approved by TDFI (see Note 1), for Tuberculosis Round 2 are the following:
a. PhilCAT;
b. WVDFI;
c. DOH; and
d. TDFI – DOTS.

Round 5:

Goal: To reduce the prevalence, incidence and mortality of TB by half in 2010 from a baseline established in 2000 in support of the Millennium Development Goals for poverty alleviation.

Objective 1:
a. To enhance the quality of DOTS implementation in the public sector through increasing the accessibility and quality of DOTS services being implemented by both the (i) PhilCAT, specifically by the nationwide establishment of public-private mix DOTS (PPMD) and (ii) DOH, specifically by improving the service side of TB control through trainings.

b. To increase the demand for DOTS services in the public and private DOTS facilities which is implemented by both the (i) WVDFI, and (ii) Holistic Community Development Initiatives (HCDI), by removing access barriers to DOTS through social mobilization and social marketing for underserved populations (urban poor).

Objective 2: To ensure access to quality DOTS services by the unreached and underserved populations through

a. Scaling-up PPMD with the installation of 100 new PPMD units;
b. Enhancing existing PPMD units;
c. Regularly supervising and monitoring of PPMD units; and
d. Ensuring the sustainability of all Global Fund PPMD units beyond project life.

Objective 3: To integrate Programmatic MDR-TB Management (PMTM) in the existing DOTS infrastructure in Metro Manila and selected high MDR-TB prevalence areas outside Metro Manila. Treatment of MDR-TB cases in the main focus of this objective, including human resource development, laboratory capacity building, health infrastructure development, and patient empowerment and community mobilization. The implementer of this objective is TDFI-DOTSPlus Clinic.

Objective 4: To sustain and strengthen TB and HIV collaboration in an epidemiologic scenario where the TB prevalence is high and HIV burden is low.

The program implementers, as approved by TDFI (see Note 1), for Tuberculosis Round 5 are the following:
a. PhilCAT;
b. WVDFI;
c. HCDI;
d. DOH; and
e. TDFI – DOTS.

HIV/AIDS Component

Round 3:

Goal: By the end of 2009, prevalence of HIV among vulnerable groups is less than 1% while prevalence of sexually transmitted infections (STI) is reduced by 50% among people in prostitution in the 11 risk sites. Also 40% of estimated people living with HIV/AIDS (PLWHAs) are receiving adequate support, care and treatment.

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

a. Intensify social mobilization and advocacy campaign;
b. Outreach and education activities;
c. Capacity building of service providers, peer educators, Community Health Outreach Workers;
d. Improvement of STI services; and
e. Strengthen monitoring and evaluation mechanism for tracking project progress implementation.

Objective 2: To scale up Voluntary Counseling and Testing (VCT), support, care and treatment for the PLHAs and their families in four geographic areas namely, Manila, La Union, Cebu and Davao. This will be accomplished through the following activities:

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

The program implementers, as approved by TDFI (see Note 1), for the HIV/AIDS Round 3 are the following:
a. Philippine NGO Council on Population, Health and Welfare, Inc. (PNGOC); and
b. TDFI.

Round 5:

Goal: To prevent the further spread of HIV/AIDS infection by maintaining an HIV/AIDS prevalence rate of less than 1% among vulnerable groups and to reduce the impact of HIV/AIDS on individuals, families and communities.

Objective 1: To reduce transmission among vulnerable groups including people in prostitutions (PIPs), interventions for injecting drug users (IDUs), men who have sex with men (MSM) and migrant workers (MWs) in 18 intervention sites.

Objective 2: To scale up support, care and treatment for people living with HIV/AIDS (PLWHAs) and their families through the addition of five (5) treatment hubs to make a total of eleven (11) treatment sites throughout the country.

Objective 3: To strengthen health management (including monitoring and evaluation) and delivery systems at both the national and local levels (cities and municipalities).

Objective 4: To conduct operational research involving out-of-school youths, street children, the informal workforce and sea-farers to assess their level of risks and vulnerabilities.

The program implementers, as approved by TDFI (see Note 1), for the HIV/AIDS Round 5 are the following:

a. PNGOC;
b. TLF Sexuality, Health And Rights Educators Collective Inc.;
c. Human Development And Empowerment Services;
d. Remedios Aids Foundation, Inc.;
e. Kabataang Gabay sa Positibong Pamumuhay, Inc.;
f. Leyte Family Development Organization;
g. Family Planning Organization of the Philippines;
h. Bicol Reproductive Health Information Network, Inc.;
i. Kanlungan Center Foundation, Inc.;
j. Baguio Aids Watch Council, Inc.;
k. Social Health Environment and Development Foundation, Inc.;
l. H.O.P.E. Volunteers Foundation, Inc.;
m. Alliance Against AIDS in Mindanao, Inc.;
n. Positive Action Philippines, Inc.;
o. Pinoy Plus Association; and
p. TDFI.

4. **Other Matters**

TDFI handles the transactions and maintains the records of the DOH as implementer of TB Rounds 2 and 5.

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