



ISSUE NO. 1
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KNOW TB

newsletter

TB CONNECT

Data analytics for informed decision making



Notified TB Cases, all forms

In 2018, a total of 329,710 (89%) tuberculosis (TB) cases were notified under the National TB Control Program (NTP), a 3.9% increase from the reported cases in the previous year [Figure 1]. Ninety-four percent (16) of the regions increased case notification [Figure 2]. All forms include new and relapse Drug-susceptible (DS) and Drug-resistant (DR) TB cases regardless of bacteriological status, anatomical site, and drug susceptibility testing result. Notified cases from private physicians were not included in the analysis. *Continued on p.2*

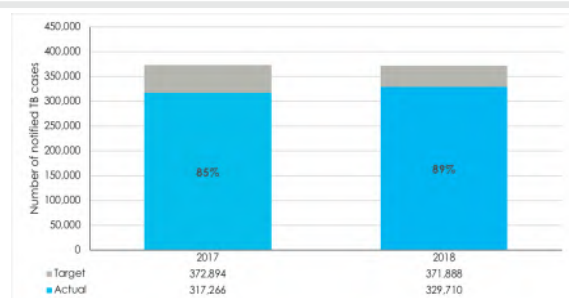


Figure 1. Notified TB Cases, 2017-2019



SPOTLIGHT

Focusing on the latest TB issues in the Philippines

Digital Solutions for Real-time TB Laboratory Test Results - Laboratory and Diagnostic Connectivity in the Philippines.

Despite substantial progress in TB control for the past 15 years, TB remains a key public health problem in the Philippines. Gaps in case detection and access to TB care services persist, ranking the Philippines as the fourth among the countries with high TB burden. These gaps are further exacerbated by delays in the release of laboratory patients results to the clinician thereby delaying initiation of anti-TB medications, management and care of TB patients. *Continued on p.4*



HEALTH HEROES

Up close and personal with TB ambassadors

Maricel Buen and Jimbo Balanguit *TB Advocates, Philippines*

By creating patient support groups and sharing their stories with others, TB Ambassadors Maricel Buen and Jimbo Balanguit hope that they can encourage more people to get screened early and treated effectively. Their journey is tough, but their commitment to save lives - stronger than ever! *Continued on p.6*



GLOBAL CHECK-UP

TB elimination efforts from around the world

Travelled a long distance, but more miles to end TB.

Despite the global awakening and increased commitment to fight tuberculosis (TB) with the availability of reliable diagnostic tools and effective medicines, TB continues to remain a major public health problem affecting the developing world disproportionately. The current pace of decline in the global burden of TB will not be enough to achieve the 2020 milestones of the End TB Strategy, for which TB incidence and mortality rates should have been falling respectively at 4–5% and 10% instead of the current rates of about 2% and 3%. *Continued on p.5*



QUESTION CORNER

Know more about TB

“What is mandatory TB Notification?”

“Can a TB patient refuse to be notified to DOH?”

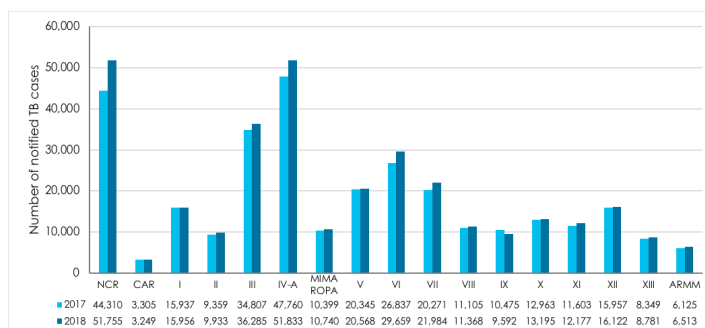
Read more on p.7



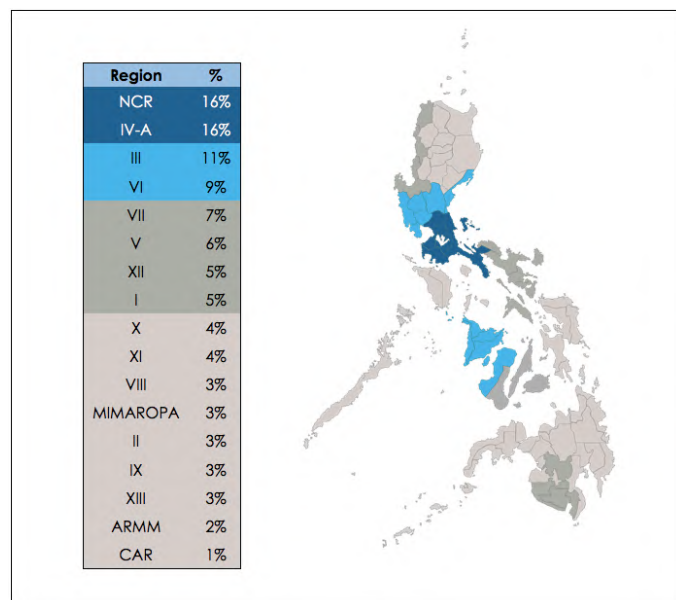
Case Notification of Tuberculosis Cases, 2018

Notified TB Cases, all forms

Figure 2. Number of notified TB cases (all forms) by region, 2017-2018

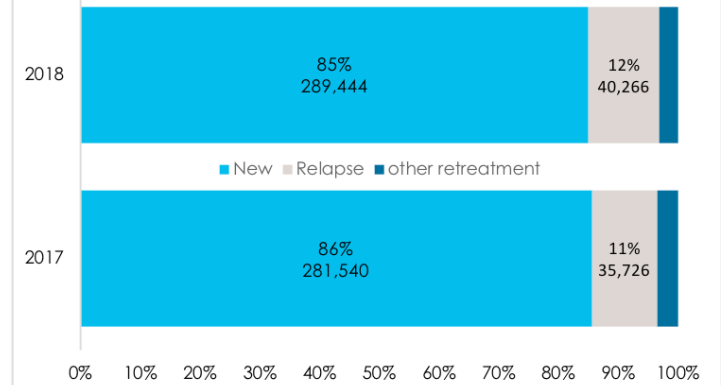


The biggest three regions in terms of number of notified cases, NCR, Region 3, and Region 4-A, accounted for 43% (139,873) of these cases (Figure 3). The rest of the Luzon regions contributed 18% (60,466) while 19% (63,011) and 20% (66,380) came from Visayas and Mindanao region, respectively.



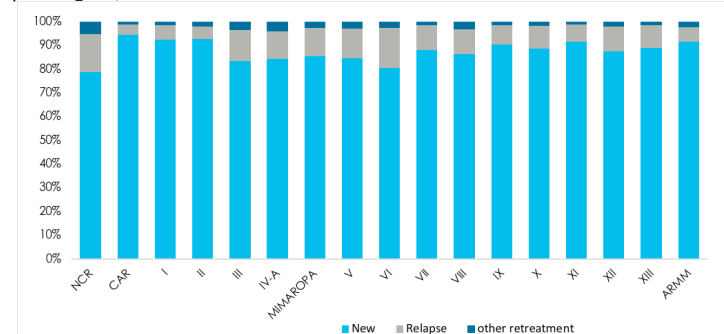
Of the total notified cases in the country, 85% (289,444) were new cases. Relapse cases, which are previously treated TB cases who have been cured or completed treatment, comprised 12% of the notified cases. The remaining 3% were other retreatment TB cases whose treatments failed, were loss to follow-up or had unknown outcomes of treatment [Figure 4].

Figure 4. Proportion of notified cases, 2017-2018

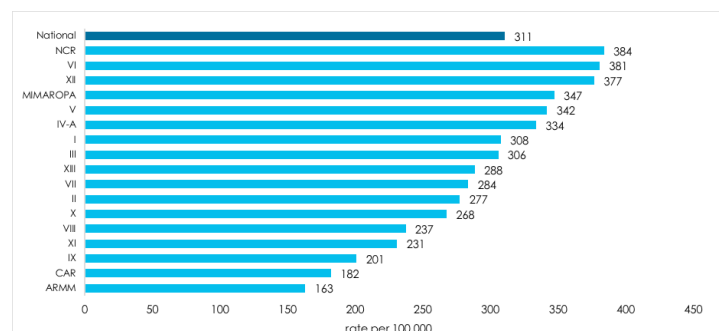


By region, Region 6 and NCR had the highest percentages of relapse cases with 17% (5,149) and 16% (8,817), respectively. Four other regions in Luzon, namely Regions 3 (13%,4,854), 4-A (12%, 6,280), MIMAROPA (12%, 1,321) and 5 (13%, 2,652) also had relatively higher proportions of relapse cases compared to the rest of the regions. The northern Luzon regions, CAR, Regions 1, and 2, had the lowest percentage of relapse cases with 4% (147), 6% (986), and 5% (533), respectively. As for other retreatment cases, NCR (5%, 2,845), Region 3 (4%, 1,393) and Region 4-A (4%, 2,234) had the highest percentages. Other regions had 3% or lower percentage of previously treated TB cases [Figure 5].

Figure 5. Percentage distribution of notified cases by registration group per Region, 2018

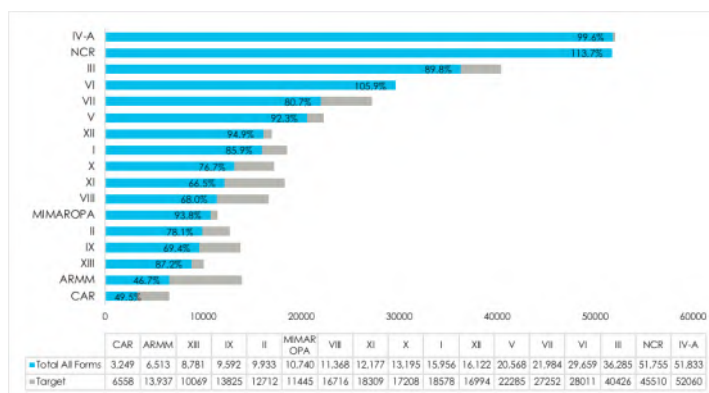


In 2017, there were 317,266 notified new and relapse TB cases out of an estimated population of 104,921,597. This is equivalent to TB case notification rate of 302 per 100,000 population. The number of notified cases of TB all forms in 2018 was 329,710, corresponding to 311 per 100,000 population case notification rate. This marked a 3% increase in TB case notification rate from 2017. The TB case notification rates varied by region ranging from 163 per 100,000 population to 384 per 100,000 population [Figure 6]. NCR had the highest case notification rate with 384 per 100,000 population, together with Region 6 (381 per 100,000 population) and 12 (377 per 100,000 population). Nine regions (53%) had case notification rates lower than 300 per 100,000 population [Figure 6].



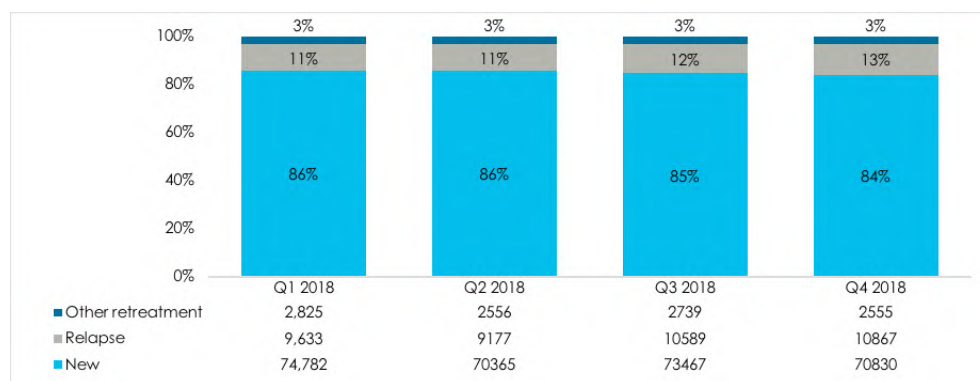
The target of the National Tuberculosis Program was to find 371,888 TB cases (all forms) in 2018. Compared to this number, the total notified TB cases represented only 89% accomplishment of the target [Figure 1]. The regional pattern of the percent of target accomplished mirrored that of the case notification rates [Figure 7]. Two regions, NCR and Region 6 attained 100% of their targets with 114% (51,755) and 106% (29,659), respectively. Several (5) Luzon regions also had high percentage of target attained with at least 85%. On the other hand, Regions 7 and 8 in the Visayas only attained 81% (21,984) and 68% (11,368), respectively. Except for Regions 12 and 13 which had 95% (16,122) and 87% (8,781) target accomplishment, respectively, all other (4) Mindanao regions had lower than 80%.

Figure 7. TB case notification accomplishment by Region, 2018



There were minimal fluctuations in the numbers of notified TB cases in the country by quarter [Figure 8]. The lowest numbers (82,098 cases) were notified during the 2nd quarter of 2018, with a 6% decline that occurred in all registration groups. Number of notified cases went up during the 3rd quarter by a similar percentage (6%, 86,795 cases) with a substantial increase contributed by the number of relapse cases (15%). During the 4th quarter, the number of new and previously treated cases went down by 7% (70,830) and 4% (2,555), respectively while the number of relapse cases increased by 3% (10,867) from the 3rd quarter levels.

Figure 8. Number of New, Relapse, and Previously-treated cases by Quarter, 2018



Drug-Resistant (DR) TB Cases

In 2018, 6,247 new drug-resistant (DR) TB cases were detected by NTP. NCR had 1,754 (28%) of these cases, followed by 987 (16%) in Region 4-A and 805 (13%) in Region 3. These three regions already accounted for majority (57%) of the new DR TB cases in 2018. The rest of Luzon regions contributed 16% (1,025). Only 26% (1,676) of the DR TB cases came the combined regions of Visayas and Mindanao [Figure 9].

The number of new DR TB cases in 2018 exceeded the 5,679 new DR-TB cases in 2017 by 9%. However, the target number of new DR-TB cases for 2018 set by NTP is bigger at 12,600. The number of DR TB cases in 2018 is only around half (49.5%) of the target. By region, only NCR reached its target. It had 114% (1,754) of the target DR TB cases. No other region reached 60% of the target. Four Luzon regions, Region 3, 4-A, MIMAROPA, and 5, had between 50 to 60% of target attained for DR TB cases. Region 6 reached half of its target (51%). All other regions ranged from 16% to 39% of target accomplished, ARMM being the lowest (16%) [Figure 10].

Figure 9. Proportion of DR-TB cases by Region, 2018

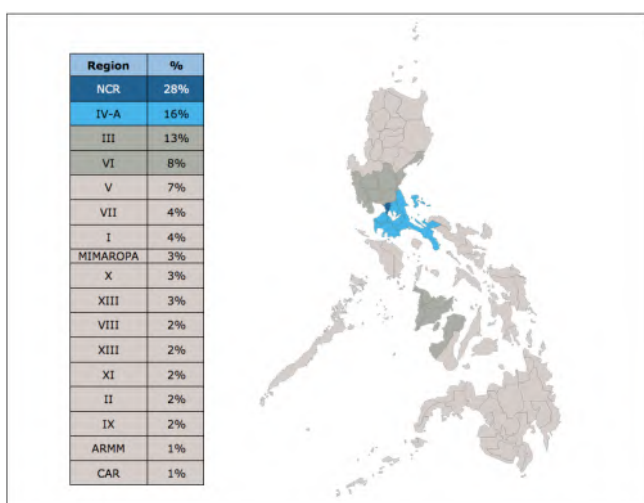
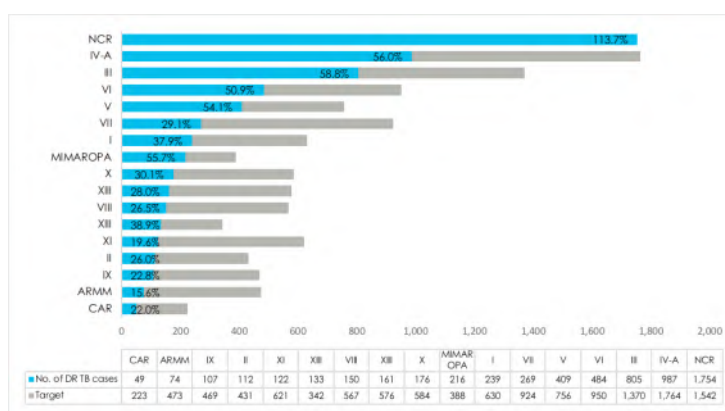


Figure 10. DR-TB cases detected by Region, 2018



Source: NTP ITIS

SPOTLIGHT

Focusing on the latest TB issues in the Philippines



DIGITAL SOLUTIONS FOR REAL-TIME TB LABORATORY TEST RESULTS – LABORATORY AND DIAGNOSTICS CONNECTIVITY IN THE PHILIPPINES

One of nine priority digital health concepts identified by the WHO Agenda for Action on Digital Health for the End TB Strategy, the adoption and use of diagnostics connectivity solutions are also monitored as core indicators for laboratory strengthening under the End TB Strategy. Based on the WHO Framework of indicators and targets for laboratory strengthening, all sites that use WHO-recommended rapid diagnostics should be transmitting results electronically to clinicians and to information management systems using data connectivity solutions no later than 2020. Remote monitoring via data connectivity solutions should be used to monitor key performance indicators at all sites that use WHO-recommended rapid diagnostics (WRD) no later than 2020.

The rapid turnaround time between specimen collection, release of diagnostic result to the patient and initiation of treatment, contributes significantly to successful treatment management and care. It also reduces the transmission of TB infection to the community. In the Philippines, hard copy laboratory results are released by the laboratory facility to the clinicians and patients throughout the case detection and patient management. Laboratory examination reports such as sputum smear microscopy, TB culture and phenotypic drug susceptibility test are recorded manually to a laboratory register while official reports are either typewritten, handwritten or encoded electronically prior to releasing to clinicians and patients.



In the advent of newer diagnostic technologies such as Mycobacterium Growth Inhibition Tube (MGIT) for liquid TB culture, line probe assay (LPA) and Xpert MTB/Rif arises the need for digital technology for laboratory and diagnostics which offers digital solutions to manage data electronically such as the Laboratory Information System (LIMS) or Laboratory Information System (LIS). The LIS manages quality assured data with the following features: requisition and receipt of tests, collection and management of specimen, workload statistics and performance of the laboratory, quality assurance, inventory management, recording and reporting of results to clinicians and patients. LIS uses laboratory diagnostic connectivity solution which speeds up the process of recording and reporting by providing the clinician and or authorised recipients access to laboratory results in real-time. The benefits of electronic data management over paper-based reporting are improved data quality, decreased work load by removing duplicate entry, easier access, analysis and data reporting.

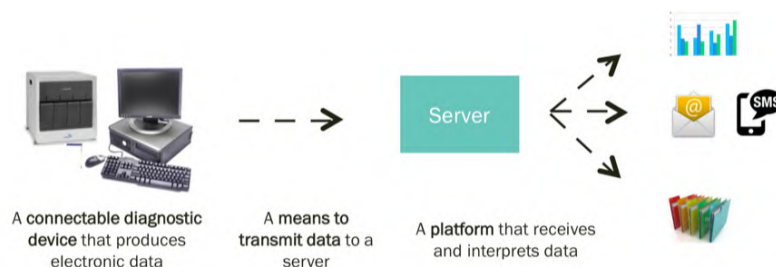


Diagnostics connectivity solutions (GLI Quick Guide to TB Diagnostics Connectivity Solutions) typically comprise of a connectable diagnostic device that produces electronic data, a software platform that receives and interprets data and a means to transmit data from the device to the software platform and to a server as shown in Figure 1. The means of transmitting data consists of a modem that utilizes available networks such as mobile 3G, Wi-fi or SMS. Connectivity solutions facilitate the automatic transmission of electronic data for a variety of uses and allow collection and use of data generated by different types of diagnostic devices.

Connectivity solutions can provide a highly cost-effective way to ensure proper functioning of a diagnostic device network and improve linkage to care and patient management.

In order to affirm to UN declaration to treat 2.5 million TB cases by 2022, nearly 9 million persons shall be screened in the Philippines. This declaration, can only be achieved by strengthening the TB Laboratory services in the country. It is critical that all sites use WRD to transmit results electronically to clinicians and patients.

Figure 1. Diagnostic Connectivity Solutions facilitate the automatic transmission and utilization of diagnostic data



Currently in the Philippines there are 3,234 TB Laboratories: 326 GeneXpert Labs, 2,867 Microscopy Labs, 28 Culture Labs, 9 DST Labs and 2 LPA Labs. Only 356 (11%) (326 Xpert, 28 culture and 2 LPA) have electronic LIS which implies that 2,878 (89%) have no Laboratory diagnostic connectivity. The Laboratory diagnostic connectivity plays a critical role in rapid real-time transmission of results to clinicians for enhanced patient centred care management and quality services.

Therefore, there is an added advantage and need in the Philippines to have a real-time laboratory diagnostic connectivity which will capture all the TB diagnostic tests, patient information, workload statistics and performance of the laboratory, quality assurance, inventory management, recording and reporting of results to clinicians and patients and also, transfer data both with internet and without internet.

Contributed by: FHI360, Laboratory and Diagnostics Team, Philippines



TRAVELLED A LONG DISTANCE, BUT MORE MILES TO END TB

Despite the global commitment to end the world's TB epidemic by 2035, as envisaged by the End TB Strategy, the current pace of decline in the TB burden is inadequate. To achieve the 2020 milestones of the End TB Strategy, TB incidence and mortality rates should be falling 4-5% and 10% respectively, instead of the current rate of 2% and 3%.^{[i],[ii]}

In 2017, an estimated 10 million people developed TB disease globally, and more than 45,000 people developed multi drug-resistant TB (MDR-TB). Of these estimated 10 million new cases, only 64% were notified to a national TB control program (NTP) and reported to WHO. This occurred despite the End TB Strategy's emphasis on universal health coverage. The majority of the remaining 3.6 million missing TB cases likely sought care outside the NTP network, mostly from non-engaged private sector providers,ⁱⁱ where quality of care is not known. As private sector providers are generally outside the purview of the NTP, it implies that the quality of care for approximately one third of TB patients remains untracked.

Seven of the highest TB burden countries (India, Indonesia, Philippines, Pakistan, Nigeria, Bangladesh and Myanmar) account for 57% of the global TB incidence and 63% of missing cases. An analysis of private healthcare providers found that 75% of initial care-seeking is in the private sector in these high burden countries. Private care providers were trained to clinically manage TB but were not supported systematically regarding public health requirements of TB care, specifically case holding to ensure and monitor treatment adherence, recording and reporting. Further, private expenditure represents 61%-74% of the total health expenditure. Although private sector delivers 15%-54% of all anti-TB drugs, private sector notifications represent only 19% (5%-28%) of the total notifications and 12% (1%-18%) of estimated incidence.^[iii]

Public-private mix (PPM) strategy, a comprehensive approach for systematic involvement of all relevant health care providers in TB control, has been employed in TB responses for over two decades. The strategy promotes the use of International Standards for TB Care to achieve global TB control targets. Economic evaluations of PPM prove that private health care provider engagement reduces the financial burden for the patient and society.^[iv] However, despite the scores of pilot PPM projects and evidence of their benefit, PPM scale-up has been modest in high TB burden countries.

A WHO-led global PPM Working Group, established by the Stop TB Partnership's DOTS Expansion Working Group, is developing global PPM policies and assisting countries to develop and implement national policies and guidelines for engaging all care providers.^[v] In 2018, WHO, with assistance from the PPM Working Group, developed a TB prevention and care PPM roadmap. The roadmap lists ten key actions NTPs with their partners and the private sector must take to scale-up provider engagement for universal access to care: 1) Build understanding about patient preferences, private sector dynamics and the rationale for engaging all providers; 2) Establish a supportive-policy and regulatory framework; 3) Set appropriately ambitious PPM targets; 4) Adapt flexible models of engagement applicable to local contexts; 5) Advocate for political commitment, action and investment in PPM; 6) Harness the power of digital technologies;

7) Allocate adequate funding for engaging all providers, including by capitalizing on financing reforms for universal health coverage; 8) Deliver a range of financial and non-financial incentives and enablers; 9) Partner with and build the capacity of intermediaries and key stakeholders; and 10) Monitor progress and build accountability.^[vi]

With this context in mind, let us now look at the Philippines, a country with a well-established NTP that has implemented a PPM strategy since 2000, yet has risen to the top four, among high TB incidence countries.^[vii] Initial health-seeking in the private sector is estimated to be as high as 70% based on patient pathway analysis, contributing to 7% of the estimated 3.6 million missing cases in the world. In 2017, only 317,266 (55%) out of 581,000 patients with TB were notified by the NTP and reported to WHO; and only 17% of these were from the private sector. This primarily underscores the lack of systematic support for notification of privately managed TB cases. In addition, an estimated 217,925 first line treatment course-equivalents of anti-TB drugs were sold annually in the Philippines through non-NTP channels, comprising 43% of the country's total anti-TB drug market (private sales plus NTP notifications), which further provides evidence of under-reporting by the private sector.^[viii]

In early 2018, the country developed the Philippine National Action Plan for PPM on Private Sector Participation in TB Care and Prevention (2018-2022) with assistance from the USAID country mission, a 5-year framework to guide the NTP and its partners in implementing PPM activities in the country. The purpose of the Action Plan is to contribute to the strategic goals and objectives of the Philippine Strategic TB Elimination Plan (PhilSTEP1) 2017-2022.

Further expansion and scale up of an appropriate PPM strategy, as a comprehensive approach for systematic involvement of all health care providers, is crucial, as the country moves to universal health care (UHC) framework with the recent passage of the law supporting this. As the country takes these steps, it should consider:

- Coupling PPM intervention scale-up with the creation of an enabling environment, including identifying needed resources. Wider engagement of medical professional organizations.
- Strategies for maintaining high quality patient-centered TB services within the NTP network, while establishing quality mechanisms in the private sector.
- Using proven innovative tools and approaches into the private sector, including locally relevant digital health solutions, to increase and sustain PPM acceptance among private providers.

As Philippines operationalizes finding to treat 2.5 million Filipinos with TB by 2022 using "business not as usual" approaches, the NTP will steer the country, under the robust leadership of the Department of Health (DOH). An unwavering commitment from all stakeholders, towards a more enhanced and sustainable engagement of private providers would substantially contribute to the global efforts to End TB.

Contributing author: Lal Sadasivan, MD, Director, Infectious Diseases-TB Portfolio, Global Health, Population and Nutrition Division, FHI 360.

i. https://www.who.int/tb/post2015_strategy/en/

ii. *Global tuberculosis report 2018*. Geneva: World Health Organization; 2018. License: CC BY-NC-SA 3.0 IGO.

iii. *Engaging private health care providers in TB care and prevention: a landscape analysis*. Geneva: World Health Organization; 2018. License: CC BY-NC-SA 3.0 IGO.

iv. Pantoja, K. Lönnroth, S. S. Lal, L. S. Chauhan, M. Uplekar, M. R. Padma, K. P. Unnikrishnan, J. Rajesh, P. Kumar, S. Sahu, F. Wares, K. Floyd: Economic evaluation of public-private mix for tuberculosis care and control, India. Part II. Cost and cost-effectiveness; *INT J TUBERC LUNG DIS* 13(6):705-712

v. World Health Organization. *Stop TB Partnership*, http://www.stoptb.org/wg/dots_expansion/ppm/members.as.

vi. *Roadmap towards ending TB in children and adolescents: second edition*. Geneva: World Health Organization; 2018. License: CC BY-NC-SA 3.0 IGO.

vii. *Public-private mix for TB prevention and care: a roadmap*. Geneva: World Health Organization; 2018. License: CC BY-NC-SA 3.0 IGO.



PATIENTS TURNED ADVOCATES

MARICEL BUEN

Maricel Buen was exposed to TB in 2011 and suffered from multi-drug resistant bacterial infection two years after her treatment. She experienced various challenges when she found out she was infected.

“Tumigil ako sa pagtatrabaho kasi siyempre hindi ka makakapagtrabaho dahil sa TB... and nung nag MDR, marami na nararamdamang sakit,” said Maricel.

(I stopped working because, you can't work well when you have TB, and when it became MDR, I experienced more complications)

“Nag self-discriminate din ako kasi ako yung naghiwalay ng mga plato and ng mga ano (gamit) ko” she added

(I also self-discriminated because I isolated my plates and other things.)

Asked why she decided to become a volunteer after her treatment, Maricel said “God extends your life with a purpose!” She expressed that it's her way to help other patients cope with their situation and to show that there's also hope for them.

Maricel is an active volunteer of the Lung Center of the Philippines for the past five years. Her routine ranges from dispensing medicines to TB patients and calling those who are lost to follow-up. She also participates in community outreach, to get referrals of possible TB patients so that they can be given proper treatment immediately.

Maricel shared that the death of her father due to TB, encouraged her to become a volunteer.

“Ayoko na maulit yung nangyari sakín na at the young age namatay yung daddy ko dahil sa TB. Ngayon, nagaadvocate ako para wala nang batang mauulila ng mga ama at ina nila,” she said.

(My dad died because of TB and I never want that to happen again. Now, I advocate so no child will experience what I experienced)

JIMBO BALANGUIT

Jimbo was diagnosed of TB when he was 14 years old and he became an MDR-TB patient six years after his first diagnosis.

“Dumating sa time na noong third year college na ako, suddenly huminto talaga ako sa pag-aaral noon kasi nag-vomit ako ng blood. So yun na pala yung worst case noon at naging resistant na daw ako,” he said

(It came to point when I suddenly had to stop my schooling because I vomited blood. I found out that it was the worst case, as I became resistant to TB treatment)

As an MDR-TB patient, he was advised, to undertake a five hours journey from Masbate to Sorsogon every day, for the next 18 months to complete the treatment.

Instead of completing his treatment in Sorsogon, Jimbo decided to complete his treatment in Manila. He experienced extreme side effects during this course and he even thought of giving it all up. But the health workers counselled him to cope with the situation.

“Then pinarealize sakín ng mga staff nurses noon sa Taguig na hindi pa huli ang lahat kasi may pinakita siya na picture ng children patients from Lung Center of the Philippines na kinaya yung side effects ng gamot. So mas pinush ko pa po yung gamutan,” he added.

(The staff nurses in Taguig helped me realize that it's not the end. They showed pictures of children patients from Lung Center of the Philippines who were able to cope with the side effects of the treatment. This gave me the determination.)

Jimbo wanted to prioritize himself after the treatment, so that he could focus on building a better life for himself and his family. But during his treatment, the passion of health workers and other volunteers made him realize that he had a calling to help those who are in need. He also decided to become a volunteer because her mother passed away due to TB.

“Na-realize ko later on noong naggagamutan na ako na ito pala yung pinagdaanan ng nanay ko. Kasi po yung nanay ko namatay



“God extends your life with a purpose,” says Maricel

“My mother died of TB when I was 12 years old, and I was not able to take care of her. I realized that even if I was not able to take care of my mother, at least I can serve others who are experiencing this challenge,” says Jimbo

rin sa TB noong 12 years old ako and hindi ko siya napagsilbihan... Yung narealize ko po non, hindi ko napagsilbihan yung nanay ko noong namatay siya sa TB but at least napagsilbihan ko yung mga kapwa namin na dumadaan sa ganitong pagsubok,” he shared.

(When I was undergoing treatment, I realized later on that this was what my mother experienced. My mother died of TB when I was 12 years old, and I was not able to take care of her. I realized that even if I was not able to take care of my mother, at least I can serve others who are also experiencing this challenge)

Both Maricel and Jimbo have a burning passion to assist persons with TB, and especially MDR TB patients. Despite the travel from Montalban, Rizal to Quezon City every day, Maricel shared that she loves to serve as a volunteer.

“Ngayon nga nag-aalangan ako na umalis sa program kasi nga yung puso ko nandito na eh. Pero kailangan ko rin magtrabaho at ipagpatuloy yung pag-aaral ko. Pero alam ko naman na yung mga patient na natulungan ng program, hindi matatapos yung naipasa namin na knowledge at moral support na kailangan ng bawat isa,” expressed Jimbo.

(I'm really hesitant to leave the program because my heart is here. But I need to work and continue my studies. However, I know that the knowledge and moral support that we share with the patients will continue. This is what everyone needs!)



ASK ME: FREQUENTLY ASKED QUESTIONS

1. WHAT IS MANDATORY TB NOTIFICATION?

The Department of Health (DOH) is implementing “Mandatory TB Notification” to achieve the vision of a TB-free Philippines. Mandatory TB notification, implies that all public and private health care providers are required by law (Republic Act 10767) to report to DOH any patient diagnosed with the TB disease.

2. WHY IS MANDATORY TB NOTIFICATION REQUIRED?

Making TB a notifiable disease recognizes that it is a major public health problem in the Philippines requiring an improved surveillance system. Mandatory TB notification will bolster case finding, help ensure high quality TB management in both the public and private sectors and assess progress towards TB disease elimination goals.

3. WHO ARE REQUIRED TO NOTIFY OR REPORT TB CASES?

Mandatory TB notification is the responsibility of all healthcare providers (i.e. health care professionals who are registered and or licensed to provide health services to patients) offering TB care services. They include providers from both public and private facilities, who are providing part or all TB services such as diagnosis, treatment and prevention; all DOH units including the Centers for Health Development (CHD) or Regional Offices; hospitals and attached agencies, local government units, other concerned government agencies and partner organizations such as professional medical societies.

4. CAN A TB PATIENT REFUSE TO BE NOTIFIED TO DOH?

DOH has the legal authority to obtain patient information, as stated in Senate Bill 1647, which provides the legal framework for notifiable diseases. This bill amends Republic Act 3573, which mandates that all communicable diseases dangerous to public health must be notified to DOH. Given the legal basis of mandatory notification, a patient may not refuse to be notified to DOH.

5. HOW DO WE ASSURE TB PATIENTS THAT THEIR INFORMATION WILL NOT BE MISUSED?

The DOH is continuously improving its information system (Integrated TB Information System or ITIS) to ensure that all patient data is safeguarded at all times. The system can only be accessed by authorized NTP personnel, who use the data to improve pro-

gram implementation (e.g. procurement of medicine, reagents, x-ray films, X-pert cartridges, etc). Viewing of personal patient information (such as address, telephone numbers) is not routinely done, unless the patient suddenly stops treatment. The information is then used by those health providers responsible to trace patients, to contact the patient and encourage them to return to treatment.

6. CAN A PATIENT BREASTFEED WHILE ON TREATMENT?

The 1st line anti-TB drugs used for drug susceptible TB are safe for the baby. Thus normal breast feeding should be continued. Timely and proper treatment will prevent transmission of TB disease from mother to baby. The baby should be put on prophylactic therapy after ruling out active TB disease, if the mother is still sputum positive when the baby is born. For MDR TB, the safety of some drugs are not established yet for the baby, hence refer to the NTP guidelines.

7. IS TB HEREDITARY?

TB is not hereditary. TB is caused by a bacteria (*Mycobacterium tuberculosis*). It spreads through air. When a person with TB coughs or sneezes, they infect others around them through air droplets. If cough etiquette is not followed, and timely treatment is not taken, family members may get infected as they are in close contact with the person with active TB disease. Hence the incorrect notion that TB is hereditary.

8. SHOULD TB PATIENTS SEPARATE THEIR UTENSILS?

There is no need to separate their utensils, because TB is transmitted through inhalation (not ingestion) of airborne droplets.

9. WHAT IS LATENT TB INFECTION?

Persons with latent TB infection do not feel sick and do not have any symptoms. They are infected with tuberculosis but do not have TB disease. The only sign of TB infection is a positive reaction to the tuberculin skin test or TB blood test. Persons with latent TB infection are not infectious and cannot spread TB infection to others. Overall, without treatment, about 5 to 10% of infected persons will develop TB at some time in their lives. About half of those people who develop TB, will do so within the first two years of infection. For persons whose immune systems are weak, especially those with HIV infection, the risk of developing TB disease is considerably higher than for persons with normal immune systems.

Message From the Secretary of Health

Welcome to the 1st edition of our KNOW TB newsletter. Every issue of the newsletter shall bring the latest data on TB case notification, treatment coverage, and treatment success generated through the Integrated TB Information System (ITIS) of the Department of Health (DOH). It will also share news from various innovative approaches to accelerate Philippines' fight against a high TB burden on both, national and regional levels.

In order to achieve the DOH commitment at the United Nations, to treat 2.5 million TB cases by 2022, nearly 9 million persons shall be screened in the Philippines.

The DOH, with the support of various implementing partners, is pursuing pioneering strategies and state-of-the-art innovations to eliminate TB. This newsletter provides global and national insights to some of these through the write-ups on the Public-Private sector initiative and real-time laboratory and diagnostics connectivity. It also shares the challenges and inspiring commitment of successfully treated TB patients, who as TB Ambassadors, are assisting the program find, treat, and prevent TB.

As innovations are structured to bring a dynamic, strategic and fresh mindset, through this newsletter, we encourage everyone to further examine new ideas, and contribute to their development and adoption in the field.

Hope this KNOW TB newsletter provides impetus to conversations and information sharing. Fundamental steps that can do marvels to improve processes, products and TB services in the health care system.

We look forward to your active contributions, queries and suggestions to make KNOW TB your information resource partner for a TB-free Philippines.

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Health Secretary



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