

COMPREHENSIVE AND UNIFIED POLICY FOR TB CONTROL IN THE PHILIPPINES

**Department of Health
Government of the Philippines**

**In collaboration with the
Philippine Coalition Against Tuberculosis**

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EXECUTIVE SUMMARY

Tuberculosis has been a major cause of illness and death in the Philippines yet TB control efforts have historically, been fragmented and uncoordinated. The National TB Control Program of the Department of Health has made significant advances in improving the quality and extent of its control efforts but the private sector and even other departments of government have not been integrated into the overall TB control activities. Recognizing the need for a more unified and concerted effort the Department of Health, assisted by the Philippine Coalition Against Tuberculosis organized various stakeholders into a working group to develop this Comprehensive and Integrated Policy for TB Control in the Philippines. Beginning in January 2002, the organizing committee began a series of stakeholders' meetings and on World TB Day, March 2002, a Memorandum of Agreement in which each stakeholder committed their support and involvement in the policy development process was signed.

Using the National Tuberculosis Program (NTP) as the core policy, two main working groups were formed. The first group was to develop the guidelines for the implementation of the NTP in government agencies other than the Department of Health. This group included the Departments of Health, Education, National Defense, Interior and Local Governments, Justice, Agriculture, Agrarian Reform, Social Welfare and Development, Science and Technology, the National Economic Development Authority, Philippine Information Agency and the National Council for Indigenous Peoples. The second group was tasked with establishing policies that would formalize the involvement of the private sector, particularly private physicians, in TB control. This group was comprised of the representatives of the Social Security System, Government Services Insurance System, Employees Compensation Commission, the Philippine Health Insurance Corporation, the Philippine Medical Association, Association of Health Maintenance Organizations of the Philippines, Employees Confederation of the Philippines, Trade Union Congress of the Philippines, Occupational Safety and Health Center (DOLE) and the Overseas Workers and Welfare Administration.

This resulting policy presents several significant achievements. First, the "Guidelines for Implementation by Government Agencies" formalizes and operationalizes the collaboration between the Department of Health and other departments of government with regards to the NTP. Second, the "Guidelines for Implementation by Private Physicians" will provide clear directions on the clinical management of TB by private practitioners that will comply with NTP policy. The

“TB Benefits Policy of the SSS/GSIS/ECC” has unified the policies of these different agencies and aligned them with the NTP. The pioneer “TB outpatient benefits package” of the Philippine Health Insurance Corporation” is presented for the first time in this policy.

The organizing committee concludes with three recommendations: 1) that a final meeting be held before the end of 2002 to formally obtain the official commitments of each stakeholder in the acceptance and implementation of the policy, 2) that a one-year grace period for dissemination and training regarding the policy beginning August 22, 2002, be implemented prior to full implementation in August 2003, and 3) that the organizing committee and all stakeholders be reconvened after two full years of implementation to evaluate the policy and recommend any necessary revisions.

MANUAL OF PROCEDURES

**FOR THE
NATIONAL TUBERCULOSIS CONTROL
PROGRAM, 2001**

DEPARTMENT OF HEALTH, REPUBLIC OF THE PHILIPPINES

FOREWORD

For decades, Tuberculosis has been causing enormous socio-economic losses to our country. Hence, controlling it to a level where it is no longer a public health problem is a priority under the Health Sector Agenda. Consequently, this will significantly contribute to the poverty reduction efforts of the government.

TB control depends largely on the capacity of various health care facilities to administer the TB management based on technically sound, evidence-based and consistent policies and procedures. Adopting standardized TB management protocols and guidelines facilitates effective program implementation in all parts of the country. *The Manual of Procedures (MOP)* for the National TB Control Program (NTP) contains guidelines on how to diagnose, treat and counsel TB patients. It further describes how the TB control program should be managed to enable us to attain our program targets in the context of devolution. This manual will be helpful to program managers and coordinators, health workers at our public and private health facilities, training officers and other individuals and organizations.

The major trigger points for the revision of the 1988 MOP was the 1993 external review of NTP and the adoption of the *Directly Observed Treatment Short Course (DOTS)* strategy by the international community to reverse the TB epidemic. This manual is a product of partnership among the Department of Health (DOH), local government units and international agencies. It has a long gestation period. Piloting of these guidelines started during the DOH project assisted by the Japanese International Cooperation Agency (JICA) in Cebu in 1994 and expanded to other areas adopting the DOTS strategy. The World Health Organization – Western Pacific Regional Office, extended technical assistance to ensure that the guidelines are consistent with technically sound and internationally accepted policies. This manual consolidates all the findings, experiences and lessons learned from the TB control projects which were assisted by our international partners like WHO, JICA, World Vision-CIDA, UHNP-World Bank, USAID, AusAID, Medicos del Mundo and ADB. The former Staff of the TB control Service DOH, steered it through the process of technical reviews and consultations to ensure that NTP guidelines are uniform, attuned with the current trends, acceptable to the health workers and operationally feasible. However, in view of the fast changing technology and systems, we anticipate that there will be changes later. Thus, we welcome comments and recommendations to sustain the MOP's relevance and appropriateness.

We hope that this Manual will be a tool to unify our efforts and attain our vision of TB-free Philippines.

MANUEL M. DAYRIT, MD, MSc
Secretary of Health

Notes on Manual of Procedures (MOP) for the National Tuberculosis Control Program, 2001 Philippines

The National tuberculosis control Program (NTP) in the Philippines was initiated in 1968 and integrated into the general health service based on World Health Organization (WHO) policy. The first *NTP Manual of Procedures (MOP)* was developed in 1988. In 1994, the *NTP Guidelines* was revised by the Department of Health (DOH) in collaboration with DOH-JICA Public Health Development Project and WHO Western Pacific Regional Health Office (WPRO) based on the recommendations of WHO, which conducted an external evaluation of the implementation of the Philippine NTP in 1993.

The *Revised NTP Guidelines* was first introduced by the DOH-JICA Public Health Development Project in Cebu province. Accordingly, the DOH adapted the *Revised NTP Guidelines* for nationwide implementation after its feasibility and effectiveness was proven.

This Manual of Procedures was developed based on the Revised NTP Guidelines to be consistent with current health situation in the Philippines. Consequently, the title of “the Revised NTP Guidelines” was changed to “*Manual of Procedures (MOP) for the National Tuberculosis Control Program, 2001 Philippines*” because its use is not only for training but also as instruction guides in the daily practice of all health workers involved in the control of TB in the country.

This manual was developed and published with technical assistance and funding from the DOH-JICA Tuberculosis Control Project (TBCP) and the WHO Western Pacific Regional Office (WPRO).

We are very grateful to all those who contributed in the development of this manual to achieve more effective ways to implement the NTP throughout the Philippines and to put TB under control in the nearest future.

October 2001

*Department of Health,
Republic of the Philippines*

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GLOSSARY and ACRONYMS

Active Case Finding	Purposive effort by a health worker to find TB cases from among TB symptomatics in the community who do not seek consultations relating to TB in a healthy facility.
BCG	Baccille Calmette-Guerin. A vaccine against TB.
BHW	Barangay Health Worker
Case Finding	An activity to discover or find TB case
Case Holding	An activity to treat TB Cases through proper treatment regimen and health education.
CHD	Center for Health Development
CHO	City Health Officer or City Health Office
Cure Rate	Cure rate is the proportion of the number of smear positive TB cases who are smear negative in the last month of treatment and on at least one previous occasion.
CXR	Chest X-ray
DOH	Department of Health
DOT	Directly Observed Treatment. This is an activity wherein a trained health worker for treatment partner personally observes the patient to take anti-TB medicines every day during the whole course of the treatment of smear positive case.
DOTS	Directly Observed Treatment Short-Course. This is a comprehensive strategy to control TB, and is composed of five components. These are: <ol style="list-style-type: none">1. Government commitment to ensuring sustained, comprehensive TB control activities.2. Case detection by sputum-smear microscopy among symptomatic patients self-reporting to health services. (Passive case finding)3. Standard short-course chemotherapy using regimes of six to eight months, for at least all confirmed smear positive cases. Complete drug taking through DOT by health workers during the whole course of treatment for all smear positive cases.4. A regular, uninterrupted supply of all essential anti-tuberculosis drugs and other materials.5. A standard recording and reporting system that allows assessment of case finding and treatment results for each patient and of the tuberculosis control program's performance overall.
Doubtful	This treatment outcome occurs when a 3-sputum-smear examination has only one positive result out of three smear examinations.
EB	Ethambutol
INH	Isoniazid

LGU	Local Government Unit
MDR – TB	Multiple drug resistant TB. A condition which is resistant against at least Isoniazid and Rifampicin
MHC	Main Health Center
MHO	Municipal Health Center
MT	Medical Technologist
NGO	Non-Government Organization
NTP	National Tuberculosis Control Program
Passive Case Finding	To find a case of tuberculosis from among TB symptomatics who present themselves at the health center.
PHN	Public Health Nurse
PHO	Provincial Health Office
PTB	Pulmonary Tuberculosis
PZA	Pyrazinamide
RAD	Return After Default
RHU	Rural Health Unit
RHM	Rural Health Midwife
RFP	Rifampicin
SM	Streptomycin
Smear Positive	This occurs when a sputum smear examination has at least two positive results.
Smear Negative	This occurs when a sputum smear examination has all three negative results.
Sputum Microscopy for Diagnosis	The sputum smear examination done for TB symptomatics to establish a diagnosis of TB. Three sputum specimens should be collected.
Sputum Microscopy for Follow-up	The sputum smear examination done to monitor the sputum status of a patient after treatment is initiated. Only one sputum specimen is collected, preferably the early morning phlegm.
Sputum Specimen	Material from the respiratory tract brought out by coughing. This material is used for smear examination.
TB	Tuberculosis
TB Symptomatic	Any person who presents with symptoms or signs suggestive of tuberculosis, in particular cough of long duration (for two or more weeks duration).
Tubercle Bacillus	<i>Mycobacterium tuberculosis</i> which causes tuberculosis. It is acid-fast stained with Ziel-Nielsen staining method.

Note: The definitions in this section apply only to the terms' usage in this manual.

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INTRODUCTION

TUBERCULOSIS (TB) remains a major public health in the Philippines. In 1998, TB ranked fifth in the 10 leading cause of death and fifth in the 10 leading causes of illness. Our country ranks second to Cambodia in terms of new smear-positive TB notification rate, 99.7 per 100,000 population, among the major countries in the WHO Western Pacific Region in 1999.

The first and second National TB Prevalence surveys done in 1981-1983 and in 1997 respectively showed the following findings:

	1981 - 82	1997
1. Percent of population with TB infection	54.5%	63.4%
2. Annual risk of TB infection	2.5%	2.3%
3. Prevalence of sputum smear positive cases	6.6/1,000	3.1/1,000
4. Radiographic findings suggestive of TB	4.2%	4.2%

The 1997 National Tuberculosis Prevalence Survey (NPS) showed that the annual risk of TB infection (i.e., probability of a child getting infected with TB within a year), which is a more sensitive indicator, showed an insignificant decline in 15 years, from 2.5 percent in 1982 to 2.3 percent in 1997. The survey also showed that TB cases are about three times more common among males than females and most of these cases are in the 30 to 59-years of age group.

In 1978, the Department of Health implemented a National TB Control Program (NTP) nationwide. In 1987, the government invested millions of pesos to strengthen it. Sputum microscopy centers were established in most of the Rural Health Units (RHUs). Short course chemotherapy (SCC) drugs for TB patients were produced and distributed by DOH. For the last five years, there were about 160,000 to 280,000 TB cases discovered annually.

Direct delivery of NTP services to the clients is now the responsibility of local government units (LGUs) in accordance with the devolution of health services as mandated under the local Government Code of 1991. However, the DOH Regional Health Office (RHO), now known as the Center for Health Development (CHD) still retains the function of formulating and monitoring the program plans, policies and guidelines including the provision of technical services, anti-TB drugs and other NTP supplies.

An external evaluation done in 1983 showed that several constraints affect the NTP program implementation. These include inadequate budget for drugs; poor quality of diagnostic test; irregular program supervision and monitoring; different approaches in diagnosis and treatment of TB patients by doctors and poor treatment compliance. This occurs when a TB patient prematurely stops treatment or takes his drugs irregularly. Thus, the new NTP policies seek to address these problems to reach the goal of controlling TB at a level where it is no longer a public health problem in the country.

The main strategy of the NTP is the Directly Observed Short Course (DOTS). This was introduced in the late 1980s in China, Vietnam, U.S., Tanzania among other countries. This strategy dramatically improved the cure rate of TB patients to more than 85 percent in areas where it has been implemented.

In 1992, the Japanese government started its assistance to the Philippine NTP through the DOH-JICA Public Health Development Project. Coordination with the local government units and pre-testing of new NTP policies and guidelines based on WHO recommendations were among the major activities done. The project covered the entire province of Cebu and it has satisfactorily demonstrated the feasibility of the new NTP policies and guidelines using DOTS.

In 1996, WHO provided financial and technical support to enhance the implementation of NTP in certain areas through CRUSH TB (Collaboration in Rural and Urban Sites to Halt TB). The new policies and strategies would also be replicated in other areas to reach at least 80 percent to the total Philippine population by the year 2000.

In 1999, DOH embarked on a Health Sector Reform Agenda (1999-2004) to improve health services through the following:

1. To provide fiscal autonomy to government hospitals.
2. To secure funding for priority public health programs.
3. To promote the development of local health systems and to ensure its effective performance.
4. To strengthen the capacities of health regulatory agencies.
5. To expand the coverage of the National Health Insurance Program.

The National Tuberculosis Control Program is among the priority public health programs under the health reform agenda.

This manual of procedures shall be used in areas where the new NTP is being implemented.

VISION, MISSION AND GOAL OF THE NTP

- Vision:** A country where TB is no longer a public health problem.
- Mission:** Ensure that TB diagnostic, treatment and information services are available and accessible to the communities in collaboration with the LGUs and other partners.
- Goal:** Morbidity and mortality from TB are reduced in half in 10 years (by the year 2010).

TARGETS OF THE NTP

The targets of the program include the following:

1. Cure at least 85 percent of the sputum smear-positive TB patients discovered.
2. Detect at least 70 percent of the estimated new sputum smear-positive TB cases.

NTP STRATEGIES

To achieve certain objectives and targets, the NTP shall focus on the following:

- A. Advocate for political commitment**
- B. Ensure the availability of drugs and other supplies**
 1. Systematic drug procurement and distribution from central (regional) to various levels
 2. Regular monitoring and inventory of anti-TB drugs and other NTP supplies
 3. Supplementation of logistics from the LGUs

- C. Improve the program management capability of health workers**
 - 1. Training of regional, provincial and city health workers
 - 2. Training of program implementers
 - 3. Supervision and monitoring visits

- D. Improve the quality of sputum smear examination at microscopy centers**
 - 1. Training of medical technologists and Microscopists
 - 2. Provision of microscopes
 - 3. Organization of national and local TB laboratory network
 - 4. Establishment of a Quality Assurance System for Field Microscopy

- E. Improve the treatment compliance of TB patients**
 - 1. Health education to all patients
 - 2. Implementation of treatment through Directly Observed Treatment (DOT)
 - 3. Provision of non-monetary incentives to health workers and volunteers

- F. Improve information system**
 - 1. Implementation of standardized recording and reporting system
 - 2. Development of an effective and efficient information processing system
 - 3. Regular data analysis

- G. Improve TB Case detection**
 - 1. Develop and disseminate effective IEC materials for community
 - 2. Improve and expand hospital based NTP in government sector
 - 3. Establish an effective private/public mix procedures

NOTES ON BCG IMMUNIZATION

It is generally accepted that in children, BCG vaccination provides a certain degree of protection against serious forms of TB, such as military TB and tuberculosis meningitis. The present recommendation by WHO in countries with high TB prevalence is that BCG should be given routinely to all infants at birth (0.05ml intra-dermally). All infants should be given BCG under the Expanded Program of Immunization (EPI).

ROLES of COLLABORATING AGENCIES

I. Department of Health (DOH) and Center for Health Development (CHD)

1. Formulate plans and policies.
2. Advocacy for political commitments and alert in community.
3. Oversee program implementation in coordination with the LGUs.
4. Provide the necessary logistics such as:
 - Anti-TB drugs
 - Laboratory supplies
 - Educational materials
 - NTP recording and reporting forms
5. Provide technical assistance, including training to LGU staff.
6. Monitor, supervise, and evaluate the NTP activities, including Quality Assurance System regularly.
7. Collate and analyze the data of all Quarterly Reports and feedback the findings and recommendations to the staff of LGUs concerned.

II. Local Government Units (LGUs)

1. Development of a local plan in consultation with DOH / CHD.
2. Advocacy for political commitments and alert in community.
3. Implement the program according to the plan
4. Designate a Provincial or City Medical NTP Coordinator and / or other staff such as nurses and medical technologists. Ensure other human resources such as doctors, PHNs, RHMs, and BHWs at municipality level.
5. Provide funds for monitoring, supervision, evaluation, training, additional NTP supplies and drugs for sputum smear negative cases (Regimen III).
6. Prepare, submit and analyze Quarterly Reports.
7. Implement a standardized Quality Assurance System for laboratory work.

FUNCTIONS of HEALTH WORKERS

I. Department of Health (DOH)

1. Participate in program planning of activities, policy-making and budget preparation at national level.
2. Promote advocacy activities for political commitments and for community awareness.
3. Overall coordination among all NTP stakeholders.
4. Ensure NTP supplies.
5. Provide regular technical assistance including training, monitoring, supervision, and evaluation to CHD / LGUs.
6. Collate and analyze the data of Quarterly Reports for future planning and policy development.

II. CHD NTP Coordinators (Medical Officer/Nurse/Medical Technologist)

1. Participate in program planning of activities and budget preparation at CHD level.
2. Promote advocacy activities for political commitments at LGUs and for community awareness.
3. Overall coordination among all NTP stakeholders at the region in consultation with the DOH (Central).
4. Ensure all NTP supplies.
5. Provide regular technical assistance including training and planning.
6. Monitor, supervise, and evaluate the implementation of NTP and recommend corrective or remedial measures at each LGU.
7. Collate and analyze the data of Quarterly Reports for future planning.
8. Submit regularly all consolidated Quarterly Reports to DOH (Central).

III. Provincial and City NTP Coordinators (Medical Officer, Nurse, Medical Technologist)

1. Organize provincial planning, budgeting, and evaluation activities.
2. Implement advocacy activities for political commitments and for community awareness.
3. Coordinate all NTP activities within Province / City.
4. Ensure all NTP supplies.
5. Conduct trainings to ensure success of program implementation.
6. Monitor, supervise, and evaluate the implementation of NTP and executive corrective or remedial measures.
7. Collate and analyze the data of Quarterly Reports of the RHUs / MHCs for future planning.
8. Consolidate all Quarterly Reports and submit them to CHD NTP Coordinator.
9. Implement Quality Assurance System for quality laboratory work at LGUs.

IV. Municipal Health Officers (MHOs) / City Health Officers (CHOs)

1. Organize planning and evaluation of NTP activities in respective RHU / MHC.
2. Utilize available resources in the area for TB control activities.
3. Supervise respective health workers to ensure the proper implementation of NTP policies such as:
 - a. Identification and examination of TB cases.
 - b. Implementation of case holding mechanisms such as DOT.
 - c. Submission of the quarterly and annual reports to PHO / CHI. Analyze them for future planning.
 - d. Referral of TB cases to other health services.
 - e. Ensure NTP drugs and supplies.
4. Attend to all diagnosed TB cases for clinical assessment, prescription of appropriate treatment regimen and management of adverse drug reactions, if any.
5. Provide continuous health education to all TB patients placed under treatment and encourage family and community participation in TB Control.
6. Coordinate with local chief executives (LCE) to ensure funds and personnel for program.

V. Public Health Nurses (PHNs)

1. Manage the procedures for case-finding activities with other NTP staff / workers.
2. Assign and supervise a treatment partner for patients who will undergo DOTS.
3. Supervise RHMs to ensure the proper implementation of DOTS.
4. Maintain and update the NTP Register.
5. Facilitate the requisition and distribution of drugs and other NTP supplies.
6. Provide continuous health education to all TB patients placed under treatment and encourage family and community participation in TB control.
7. Conduct training of the health workers in coordination with MHO / CHO.
8. Prepare and submit the Quarterly Reports to PHO / CHO. Analyze the data together with the MHO / CHO for future planning activity.

VI. Rural Health Midwives (RHMs)

1. Implement case-finding activities with other health workers.
 - a. Identify TB symptomatics and collect sputum specimens for microscopy.
 - b. Refer all diagnosed TB cases to the medical officer or nurse for clinical evaluation and initiation of treatment.
 - c. Maintain and update the NTP Treatment Cards. (TB Symptomatics Masterlist / TB Symptomatics Target Client to be optionally utilized).
2. Implement DOT with treatment partners
 - a. Provide continuous health education to all patients placed under treatment and encourage family and community participation in TB control activities.
 - b. Conduct regular consultation meeting (preferably weekly) during the course of treatment with the assistance of MHO (CHO) / PHN.
 - c. Collect sputum specimen for follow-up examination on the scheduled date during the course of treatment.
 - d. Report and retrieve defaulters within two (2) days.
 - e. Refer patients with adverse drug reactions to the MHO / CHO for evaluation and management.
 - f. Supervise and instruct BHWs who would be major treatment partners to ensure proper implementation of DOT.

VII. Medical Technologists or NTP Microscopists

1. Do sputum smear examination for diagnosis and follow-up.
2. Submit the results of the sputum smear examination to the MHO, PHN, and RHM.
3. Maintain and update the NTP Laboratory Register.
4. Prepare the Quarterly Report on Laboratory activities and submit it to the MHO/CHO.
5. Prepare and submit quarterly laboratory requirement to the MHO / CHO.
6. Submit all slides to the provincial or city NTP Coordinator for monthly / quarterly Quality Assurance check.

VIII. Barangay Health Workers (BHWs)

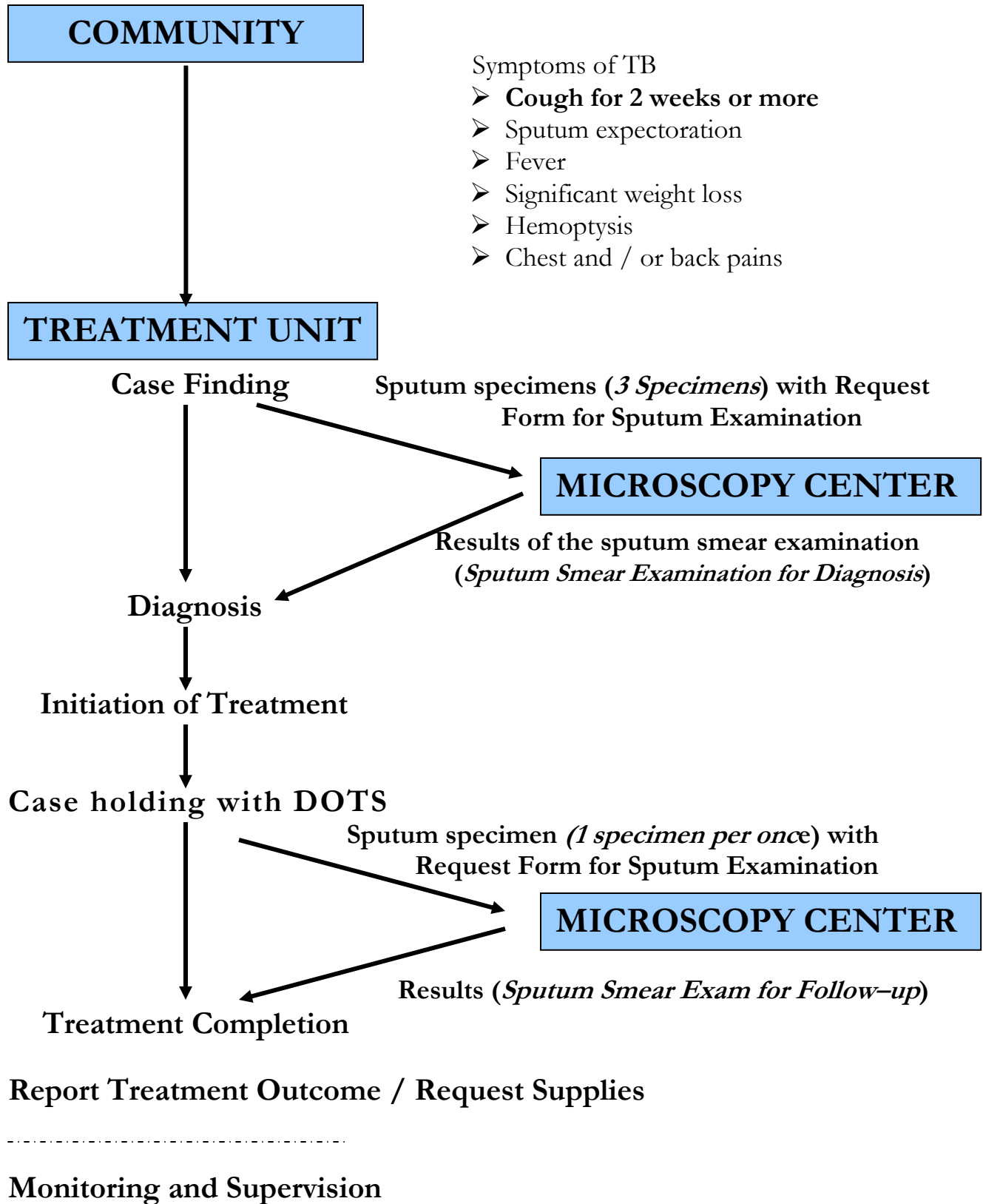
Barangay Health Workers (BHWs) are one of the key-role players in NTP to implement DOTS. It is one of our privileges to have BHWs who voluntarily contribute to the community of the Philippines.

1. Refer TB symptomatics to the RHU or BHS for sputum collection.
2. Implement DOT together with RHMs / PHN / MHO.
3. Keep and update the NTP ID Cards.
4. Report and retrieve defaulters within two (2) days.
5. Attend regular consultation meeting with the RHMs / PHN / MHO together with the patient.
6. Refer patients with adverse reactions to the health workers (RHMs / PHN MHO).
7. Provide health education to the patient, family members and the community.

IX. Hospital-based NTP Coordinators

1. Coordinate all NTP activities in the hospital with the assistance of the CHD and Provincial NTP Coordinators.
2. Supervise hospital NTP health workers to ensure the proper implementation of the NTP policies such as:
 - a. Identification and examination of TB symptomatics with sputum smear examination.
 - b. Implementation of the DOT for cases.
 - c. Ensure the anti-TB drugs and supplies.
 - d. Referral of patients to RHU / MHC for continuation of the treatment.
(NTP Referral / Transfer Form should be properly filled in by doctor or nurse.)
 - e. Provide continuous health education to all patients placed under DOT. Encourage family members of patient to participate in TB control activities.

FLOW of NTP ACTIVITIES



NTP POLICIES and PROCEDURES

A. CASE FINDING

The basic step in TB control is the identification and diagnosis of TB cases among individuals with suspected signs and symptoms of TB. This is referred to as case finding. Fundamental to case finding is the detection of infectious cases through direct sputum smear examination. This is the principal diagnostic method adapted by the new NTP because of the following reasons:

1. It provides a definitive diagnosis of active TB.
2. The procedure is simple.
3. It is economical.
4. A microscopy center could be organized even in remote areas.

I. OBJECTIVE

The general objective of case finding is the early identification and diagnosis of TB cases.

II. POLICIES

1. **Direct sputum smear examination shall be the primary diagnostic tool in NTP case finding.**
 - a. All symptomatics identified shall be made to undergo smear examination for diagnosis prior to initiation of treatment, regardless of whether they have available X-ray results or whether they are suspected of having extra-pulmonary TB. The only contraindication for sputum collection is massive hemoptysis.
 - b. It is only after a pulmonary TB symptomatics has undergone a sputum examination for diagnosis with three sputum specimens and subsequently yielded negative results that he shall be made to undergo other diagnostic tests such as X-ray, culture and others, if necessary.
 - c. Sputum smear examination is the preferred method for the diagnosis of TB. No diagnosis of TB shall be made based of the result of X-ray examinations alone. Skin tests for TB infection (PPD skin tests) should not be used as a basis for the diagnosis of TB in adults.

- d. All municipal and city health offices shall be encouraged to establish and maintain at least one microscopy unit in their areas of jurisdiction.

2. Passive case finding shall be implemented in all health stations.

Concomitant active case finding shall be encouraged only in areas where a cure rate of 85 percent or higher has been achieved, or in areas where no sputum smear positive case has been reported in the last three months.

3. Only adequately trained medical technologist or NTP microscopists shall perform sputum smear examination (smearing, fixing and staining of sputum specimens, reading the smear).

III. PROCEDURES

1. Identification of TB Symptomatics is the responsibility of all RHU and BHS staff.

- The responsible person shall identify TB symptomatics among patients consulting at the health center. These are persons having **coughing for two or more weeks duration**, and those with or without one or more of the following signs and symptoms:
 - a) fever
 - b) sputum expectoration
 - c) significant weight loss
 - d) hemoptysis or recurrent blood-streaked sputum
 - e) chest and/or back pains not referable to any musculo-skeletal disorders
 - f) other symptoms such as sweat with chills, fatigue, body malaise, shortness of breath
- The responsible person shall register the identified TB symptomatics in the **TB Symptomatics Masterlist** (or TB Symptomatics Client List) and advise him/her to undergo sputum smear examination for diagnosis as soon as possible.
- The responsible person shall encourage household members of identified TB cases, who are also TB Symptomatics, to undergo sputum examination.

2. Collection and transport of sputum specimens to the Microscopy Center are the responsibilities of midwives at the RHU AND BHS.

- The midwife shall explain the purpose of the sputum examination to the TB symptomatics before collecting his/her sputum.
- The midwife shall demonstrate how to produce good sputum by asking the patient to breathe in air deeply and at the height of inspiration, ask the patient to cough strongly and spit the sputum in the container. The midwife shall supervise the patient during the procedure and observe contamination precautions.
- The midwife shall collect three specimens within two days according to these procedures:
 - ✓ **First specimen is also referred to as spot specimen.** It is collected at the time of consultation, or as soon as the TB symptomatics is identified.
 - ✓ **Second specimen or early morning specimen.** It is the very first sputum proceeded in the morning and collected by the patient according to the instructions given by the midwife.
 - ✓ **Third specimen is also referred to as spot specimen.** It is collected at the time TB symptomatics comes back to health facility to submit the second specimen.
- The midwife shall label the body of the sputum cup with the patient's complete name and the name of the referring unit.
- The midwife shall seal each sputum specimen container, pack it securely and transport the same to a microscopy unit or laboratory as soon as possible or not later than four days from collection. Otherwise, the specimens should be properly stored in cool, dark, and safe place. No specimen shall remain unexamined over the weekend. The specimen should be sent together with the laboratory request form for sputum smear examination to the microscopy center.

3. Smearing, fixing, staining and reading of sputum specimens are the responsibilities of the trained NTP medical technologist or NTP microscopist at microscopy center. They will do the following:

- a. Record the information in the NTP Laboratory Register
- b. Smear, fix, stain and read the slides.
- c. Record the examination results in the NTP Laboratory Register and the lower portion of the Laboratory Request Form for Sputum Examination

- d. Inform the midwife and/or the nurse of the results of the examination as soon as it is available by sending back the accomplished Laboratory Request Form for Sputum Examination to the referring unit.
- e. Interpret smear examination result or the individual readings of the three specimens and the final written laboratory diagnosis in the sputum microscopy results portion of the returned Laboratory Request Form for Sputum Examination to determine classification, such as:
 - ✓ **Smear positive** result occurs when at least two sputum smear results are positive. When the sputum collection unit receives this positive results, the nurse/midwife shall inform the patient of the result of the sputum examination and refer him/her to the MHO for assessment and initiation of treatment.
 - ✓ Doubtful results show only **one** positive out of three sputum specimens examined. The nurse shall inform the midwife of the result of the sputum examinations to allow her to collect another three sputum specimens.

If at least one specimen from the second set of specimen turns out to be positive, the laboratory diagnosis is **positive**. Refer the patient to MHO for assessment and initiation of treatment.

If all three specimens from the second set of specimen turn out to be negative, the laboratory diagnosis is **negative**. Refer the patient to MHO for further assessment with X-ray examination.

- ✓ **Smear negative** shows that all three sputum smear results are negative. The nurse shall inform the TB symptomatics about the result of the sputum examination and refer the patient to MHO for further assessment. The municipal health officer may treat the patient with symptomatics treatment of antibiotics and/or anti-cough agents for two to three weeks. If symptoms persist, collect another three specimens for smear examination.

FLOW CHART FOR THE DIAGNOSIS OF PULMONARY
TUBERCULOSIS (see flow chart filename)

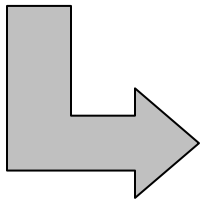
SAMPLE FLOW CHART FOR THE DIAGNOSIS OF SMEAR-NEGATIVE
PULMONARY TUBERCULOSIS (see flow chart filename)

GUIDE to CASE FINDING

SPUTUM COLLECTION UNIT <i>(To be accomplished by the RHM)</i>
1. Register the patient in TB Symptomatics Masterlist <i>(or TB Symptomatics Client List)</i> (See Annex 1, p. 59).
2. Label each sputum containers (name and serial no. 1, 2, 3).
3. Collect 3 sputum specimens (spot, early morning, spot).
4. Fill-up the <i>Laboratory Request Form for Sputum Examination</i> (see Annex 2, p. 61).
5. Pack and send the specimen/s to the Microscopy Center with the <i>Laboratory Request Form for Sputum Examination</i> .

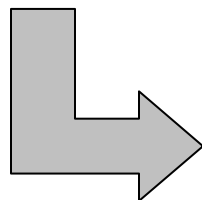
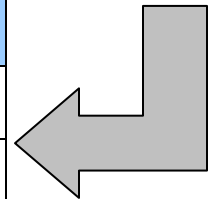
TB Symptomatics with symptoms as:

- * Cough for 2 weeks or more
- * Fever
- * Significant weight loss
- * Chest and / or Back pains
- * Hemoptysis



MICROSCOPY CENTER <i>(To be accomplished by the MT)</i>
1. Register in the <i>NTP Laboratory Register</i> (see Annex 3, p. 63)
2. Record the date received and the Laboratory Serial No. in the <i>Laboratory Request Form for Sputum Examination</i> (see Annex 2, p. 62).
3. Sputum Smear Examination: smearing, fixing, staining and reading slides
4. Record the results in the <i>Laboratory Request Form for Sputum Examination</i> (see Annex 2, p. 62) and in the <i>NTP Laboratory Register</i> (see Annex 3, p. 63).
5. Send back accomplished <i>Laboratory Request Form for Sputum Examination</i> the collection unit. (see Annex 3, p. 63).

SPUTUM COLLECTION UNIT <i>(To be accomplished by the RHM)</i>
1. Record the results in the <i>TB Symptomatics Masterlist</i> <i>(or TB Symptomatics Client List)</i> (see Annex 1, p. 59)
2. Inform and explain the result to the patient (If doubtful, immediately collect another 3 specimens for confirmation).
3. Refer to MHO and PHN.



**DIAGNOSIS AND
INITIATION OF TREATMENT**

GUIDE TO DIAGNOSIS and INITIATION of TREATMENT

CLINICAL DIAGNOSIS	
• To determine patient type and classification and is done by RHM, PHN, MHO •	
1. Verify information gathered on case finding	<ul style="list-style-type: none"> • Symptoms/condition of patient • Result of sputum examination • Result of further examination (i.e. CXR, Culture, etc.) • Source of infection
2. Verify sputum smear examination results	
3. Review history of previous treatment	

INITIATION OF TREATMENT	
To be done by MHO	1. Physical assessment and prescription of appropriate regimen for the TB patient (according to the patient type and the classification)
To be done by PHN (initially)	2. Registration <ul style="list-style-type: none"> • Fill-up the <i>NTP Treatment Card</i> (see Annex 4, p. 64-66) • Fill-up two <i>NTP ID Cards</i> (see Annex 5, p. 67), one is for the treatment partner and the other is for the patient • Register in the <i>TB Register</i> (see Annex 6, p. 68-69)
To be done by the health workers	3. Health education with emphasis on key messages such as: <ul style="list-style-type: none"> • TB is infectious. • TB can be cured but requires regular drug intake. • Results of irregular drug intake. • Side effects of anti-TB drugs. • Importance of follow-up sputum smear examinations. • Importance of family/treatment partner support.
To be done by PHN	4. Intake of first dose <ul style="list-style-type: none"> • Record the date when treatment started. • Record the due date of the 1st follow-up sputum examination in the <i>NTP Treatment Card</i> (see Annex 4, p. 66) and <i>NTP ID Cards</i> (see Annex 5, p. 67).
To be done by The health workers and treatment partners	5. DOT <ul style="list-style-type: none"> • Assign a treatment partner. • Do DOT for both intensive and Maintenance phases of treatment. • Conduct weekly consultation meeting at the health facility during the whole course of treatment.
To be done by: <ol style="list-style-type: none"> 1) PHN 2) RHM 3) Treatment Partner 4) TB Patient 	6. Record keeping <ol style="list-style-type: none"> 1) Maintain and update the <i>TB Register</i> 2) Maintain and update the <i>NTP Treatment Card</i> at the RHU / BHS (see Annex 4, p. 65-66). 3) Maintain and update the <i>NTP ID Cards</i> both of the treatment partner and the patient (see Annex 5, p. 67). 4) Keep the <i>NTP ID Card</i> (see Annex 5, p. 67).

B. Case Holding

The procedure that ensures that patients complete treatment is referred to as case holding. Chemotherapy is the only way to stop the transmission of TB. It is senseless to search for cases if they could not be treated properly after they have been found. It would only encourage false hopes on the part of the patient. While effective anti-TB drugs are available in the country, there are still many TB patients who are not cured. This is due to many patients who stop taking or irregularly take their drugs. The long duration of treatment, six months on the average, makes it most likely for patients to be remiss in drug intake. Treatment compliance is necessary to cure TB and avoid drug resistance.

Poor treatment compliance may lead to the following outcomes: chronic infectious illness, death or drug resistance. Second line anti-TB drugs for drug resistant cases are very expensive and most are not available in the country. The best way to prevent the occurrence of drug resistance is through regular intake of drugs for the prescribed duration. The strategy developed to ensure treatment compliance is called **Directly Observed Treatment (DOT)**. DOT works by assigning a responsible person to observe or watch the patient take the correct medications daily during the whole course of treatment.

I. Objective

The general objective of chemotherapy is to treat TB cases effectively and completely, especially pulmonary sputum smear positive cases.

II. DEFINITION OF TERMS

- A. **Classification of TB Cases** – TB cases shall also be classified based on the location of lesions as well as the result of sputum smear examination.

TABLE 1. CLASSIFICATION OF TB CASES

Location of Lesion	Sputum–Smear Examination	Definition of Terms
<p>Pulmonary TB (PTB)</p>	<p>Smear positive</p>	<ol style="list-style-type: none"> 1. A patient with at least two sputum specimens positive for AFB, with or without radiographic abnormalities consistent with active TB, or 2. A patient with one sputum specimen positive for AFB and with radiographic abnormalities consistent with active TB as determined by a clinician, or 3. A patient with one sputum specimen positive for AFB with sputum culture positive for <i>M. tuberculosis</i>
	<p>Smear negative</p>	<p>A patient with at least three sputum specimens negative for AFB with radiographic abnormalities consistent with active TB, and there has been no response to a course of antibiotics and/or symptomatic medications, and there is a decision by a Medical Officer to treat the patient with anti-TB drugs.</p>
<p>Extra-Pulmonary TB</p>	<ol style="list-style-type: none"> 1. A patient with at least one mycobacterial smear / culture positive from an extra-pulmonary site (organs other than the lungs: pleura, lymph nodes, genito-urinary tract, skin, joints and bones, meninges, intestines, peritoneum and pericardium, among others), or 2. A patient with histological and / or clinical evidence consistent with active TB and there is a decision by a Medical Officer to treat the patient with anti-TB drugs. 	

- B. Types of TB Cases** – TB cases shall be categorized based on the history of anti-TB treatment. A thorough understanding on the types of TB cases is necessary in determining the correct treatment regimen.

Table 2. TYPES OF TB CASES

Types of TB Cases	Definition of Terms
New	A patient who has never had treatment for TB or who has taken anti-tuberculosis drugs for less than one month.
Relapse	A patient previously treated for tuberculosis who has been declared cured or treatment completed, and is diagnosed with bacteriologically positive (smear or culture) tuberculosis.
Failure	A patient who, while on treatment, is sputum smear positive at five months or later during the course of treatment.
Return after Default (RAD)	A patient who returns to treatment with positive bacteriology (smear or culture), following interruption of treatment for two months or more.
Transfer-In	A patient who has been transferred from another facility with proper referral slip to continue treatment.
Other	All cases that do not fit into any of the above definitions This group includes: <ol style="list-style-type: none"> 1. A patient who is starting treatment again after interrupting treatment for more than two months and has remained or became smear-negative. 2. A sputum smear negative patient initially before starting treatment and became sputum smear-positive during the treatment. 3. Chronic case: a patient who is sputum positive at the end of a re-treatment regimen.

- C. Directly Observed Treatment (DOT)** – DOT is a strategy developed to ensure treatment compliance by providing constant and motivational supervision to TB patients. DOT works by having a responsible person, referred to as **treatment partner**, watching the TB patient take medicines everyday during the whole course of treatment.

1. Who will undergo DOT?

All smear positive TB cases should undergo DOT.

2. Who could serve as a treatment partner of a TB patient during DOT?

Any of the following could serve as treatment partner of a Tb patient:

- ✓ Staff of the health center or clinic such as the midwife or the nurse.
- ✓ Member of the community such as the BHW, local government official or former Tb patient.
- ✓ Member of the patient's family (last priority).

3. Where to do DOT?

DOT can be done in any accessible and convenient place (e.g. health facility, treatment partner's house, patient's place of work, patient's house) as long as the treatment partner can effectively ensure the patient's intake of the prescribed drugs and monitor his/her reactions to the drugs.

4. How long is treatment supervised?

The patient's daily anti-TB drug intake should be supervised **during the intensive and maintenance phases of short-course chemotherapy for all smear positive TB patients.**

III. Policies

- A. Treatment of all TB cases shall be based on reliable diagnostic technique, namely, sputum smear examination aside from clinical findings.
- B. Domiciliary treatment shall be the preferred mode of care.
- C. Patients recommended for hospitalization are those with the following conditions:
 - 1. massive hemoptysis
 - 2. pleural effusion obliterating more than 1/2 of a lung field
 - 3. military TB
 - 4. TB meningitis
 - 5. TB pneumonia
 - 6. those requiring surgical intervention
 - 7. those with complications
- D. No patient shall initiate treatment unless the patient and health workers have agreed upon a case holding mechanism for treatment compliance.
- E. The national (regional) and local government units shall ensure the provision of drugs to all sputum positive TB cases.

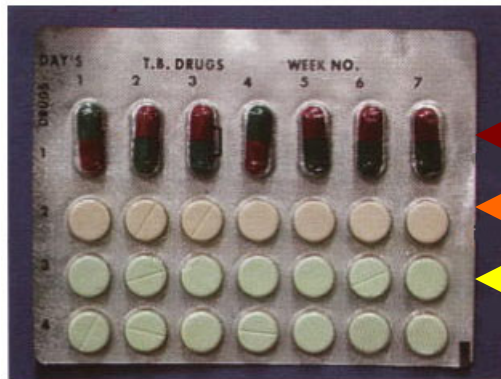
G. Drug dosage adjustment according to the initial body weight of patient

Simply add one tablet of INH (100mg), PZA (500mg) and EB (400mg) each for the patient with more than 50kg body weight before the initiation of the treatment (see Table 3). Modify drug dosage within acceptable limits according to the body weight of patient weighing less than 30kg at the time of diagnosis (see Table 4).

Table 4. DRUG DOSAGE ADJUSTMENT

Drug	Dose per kg body weight and maximum dose
Isoniazid	5 (4-6) mg/kg, and not exceed 400mg daily
Rifampicin	10 (8-12) mg/kg, and not to exceed 600mg daily
Pyrazinamide	25 (20-30) mg/kg, and not to exceed 2g daily
Ethambutol	15 (15-20) mg/kg, and not to exceed 1.2g daily
Streptomycin	15 (12-18) mg/kg, and not to exceed 1g daily

Type I Blister Pack:



Rifampicin: one capsule of 450mg

Isoniazid: one tablet of 300mg

Pyrazinamide: two tablets of 500mg

Type II Blister Pack:



Rifampicin: one capsule of 450mg

Isoniazid: one tablet of 300mg

Ethambutol tablet and streptomycin vial:



Ethambutol: two tablets of 400mg



Streptomycin: one vial of 1.0g

IV. Procedures

A. Registration and initiation of Treatment

1. Inform the patient that he/she has TB and motivate the patient to undergo treatment.
2. Refer the patient to a medical officer for pre-treatment evaluation and initiation of treatment.
3. Open the **NTP Treatment Card** and two **NTP ID Cards** (one is for the treatment partner and the other is for the patient) and start the treatment using any of the three treatment regimens best suited to the patient's disease classification, type and previous history of treatment.
4. Register the patient in the **NTP TB Register**. Refer the patient to the most accessible BHS where he/she can have his/her treatment supervised.

B. Ensuring Treatment Compliance through “DOT”

1. Explain the importance of treatment compliance to the patient.
2. Administer the patient's drugs daily. The patient and his/her treatment partner shall meet at their agreed treatment unit everyday. The treatment partner shall make sure that the patient swallows his/her drugs daily. After intake of the drugs, the treatment partner shall check and sign the **treatment partner's NTP ID Card** as well as the **patient's NTP ID Card**.
3. On Saturdays, Sundays and holidays, when the health center or clinic is closed, treatment could be done at home but should be supervised by a family member.
4. The treatment partner shall regularly motivate the TB patient to continue treatment. The treatment partner shall emphasize key messages, such as:
 - ✓ TB should be cured but requires regular drug intake for the prescribed duration.
 - ✓ The patient should report any adverse reaction to the drugs.
 - ✓ The patient should undergo follow-up sputum examination on specified dates (see Table 5, p. 28-29).
5. The responsible health worker (MHO or PHN or RHM) shall conduct **regular (preferably weekly) consultation** with the treatment partner together with the patient for treatment evaluation at BHS or RHU.

6. The treatment partner and all the health workers shall immediately exert effort to retrieve a patient upon failure to report on the day the patient is expected.
7. To monitor the response to treatment, follow-up sputum examination should be done on the specified date (see Table 5, p. 28-29). Sputum-smear examination for follow-up requires only one specimen collection, preferably in the early morning.

Table 5a. SCHEDULE OF SPUTUM SMEAR FOLLOW-UP EXAMINATION

(Category I)

Schedule of Sputum Smear Follow-up Examination	Category I (2HRZE/4HR)	
	Regular Treatment	With One Month of Extension (HRZE)
Towards the end of the 2 nd month	YES	(If positive)
Towards the end of the 3 rd month	(If negative)	YES
Towards the end of the 4 th month	YES	
Towards the end of the 5 th month		YES
Towards the end of the 6 th month	YES ^(*1)	
Towards the end of the 7 th month		YES ^(*1)

***1** Check the follow-up sputum smear examination at the end of the treatment (during the last week of treatment) for the patient who has smear positive in the last follow-up smear examination and shows smear negative in the repeated smear examination. (see Tables 7a, p. 33-34).

Table 5b. SCHEDULE OF SPUTUM SMEAR FOLLOW-UP EXAMINATION

(Category II and Category III)

Schedule of Sputum Smear Follow-up Examination	Category II (2HRZES/1HRZE/5HRE)		Category III (2HRZ/4HR)
	Regular Treatment	With One Month of Extension (HRZE)	
Towards the end of the 2 nd month			YES
Towards the end of the 3 rd month	YES	(If positive)	
Towards the end of the 4 th month	(If negative)	YES	
Towards the end of the 5 th month	YES		
Towards the end of the 6 th month		YES	
Towards the end of the 7 th month			
Towards the end of the 8 th month	YES (*2)		
Towards the end of the 9 th month		YES (*2)	

***2** Check the follow-up sputum smear examination at the end of the treatment (during the last week of the treatment for the patient who has smear positive in the last follow-up smear examination and shows smear negative on the repeated smear examination (see Tables 8a, 8b, p. 35-36)

C. Management of Seriously-ill Cases and HIV Co-Infected Cases

1. Refer seriously ill patients to the nearest hospital facility for evaluation and appropriate treatment.
2. Refer TB cases with known concomitant HIV infection to a medical officer for appropriate action.

SUMMARY OF TREATMENT MODIFICATION BASED ON THE SPUTUM FOLLOW-UP EXAMINATION RESULTS

CATEGORY - 1

1 st mo.	2 nd mo.	3 rd mo.	4 th mo.	5 th mo.	6 th mo.	7 th mo.	
HRZE		HR					
		If negative,	↑	↑	↑	↑*	
If positive,		HRZE	HR				
With Extension		↑	↑	↑	↑	↑*	

CATEGORY - II

1 st mo.	2 nd mo.	3 rd mo.	4 th mo.	5 th mo.	6 th mo.	7 th mo.	8 th mo.	9 th mo.
HRZES		HRZE	HRE					
		If negative,	↑	↑	↑	↑	↑*	
If positive,		HRZE	HRE					
With Extension		↑	↑	↑	↑	↑	↑	↑*

CATEGORY - III

1 st mo.	2 nd mo.	3 rd mo.	4 th mo.	5 th mo.	6 th mo.
HRZ		HR			
		↑			

* Check the follow-up sputum smear examination at the end of the treatment for the patient who has smear positive in the last follow-up smear examination and shows smear negative in the repeated smear examination.

D. Management of Adverse Reactions to Drugs

Closely monitor the occurrence of minor and major reactions to drugs, especially during the intensive phase. (see Table 6).

Table 6. GUIDE IN MANAGING SCC DRUGS SIDE EFFECTS

Side effects	Drug (s) responsible	What to do?
Minor side effects – Patient should be encouraged to continue taking medicines.		
1. Gastro-intestinal intolerance	Rifampicin	Give medication at bedtime.
2. Mild skin reactions	Any kind of drugs	Give anti-histamines.
3. Orange / red colored urine	Rifampicin	Reassure the patient.
4. Pain at the injection site	Streptomycin	Apply warm compress. Rotate sites of injection.
5. Burning sensation in the feet due to peripheral neuropathy	Isoniazid	Give Pyridoxine (Vitamin B6): 100 – 200mg daily for treatment 10mg daily for prevention.
6. Arthralgia due to hyperuricemia	Pyrazinamide	Give aspirin or NSAID.
7. Flu-like symptoms (fever, muscle pains, inflammation of the respiratory tract)	Rifampicin	Give antipyretics.
Major side effects: Discontinue taking medicines and refer to MHO / CHO immediately.		
1. Severe skin rash due to hypersensitivity	Any kind of drugs (especially streptomycin)	Discontinue anti-TB drugs and refer to MHO / CHO.
2. Jaundice due to hepatitis	Any kind of drugs (especially Isoniazid, Rifampicin and Pyrazinamide)	Discontinue anti-TB drugs and refer to MHO / CHO. If symptoms subside, resume treatment and monitor clinically.
3. Impairment of visual acuity and color vision due to optic neuritis	Ethambutol	Discontinue Ethambutol and refer to an ophthalmologist.
4. Hearing impairment, ringing of the ear and dizziness due to the damage of the eighth cranial nerve	Streptomycin	Discontinue Streptomycin and refer to MHO / CHO.
5. Oliguria or albuminuria due to renal disorder	Streptomycin Rifampicin	Discontinue anti-TB drugs and refer to MHO / CHO.
6. Psychosis and convulsion	Isoniazid	Discontinue Isoniazid and refer to MHO / CHO.
7. Thrombocytopenia, anemia, shock	Rifampicin	Discontinue anti-TB drugs and refer to MHO / CHO.

E. Monitoring Patient Response to Treatment

Monitor the sputum smear status of all patients under treatment, including initially sputum smear negative patients, according to the standard schedule (see Table 5, p. 28-29) and modify treatment based on the sputum follow-up examination results (see Tables 7a, 7b, 8a, 8b, p. 33-36).

TREATMENT MODIFICATIONS BASED ON THE RESULTS OF THE SPUTUM FOLLOW-UP EXAMINATIONS

Regimen I

- ✓ Do sputum smear examinations for follow-up towards the end of the 2nd m. of treatment.
- ✓ If the sputum examination result is **NEGATIVE**, start Maintenance Phase (HR) and follow Table 7a.
- ✓ If the sputum examination result is **POSITIVE**, extend intensive Phase (HRZE) for another one month and refer to Table 7b.

Table 7a. Treatment Modification Based on the Results of the Sputum Follow-up Examinations for Regimen – I Without Extension

Towards the end of the 4 th month	In the beginning of the 6 th month		Towards the end of the 6 th month (*1)
If smear negative, continue the maintenance phase (HR).	If smear negative, continue the maintenance phase until the end of the treatment course and declare as “cure”.		
	If smear positive, repeat smear examination immediately for confirmation and consult with Provincial/City/CHD TB Coordinators through MHO/CHO.	If smear negative in the repeated smear examination, continue the maintenance phase (HR) and do the smear examination towards the end of the 6 th month of treatment.	If smear negative, declare as “Cure.”
If smear positive again in the repeated smear examination, declare as “Treatment Failure,” then re-register as “Failure” and start Regimen II.		If smear positive, declare as “Treatment Failure,” then re-register as “Failure” and start Regimen – II.	
If smear positive, continue the maintenance phase (HR).	If smear negative, continue the maintenance phase (HR) and do the smear examination towards the end of the 6 th month of treatment.		If smear negative, declare as “Cure.”
	If smear positive, declare as “Treatment Failure,” then re-register as “Failure” and start Regimen II.		If smear positive, declare as “Treatment Failure,” then re-register as “Failure” and start Regimen – II.

- *1 Check the follow-up sputum smear examination towards the end of the 6th month of the treatment only for the patient who has smear positive in the beginning of the 6th month and shows smear negative in the repeated smear examination; and for the patient who has smear positive towards the end of the 4th month turns out to be negative in the beginning of the 6th month.

Table 7b. Treatment Modifications Based on the Results of the Sputum Follow-up Examinations for Regimen – I With Extension

Towards the end of the 3 rd mo.	Towards the end of the 5 th mo.	In the beginning of the 7 th month		Towards the end of the 7 th month (*2)	
If smear negative, start the maintenance phase (HR).	If smear negative, continue the maintenance phase (HR).	If smear negative, complete the maintenance phase until the end of the treatment course and declare as “Cure”.		If smear negative, declare as “Cure.” If smear positive, declare as “Treatment Failure,” then re-register as “Failure” and start Regimen – II.	
		If smear positive, repeat smear examination immediately for confirmation and consult with Provincial/City / CHD TB Coordinators through MHO/CHO.	If smear negative in the repeated examination, continue the maintenance phase (HR) and do the smear examination towards the end of the 7 th month of treatment		If smear positive in the repeated examination, declare as “Treatment Failure,” then re-register as “Failure” and start Regimen – II.
			If smear positive, declare as “Treatment Failure,” and start Regimen – II.		
	If smear positive, continue the maintenance phase (HR) anyway.	If smear negative, continue the maintenance phase (HR) and do the smear examination towards the end of the 7 th month of treatment.		If smear negative, declare as “Cure.” If smear positive, declare as “Treatment Failure,” then re-register as “Failure” and start Regimen - II.	
		If smear positive, declare as “Treatment Failure,” and start Regimen – II.			
If smear positive, start the maintenance phase (HR) anyway	If smear negative, continue the maintenance phase (HR).	If smear negative, complete the maintenance phase until the end of the treatment course and declare as “Cure.”		If smear negative, declare as “Cure.” If smear positive, declare as “Treatment Failure,” then re-register as “Failure” and start Regimen – II.	
		If smear positive, repeat smear examination immediately for confirmation and consult Provincial/ City/CHD TB Coordinators through MHO/CHO.	If smear negative in the repeated examination, continue the maintenance phase (HR) and do the smear examination towards the end of the 7 th month of treatment.		If smear positive in the repeated examination, declare as “Treatment Failure,” then re-register as “Failure” and start Regimen – II.
			If smear positive, declare as “Treatment Failure,” and start Regimen – II.		
	If still smear positive, declare as “Treatment Failure,” then re-register as “Failure” and start Regimen – II.				

*2 Check the follow-up sputum smear examination towards the end of the 7th month treatment only for the patient who has smear positive in the beginning of the 7th month and shows smear negative in the repeated smear examination; and for the patient who has smear towards the end of the 5th month and turns out to be negative in the beginning of the 7th month.

Regimen II

- ✓ Do sputum smear examination for follow-up **towards the end of the 3rd mo. of treatment.**
- ✓ If sputum examination result is **NEGATIVE, START Maintenance Phase (HRE)** and refer to **Table 8a.**
- ✓ If sputum examination result is **Positive, extend Intensive Phase (HRZE)** for another one (1) month and refer to **Table 8b.**

Table 8a. Treatment Modifications Based on the Results of the Sputum Follow-up Examinations for Regimen – II Without Extension

Towards the end of 5 th month	In the beginning of the 8 th month		Towards the end of the 8 th month (*3)
If smear negative, continue the maintenance phase (HRE).	If smear negative, complete the maintenance phase until the end of the treatment course and declare course as “Cure.”		
	If smear positive, repeat smear examination immediately for confirmation and consult with Provincial/City/CHD TB Coordinators through MHO / CHO.	If smear negative in the repeated smear examination, continue the maintenance phase (HRE) and do the smear examination towards the end of the 8 th month.	If smear negative, declare as “Cure.”
		If smear positive again in the repeated smear examination complete the maintenance phase (HRE) until the end of the treatment course and declare as “Treatment Failure.”	If smear positive, declare as “Treatment Failure.”
If smear positive, continue the maintenance phase (HRE) anyway.	If smear negative, continue the maintenance phase (HRE) and do the sputum smear examination towards the end of the 8 th month.		If smear negative, declare as “Cure.”
	If smear positive, continue the maintenance phase (HRE) until the end of the treatment course and declare as “Treatment Failure.”		If smear positive, declare as “Treatment Failure.”

***3** Check the follow-up sputum smear examination towards the end of the 8th month of treatment only for the patient who has smear positive in the beginning of the 8th month and shows smear negative in the repeated smear examination; and for the patient who has smear positive towards the end of the 5th month and turns out to be negative in the beginning of the 8th month.

Table 8b. Treatment Modifications Based on the Results of the Sputum Follow-up Examinations for Regimen – II With Extension

Towards the end of the 4 th month	Towards the end of the 6 th month	In the beginning of the 9 th month		Towards the end of the 9 th month (*4)	
If smear positive or smear negative, start the maintenance phase (HRE) anyway.	If smear negative, continue the maintenance phase (HRE).	If smear negative, complete the maintenance phase until the end of the treatment course and declare as “ Cure. ”			
		If smear positive, repeat smear examination immediately for confirmation and consult with Provincial/City/CHD TB Coordinators through MHO/CHPO.	If smear negative in the repeated smear examination, continue the maintenance phase (HRE) and do the smear examination towards the end of the 9 th month of treatment.	If smear negative, declare as “ Cure. ”	
			If smear positive again in the repeated smear examination, complete the maintenance phase (HRE) until the end and declare as “ Treatment Failure. ”	If smear positive, declare as “ Treatment Failure. ”	
		If smear positive, continue the maintenance phase (HRE) anyway.	If smear negative, continue the maintenance phase (HRE) and do the smear examination towards the end of the 9 th month of treatment.		If smear negative, declare as “ Cure. ”
			If still smear positive, complete the maintenance phase (HRE) until the end of the treatment course and declare as “ Treatment Failure. ”		If smear positive, complete the maintenance phase (HRE) until the end of the treatment course and declare as “ Treatment Failure. ”

*4 Check the follow-up sputum smear examination towards the end of the 9th month of treatment only for the patient who has smear positive in the beginning of the 9th month and shows smear negative in the repeated smear examination; and for the patient who has smear positive at the end of the 6th month and turns out to be negative in the beginning of the 9th month.

B. Managing of Lost and Referred Cases

1. Perform routine smear examination to lost and defaulted cases who came back for chemotherapy. Refer patient to a medical officer for re-evaluation and re-treatment.
2. New smear positive patients who interrupted treatment, should be managed according to recommended schedule (see Table 9a, p. 38).
3. Relapse and failure cases who interrupted treatment, shall be managed according to recommended schedule (see Table 9b, p. 39).
4. Treatment will be continued for patients who were properly referred or transferred with referral slip. However, sputum smear examination for diagnosis should be performed for patients without an accompanying properly accomplished referral slip.

Table 9a. Treatment Modifications for New Smear-Positive Cases Who Interrupted Treatment

Length of Treatment	Length of Interruption	Do a smear?	Result of smear	Register again?	Treatment Modification
Less than one month	Less than 2 weeks	No		No, use the same treatment card.	Continue Regimen - I
	2 weeks or more	Yes	Positive	No, open a new treatment card.	Start again on Regimen – I
			Negative	No, use the same treatment card.	Continue Regimen - I
One to two months	Less than 2 weeks	No		No, use the same treatment card.	Continue Regimen - I
	2 to 8 weeks	Yes	Positive	No, use the same treatment card.	Complete the remaining Intensive Phase, add one extra month of Intensive Phase.
			Negative	No, use the same treatment card.	Continue Regimen - I
	More than 8 weeks	Yes	Positive	Close the previous registration as “ Defaulter ”, then re-register as “ RAD ”, open a new treatment card.	Start on Regimen – II
			Negative	Close the previous registration as “ Defaulter ”, then re-register as “ Other ”, but use the same treatment card.	Continue Regimen - I
	More than two months	Less than 2 weeks	No		No, use the same treatment card.
2 to 8 weeks		Yes	Positive	Close the previous registration as “ Defaulter ” (*1), then re-register as “ RAD ”, open a new treatment card.	Start on Regimen – II
			Negative	No, use the same treatment card.	Continue Regimen - I
More than 8 weeks		Yes	Positive	Close the previous registration as “ Defaulter ”, then re-register as “ RAD ”, open a new treatment card.	Start on Regimen – II
			Negative	Close the previous registration as “ Defaulter ”, then re-register as “ Other ”, open a new treatment card.	Continue Regimen - I

*1 This is the exceptional case to define as “**Defaulter**” for a patient who interrupted treatment of less than eight weeks.

**Table 9b. Treatment Modification for Relapse and Failure Cases
Who Interrupted Treatment**

Length of Treatment	Length of Interruption	Do a smear?	Result of smear	Register again?	Treatment Modification
Less than one month	Less than 2 weeks	No		No, use the same treatment card.	Continue Regimen - II
	2 weeks or more	Yes	Positive	No, open a new treatment card.	Start again on Regimen – II
			Negative	No, use the same treatment card.	Continue Regimen - II
One to two months	Less than 2 weeks	No		No, use the same treatment card.	Continue Regimen - II
	2 to 8 weeks	Yes	Positive	No, use the same treatment card.	Complete the remaining Intensive Phase, add one extra month of Intensive Phase.
			Negative	No, use the same treatment card.	Continue Regimen - II
	More than 8 weeks	Yes	Positive	Close the previous registration as “ Defaulter ”, then re-register as “ RAD ”, open a new treatment card.	Start on Regimen – II
			Negative	Close the previous registration as “ Defaulter ”, then re-register as “ Other ”, but use the same treatment card.	Continue Regimen - II
	More than two months	Less than 2 weeks	No		No, use the same treatment card.
2 to 8 weeks		Yes	Positive	Close the previous registration as “ Defaulter ” (*2), then re-register as “ RAD ”, open a new treatment card.	Start on Regimen – II
			Negative	No, use the same treatment card.	Continue Regimen - II
More than 8 weeks		Yes	Positive	Close the previous registration as “ Defaulter ”, then re-register as “ RAD ”, open a new treatment card.	Start on Regimen – II
			Negative	Close the previous registration as “ Defaulter ”, then re-register as “ Other ”, open a new treatment card.	Continue Regimen - II

*2 This is the exceptional case to define as “**Defaulter**” for a patient who interrupted treatment of less than 8 weeks.

C. Outcome of Treatment

A patient who undergoes treatment may achieve any of the following treatment outcomes:

1. **Cure:** A sputum smear positive patient who has been completed treatment and is sputum smear negative in the last month of treatment and on at least one previous occasion.

(Note: We have changed the definition of “cure” as above, however, we have not changed the policy to collect follow-up sputum specimen with three occasions for smear positive case – at the end of the Intensive Phase, in the middle of the Maintenance Phase, and at the end of the Maintenance Phase.)

2. **Treatment Completed:** A patient who has completed treatment but does not meet the criteria to be classified as cure or failure.

This group includes:

- A sputum smear-positive patient initially who has completed treatment without follow-up sputum examinations during the treatment, or with only one negative sputum examination during the treatment, or without sputum examination in the last month of treatment.
- A sputum smear-negative patient who has completed treatment.

3. **Died:** A patient who dies for any reason during the course of treatment.

4. **Treatment Failure:**

- A patient who is sputum smear-positive at five months or later during the treatment.
- A sputum smear-negative patient initially before starting treatment and becomes smear-positive during the treatment.
(Note: This case will be re-registered as “other” with a new TB case number.)

5. **Defaulter Failure:** A patient whose treatment was interrupted for two consecutive months or more.

6. **Transfer out:** A patient who has been transferred to another facility with proper referral. Transfer slip for continuation of treatment.

GUIDE TO CASE HOLDING

AT THE TREATMENT UNIT (BHS and RHU)	
To be accomplished by the health workers	<ol style="list-style-type: none"> Conduct health education to patient and his/her family on the following key messages: <ul style="list-style-type: none"> ✓ Importance of regular drug intake ✓ Results of irregular drug intake ✓ Side effects of anti-TB drugs ✓ Necessity of follow-up sputum smear examinations ✓ Importance of family and treatment partner support Conduct weekly consultation meeting with patient and treatment partner during the course of treatment.
To be accomplished by the PHN/RHM and treatment partner	<ol style="list-style-type: none"> Monitor and record treatment regularity. <ul style="list-style-type: none"> ✓ TB Register (PHN), (see Annex 6, p. 68-69). ✓ NTP Treatment Card (RHM), (see Annex 4, p. 65-66). ✓ NTP ID Card (Treatment Partner and TB patient) (see Annex 5, p. 67).
To be accomplished by the RHM	<ol style="list-style-type: none"> Do follow-up sputum smear examinations on time. <ul style="list-style-type: none"> ✓ Label container with the name of the patient and serial No. 1, 2, 3. ✓ Collect 1 sputum specimen (preferably early morning specimen). ✓ Fill up the <i>NTP Laboratory Request Form for Sputum Examination</i> (see Annex 2, p. 61).



AT THE MICROSCOPY CENTER <i>(To be accomplished by the NTP Medical Technologist or Microscopist)</i>	
	1. Register in the <i>NTP Laboratory Register</i> (date received and serial number) (see Annex 3, p. 63).
	2. Smearing, fixing, staining and microscopic examination.
	3. Record the results in the <i>Laboratory Request Form for Sputum Examination</i> (see Annex 2, p. 62) and in the <i>NTP Laboratory Register</i> (see Annex 3, p. 63).
	4. Send the <i>Laboratory Request Form for Sputum Examination</i> to the treatment unit.



AT THE TREATMENT UNIT (BHS and RHU)	
To be accomplished by the RHM	Record the sputum smear examination results and due date of next sputum smear follow-up examination in the <i>NTP Treatment Card</i> (see Annex 4, p. 66). Any follow-up examination with smear positive result must be referred to the medical officer.
To be accomplished by the PHN	Record the results in the <i>NTP TB Register</i> . (see Annex 6, p. 68-69)
To be accomplished by the RHM	Inform the treatment partner of the sputum smear examination results so that she can update the <i>NTP ID Card</i> . (see Annex 5, p. 67)
To be accomplished by the PHN and RHM	<p>Upon Treatment Completion</p> <ol style="list-style-type: none"> Evaluate and record the treatment outcome in the <i>NTP TB Register</i> (see Annex 6, p. 68-69) and <i>NTP Treatment Card</i> (see Annex 5, p. 66). Prepare the <i>Quarterly Report on Treatment Outcome</i> and submit it (see Annex 10a, p. 77).

GUIDE TO ENSURE TREATMENT

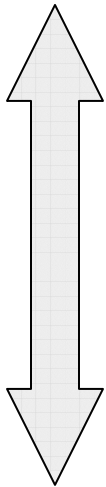
Recorded Information should be checked to ensure individual treatment.

NTP TREATMENT CARD

(to be accomplished by the RHM)

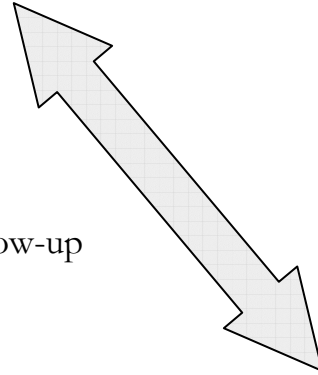
Record of Individual Patients

- TB Case Number
- Classification, Type and Regimen
- Sputum examination results on diagnosis, for follow-up
- Drug collection
- Defaulter action
- Treatment outcome



PHN should check the following information weekly. These are:

- Is the diagnosis correct?
- Is the treatment regimen appropriate?
- Are all smear-positive cases registered and treated properly with DOT?
- Are drugs collected on time?
- Are follow-up exams done on time?
- Are treatments regular and effective?
- Are actions taken to retrieve defaulters?



Laboratory Register

(to be accomplished by the MT)

Record of laboratory examination

Sputum results

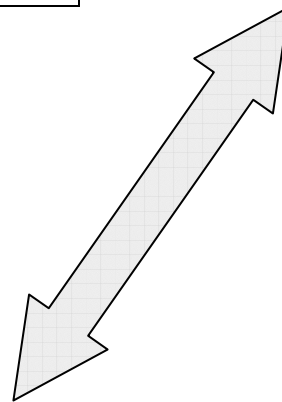
- 3 sputum collection
- -smear examination results on diagnosis / for follow-up

NTP TB Register

(to be accomplished by the PHN)

Record of Treatment Activity in the RHU

- TB Case Number
- Classification, Type and Regimen
- Sputum examination results on diagnosis and for follow-up
- Defaulter action
- Treatment outcome



RECORDING and REPORTING

Records that contain accurate, complete and up-to-date information on patient diagnosis, treatment, follow-up examinations and treatment outcome must be made available to ensure the provision of appropriate and effective patient's care. Such records are also important in the implementation of a successful TB control program.

Records enable health workers to ensure that each TB symptomatics found is examined and more importantly, TB patients are cured. Reports are important sources of information on patient coverage and care; program efficiency and effectiveness; and availability of drugs and other NTP supplies at health service units. In this manual, recording and reporting is designed to generate and provide the minimum set of information required for program planning at different levels.

I. OBJECTIVES

1. To provide program implementers with information to serve as basis for planning on how best to assist their clients and patients.
2. To provide program supervisors with information to serve as basis for planning on how best to assist TB control program implementers.

II. POLICIES

1. Recording and reporting for NTP shall be implemented on all health facilities in the country, including government and private hospitals.
2. Reporting TB cases should be made mandatory to private physicians and private clinics after agreement with parties concerned shall have been made.
3. Recording and reporting shall include all cases of TB, classified according to internationally accepted case definitions.
4. Recording and reporting for NTP shall use, as much as possible, the FHSIS network for routine reporting and feedback.
5. Recording and reports should allow for the calculation of the main indicators for program evaluation (see Table 12, p. 55).
6. All four quarterly reports should be sent to DOH through the CHD.

III. NTP RECORDING FORMS

A. TB Symptomatics Masterlist / TB Symptomatics Target Client List (Optional)

It is an optional tool to confirm the three sputum collection at sputum collection unit such as RHU / BHS. This Masterlist is maintained by the RHM to keep track of accomplished sputum-smear examinations for three specimens and confirmed diagnosis of TB Symptomatics (see Annex 1, p. 59). The Symptomatics Target Client List of FHSIS would be used instead in the area where the TB Symptomatics Masterlist is not available.

B. NTP Laboratory Request Form for Sputum Examination

This Form is accomplished by the nurse and the midwife when they request for sputum-smear examination (diagnosis or follow-up). Every specimen shall be sent together with this Laboratory Request Form to the microscopy center. The filled form should be returned to the referring unit as soon as the result of the sputum smear examinations are obtained by NTP medical technologist and microscopist (see Annex 2, p. 60-62).

C. NTP Laboratory Register

This register contains all information on sputum-smear examinations done by the NTP trained medical technologist and microscopist on TB Symptomatics as well as TB patients undergoing treatment. It can be used to check microscopy data recorded on the NTP TB Register. The NTP medical technologist and microscopist shall maintain the forms at the microscopy center or referral laboratory unit (see Annex 3, p. 63).

D. NTP Treatment Card

All TB patients admitted to the treatment program should have a TB treatment card. This card should be filled-up completely with all the necessary information about the TB patient and the treatment he/she is receiving including drug intake and collection as well as the results of sputum follow-up examinations. This NTP Treatment Card is maintained and updated by the midwife at the health unit (BHS/RHU) where the patient is receiving treatment (see Annex 4, p. 64-66).

E. NTP Identification Card

Once a patient is diagnosed as a TB case, he will be issued an NTP Identification Card. The NTP ID Card is a handy source of information on the patient's diagnosis, treatment regimen, schedule of drug taking and follow-up sputum smear examinations. The treatment partner initials the NTP ID Card each time he/she sees the patient take his/her drugs. In addition, the treatment partner keeps and maintains the same NTP ID Card for him/herself to monitor the patient's drug taking compliance. Both the **TB patient** and the **Treatment partner** keep the NTP ID Card. The treatment partner signs on these cards (see Annex 5, p. 67). It is recommended to continue the use of the NTP Treatment Sheet for the treatment partner in the area where it is available.

F. NTP TB Register

This register is maintained by the nurse assigned at the RHU or MHC. It gives information on the type and classification of TB cases, treatment regimen, monitoring of sputum follow-up and treatment outcomes of all patients in a catchment area. This is one of the main sources of data in the calculation of the treatment outcome and other main epidemiological indicators in NTP (see Annex 6, p. 68-69).

G. NTP Referral / Transfer Form

This form should be filled in by the nurse or the municipal health officer **in duplicate** (one copy is for the patient and the other is for the referring unit) or **in triplicate** (one copy is for the patient, the second is for the referring unit and the third copy is for the Provincial/City TB Coordinator). This form is needed when a patient is referred to another health unit for further needed when a patient is referred to another health unit for further continuation of treatment. **The receiving unit completes the lower portion of the form upon receipt from the patient. The duplicate copy is sent back to the referring unit.** It is recommended that referring unit ask for the treatment outcome of the transferred-out patient at the receiving unit afterwards in order to confirm the treatment outcome (see Annex 7, p. 70-72).

H. Responsible Persons for the Recording Forms

Table 10. Responsible Persons for the Recording Forms

Recording	Responsible for Initial Recording	Responsible for Maintenance and Updating
TB Symptomatics Masterlist / TB symptomatics Target Client List (Optional)	RHM	RHM at BHS or RHU
NTP Laboratory Request Form for Sputum Examination	RHM / PHN	
NTP Laboratory Register	Medical Technologist and Microscopist	Medical Technologist and Microscopist
NTP Treatment Card	PHN	RHM or PHN at BHS and RHU
NTP Identification Card	PHN	Treatment partner (kept by the treatment partner and the patient)
NTP TB Register	PHN	PHN At RHU
NTP Referral / Transfer Form	PHN and MHO	

IV. NTP REPORTING FORMS

A. Quarterly Report on Laboratory Activities

This report is made by the NTP trained medical technologist or microscopist at the microscopy center. It provides information on the total number of TB symptomatics examined, the total number of TB symptomatics collected three sputum specimens and the total number smear-positive cases discovered every quarter (see Annex 8a, p. 73).

This Quarterly Report is sent from the RHU / MHC to the Provincial or City NTP Coordinators quarterly. Then the Provincial or City NTP Coordinators analyze and consolidate the data by province and city and send them to the CHD NTP Coordinators. Afterwards, the CHD NTP Coordinators forward it to the DOH.

B. Quarterly Report on New TB Cases and Relapses

This report is made by the PHN through the MHO at the RHU / MHC and submitted to the Provincial or City NTP Coordinators quarterly. It is the summary report on the NTP case finding on new smear-positive cases, relapses and new smear-negative cases. The information is used by the provincial, city, CHD, central NTP Coordinators to evaluate case finding on new smear-positive and relapse cases including new smear-negative cases (see Annex 9a, p. 75).

The provincial or city NTP Coordinators analyze and consolidate the data from the RHU and send them to the CHD NTP Coordinators. Then the CHD NTP Coordinators forward the data by province and city to the DOH NTP Coordinators.

LOGISTICS MANAGEMENT

Health centers should have adequate supply of anti-TB drugs and other NTP supplies in order to provide quality NTP services. The latter includes sputum cups, glass slides, syringes, reagents and recording and reporting forms. The buffer stock must also be maintained at all levels to avoid stock-outs. The adequate reserve level must be as follows:

DOH / CHD level	Six months
Provincial / City level	Three month
Rural Health Unit and City Health Unit	Three months

Anti-TB drugs and laboratory supplies shall be procured by the CHD. These will be directly sent to the provinces or cities who will in turn distribute them to the health centers. To avoid stock-outs or oversupply, the **Quarterly Report on Drug Inventory and Requirement** (see Annex 9a, p. 75) must be carefully prepared and submitted on time, to the provincial or city NTP Requirement Coordinator by the RHUs to allow the provincial or city NTP Coordinator to send the consolidated data by province and city to the CHD NTP Coordinator on time.

The number of SCC Drugs to be requested is determined by the following (see Table 11):

1. Compute the total number of blister packs/tablets needed based on the number of patients registered in the previous quarter.
2. Multiply this by two (include the buffer stock).
3. Deduct the drugs left from the past quarter. The number of drugs to be ordered shall be based on the difference arrived at.

Table 11. The Number of Blister Packs Required Per Regimen

Treatment Regimen by Patient Category	Blister Pack/ Tablet/Vial	Number of BPs/ Tablets/Vials
REGIMEN – I	Type I blister pack	8 packs
	Type II blister pack	16 packs
	Ethambutol tablet	112 tablets
REGIMEN – II	Type I blister pack	12 packs
	Type II blister pack	20 packs
	Ethambutol tablet	448 tablets
	Streptomycin vial	56 vials
REGIMEN - III	Type I blister pack	8packs
	Type II blister pack	16 packs

Reminders:

- ✓ Drugs must be stored in secured, clean and cool place at all times.
- ✓ Always observe the **First Expiring, First Out (FEFO)** rule.
- ✓ Secure and give entire supply of drugs required for the entire duration of treatment per TB patient to the midwife in charge of the patient.

Note:

- ✓ The Contact Distribution System (CDS) for Core Essential Drugs will be utilized in areas where the CDS is available.

MONITORING, SUPERVISION and EVALUATION

Monitoring is an ongoing process of collecting and analyzing information about program implementation. It involves regular assessment of whether activities are being carried out as planned and how the activities are being done. Monitoring goes beyond following up on the progress of planned activities to identifying problems and implementation bottlenecks. Data and information gathered through monitoring should be immediately processed, analyzed and disseminated to people who can act and react. Monitoring is not completely separable from evaluation, except that in monitoring focuses on ongoing implementation, while evaluation focuses on effectiveness, results and impact.

Supervision is an essential management tool to ensure that the implementers correctly, effectively and efficiently carry out policies, standards and procedures of the program. It is also an opportunity for supervisors to do the following:

1. Discuss with health workers important issues related to the program.
2. Check records and reports.
3. Acknowledge and re-enforce good performance.
4. Help health workers identify and correct inadequacies or weaknesses in performance.
5. Give feedback and solicit ideas on how to improve the program implementation.

Evaluation is the regular assessment of the process or development of any program or project with particular focus on its effectiveness and impact. This process is carried out by each of the NTP Coordinators by analyzing indicators, data and relevant information from records and reports and feedbacks from field health implementers, surveys and studies from other agencies.

I. OBJECTIVES

- A.** To supervise and monitor on a regular basis, the health status of patients from records and reports in order to improve and maintain the NTP activities at all level.
- B.** To evaluate on a regular basis all NTP activities by using indicators derived from records and reports in order to identify problems and solve them.

II. POLICIES

- A.** The provincial or city NTP Coordinators are the NTP supervisors at the RHU or MHC level. The provincial or city NTP Coordinators shall visit regularly (at least quarterly) RHUs or MHCs to monitor the progress and performance of NTP. This activity shall be done in coordination with the DOH / CHD NTP Coordinators.
- B.** The municipal health officer and nurse are the NTP supervisors at the RHU and BHS levels. They shall also visit the areas regularly. Regular supervisory visits to the health facilities will create good working relationships between the Coordinators and the health workers. The frequency of the visit will depend on the level of performance of the health unit as well as the performance of the health workers.
- C.** The health staff concerned with NTP at each level (RHU, city, province, CHD, DOH) shall regularly analyze the data of quarterly reports using indicators and send feedback of findings to the staff or authorities concerned.

III. PROCEDURES

A. Procedures for the Conduct of Monitoring and Supervision Activities

Identify the areas to be visited and determine the frequency of the visits. Those with problems should be visited more frequently. Use the following guidelines for supervisory visits:

1. Compare and verify.
 - ✓ NTP TB Register with NTP Laboratory Register
 - ✓ NTP TB Register with NTP Treatment Cards
 - ✓ NTP TB Register with NTP Treatment Cards

2. Review the NTP treatment cards.
 - ✓ TB Case Number
 - ✓ Type and classification of patient
 - ✓ Regimen of treatment
 - ✓ Sputum examination results on diagnosis and for follow-up
 - ✓ Drug collection
 - ✓ Treatment outcome
 - ✓ Review the NTP TB Register
 - ✓ TB Case Number
 - ✓ Type and classification of patient
 - ✓ Sputum examination results on diagnosis and for follow-up
 - ✓ Conversion rate at the end of the 2nd and 3rd month of treatment
 - ✓ Treatment outcome

3. Review NTP Laboratory Register.
 - ✓ TB Case Number for the follow-up examination
 - ✓ Rate of three sputum specimen collection
 - ✓ Positive rate
 - ✓ Observe health workers

4. Interview health workers and patients.

5. Conduct physical inventory of logistics and other NTP supplies.

After gathering all relevant information, the supervisor must inform or advise the health worker of the findings from the visit. Recommendations should preferably be furnished in writing. Courses of action to address deficiencies, mistakes and carelessness must be discussed and solutions agreed upon by both supervisor and the concerned health worker.

B. Procedures for evaluation

1. During the first week of each quarter, the nurse at the RHU shall prepare the **Quarterly Report on the Treatment Outcome of Pulmonary TB Cases** of cases registered during the earlier 13 and 14 months. The medical technologist or microscopist shall also prepare the **Quarterly Report on NTP Laboratory Activities** of the cases registered during the previous quarter. The MHO shall analyze all the quarterly reports to evaluate the performance of the NTP activities at the RHU. In turn, the nurse and the medical technologist or microscopist shall submit the reports to the provincial or city NTP Coordinator through the MHO. All staff concerned shall evaluate their performance by analyzing indicators such as the proportion of pulmonary smear positive cases out of all pulmonary cases; three sputum collection rate; positive rate; rate of sputum smear positive cases per population; sputum conversion rate at the end of two (three) months of treatment for new smear positive cases and cure rate. *Treatment failure cases should not be included in the Quarterly Report on New Cases and Relapses of TB, as they have already been reported. Transfer-in patient should be counted in the health facility where they came from.*
2. All quarterly reports are prepared from the **NTP TB Register** and the **NTP Laboratory Register**. Therefore, the information in the report is only as accurate as the information recorded in the NTP TB Register and the NTP Laboratory Register. The quarterly reports are based on the following coverage period:

1st quarter	January 1 – March 31
2nd quarter	April 30 – June 30
3rd quarter	July 1 – September 30
4th quarter	October 1 – December 31

The provincial and city NTP Coordinators shall consolidate and analyze all quarterly reports coming from the implementing RHUs. The consolidated data by province and city reports shall be sent to the CHD NTP Coordinators for analysis. The consolidated data by province and city of all Quarterly Reports shall be sent by the CHD NTP Coordinators to the DOH NTP Coordinators for analysis. Recommended courses of action based on findings from indicators (see Table 12, p. 55) from the quarterly reports should be used or applied to ensure the effective implementation of the TB control program.

Table 12. PROGRAM INDICATORS

INDICATORS	CALCULATION	DATA SOURCE
CASE FINDING		
1. Proportion of pulmonary smear positive cases out of all pulmonary cases (%)	$\frac{\text{Total number of Pulmonary smear-positive cases (new and Relapse) registered}}{\text{Total number of pulmonary (New smear-positive, New smear-negative, and Relapse) cases registered.}} \times 100$	Quarterly Report on Case Finding (TB register)
2. Three-sputum collection rate (%)	$\frac{\text{Number of TB symptomatics who submitted 3 sputum specimens}}{\text{Total number of TB Symptomatics examined}} \times 100$	Quarterly Report on Laboratory Activities (Laboratory Register)
3. Positive rate (%)	$\frac{\text{Number of sputum smear-positive cases discovered}}{\text{Total number of TB Symptomatics examined}} \times 100$	Quarterly Report on Laboratory Activities (Laboratory Register)
4. Case-Notification Rate of New smear-positive cases per 100,000 population	$\frac{\text{Number of New smear-positive cases notified}}{\text{Total number of population in the specified areas}} \times 100,000$	Quarterly Report on Case Finding (TB Register) Population Statistics
CASE HOLDING		
5. Sputum conversion rate at the end of 2 (3) months of treatment for New smear positive cases (%)	$\frac{\text{Number of New sputum smear-positive cases which are smear negative at the end of 2 (3) months of treatment}}{\text{Total number of New sputum smear-positive cases registered during some period of time}} \times 100$	TB register
6. Treatment outcomes for each New smear-positive cases, New smear-positive cases, Relapse cases and Failure cases(%) (Reminder: There is no cure rate applied to smear-negative cases.)	<ul style="list-style-type: none"> * Cure rate: $\frac{\text{Number of cases who were cured}}{\text{Total number of cases registered}} \times 100$ * Completion rate: $\frac{\text{Number of cases who completed treatment}}{\text{Total number of cases registered}} \times 100$ * Death rate: $\frac{\text{Number of cases who died during the treatment}}{\text{Total number of cases registered}} \times 100$ * Treatment Failure rate: $\frac{\text{Number of smear-positive cases who still smear positive at five months or more of treatment}}{\text{Total number of cases registered}} \times 100$ * Defaulter rate: $\frac{\text{Number of cases who were defaulted}}{\text{Total number of cases registered}} \times 100$ * Transfer-out rate: $\frac{\text{Number of cases who transferred to another Health facility with a proper referral / transfer slip}}{\text{Total number of cases registered}} \times 100$ 	Quarterly Report on the Treatment Outcome of Pulmonary TB cases (TB Register)

Annex

Recording and Reporting Forms

Recording Forms

- 📄 TB SYMPTOMATICS MASTERLIST (optional)
- 📄 NTP LABORATORY REQUEST FORM FOR SPUTUM EXAMINATION
- 📄 NTP LABORATORY REGISTER
- 📄 NTP TREATMENT CARD
- 📄 NTP IDENTIFICATION CARD
- 📄 TB REGISTER
- 📄 NTP REFERRAL / TRANSFER FORM

Reporting Forms and Counting Sheets

- 📄 QUARTERLY REPORT ON NTP LABORATORY ACTIVITIES
- 📄 COUNTING SHEET FOR LABORATORY ACTIVITIES REPORT

- 📄 QUARTERLY REPORT ON NEW CASES AND RELAPSES OF TUBERCULOSIS AND ON DRUG INVENTORY & REQUIREMENT
- 📄 COUNTING SHEET FOR CASE FINDING BY TYPES / DRUG INVENTORY

- 📄 QUARTERLY REPORT ON THE TREATMENT OUTCOME OF PULMONARY TB CASES REGISTERED 13 – 15 MONTHS EARLIER
- 📄 COUNTING SHEET FOR QUARTERLY REPORT ON THE TREATMENT OUTCOME OF PULMONARY TB CASES

ANNEX 1

TB SYMPTOMATICS MASTERLIST (optional)

Family Serial No. (I)	Date of Registration (II)	Name (III)	Address (IV)	Age (V)	Sex (VI)	Date Sputum Collection/Examination Results						X-ray finding		TB Case Number (VII)	Remarks (VIII)		
						I*	II*	III*	IV*	V*	VI*	Result (VII)	Result (VIII)			Date (IX)	Result (X)
1	8-21-99	CRUZ, Roy J.	Sitio Nella Casoy I	34	M	8-21-99	8-27-99	8-27-99								99021116	Positive Start Reg.]
2	8-22-99	SANTOS, Rudy J.	Daughters, KM. 17	21	M	8-22-99	8-28-99	8-28-99	8-27-99	8-28-99	8-28-99	8-30-99	9-3-99			99021351	Doubtful/ Negative Start Reg. II
3	8-25-99	LOPEZ, LINDA H.	Casoy II (beside BHS)	40	F	8-25-99	8-26-99	8-26-99									Negative Referral to PHO
4	8-29-99	PALMA, ROSA M.	Casoy I (Near Church)	61	F	8-29-99	8-30-99	8-30-99								99021355	Positive Start Reg. I.

The following are the descriptions of the items to be recorded on the **TB Symptomatics Masterlist**.

- (1) The family serial number based on the family consultation record or annual serial number for TB symptomatics in the clinic.
- (2) The date (m0/dd/yr) when the TB symptomatics is discovered.
- (3) Patient's full name, with the **family** name written first and followed by the **first** name.
- (4) Patient's full address including landmarks/telephone number (if possible) so that the patient can be traced in case he/she does not return to get his/her examination results.
- (5) The exact age of the patient.
- (6) To indicate the sex of the patient, write **M** for male and **F** for female.
- (7) The date when each sputum specimen is collected and its corresponding results written below.
- (8) The date and results of sputum collection in TB Sx with doubtful smear results on the first examination.
- (9) The date (mo/dd/yr) when the patient is referred for an X-ray examination.
- (10) Date when the X-ray finding is received by the health worker and its results is written below.
- (11) TB Case Number for patients who have been diagnosed with TB and registered.
- (12) Any significant information pertaining to symptomology, referral or diagnostic findings, such as "patient with massive hemoptysis, referred to hospital," among other remarks.

ANNEX 2

NTP LABORATORY REQUEST FORM FOR SPUTUM EXAMINATION

TO BE FILLED UP BY MIDWIFE/TREATMENT UNIT

Name of collection Unit : _____ Date of Submission : _____

Name of Patient : _____ Age : _____ Sex : M F

Address (in full): _____

Disease Classification : Pulmonary Extra-pulmonary

Site : _____

Reason for Examination Diagnosis Follow-up Others

↓
TB Case No.: _____

Specimen	Date of Collection
1	
2	
3	

Signature of Specimen Collector : _____ Remarks : _____

(Be sure to enter the patient's TB Case No. for follow-up of patient's Chemotherapy)

TO BE FILLED UP BY MICROSCOPY UNIT / LABORATORY PERSONNEL

Date received : _____

Laboratory Serial No. _____

Specimen	1	2*	3*
Visual Appearance*			
Reading			
Laboratory Diagnosis			

* Specimen #2 & 3 = not applicable if sputum follow-up

** Muco-purulent, bloodstained, saliva, etc.

Date of Examination : _____ Examined by (Signature): _____

The completed form (with results) should be sent to the treatment unit to record the results on the record.

Annex 2 Laboratory Request Form for Sputum Examination (Upper Portion)

**NTP LABORATORY REQUEST FORM
FOR SPUTUM EXAMINATION**

TO BE FILLED UP BY MIDWIFE/TREATMENT UNIT

Name of collection Unit: PALAY, BHS (1) (5) (6) Date of submission: 3-23-96 (9) (2)

Name of Patient: DELA PAZ, JUAN J. (3) Age: 54 (4) Sex: M F (5)

Address (in full): Sitio Kawayan, Palay San Jose, Rizal (6)

Disease Classification: Pulmonary Extra-pulmonary Site: _____ (7)

Reason for Examination: Diagnosis Follow-up Others (8)

↓

TB Case No. _____ (9)

Specimen	Date of Collection
1	<u>3-21-96</u>
2	<u>3-22-96</u>
3	<u>3-22-96</u>

Signature of Specimen Collector: [Signature] (11) Remarks: _____ (12)

(Be sure to enter the patient's TB case No. for follow-up of patient's Chemotherapy)

The following are the descriptions of the items to be recorded on the upper portion of the Laboratory Request Form for Sputum Examination.

- (1) The name of health facility (BHS/RHU) where sputum specimen was collected.
- (2) The date (mo/dd/yr) when the sputum specimen are sent to the laboratory/microscopy unit.
- (3) Patient's full name with his/her **family name** first followed by his/her **first name**.
- (4) The exact age of the patient.
- (5) To indicate the sex of the patient, write **M** for male and **F** for female.
- (6) Patient's full address including landmarks/telephone number (if possible) so the patient can be traced in case he/she does not return to get his examination results.
- (7) The **Pulmonary** box is marked/checked if patient is a pulmonary TB suspect. Mark/check the **Extra-pulmonary** box for TB of organs other than the Lung, i.e. pleura (TB pleurisy), bones, genito-urinary tract etc., and the site (name of the organ or body part is written).
- (8) The **diagnosis box** is marked/checked for the sputum collected from tuberculosis symptomatic (three specimen). The **follow-up box** is marked/checked to follow-up smear status of patients under treatment (one specimen). Mark/check the box on **Others** for reasons other than the two.
- (9) TB Case Number from treatment card/TB registry of patients for follow-up.
- (10) The date of collection of each sputum specimen should correspond to the number labeled on the sputum container; for diagnosis (three specimen), for follow-up (one specimen).
- (11) Place the signature of the sputum collector or head of the referring treatment unit.

Annex 2 Laboratory Request Form for Sputum Examination (Lower Portion)

TO BE FILLED UP BY MICROSCOPY UNIT/LABORATORY PERSONNEL

(2) SPUTUM MICROSCOPY RESULTS

Date received : (3) 9-23-98

Laboratory Serial No.: (1) 016

Specimen	(5) 1	(3) 2*	(4) 3*
Visual Appearance*	<u>muco-purulent</u>	<u>muco-purulent</u>	<u>muco-purulent</u>
Reading	<u>0</u>	<u>2+</u>	<u>3+</u>
Lab. Diagnosis	<u>POSITIVE</u>		

* Specimen # 2 & 3 = not applicable if sputum follow-up
** muco-purulent, blood stained, saliva, etc.

Date of Examination: (6) 9-23-98 Examined by ; signature : (7) [Signature]

The following are the instructions on how to fill-up the lower portion of the Laboratory Request Form for Sputum Examination (*to be accomplished by the NTP Medical Technologist or Microscopist*).

- (1) Write the date when the sputum specimen was received with this form at the laboratory or microscopy center.
- (2) Indicate the laboratory annual serial number designated for each specific sputum microscopy examination in the laboratory or microscopy center.
- (3) Write the observed visual appearance of each specimen submitted. The quality of the specimens collected may affect the quality of the examination.
- (4) Write the readings of each specimen examined for sputum microscopy. This is either negative or positive. If negative, indicate "0." if positive, indicate the positivity grading as follows:

"1" = 1 – 9 bacilli seen
"2" = 10 – 299 bacilli seen
"3" = 300 and above bacilli seen

- (5) Record the overall evaluation of the specimens submitted for sputum microscopy. A **POSITIVE** result should have at least two specimens positive. A **NEGATIVE** result should have at least three specimens negative. A **DOUBTFUL** result has only one specimen positive.
- (6) Write the date when the specimens were examined.
- (7) The NTP Medical Technologist or Microscopist who actually examined the sputum specimen must sign in the space provided in the form.

ANNEX 3

NTP LABORATORY REGISTER

(1) Lab Serial No.	(2) Date of Regist- ration	(3) Name	(4) Age	(5) Sex	(6) Name of Collection/ Treatment Unit	(7) Address (for new patient)	(8) Examined for		(9) Date of Examination / Result			(10) Remarks	(11) Sign of MT
							Dx	Follow- up (TB case number)	1st	2nd	3rd		
031	8-25-99	SANTOS, Grace	33	F	Santal BHS	Km. 51	✓		8-25-99	8-25-99	8-25-99	Muco-purulent Negative	Ep/
032	8-27-99	IBANEZ, Rudy	45	M	Ligaya BHS	Ligaya 2	✓		8-27-99	8-27-99	8-27-99	Muco-purulent Positive	Ep/
033	9-1-99	PAZ, Luis	30	M	Santal BHS	Santal South	✓		9-1-99	9-1-99	9-1-99	Muco-purulent Positive	Ep/
034	9-1-99	MCINTO, Jasmin	39	F	Payabas BHS	P. Gomez			9-1-99			Salivary Negative	Ep/
035	9-1-99	BASILIO, Crispin	70	M	Carmona BHS	Pulo 2 Carmona			9-1-99			Muco-salivary Negative	Ep/
036	9-2-99	DELA CRUZ, Johanne	38	M	Carmona BHS	Pulo 3 Carmona	✓		9-2-99	9-2-99	9-2-99	Muco-purulent doubtful/ Positive	Ep/
037	9-2-99	CRUZ, Joan	41	F	Manga BHS	Km. 48			9-2-99			Salivary Negative	Ep/

Following are the descriptions of the items to be recorded in the lower portion of the Laboratory Request Form for Sputum Examination (*to be accomplished by the NTP Medical Technologist or Microscopist*).

- (1) The laboratory serial number assigned for every examination made, whether for diagnosis or for follow-up.
- (2) The date when the 1st sputum specimen is received by the microscopic center.
- (3) Patient's full name with his **family name** written first in capital/ large letters followed by the **first name**.
- (4) The exact age of the patient.
- (5) Indicate patient's sex with the letter **M** for male and the letter **F** for female.
- (6) The name of health facility where sputum for diagnosis was collected or name of treatment unit for patients on follow-up.
- (7) Patient's full address should include landmarks or telephone number (if available).
- (8) Dx is checked for diagnosis. The **TB Case Number** is indicated in the column on follow-up examination.

- (9) The date and the results of each sputum specimen examined as indicated in the columns involved.
- (10) The column on remarks is utilized for significant information pertaining to the examination, i.e., **Positive, Negative, Doubtful, muco-purulent, salivary** or **inadequate** specimen.
- (11) Signature of NTP Medical Technologist or Microscopist who actually examined the sputum specimens.

ANNEX 4

NTP Treatment Card

Annex 4 (Continuation)

NTP Treatment Card

TB CASE NUMBER (1)					DATE THE CARD IS OPENED(2) Month day year	REGION & PROVINCE	BHS/RHU/HOSP./OTHERS(4)												
NAME OF PATIENT (5)					OCCUPATION (6)		AGE(7)	SEX(8) M F	WEIGHT (9) kg										
ADDRESS (10)					NAME/RELATIONSHIP/ADDRESS(CONTACT PERSON) (11)			No. of House Hold Contacts: (12)											
CLASSIFICATION OF TB:(13) <input type="checkbox"/> No <input type="checkbox"/> Yes Duration: <input type="checkbox"/> less than 1 mo. <input type="checkbox"/> more than 1 mo. Specify drugs: When: _____ Where: _____							BCG SCAR(14) <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Doubtful												
CLASSIFICATION OF TB:(15) <input type="checkbox"/> PULMONARY <input type="checkbox"/> EXTRA-PULMONARY site:					CATEGORY (encircle): (17)														
TYPE OF PATIENT:(16) <input type="checkbox"/> NEW <input type="checkbox"/> RETURN AFTER DEFAULT <input type="checkbox"/> RELAPSE <input type="checkbox"/> FAILURE <input type="checkbox"/> TRANS. IN <input type="checkbox"/> OTHER					I. 6-SCC (2HRZE/4HR) New Case 3. Smear (+) 4. Seriously ill 2.1. Smear (-): MA or FA radiographic lesion 2.2. Extra-pulmonary					II. 8-SCC (2HRZES/1HRZE/5HRE) 1. RELAPSE 2. FAILURE 3. RETURN AFTER DEFAULT 4. OTHER (smear+)					III. 6-SCC (2HRZ/4HR) New Case 1. Smear (-): Minimal 2. Extra-pulmonary not seriously ill				
TREATMENT STARTED:(18) month _____ day _____ year _____																			

The following are the instruction on how to record information on the form.

- 1) Write the TB Case Number assigned to a TB case from the TB register.
- 2) Write the date when this NTP Treatment Card was opened.
- 3) Write the name of the region and province where the treatment facility is located.
- 4) Write the name of the health facility/treatment unit where the patient is receiving TB treatment.
- 5) Write the patient's full name with his **family name** written first in capital letters followed by the **first name**.
- 6) Write the patient's occupation and place of work.
- 7) Write the exact age of the patient.
- 8) To indicate patient's sex, encircle the letter **M** for male and the letter **F** for female.
- 9) Write the patient's weight in kilogram before the initiation of chemotherapy.
- 10) Write the patient's full address including landmarks/telephone number (if available) to easily trace him/her.
- 11) Write the name/relationships/address of a person who can assist the patient for a regular treatment during the entire treatment course.
- 12) Indicate the number of persons living with the patient.
- 13) Indicate the exact history of patient's previous TB treatment should be carefully recorded. If the patient has previous TB treatment history, mark **Yes** and mark whether it is less than a month or more than a month and specify the drug administered to him/her; record the year and the place the patient received TB medicines.
- 14) Mark/check the appropriate box whether patient has BCG scar or not.
- 15) Check/mark the appropriate box indicating the classification of the patient (Pulmonary or Extra-pulmonary TB).
- 16) Mark/check the space that indicates the type of patient based on the previous TB treatment history and results of sputum examination before treatment (New, Relapse, Transferred In, Return After Default, Failure, Other).
- 17) Write the patient's treatment regimen by the category, I, II or III.
- 18) Write the date when the first dose is actually taken by the patient.

Annex 4 (Continuation)

NTP Treatment Card

SPUTUM EXAMINATION RESULTS(19)			
Month	Due Date	Date Examined	Result
0		9-10-98	1
2	11-1-98	11-3-98	0
3			
4	1-2-99		
5			
6			
>7			
REMARKS: (21)			

TREATMENT OUTCOME: (20)

<input type="checkbox"/> CURE Date: / /	<input type="checkbox"/> TREATMENT FAILURE Date: / /
<input type="checkbox"/> TREATMENT COMPLETED Date: / /	<input type="checkbox"/> DEFAULTER Date: / /
<input type="checkbox"/> DIED Date: / / Cause: _____	<input type="checkbox"/> TRANSFER OUT Date: / / Specify: _____

Name of Treatment Partner: (22) _____ Designation: (23) _____

i. Month 0 pertains to the sputum examination result before treatment. Fill up the date examined and the result of the sputum examination before treatment in the columns

Drug Intake (Intensive Phase)(24) The Due Date when follow-up sputum examination is scheduled, the Date Examined when the sputum examination is actually made and the Result of the follow-up sputum examination should be filled up carefully in the columns of Month 2 to Month >7 according to the schedule of following-up sputum examination.

Month	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
ii.	Mark one of the Treatment Outcome Cured Treatment Completed, Died, Treatment Failure, Defaulter, Transfer Out. The date is when the patient stopped taking medicines.																														
iii.	Write any pertinent information concerning the diagnosis and treatment process of the patient.																														

Drug Intake (Maintenance Phase)

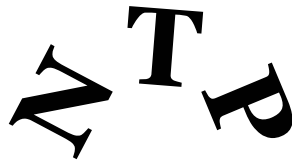
Month	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
iv.	Write the name of treatment partner assigned to the patient.																														
v.	Write the designation of the treatment partner, PHN, RHM, or BHW.																														

Remarks: (25)

- (24) Mark the date the treatment partner collects the medicines for the following one week at BHS and draw line between marks. If the midwife at the BHS as treatment utilizes this TB Treatment Card as a TB Identification Card, each box should be marked, to indicate the day and month, when the patient took his/her anti-TB drugs in front of the midwife (treatment partner).
- (25) Record pertinent information that occur during the treatment course, i.e. adverse reactions and reasons for failure to follow-up/ tracing action.

ANNEX 5. NTP IDENTIFICATION CARD

- MGA PAALALA**
1. Ang TB ay nakakahawa pero nagagamot
 2. Ang mga gamut ay kailangan araw-araw na inumin upang tuluyang gumaling.
 3. Kailangan magpauri ng plema sa itinakdang araw ng Health Worker upang malaman kung gumagaling na.
 4. Kapag magaling ka na higit kang makakatulong sa iyong pamilya at kabarangay.



IDENTIFICATION CARD
(1)

- (1) The case number designated to a TB case from the TB Register after initiation of treatment / registration is completed.
- (2) The name of the health facility / treatment unit where the patient is receiving TB treatment.
- (3) The full name of the patient (family name written first, followed by the given name).
- (4) The exact address of the patient. Indicate the landmarks and telephone number (if any) to easily trace for necessary action.
- (4) The name of the treatment partner (a responsible person supervising the patient's daily drug intake).

Annex 5. NTP IDENTIFICATION CARD

Disease Classification (6)
(9):

- Pulmonary
 Extra-pulmonary
site: _____

CATEGORY (7): I / II / III

Treatment started: _____

Type of Patient (8):

- New Failure
 Relapse Return After Default
 Transfer in
 Other

Sputum Examination Results

- Before TX : _____
End of 2 m: _____
End of 3 m: _____
End of 4 m: _____
End of 5 m: _____
End of 6 m: _____
> 7 m: _____

Drug Intake (Intensive Phase) (10)

Month	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31

Drug Intake (Maintenance Phase)

Month	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31

- (6) Disease Classification: Tick one.
- (7) Indicate the prescribed treatment regimen. Indicate the exact date when the treatment started.
- (8) Type of Patient: New, Relapse, Transfer-In, Return after default, Failure, Other.
- (9) All sputum examinations done to the patient. Before TX is for the examination before treatment. The succeeding month is for follow-up examinations results.
- (10) DRUG INTAKE WITH DOT: Indicate the month and tick or sign the corresponding day when the treatment was started. Tick each box, indicating the day and the month, when the patient took his/her anti-TB drugs in front of the treatment partner. Indicate a missed day with a blank.

ANNEX 7

NTP REFERRAL / TRANSFER FORM

(Fill out in duplicate/triplicate with carbon paper between sheets)

To:

Please facilitate the completion of treatment of the patient bearing this referral form.

(To be accomplished by the Referring Treatment Unit)

1. Name of Referring Unit:
2. Full address of Referring Unit:
3. Telephone / Fax number of Referring Unit:
4. Name of the Patient: _____
5. Age: _____
6. Sex: M, F
7. Address of the Patient:
8. New Address of the Patient:
9. TB Case Number:
10. Date Treatment Started: _____
11. Category: I / II / III
12. Classification of the Patient: Pulmonary, Extra-pulmonary, _____ site:
13. Type of the Patient: New, Relapse, Failure, Return After Default, Transfer In, Other
14. Smear Examination result on diagnosis: Positive, Negative, not done, unknown
15. Treatment Course and Smear Examination results

Month	Before Tx.	1	2	3	4	5	6	7	8	9	10
Drugs		H R Z E S									
Smear Exam.											

* Indicate the period of treatment given with line.

16. Remarks:
17. Printed Name / Signature & Designation: _____
18. Date referred:

(To be accomplished by the Receiving Treatment Unit)

1. Name of Receiving Unit: _____
2. Date Received:
3. Full address of Receiving Unit:
4. Telephone / Fax number of Receiving Unit:
5. Name of the Patient: _____
6. Age: _____
7. Sex: M, F
8. TB Case Number at Receiving Unit:
9. Printed Name / Signature & Designation

(Please send this back to the Referring Unit as soon as the patient has reported and been registered.)

Annex 7 NTP Referral / Transfer Form (Continuation)

The following are instructions on how to fill up the upper portion of the NTP Referral/Transfer Form.

- (1) Write the name of the health facility where the patient is registered and receiving treatment for TB.
- (2) Write the full address of the health facility where the patient is registered.
- (3) Write telephone and/or fax number of the health facility where the patient is registered.
- (4) Write the full name of the patient with his/her family name written first in large letters.
- (5) Write the exact age of the patient.
- (6) Indicate the patient's sex with the letter **M** for male and the letter **F** for female.
- (7) Write the patient's full address.
- (8) Write the patient's new address with telephone number to easily trace him/her for necessary action.
- (9) Write the TB Case number assigned to the patient in the TB Register.
- (10) Write the date (mo/dd/yr) when treatment for TB was started as indicated in the NTP Treatment Card.
- (11) Encircle the appropriate regimen prescribed to the patient by the category.
- (12) Check/mark the appropriate box that indicates the patient's classification, e.g., Pulmonary or Extra-pulmonary.
- (13) Check/mark the appropriate box that indicates the patient's by the category.
- (14) Check/ mark the appropriate box on the result on diagnosis.
- (15) Write the drugs prescribed for the patient and the smear examination results on diagnosis and for follow-up by following the example below.

Month	Before Tx.	1	2	3	4	5	6	7	8	9	10
Drugs		H R Z E S	→	→	→						
Smear Exam.											

* Indicate the period of treatment given with line.

- (16) Write any pertinent action on the patient's referral or transfer (e.g. "transferred for continuation of treatment" or "with massive hemoptysis, advised for hospitalization")
- (17) The person who accomplished the NTP Referral / Transfer Form must write and sign his/her name and indicate him/her designation of the form.
- (18) Write date (mo/dd/yr) when this NTP Referral / Transfer form was accomplished.

Annex 7 NTP Referral / Transfer Form (Continuation)

(To be accomplished by the Receiving Treatment Unit)

1. Name of Receiving Unit:_____
2. Date Received:_____
3. Full address of Receiving Unit:_____
4. Telephone / Fax number of Receiving Unit:_____
5. Name of the Patient:_____
6. Age:_____ 7. Sex: [] M, [] F.
8. TB Case Number at Receiving Unit:_____
9. Printed Name / Signature & Designation _____

(Please send this back to the Referring Unit as soon as the patient has reported and been registered.)

The following are instructions on how to fill up the lower portion of the NTP Referral / Transfer Form.

- (1) Write the name of the health facility where the patient is currently receiving treatment.
- (2) Write the date (mo/dd/yr) when this NTP Referral / Transfer Form was received by the receiving unit.
- (3) Write the full address of the receiving unit.
- (4) Write the telephone and fax number(s) of the receiving unit.
- (5) Write the full name of the patient with his/her family name written first in large letter.
- (6) Indicate the patient's sex with the letter **M** for male and the letter **F** for female.
- (7) Write the new TB Case Number at the receiving unit where the patient is currently receiving treatment.
- (8) The person who accomplished the NTP Referral / Transfer Form must write and his/her name and indicate him/her designation on the lower portion of the NTP Referral / Transfer Form.

ANNEX 8a

QUARTERLY REPORT ON NTP LABORATORY ACTIVITIES

Name of Province/City : _____ TB symptomatics/Patients examined during the _____ Quarter of _____

Name of RHU/City HC : _____ Date reported: _____
Prepared by: _____

CASE FINDING:

1. No. of TB Symptomatics examined:	
2. No. of TB Symptomatics with 3 sputum specimens:	
3. No. of TB Symptomatics diagnosed as <u>smear-positive</u> with 2 or more positive results: (including the number of doubtful cases in the 1 st collection with at least one positive result in the 2 nd collection set)	
4. No. of TB Symptomatics with <u>Doubtful</u> result:	

TREATMENT FOLLOW-UP

5. No. of Follow-up examinations done:	
--	--

Annex 8b

(See flow chart filename)

Annex 9b

Annex 10a

Annex10b

(See flowchart filename)

TUBERCULOSIS CONTROL PROGRAM POLICIES FOR PARTICIPATING GOVERNMENT AGENCIES

Introduction:

Tuberculosis is a nationwide public health problem. It ranked 6th in Mortality (36.1/100,000 population 1997, NEC Report) as well as in Morbidity (169.1/100,000 population 2000, NEC Report) in the country. It affects mostly the productive age group of 20 – 59 years old (about 70%). About 75 people die of tuberculosis everyday.

Internationally, the Philippines ranked 3rd in the Western Pacific Region in terms of Case Notification Rate at 128.5/100,000 population (WHO Report, 2000). It is one of the 22 high-burdened countries in the world.

With these problems on hand, it is imperative that the problem of tuberculosis control is a national concern. That the Department of Health is not the sole owner of control measures. It is indeed a shared responsibility. Government agencies play an important role in the control of this disease.

One of the identified problems in the TB Control is the diversified method of control measures of tuberculosis among the government sector with varied regimentation in the treatment of tuberculosis has been used.

While it is true that some government agencies have their program on tuberculosis, it was noted that it did not jibe with the internationally accepted strategies which the Department of Health is following. It is the DOTS Strategy which has been adopted worldwide by most countries and was found to be an effective way to control tuberculosis even in the poorest countries. Hence, these policies and guidelines is designed to standardized the approach of TB control among the government stakeholders that would ultimately benefit the TB patients.

Objectives:

General Objective:

To ensure that Government Agencies support the National Tuberculosis Control Program and adopt the DOTS Strategy.

Specific Objectives: that by August, 2003 onwards

1. Each government agency involved shall implement the identified policies and guidelines in their specific agencies
2. Better collaboration among government agencies is enhanced
3. Better reporting of TB cases achieved

Policies and Guidelines:

A. On Casefinding:

Casefinding is an essential component in the control of tuberculosis. Its objective is to identify the sources of infection in the community, that is to find the persons discharging the tubercle bacilli and put them to treatment to render non-infectious initially and ultimately cure them.

Definition of Terms:

1. TB Symptomatics – a person having ***cough for two (2) weeks or more*** alone or in combination with any one or more of the following sign and symptoms:
 - a. fever
 - b. chest and backpains not referable to any musculo-skeletal disorders
 - c. weight loss and loss of appetite
 - d. hemoptysis or blood streak sputum
 - e. other symptoms

2. Diagnostic Classification of Smear Examination
 - a. Smear Positive – when all the three sputum smears or at least two (2) of the three sputum smears are positive for acid fast bacilli
 - b. Doubtful – when only one of the three sputum smears is positive for acid fast bacilli

Note: If doubtful result, another three (3) sputum smears should be collected just as if starting diagnosis again

- c. Smear Negative – when all three sputum smears are negative for acid fast bacilli

3. TB Disease and Infection

Policies and Guidelines:

1. Direct Sputum Microscopy shall be the primary diagnostic tool in NTP casefinding
 - 1.1 During Consultation of TB Symptomatic Employees in the Clinic [DAR, DA, DND (AFP & VMMC), DILG (PNP), DepEd, DOJ]
 - 1.1.1 All patients and employees having symptoms consulting the clinic shall undergo sputum examination regardless of whether there is chest x-ray results
 - 1.1.2 Three sputum collections shall be done to each patient within two days upon consultation
 - A first **spot** sputum collection is done upon consultation in the clinic
 - A second collection is done by the patient himself/herself at home the following day upon waking-up in the morning. This is called **early morning** collection. This specimen is brought to the clinic.
 - Upon bringing this specimen to the clinic, the second spot collection is done. This completes the three (3) sputum specimen collections within two days upon consultation to the clinic.
 - 1.1.3 For agencies without microscopy facility (DOST, NEDA, AFP-DND) in their central and peripheral clinic, the TB symptomatic employees shall be referred to the nearest Rural Health Unit/Health Center/HMO with properly accomplished referral form (see annex 1).
 - 1.2 During Annual Check-up [DSWD, DND, DepEd, DAR, DA, NEDA, DOST, DILG (PNP, BJMP, BF)]
 - 1.2.1 All employees found to have Chest x-ray findings compatible with TB during their annual check-up shall be referred to the agency clinic for sputum microscopy.
 - 1.2.2 For agencies without sputum microscopy laboratory (DOST, NEDA), referral to the nearest health center/rural health unit for sputum microscopy shall be done.
 - 1.2.3 Three sputum specimen shall be collected to each patient for diagnosis (see 1.1.2 instruction on sputum collection)

- 1.3 For agencies (PIA) that has no clinic facility and no annual check-up done to their employees, proper referral shall be done to the nearest health center/rural health unit for diagnosis.
2. Sputum microscopy shall be performed only by trained medical technologist/microscopist.
 - 2.1 Medical Technologist/Microscopist shall undergo training on sputum microscopy. This shall be coordinated with the TB Unit-Infectious Disease Office, Department of Health
 - 2.2 Schedule and conduct of training shall be undertaken by the National TB Reference Laboratory, Research Institute of Tropical Medicine, Department of Health at Alabang, Muntinlupa, Metro Manila.
3. Dependents of employees (DND) who are symptomatics shall be referred to the nearest health center/rural health unit for diagnostic examination
4. Clientele (of DAR, DA, DSWD, NCIP) who are symptomatics shall be referred to the nearest health center/rural health unit/BHS.

B. On Case holding:

Case holding does not only refer to treatment per se, but also means, making sure that the TB patients religiously take all their anti-TB drugs everyday without fail until they complete their treatment. This would ensure cure of TB patients, prevents deaths due to TB and most importantly prevent multi-drug resistance.

Definition of Terms:

1. Classification of TB Patients – TB cases shall be classified based on the location of the lesions as well as the result of the sputum smear examination
 - a. Pulmonary TB (PTB):
 - Smear Positive:
 1. a patient with at least two (2) sputum smear specimens positive for AFB of the three sputum smears, or
 2. a patient with one sputum smear positive for AFB and with radiographic findings compatible with active TB as determined by a clinician, or
 3. a patient with one sputum specimen positive for AAFB with sputum culture positive for M. tuberculosis.

- Smear Negative:

A patient with at least three sputum specimen negative for AFB with radiographic abnormalities compatible with active TB and there has been no response to a course of antibiotic treatment and/or symptomatic medications and a decision of the medical officer to treat the patient with anti-TB drugs.

b. Extra-pulmonary TB:

- A patient with at least one positive mycobacterial smear/culture from and extra-pulmonary site (organs other than the lungs: pleura, lymph nodes, genito-urinary tract, skin, joints and bones, meninges, intestines, peritoneum and pericardium, among others), or
- A patient with histological and/or clinical evidence consistent with active TB and there is a decision of the Medical Officer to treat the patient with anti-TB drugs.

2. Types of Patients – TB cases shall be categorized based on the history of treatment. This is important since this is necessary to determine the correct treatment regimen to be given to the patient. TB Cases shall be categorized based on the history of treatment:

- a. New – a patient who has never had treatment for TB or who had a history of taking anti-TB drugs previously for less than a month.
* Patients continuing treatment after one month
- b. Relapse – a patient previously treated for tuberculosis who has been declared cured or treatment completed, and is diagnosed with bacteriologically positive (smear or culture) tuberculosis
- c. Failure – a patient who, while on treatment, remains or become smear positive again at five (5) months or later
- d. Return After Default (RAD) – a patient who returns to treatment with positive bacteriology (smear or culture), following interruption of treatment for two (2) months or more
- e. Transfer-In – a patient who has been transferred from another facility with proper referral slip to continue treatment
- f. Other – all cases who do not fit into any of the above definitions.

This includes among others:

- A patient who is starting treatment again after interrupting treatment for more than two months and has remained or became smear negative
 - A sputum smear negative patient initially before starting treatment and became sputum smear positive during treatment
 - Chronic Case: a patient who is sputum positive at the end of re-treatment regimen
3. DOTS Strategy – a comprehensive strategy to ensure cure of TB patients. It has five elements namely:
- Political Commitment – funding and support from the local executives and other government agencies and private sectors to execute
 - Microscope – to confirm whether or not TB bacilli are present in the sputum
 - Drugs for TB – complete drug requirement for each patient should be available at all times in the health facility
 - DOT (Directly Observed Treatment or Supervised Treatment) – a health worker called a “Treatment Partner” is assigned to each patient to make sure that the patient is swallowing all his/her drugs everyday until completion of treatment. DOT is just one of the components of the strategy.
 - Reporting Books – part of the system that documents the progress of each patient until totally cured.

Policies and Guidelines: (DAR, DA, DND, DILG-PNP, DSWD, DOJ, DepEd)

1. Treatment of TB cases shall consist of at least three (3) anti-TB drugs during the intensive phase and two (2) drugs in the maintenance phase.
2. Each agency shall ensure that all patients diagnosed to have tuberculosis are assured of complete course of anti-TB drugs.

3. Complete drug regimen shall be provided for each patient once started on treatment. In the event that there is shortage of drugs in the clinic, no newly diagnosed patient shall be started on treatment. No borrowing of drugs from the ongoing patients is allowed since the arrival of the next batch of drugs is not clear/guaranteed.
4. DOT (Directly observed treatment or supervised treatment) shall be adopted in the treatment of TB patients. It shall be done at the agency clinic, supervised by the clinic nurse/attendant. On Saturdays, Sundays and Holidays, Anti-TB drugs shall be taken at home by the patient himself/herself supervise by a family member.
5. Daily intake of drugs shall be supervised by the clinic nurse/attendant and recorded in the treatment card and identification card of the patient as proof of treatment.
6. Health Education shall be done during initiation of treatment and on continuous basis during the daily supervision of treatment. Messages shall include the importance of daily intake of drugs and completing treatment. It should also include the schedule of sputum follow-up examination as well its importance.

- include side-effects (drug reaction)
7. Sputum follow-up examination shall be done to all TB cases as scheduled to monitor treatment response (see annex 2 for schedule of sputum follow-up by category of treatment).
8. Patients who fail to come to the clinic for daily administration of treatment shall be followed-up/reminded for him/her to report back to the clinic within 2 days during the intensive phase and within a week during the maintenance phase.
9. Treatment outcome shall be determined and analyzed for each patient.

C. On Recording and Reporting: (DAR, DA, DILG, DepEd, DND, DOJ)

1. Records and reports shall be adopted from the National TB Control Program
2. Treatment Card (annex 3) shall be used for each TB patient for individual assessment of treatment response of patient and as proof of treatment of TB patients.

3. Identification Card (ID) (annex 4) shall be provided each TB patients on treatment
4. A register of TB symptomatic called the NTP Laboratory Register (annex 5) and NTP TB Case Register (annex 6) for patient put to treatment shall be maintained for program assessment and individual's treatment outcome.
5. The standard referral form shall be used in referring TB symptomatics for diagnosis and of TB patients for continuation of treatment in another facility whenever applicable.
6. Quarterly report on New Cases and Relapses (Casefinding Report – annex 6) and Treatment Result (Cohort Analysis Report – annex 7) shall be sent to respective Regional Health Office.

Training:

Training of health personnel of the different agencies implementing the program is an important support component of the program. Their knowledge and skills is necessary to implement the program correctly and effectively. Health workers should know the different types of TB patients in order to know the correct treatment regimen to be given to different types of patients. Monitoring of treatment response will help assess the effectiveness of the drugs as well as the efficiency of the program. Without this information known to the health staff, implementation of the program will be haphazardly done that would lead to non-cure of TB patients and possible development of drug resistance.

Policies and Guidelines

1. Conduct orientation to the regional/provincial offices by the corresponding Agency in coordination with the Regional Health as necessary (DAR, DA, DSWD,DILG-PNP,LGU, DND, DOJ, DepEd)
2. Conduct orientation of school principal and administrators and all school health personnel on DOTS Strategy (DepEd)
3. Conduct communication skills training for health personnel on TB messages (DepEd)
4. Conduct sputum microscopy for Medical Technologists (DA, DAR, DILG,DOJ DND)and nurses(DepEd) in coordination with Regional and Central Office (DOH).

Monitoring and Evaluation:

Monitoring is a process of collecting and analyzing information about the program implementation. It also involves dissemination and feedbacking of findings and recommendations to improve the program implementation. *Evaluation* is the assessment of the program focusing on its effectiveness and impact.

Policies and Guidelines: (DAR, DA, DILG, DepEd, DND, DOJ)

The Technical Working Group Member of each agency shall:

1. Be responsible for the monitoring and evaluation of the program in their respective agency
2. Conduct physical inventory of drugs and other logistics necessary for the program implementation and issue requisition for the needed logistics quarterly if applicable.
3. Regularly accomplish and analyze the quarterly reports (on casefinding and cohort analysis) and send to Regional Health Office on the second month of succeeding quarter.
4. Conduct annual evaluation of the program implementation in collaboration with the Regional Health Office (NTP Coordinators).
5. Shall participate in the monitoring of TB projects implementation (NEDA)

Health Education and Advocacy

1. Development of modules for elementary and secondary students on the prevention and control of tuberculosis (DepEd)
2. Support information campaign of the programs (*all agencies*)
3. Develop campaign materials (PIA, DepEd, DILG-LGU) and other agencies.
4. Health education and information dissemination about tuberculosis disease, its prevention and control to their respective clientele (*all agencies*)

GUIDELINES FOR IMPLEMENTATION BY PRIVATE PHYSICIANS AND HEALTH FACILITES

Introduction

Private physicians in the Philippines have not always been in agreement with the Department of Health regarding the management of tuberculosis. However, since the formation of the Philippine Coalition Against Tuberculosis in 1994 and the development of the Philippine Clinical Practice Guidelines on the Diagnosis, Treatment and Control of Pulmonary Tuberculosis (National Consensus on TB) in 2000, representatives of the public and private sectors have worked closely to unify the approach to managing TB in the country.

The 1997 National TB Prevalence Survey highlighted the importance of private physicians in TB control in the Philippines when it showed that 46% of 592 individuals with TB-like symptoms who sought health care consulted private physicians. This was greater than the 30% that consulted at public health centers.

Despite the large proportion of TB patients consulting private physicians, the appropriate infrastructure for TB control has yet to be established in the private sector. This refers to a system using standardized diagnostic criteria and supervised treatment regimens, recording and reporting and access to an uninterrupted supply of anti-TB drugs, all of which are included in the World Health Organization-recommended strategy of Directly Observed Treatment, Short-course (DOTS).

These guidelines hope to link private physicians more closely to the National TB Program by aligning the diagnostic criteria and treatment regimens used and by promoting DOTS. In so doing, these guidelines will lay the foundation for the TB control infrastructure in the Private sector. These guidelines cover the management of TB in older children, adolescents and adults. A multi-sectoral Task Force for TB in Children” was organized by the Department of Health which included representatives from the private sector. The Task Force developed recommendations for the Management of TB in Children, which now requires validation in pilot projects. Once validated, these recommendations may potentially be integrated into the comprehensive policy for TB control.

Definitions

1. **Tuberculosis or TB** is an infectious disease caused by the microorganism called *Mycobacterium tuberculosis*. The microorganism enters the body by inhalation through the lungs. They spread from the initial location in the lungs to other parts of the body via the blood stream, the lymphatic system, via the airways or by direct extension to other organs.
2. **Pulmonary tuberculosis** refers to disease involving the lung parenchyma. It is the most frequent form of the disease, occurring in over 80% of cases. This form of tuberculosis may be infectious.

2.1. **Symptomatic pulmonary TB case** refers to an individual with symptoms of pulmonary TB and is found to have one of the following:

- a. at least two sputum specimens positive for acid-fast bacilli (AFB), with or without radiographic abnormalities consistent with PTB, **OR**
- b. one sputum specimen positive for AFB and with radiographic abnormalities consistent with PTB, **OR**
- c. one sputum specimen positive for AFB with sputum culture positive for *M. tuberculosis*, **OR**
- d. all three sputum specimens negative for AFB but with radiographic abnormalities consistent with PTB, with no history of anti-TB treatment and with a previous normal chest x-ray.

Symptoms of pulmonary TB **include cough for two or more weeks duration and one or more of the following signs and symptoms:**

- a. fever
- b. sputum expectoration
- c. significant weight loss
- d. hemoptysis or recurrent blood-streaked sputum
- e. chest and/or back pains not referable to any musculo-skeletal disorders
other symptoms such as chills, fatigue, body malaise, shortness of breath

2.1. **Asymptomatic pulmonary TB case** refers to an individual without symptoms of pulmonary TB and is found to have one of the following:

- a. radiographic abnormalities consistent with PTB and at least one sputum specimen positive for AFB, **OR**

- b. previous chest x-ray normal, current chest x-ray shows abnormalities consistent with PTB, and 3 sputum acid-fast smears are negative **OR**
- c. previous chest x-ray showed abnormality consistent with PTB, current chest x-ray shows progression of radiographic abnormality, and 3 sputum acid-fast smears are negative **OR**

N.B. If current CXR shows abnormality consistent with PTB and 3 sputum specimens are negative for AFB, but no previous CXR is available and the patient does not fulfill the criteria for PTB, follow-up CXR and sputum examination should be done at least a month after..

- 3. **Extra-pulmonary tuberculosis** is tuberculosis affecting organs other than lungs, most frequently pleura, lymph nodes, spine, joints, genitourinary tract, nervous system or abdomen. Tuberculosis may affect any part of the body.
- 4. **Latent TB Infection** – Individuals who have inhaled the TB bacteria some time in the past and have been found to have a positive tuberculin skin test and NO clinical, bacteriological or radiographic evidence of active TB are said to have “Latent TB Infection (LTI). Persons with LTI are not infectious to others and the identification of LTI is therefore, NOT a part of the NTP. The NTP prioritizes the identification of infectious pulmonary TB cases. If a private physician wishes to determine if a person has LTI, the cost of the Purified Protein Derivative (PPD) used for tuberculin skin testing must be shouldered by the patient, physician or other entity outside of the NTP.

Case Finding (Diagnosis)

- A. **Symptomatic Pulmonary TB** – Direct sputum microscopy shall be the primary diagnostic tool in casefinding. All TB symptomatics shall be made to undergo smear examination regardless of whether they have available x-ray results or whether they are suspected of having extra-pulmonary TB. Sputum examination should be done with (3) sputum specimens. Other diagnostic examinations such as x-ray and culture may also be done, if necessary. The sequence of obtaining these may differ as long as the required examinations are performed. No diagnosis of TB shall be made based on the result of x-ray examinations alone. Skin test for TB infection (PPD skin test) should not be used as a basis for the diagnosis of TB in adults.
- B. **Asymptomatic Pulmonary TB** – these are individuals who do not have any of the symptoms of pulmonary TB but who for some reason (e.g. screening for employment, annual employment check-up, medical clearance for a surgical procedure, etc.) obtained a chest x-ray which shows abnormalities consistent

with pulmonary TB and have at least one of three sputum examinations positive for acid-fast bacilli. Also in this group are individuals who have chest x-ray abnormalities consistent with PTB which were not present on a previous chest radiograph or which progressed compared to a previous radiograph, even if all three sputum examinations are negative for acid-fast bacilli.

C. Extrapulmonary TB – as in NTP

IV. Case Holding (Treatment)

Case holding does not only refer to treatment per se, but also means making sure that the TB patient religiously take all their anti-TB drugs everyday without fail until they complete their treatment. The strategy developed to ensure treatment compliance is called Directly Observed Treatment (DOT). DOT works by assigning a responsible person, referred to as the treatment partner, to observe or watch the patient take the correct medications daily during the course of treatment. DOT can be done in any accessible and convenient place (e.g. health facility, treatment partner's house, patient's place of work, patient's house) as long as the treatment partner can effectively ensure the patient's intake of the prescribed drugs and monitor his/her reactions to the drugs.

1. Treatment of TB cases shall consist of at least three anti-TB drugs during the intensive phase and two (2) drugs in the maintenance phase.
 - 1.1. Symptomatic PTB – Treatment to be given shall be the same as in NTP (refer to Table 3 Treatment Regimens p 25 NTP Manual of Procedures)
 - 1.2. Asymptomatic PTB – Category III (refer to Table 3)
 - 1.3. Extrapulmonary TB – as in NTP
2. Complete drug regimen shall be provided for each patient once started on treatment.
3. DOT Directly Observed (Directly observed treatment or supervised treatment) shall be adopted in the treatment of TB patients.
4. Sputum follow-up examination shall be done to all TB cases as scheduled to monitor treatment response. (Refer to Table 5a & 5B NTP Manual of Procedures.).
5. Treatment outcome shall be determined for each patient.

Latent TB Infection (LTI): The diagnosis and treatment of LTI is NOT part of the NTP or this comprehensive policy for TB control. If a private physician

wishes to carry out such diagnosis and treatment it can not be subsidized by the National TB Program or the Philippine Health Insurance Corporation.

V. Recording and Reporting

1. Records and reports shall be adopted from the National TB Control Program.
2. Treatment card shall be used for each TB patient for individual assessment of treatment response of patient and as a proof of treatment of TB patients.
3. The standard NTP referral form shall be used in referring TB symptomatics for diagnosis or for treatment to a public health facility.
4. Patients diagnoses with TB disease shall be reported to the Philippine Coalition Against Tuberculosis or other such body designated to manage the National Data Base.

GUIDELINES FOR IMPLEMENTATION BY GOVERNMENT AGENCIES

Introduction:

The problem of tuberculosis is a national concern; both the private sector and government agencies other than the Department of Health play a vital role in the control of tuberculosis. Tuberculosis case finding and treatment services are delivered largely through the health services provided by the RHU's and health centers nationwide under the Department of Interior and Local Government (DILG). On top, other government agencies e.g. Department of Education (DepED) and Department of National Defense (DND) also provide tuberculosis casefinding and treatment services to their employees and dependents (DND). There is also a potential for TB occurring among employees and clients of other government agencies, thus the need to also develop a tuberculosis program.

One of the problems identified in the implementation of the tuberculosis control program by government agencies is the lack of uniformity in the procedures applied for casefinding and treatment. This lack of uniformity often times has resulted to both inaccurate diagnosis and poor treatment. Standardizing the approach to tuberculosis control will make the program more efficient. There will be accurate diagnosis of TB disease, higher cure rates and ultimately a greater reduction in the TB problem.

A government agency could participate in the implementation of the National Tuberculosis Program by establishing a DOTS Center, which will provide two TB services: (1) case finding by direct sputum microscopy and (2) TB treatment using DOT (Direct Observed Treatment) to employees, dependents and their clientele. For those agencies that may not be able to set up a DOTS Center, employees, dependents and clientele with symptoms of TB may be referred to the nearest local government health facility for sputum microscopy and those found with TB disease may also be treated in the same facility.

Participating Agencies

1. Department of Education (DepED)

The Department of Education (DepED) through its School Health and Nutrition Center (SHNC) provides effective health and nutrition services to their students, teachers and non-teaching personnel. The SHNC takes charge of the over-all management of the Integrated School Health and Nutrition Program

(SHNP), which is a comprehensive education and service package delivered to the schools, eventually to the homes and communities. The main objective of SHNP is to promote, protect and maintain the health and nutritional status of students and school personnel through the provision of various health and nutrition services and education.

Among the communicable disease programs presently implemented by DepED is tuberculosis control. The program components implemented are case finding, treatment, information education and communication (IEC), capability building, and monitoring and evaluation. TB case finding and treatment services are provided to elementary, secondary teachers and non-teaching personnel through the DepED Division and School Clinics nationwide.

2. Department of Interior and Local Government (DILG)

The Department of Interior and Local Government is the government agency which has the authority over 1689 Local Government Units located nationwide in 79 provinces, 114 cities and 1496 municipalities who serve as the main implementers of the National Tuberculosis Program. It also has authority over 108,000 members of the Philippine National Police (PNP), the National Police Commission (NPC), the Bureau of Fire Protection, the Philippine Public Safety College and the Bureau of Jail Management and Penology.

The main function of DILG is to oversee and monitor the implementation of the Local Government Code of 1991, enhance the capabilities of the LGU's for self-governance, and implement plans and programs for local autonomy. As part of its overall function, DILG undertakes relevant measures regarding fire protection and jail management and penology, ensure humane treatment and rehabilitation of inmates. Among the relevant measures that may be undertaken, is tuberculosis control among the members of the Philippine National Police, the inmates in jails nationwide and employees and clientele of other attached agencies

3. Department of National Defense (DND)

The Armed Forces of the Philippines (AFP) is one of the agencies under the Department of National Defense. It has its own medical services that cater to the health needs of soldiers and their dependents. Medical services in the AFP are under the supervision of the Office of the Surgeon General.

The three (3) major services of the AFP namely: Philippine Army (PA), Philippine Navy (PN), and the Philippine Air Force (PAF) has its own Chief Surgeon's Office. These offices are in charge of the medical service in their units.

The medical service delivery in the AFP is through the 30 hospitals (8 PAF, 2 PN, 9 PA and 11 AFP Wide Service Support Units) and 28 medical dispensaries strategically located all over the country that deliver medical services to its soldiers and dependents. Among the medical services that will be delivered to the three major services of the AFP: the Philippine Army (PA), Philippine Navy (PN) and the Philippine Air Force (PAF) are TB case finding and treatment services.

4. Department of Justice (DOJ)

The different agencies and offices of the Department serve as the instrument by which programs and services instituted by the Department are delivered to the people. Among the eleven- (11) agencies under the DOJ is the Bureau of Corrections that is charged with custody and rehabilitation of national offenders, that is those sentenced to serve a term of imprisonment of more than three (3) years. Among its mandate is to provide humane treatment by supplying the inmates' basic needs and implementing a variety of rehabilitation programs designed to change their pattern of criminal and anti-social behavior. Headed by a Director, the Bureau has a strength of 2,362 employees, 61% of whom are custodial officers, 33% are administrative personnel and 6% are members of the medical staff.

The Bureau has seven (7) operating units located nationwide, namely: The New Bilibid Prison in Muntinlupa, the Correctional Institution for Women in Mandaluyong City, Iwanhig Prison and Penal Farm in Puerto Princesa, Sablayan Prison and Penal Farm in Occidental Mindoro, San Ramon Prison and Penal Farm in Zamboanga City, Leyte Regional Prison in Abuyog, Leyte and Davao Prison and Penal Farm in Panabo, Davao Province. A TB control program among inmates in the New Bilibid Prison in Muntinlupa is presently being implemented.

5. Department of Social Welfare and Development (DSWD)

The Department of Social Welfare and Development is the lead government agency in formulating national social welfare and development policies, plans and statistics, especially as these relate to family development and poverty groups. DSWD is an advocate for social welfare and development concerns, to include disadvantaged families, children/youth, women, senior citizens, persons with disabilities and similarly situated individuals.

DSWD provides assistance to local government units, non-government organizations, and other members of civil society in effectively implementing programs, projects and services that will alleviate poverty and empower

disadvantaged individuals, families and communities for an improved quality of life. Among the attached agencies are: the Council for Welfare of Children, Intercountry, Adoption Board and the National Council for the Welfare of Disabled Persons.

6. Department of Agriculture (DA)

The Department of Agriculture is the principal agency of the Philippine government responsible for the promotion of agricultural development and growth. In pursuit of this, it provides the policy framework, helps direct public investments, and in partnership with local government units (LGU's) provides the support services necessary to make agriculture and agri-based enterprises profitable and to help spread the benefits of development to the poor, particularly those in rural areas. There are 21 agencies affiliated with the DA and these include the National Food Authority, the National Nutrition Council, the National Tobacco Administration, and the Philippine Coconut Authority.

7. Department of Agrarian Reform (DAR)

The Department of Agrarian Reform is the principal agency responsible for implementing the Comprehensive Agrarian Reform Program (CARP). Its mission is to improve land tenure through better access to and more equitable distribution of land and the fruits thereof. It shall also enhance the welfare and promote the development of Program beneficiaries through coordinated delivery of essential support services. DAR has a grand total workforce of 13,574, 974 from the central office and 12,590 from Regions I to XII including CAR and CARAGA. DAR also has a total of 1,452 Agrarian Reform Communities (ARCs) and a grand total of 749,275 Agrarian Reform beneficiaries.

8. Department of Science and Technology (DOST)

The Department of Science and Technology is the premier science and technology body in the country charged with the twin mandate of providing central direction, leadership and coordination of all scientific and technological activities. In pursuit of its vision of a competent and competitive science and technology community with a social conscience, DOST works with the S & T community.

DOST has five (5) Sectoral Planning Councils, seven (7) Research and Development Institutes, seven (7) Service Institutes, two (2) Collegial bodies, 14 Regional Offices and 73 Provincial S & T Centers.

9. National Economic Development Authority (NEDA)

The National Economic Development Authority (NEDA) is the country's independent social and economic development planning and policy coordinating body. NEDA task is to formulate development plans and ensure that plan implementation achieves the goals of national development. Six government agencies are attached to the NEDA for purposes of administrative supervision. These are: Tariff Commission (TC), Philippine National Volunteer Service Coordinating Agency (PNVSCA), the Population Commission (POPCOM), National Statistical Coordination Board (NSCB), National Statistics Office (NSO), and Statistical Research and Training Center (SRTC). Moreover, the Philippine Institute for Development Studies (PIDS) is attached to the NEDA for policy and program coordination

10. National Commission on Indigenous Peoples (NCIP)

The National Commission on Indigenous Peoples (NCIP) is an agency created under R.A. 8371, otherwise known as the Indigenous Peoples Rights Act. Its mandate is to protect and promote the interest and well being of the indigenous peoples with due respect to their beliefs, customs, traditions and institutions. As such, it shall serve as the primary government agency responsible for the formulation and implementation of pertinent and appropriate policies, plans and programs to carry out the policies set forth in the new law.

It caters to more than 12 million indigenous peoples of 110 ethnic tribes spread out all over the country. It has 12 Regional Offices, 46 Provincial Offices, and 108 community service centers.

NCIP intends to support the NTP through TB health education and information dissemination and referral of TB patients to the nearest health center/rural health unit/barangay station for casefinding and treatment.

Policies and Guidelines:

A. On Casefinding:

Casefinding is an essential component in the control of tuberculosis. Its objective is to identify the sources of infection in the community, that is to find the persons discharging the tubercle bacilli and put them to treatment to render non-infectious initially and ultimately cure them.

Identification of patients with TB disease among the target population or employees may be done during consultation at the agency clinic or during the annual check-up of the agency employees. All those found with TB symptoms or those with shadows suggestive of TB during routine check up shall be made to undergo sputum microscopy at the agency clinic by a trained medical technologist/microscopist. If the agency does not have the facility for sputum examination, a referral may be made to the nearest health facility (Rural Health Unit (RHU)/Health Center (HC)/ Health Maintenance Organization (HMO).

Government agencies without a clinic may refer their employees or clientele with TB symptoms to the nearest health facility.

Definition of Terms:

1. TB Symptomatics – a person having *cough for two (2) weeks or more* alone or in combination with any one or more of the following signs and symptoms:
 - a. fever
 - b. chest and backpains not referable to any musculo-skeletal disorders
 - c. weight loss and loss of appetite
 - d. hemoptysis or blood streak sputum
 - e. other symptoms
2. Diagnostic Classification of Smear Examination
 - 2.1. Smear Positive – when all the three sputum smears or at least two (2) of the three sputum smears are positive for acid fast bacilli
 - 2.2. Doubtful – when only one of the three sputum smears is positive for acid fast bacilli

Note: If doubtful result, another three (3) sputum smears should be collected just as if starting diagnosis again
 - 2.3. Smear Negative – when all three sputum smears are negative for acid fast bacilli

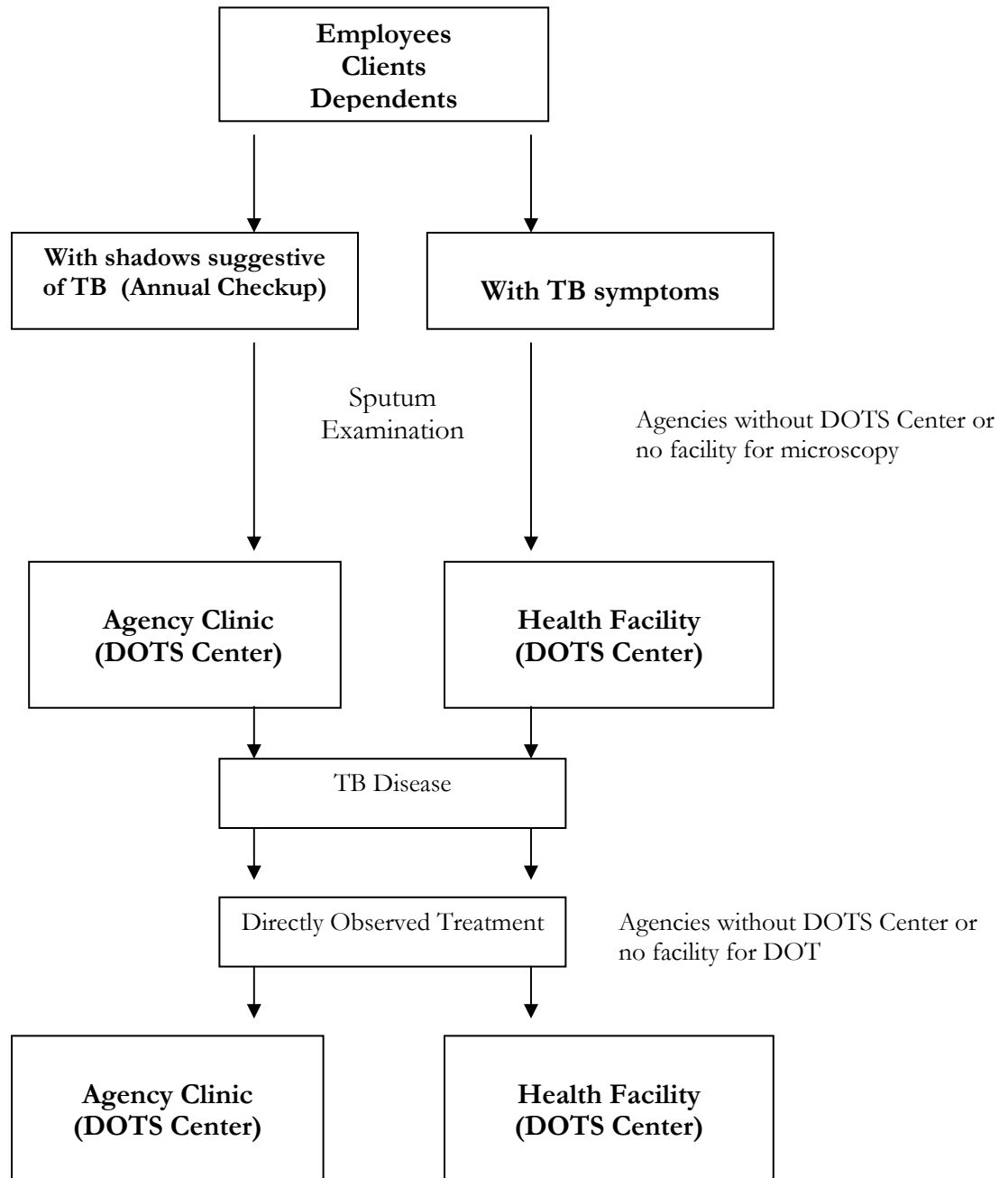
Policies and Guidelines:

1. Direct Sputum Microscopy shall be the primary diagnostic tool in NTP casefinding.

- 1.1. Employees consulting the agency clinic e.g. DOJ, DepED, DILG (PNP, BJMP, BF), DA, DAR, DND (AFP & VMMC) with signs and symptoms of TB shall be made to undergo sputum examination regardless of whether they have available chest x-ray results.
The employee shall be referred for sputum examination to the nearest health facility (Rural Health Unit (RHU)/Health Center (HC)/ Health Maintenance Organization (HMO), if the agency does not have a facility e.g. DOST, NEDA, NCIP. Referral shall be made using the appropriate NTP form (Annex 2 NTP Laboratory Request Form for Sputum Examination, p. 60-62)
- 1.2. Employees found to have chest x-ray findings compatible with TB during their annual check-up shall also be referred to the agency clinic e.g. DOJ, DepED, DILG (PNP, BJMP, BF), DA, DAR, DND (AFP & VMMC) or the nearest health facility for sputum microscopy in the case of agencies with no facility of their own e.g. DOST, NEDA, NCIP.
- 1.3. Employees of government agencies with no annual check-up and do not also have a clinic e.g. PIA, who will develop TB symptoms shall be referred to the nearest health facility for diagnosis. Referral shall be made using the appropriate NTP form (Annex 2 NTP Laboratory Request Form for Sputum Examination, p. 60-62)
- 1.4. TB symptomatic clientele of government agencies without a facility for sputum microscopy e.g. DAR, DA, DSWD, NCIP shall be referred to the nearest health facility for diagnosis. Referral shall be made using the appropriate NTP form (Annex 2 NTP Laboratory Request Form for Sputum Examination, p. 60-62)
- 1.5. Dependents of employees e.g. DND with symptoms of TB shall be referred to the nearest health facility for diagnosis. Referral shall be made using the appropriate NTP form (Annex 2 NTP Laboratory Request Form for Sputum Examination, p. 60-62)
2. Only an adequately trained medical technologist or NTP microscopist shall perform sputum examination (smearing, fixing and staining of sputum specimens, reading the smear). The procedure for identification of TB symptomatics, collection and transport of sputum specimen, and smearing shall follow the NTP procedures (Manual of Procedures p14-16)
 - 2.1. Training of medical technologist/microscopist shall be coordinated with the TB Unit-Infectious Disease Office, Department of Health

- 2.2. Training of the agency medical technologist/microscopist shall be undertaken by the National TB Reference Laboratory, Research Institute of Tropical Medicine, Department of Health at Alabang Muntinlupa, Metro Manila.

**NTP IMPLEMENTATION
Government Agencies**



B. On Case holding:

Caseholding does not only refer to treatment per se, but also means, making sure that the TB patient religiously take all his/her anti-TB drugs everyday without fail until he/she complete treatment. This would ensure cure of TB patients, prevent deaths due to TB and most importantly prevent multi-drug resistance.

The strategy to ensure treatment compliance is called Directly Observed Treatment. Direct observation of treatment means that a supervisor watches the patient swallowing the tablets. Observation of treatment may be done at the agency clinic or the nearest health facility for those agencies without a clinic. The supervisor or the treatment partner may either be a health worker or a trained volunteer worker.

Definition of Terms:

The definition of a TB case is based on the location of the lesion as well as the result of the sputum smear examination. TB cases are categorized based on the history of anti-TB treatment. A complete understanding of the various types of TB cases is necessary in determining the correct treatment regimen.

1. Pulmonary Smear Positive TB (PTB)

- 1.1. A patient with at least two (2) sputum smear specimens positive for AFB of the three sputum smears, with or without radiographic abnormalities consistent with TB **or**
- 1.2 A patient with one sputum specimen positive for AFB and with radiographic findings consistent with active TB as determined by a clinician, **or**
- 1.3 A patient with one sputum specimen positive for AFB with sputum culture positive for M. tuberculosis.

2. Pulmonary Smear Negative TB: A patient with at least three sputum specimen negative for AFB with radiographic abnormalities compatible with active TB **and** there has been no response to a course of antibiotic treatment and/or symptomatic medications and a decision of the medical officer to treat the patient with anti-TB drugs.

3. Extra-pulmonary TB

- 3.1. A patient with at least one positive mycobacterial smear/culture from and extra-pulmonary site (organs other than the lungs: pleura, lymph nodes, genito-urinary tract, skin, joints and bones, meninges, intestines, peritoneum and pericardium, among others), **or**
- 3.2. A patient with histological and/or clinical evidence consistent with active TB and there is a decision of the Medical Officer to treat the patient with anti-TB drugs.
4. **New** – A patient who has never had treatment for TB or who had a history of taking anti-TB drugs previously for less than a month.
 - * Patients continuing treatment after one month
5. **Relapse** – A patient previously treated for tuberculosis who has been declared cured or treatment completed, and is diagnosed with bacteriologically positive (smear or culture) tuberculosis
6. **Failure** – A patient who, while on treatment, remains or become smear positive again at five (5) months or later during the course of treatment.
7. **Return After Default (RAD)** – A patient who returns to treatment with positive bacteriology (smear or culture), following interruption of treatment for two (2) months or more
8. **Transfer-In** – a patient who has been transferred from another facility with proper referral slip to continue treatment
9. **Other** – all cases who do not fit into any of the above definitions.

This includes among others:

- A patient who is starting treatment again after interrupting treatment for more than two months and has remained or became smear negative.
 - A sputum smear negative patient initially before starting treatment and became sputum smear positive during treatment.
 - Chronic Case: A patient who is sputum positive at the end of re-treatment regimen.
10. **DOTS Strategy** – A comprehensive strategy to ensure cure of TB patients. It has five elements namely:

- **Political Commitment** – funding and support from the local executives and other government agencies and private sectors to execute
- **Microscope** – to confirm whether or not TB bacilli are present in the sputum
- **Drugs for TB** – complete drug requirement for each patient should be available at all times in the health facility
- **DOT** (Directly Observed Treatment or Supervised Treatment) – a health worker called a “Treatment Partner” is assigned to each patient to make sure that the patient is swallowing all his/her drugs everyday until completion of treatment. DOT is just one of the component of the strategy.
- **Reporting Books** – part of the system that documents the progress of each patient until totally cured.

Policies and Guidelines:

1. Treatment of TB cases shall consist of at least three (3) anti-TB drugs during the intensive phase and two (2) drugs in the maintenance phase. Treatment Regimen shall follow the recommendation of the NTP (Refer to Table 3 p. 25 and Table 4 p. 26).
2. DOT (Directly observed treatment or supervised treatment) shall be adopted in the treatment of TB patients. It shall be done at the agency clinic, supervised by the clinic nurse/attendant. On Saturdays, Sundays and Holidays, anti-TB drugs shall be taken at home by the patient himself/herself supervise by a family member. For agencies without treatment facility e.g. DOST, NEDA, PIA patients shall be referred for DOT to the nearest health facility.
 - 2.1. Each participating government agency who will be treating their own patients e.g. DepEd, DILG-PNP, DA, DAR, DSWD, DND, DOJ shall ensure that all patients started on treatment are assured of a complete course of anti-TB drugs.
 - 2.2. No newly diagnosed patient shall be admitted for treatment if there is shortage of drugs in the clinic. Borrowing of drugs from the ongoing patients shall not allowed since the arrival of the next batch of drugs is not clear/guaranteed.

2.3. Daily intake of drugs shall be recorded in the treatment card and identification card of the patient as proof of treatment.

3. Health Education shall be done during initiation of treatment and on continuous basis during the daily supervision of treatment. Messages shall include the importance of daily intake of drugs and completing treatment. It should also include the schedule of sputum follow-up examination as well its importance. Side effects (drug reaction) shall also be included.
4. Sputum follow-up examination shall be done to all TB cases as scheduled to monitor treatment response. (Refer to Table 5a. and 5b p. 29 and 30 for schedule of sputum follow-up by category of treatment).
5. Patients who fails to come to the clinic for daily administration of treatment shall be followed-up/reminded for him/her to report back to the clinic within 2 days during the intensive phase and within a week during the maintenance phase.
6. Treatment outcome shall be determined and analyzed for each patient. (Refer to page 40 for the various treatment outcome and definition)

C. On Recording and Reporting

1. Participating government agencies e.g. DepEd, DILG, DA, DAR, DND, DOJ shall adopt the NTP records and reports in the implementation of the TB program. (Refer to Annex 1 to Annex 10b NTP Core Policies and Procedures pages 59-78)
2. Treatment Card shall be used for each TB patient for individual assessment of treatment response of patient and as proof of treatment of TB patients. (Refer to Annex 4 pages 64-66 NTP Core Policies and Procedures)
3. Identification Card (ID) shall be provided each TB patients on treatment. (Refer to Annex 5 page 67 NTP Core Policies and Procedures)
4. A register of TB symptomatic called the NTP Laboratory Register (Refer to Annex 3 page 63 NTP Core Policies and Procedures) and NTP TB Case Register (Annex 6 pages 68-69 page 67 NTP Core Policies and Procedures) for patient put to treatment shall be maintained for program assessment and individual's treatment outcome.
5. The standard referral form shall be used in referring TB symptomatics for diagnosis and of TB patients for continuation of treatment in another facility

whenever applicable. (Refer to Annex 7 pages 70-72 NTP Core Policies and Procedures).

6. Quarterly report on New Cases and Relapses (Refer to Casefinding Report Annex 9a page 75 page 67 NTP Core Policies and Procedures) and Treatment Result (Cohort Analysis Report Annex 10a page 77 page 67 NTP Core Policies and Procedures) shall be sent to respective Regional Health Office.

D. On Training

Training of health personnel of all agencies participating in the implementation of the NTP is an important support component of the program. A good knowledge of the tuberculosis control program policies, guidelines and procedures is necessary to implement an effective TB program. Health workers should have the knowledge and skills to identify TB symptomatics, carry out sputum microscopy; give the appropriate treatment regimen; monitor treatment response; and maintain the necessary NTP records and reports. Without these knowledge and skills, there will be a poor program implementation, which may ultimately lead to non-cure of TB patients and possible development of drug resistance.

Policies and Guidelines

1. Participating government agencies (DepEd, DILG-PNP, LGU, DA, DAR, DSWD, DND, DOJ,) shall conduct NTP orientation at the regional/provincial offices in coordination with the DOH Regional Health Office whenever necessary.
2. Participating government agencies (DepEd, DILG-PNP, LGU, DA, DAR, DSWD, DND, DOJ) shall conduct sputum microscopy training for medical technologists and nurses (DepEd) in coordination with the Regional and Central Office of the DOH.
3. DepEd shall conduct orientation of school principal and administrators and all school health personnel on DOTS Strategy.
4. DepEd shall conduct communication skills training for health personnel on TB messages.

E. On Monitoring and Evaluation

Monitoring is a process of collecting and analyzing information about the program implementation. It also involves dissemination and feedbacking of findings and recommendations to improve the program implementation. Evaluation is the assessment of the program focusing on its effectiveness and impact. (Refer to NTP Core Policies and Procedures for Guide on Monitoring, Supervision and Evaluation pages 52-54)

Policies and Guidelines (DepEd, DILG, DA, DAR, DND, DOJ)

The Technical Working Group Member of each agency shall:

1. Monitor and evaluate the NTP program in their respective agency
2. Conduct physical inventory of drugs and other logistics necessary for the program implementation and issue requisition for the needed logistics quarterly if applicable.
3. Regularly accomplish and analyze the quarterly reports (on casefinding and cohort analysis) and send to Regional Health Office on the second month of succeeding quarter.
4. Conduct annual evaluation of the program implementation in collaboration with the Regional Health Office (NTP Coordinators).
5. Participate in the monitoring of TB projects implementation (NEDA)

Health Education and Advocacy

1. Development of modules for elementary and secondary students on the prevention and control of tuberculosis (DepEd)
2. Support information campaign of the programs (*all agencies*)
3. Develop campaign materials (PIA, DepEd, DILG-LGU) and other agencies.
4. Health education and information dissemination about tuberculosis disease, its prevention and control to their respective clientele shall be the responsibility of all participating agencies

GSIS SSS AND ECC TB BENEFITS POLICY

INTRODUCTION

The Government Service Insurance System (GSIS) administers the Social Security Protection Program of GSIS and the Employees Compensation (EC) Program of the Employees' Compensation Commission to workers in the public sector. GSIS provides for the replacement of income lost in times of sickness and disability as well as other benefits due to an illness under RA 8291, the GSIS ACT of 1997.

The Social Security System (SSS) administers two programs: the Social Security Protection and the Employees Compensation (EC) Program of the Employees' Compensation Commission to workers in the private sector. Basically, the SSS provides for the replacement of income lost in times of sickness, disability, maternity, old age and death under RA 8282, the Social Security Act of 1997.

The Employees' Compensation Commission (ECC) through the Employee's Compensation (EC) Program provides compensation package for public and private sector employees and their dependents in the event of work-related contingencies. It was created under Presidential Decree No. 626, which was made effective on January 1975. The primary aim of the EC program is to help workers and their dependents, in the event of work-related injury, sickness, disability or death, to promptly receive meaningful and adequate income benefits, medical or related services, and rehabilitation services. Among the compensable diseases under the EC program is tuberculosis.

The diagnostic criteria for TB disease previously used by GSIS, SSS and ECC in the evaluation of benefits for TB disease were loose and allowed both overdiagnosis and underdiagnosis. The more stringent diagnostic criteria in the current policy will improve the diagnosis of TB and allow for more appropriate compensation by the GSIS, SSS and ECC.

POLICY

1. GSIS/SSS shall provide Initial Temporary Total TB Disability (TB Sickness) Benefit of 30 days to qualified members diagnosed with TB disease. The member may apply for extension of this benefit to a maximum of three 30-day extensions if he/she meets the acceptable criteria.

2. GSIS/SSS shall provide Permanent TB Disability Benefit to members with tuberculosis whose sputum acid-fast stain remains positive at the end of 120 days and/or with impairment classification (Annex 1: American Thoracic Society) of class 2 or higher. Those with impairment classification of Class 1 and with at least mildly impaired respiratory function by spirometry or peak flow determination shall also be entitled to Permanent Disability Benefit. Qualified members with TB of an extrapulmonary site may apply for Permanent TB Disability Benefit based on the severity of functional impairment of the organ system involved (SSS/GSIS Manual for Disability).
3. GSIS/SSS shall report members who applied for Temporary Total Disability (TB Sickness) Benefit to the Philippine Coalition Against Tuberculosis or other such body designated to manage the National TB Data Base.
4. ECC shall provide Initial Temporary Total TB Disability (TB Sickness) to be given in the form of income benefit and reimbursement of medical expenses to qualified GSIS and SSS members diagnosed with work-connected TB disease. The member may apply for extension of this benefit to a maximum of three 30-day extensions if he/she meets the acceptable criteria.
5. ECC shall provide Permanent TB Disability Benefit to separated GSIS and SSS members with work-connected TB disease who shall remain to be sputum positive at the end of 120 days and/or with impairment classification of class 2 or higher (Annex 1. American Thoracic Society). Those with impairment classification of Class 1 and with at least mildly impaired respiratory function by spirometry or peak flow determination shall also be entitled to Permanent Disability Benefit. Qualified members with TB of extrapulmonary site may apply for Permanent TB Disability Benefit based on the severity of functional impairment of the organ involved (Annex 2).

Definitions

1. **TB disease** refers to both pulmonary and extrapulmonary tuberculosis.
2. **Pulmonary TB** refers to disease involving the lung parenchyma and is either symptomatic or asymptomatic.
3. **Symptoms of Pulmonary TB** include cough for two or more weeks duration and one or more of the following signs and symptoms:
 - a. fever
 - b. sputum expectoration

- c. significant weight loss
 - d. hemoptysis or recurrent blood-streaked sputum
 - e. chest and/or back pains not referable to any musculo-skeletal disorders
other symptoms such as chills, fatigue, body malaise, shortness of breath
4. **Symptomatic pulmonary TB case** refers to an individual with symptoms of pulmonary TB and is found to have one of the following:
- a. at least two sputum specimens positive for acid-fast bacilli (AFB), with or without radiographic abnormalities consistent with PTB, **or**
 - b. one sputum specimen positive for AFB and with radiographic abnormalities consistent with PTB, **or**
 - c. one sputum specimen positive for AFB with sputum culture positive for M. tuberculosis, **or**
 - d. all three sputum specimens negative for AFB but with radiographic abnormalities consistent with PTB, with no history of anti-TB treatment and with a previous normal chest x-ray.
5. **Asymptomatic pulmonary TB case** refers to an individual without symptoms of pulmonary TB and is found to have one of the following:
- a. radiographic abnormalities consistent with PTB and at least one sputum specimen positive for AFB, **or**
 - b. previous chest x-ray normal, current chest x-ray shows abnormalities consistent with PTB, and 3 sputum acid-fast smears are negative, **or**
 - c. previous chest x-ray showed abnormality consistent with PTB, current chest x-ray shows progression of radiographic abnormality, and 3 sputum acid-fast smears are negative, **or**
 - d. current CXR shows abnormality consistent with PTB and 3 sputum specimens are negative for AFB, but no previous CXR is available.
6. **Extra-pulmonary tuberculosis** is TB disease involving tissues other than the lungs (pleural and mediastinal lymph node TB are considered extrapulmonary TB). An individual is considered to have extrapulmonary TB if he/she has the clinical presentation consistent with TB disease of the site involved and the following:

- a. Certification from the attending physician attesting to the diagnosis of extrapulmonary TB

and

- b. at least one mycobacterial smear/culture positive from an extra-pulmonary site (organs other than the lungs), **or**

histological and/or radiographic evidence from the involved site consistent with TB.

7. **Work connected tuberculosis** is tuberculosis disease acquired during the course of employment, the pre-employment evaluation which include history & physical examination, and other test preclude the diagnosis of tuberculosis.

IV. TB BENEFITS

The GSIS under R.A. No. 8291 and SSS under the Security act of 1997 provide replacement of income lost for the number of days an eligible member is unable to work due to TB disease (Temporary Total TB Disability Benefit or TB Sickness Benefit in the case of SSS) At the same time the EC program also pays income benefit to eligible GSIS/SSS member with work-connected TB disease in addition to reimbursements of related medical expenses under the Security Act of 1997.

For Permanent TB Disability, partial or total, GSIS/SSS pays a cash benefit in monthly pension or lump sum to eligible members with permanent total disability due to TB disease. For work-connected TB, EC pays an amount equivalent to the monthly income benefit, plus ten percent thereof for each dependent child, but not exceeding five, beginning with the youngest and without substitution. Additional benefits under the EC program include reimbursement of medical expenses and rehabilitation services for permanent disability due to TB disease.

- A. **Temporary Total TB Disability (TB Sickness) Benefit Package**– is an income benefit paid to an eligible GSIS/SSS member who has exhausted his/her sick leave for the number of days he is unable to work due to tuberculosis. Under the EC Program, an eligible GSIS/SSS member who suffer work-connected TB shall, starting on the very first day, may enjoy both his leave with pay and EC benefit at the same time.

1. Packages

- 1.1. **GSIS/SSS:** The Temporary Total TB Disability (TB Sickness) Benefit is given in the form of a daily benefit computed based on the current compensation rates of the respective System. The minimum and maximum benefits established by the System vary and maybe subject to change.
- 1.2. **ECC:** The Temporary Total Disability (TB Sickness) Income benefit under the EC program is 90% of the employee's daily salary credit as determined by the System. This income benefit shall not be more than P200 per day for private workers and P90 per day for government employee, to be paid beginning on the first day but shall not be paid longer than 120 days. In addition, the member with TB disease is also entitled to reimbursement of his/her medical and related expenses.

2. System Requirements for Eligibility

- 2.1. **A GSIS member** is qualified to avail of this benefit from GSIS if
 - a. he/she is in the service at the time of disability and has exhausted his/her sick leave credits; **or**
 - b. if separated, has at least rendered three (3) years of service and has paid at least six (6) monthly contributions in the twelve-month period immediately preceding his disability.
- 2.2. **An SSS member** is qualified to avail of this benefit from SSS if:
 - a. he/she is unable to work due to TB disease;
 - b. he/she has paid at least three months of contributions within the 12-month period immediately before the semester of sickness;
 - c. he/she has used up all the current company sick leaves with pay for the current year;
 - d. he/she has notified his/her employer or the SSS, if he/she is a separated, voluntary or self-employed member.
- 2.3. **A GSIS/SSS member** is qualified to avail of this benefit simultaneously with benefits under the social security program regardless of whether he/she has or has not exhausted his/her sick leave credits from the ECC if:
 - a. he/she has been duly reported to the System;
 - b. he/she has work-connected tuberculosis;

- c. the system has been duly notified of his/her TB disease. His/her employer shall be liable for the benefit if the illness occurred before the employee is duly reported to the System.

3. Medical Requirements

3.1. Initial Temporary Total TB Disability (TB Sickness) Benefit Package

3.1.1. Pulmonary TB

- a. attending physicians report (initial portion of the TB Benefit Form)
- b. results of 3 separate sputum examinations for AFB or culture
- c. chest x-ray result with findings consistent with pulmonary TB and film as support for TB diagnosis
- d. verification of TB diagnosis by GSIS/SSS physician

3.1.2. Extrapulmonary TB

- a. referral from attending physician with history and physical examination
- b. positive TB culture result of fluid or tissue from involved site or histological evidence from the site involved
- c. certification from the attending physician attesting to the diagnosis of TB of the extrapulmonary site concerned.
- d. verification of TB diagnosis by GSIS/SSS physician

3.2. Extension of Temporary Total TB Disability (TB Sickness) Benefit Package. An extension of 30 days beyond the initial benefit maybe given to a member with TB disease who fulfills the following requirements:

3.2.1. Pulmonary TB

Still sputum (+) or becomes sputum (+) on the basis of three sputum follow-up examinations at least 3 weeks from the previous examination or impairment classification of class 1 or higher

3.2.2. Extrapulmonary TB

The only requirement is a certification from the attending physician that the patient has extrapulmonary tuberculosis and still needs time off from work while continuing treatment.

B. Permanent Partial TB Disability Benefit Package. This is a cash benefit in monthly pension or lump sum paid to an eligible GSIS/SSS member who at the end of 120 days becomes permanently disabled, partially due to TB disease. The benefits under the EC program include reimbursement of medical expenses and a monthly pension, which may be enjoyed simultaneously with benefits under the social security program for work-connected tuberculosis.

1. Packages

- 1.1. **GSIS/SSS Package.** The Permanent Partial TB Disability Benefit is given in the form of a cash payment to a SSS/GSIS member with TB disease who meets the criteria for permanent partial disability. The amount and duration of compensation package is based on the current policy of the respective System, which are subject to change.
- 1.2. **ECC Package.** The Permanent Partial TB Disability (PPD) benefit is a monthly income benefit, beginning on the first month of disability and shall continue for a period as specified. If the indicated number of months exceed twelve, the income benefit shall be paid in monthly pension; otherwise the System may pay income benefit in lump sum or in monthly pension. In addition, the member with TB disease is also entitled to reimbursement of his/her medical and related expenses. The minimum monthly pension is P2, 000.

2. System Requirements for Eligibility

- 2.1. A **GSIS member** is qualified to avail of this benefit if
 - a. he/she is in the service at the time of disability; or
 - b. he/she is separated from the service and has paid 36 monthly contributions within the last 5 years immediately preceding the disability or has paid a total of at least 180 monthly contributions.
- 2.2. An SSS member is qualified to avail of this benefit if he/she has paid at least one monthly contribution prior to the semester of contingency
- 2.3. A **GSIS/SSS member** is qualified to avail of this benefit from the ECC if he/she satisfies the following conditions:
 - a. he/she has been duly reported to the System;
 - b. he/she sustained the permanent partial disability as a result of work-connected TB disease.

3. Medical Requirements

3.1. Pulmonary Tuberculosis

- a. he/she met the criteria for PTB and has proof of at least 100 days of documented treatment
- b. he/she is still sputum positive at the end of the Temporary Total Disability
- a. he/she has an impairment classification of Class 1 to 3 (ATS, Annex 1) and Functional Independence Measure (FIM) classification for permanent partial disability (Annex 2)

3.2 Extrapulmonary Tuberculosis

- a. he/she met the criteria for extra pulmonary TB and has proof of at least 100 days of documented treatment
- b. he/she satisfies functional impairment classification for Permanent Partial Disability of organ system involved and Functional Independence Measure (FIM).

C. Permanent Total TB Disability Benefit. This is a cash benefit in monthly pension or lump sum paid to a qualified GSIS/SSS member with Permanent Total Disability due to TB disease. The benefits under the EC program include reimbursement of medical expenses and rehabilitation plus a monthly pension for which may be enjoyed simultaneously with benefits under the social security program for work-connected tuberculosis.

1. Packages

- 1.1. **GSIS/SSS Package.** The Permanent Total TB Disability Benefit is given in the form of lump sum or a monthly income benefit for life plus cash payment or a cash payment alone guaranteed for five years. The amount and duration of compensation package is based on the current policy of the respective System, which are subject to change.
- 1.2. **ECC Package.** The Permanent Total TB Disability Benefit under the EC include reimbursement for medical expenses and a monthly pension plus 10 percent for each of the five dependent children beginning with the youngest and without substitution. A permanent total disability pensioner is also given a supplemental allowance of P575 a month for his/her extra needs arising from his/her disability. The monthly pension is guaranteed for five years but will be suspended if the employee is gainfully employed, recovers from his/her permanent disability, or fails

to present himself/herself for examination at least once a year upon notice by the GSIS/SSS or fails to submit a quarterly medical report certified by his/her attending physician.

2. System Requirements for Eligibility

- 2.1. **A GSIS** member is qualified to avail of this benefit under the following conditions:
 - a. He/she is in the service and has paid at least 180 monthly contributions **or**
 - b. He/she is in the service at the time of disability **or** he/she is separated from the service and has paid 36 monthly contributions within the last 5 years immediately preceding the disability or has paid a total of at least 180 monthly contributions. **or**
 - c. He/she is separated from the service with at least 3 years of service but has not paid 36 monthly contributions within the last 5 years immediately preceding the disability.
- 2.2. An SSS member is qualified to avail of this benefit if he/she has paid one monthly contribution prior to the semester of contingency
- 2.3 **A GSIS/SSS member** is qualified to avail of this benefit from the ECC if he/she satisfies the following conditions:
 - a. he/she has been duly reported to the System;
 - b. he/she sustained the permanent partial disability as a result of work-connected TB disease.

3. Medical Requirements

3.1. Pulmonary Tuberculosis

- a. he/she met the criteria for PTB and has proof of at least 100 days of documented treatment
- b. he/she is still sputum positive at the end of the temporary total disability
- c. he/she has an impairment classification of Class 4 (ATS, Annex 1) and Functional Independence Measure (FIM) classification of Permanent Total Disability (Annex 2)

3.2. **Extrapulmonary TB**

- a. he/she met the criteria for extra pulmonary TB and has proof of at least 100 days of documented treatment
- a. he/she satisfies functional impairment classification for Permanent Total D Disability of organ system involved and Functional Independence Measure (FIM) classification of total disability.

Procedure for Claims

A. GSIS

1. Initial Temporary Total Disability

- 1.1. Members diagnosed with TB disease are required to submit the following:

- a. Income Benefit Claim for Payment
- b. Completed TB Benefit Form (initial portion) with the following as attachments:

Pulmonary TB: official results of 3 AFB sputum examination, x-ray films and official results of mycobacterial or TB culture examination if available.

Extrapulmonary TB: history and physical examination of attending physician, histopathology examination result of involved tissue or results of culture of fluid or tissue from involved site, and certification from the attending physician attesting to the diagnosis of TB of the extrapulmonary site concerned.

- 1.2. A GSIS physician shall evaluate the application and give the appropriate recommendation.
- 1.3. GSIS shall keep a copy of the TB Sickness Benefit Form and another copy shall be submitted to the Philippine Coalition Against Tuberculosis or other such body designated to manage the National TB Database on a monthly basis.
- 1.4. GSIS shall pay the approved benefit in the form of income benefit checks directly to the employee.

2. Extension of Temporary Total TB Benefit

2.1. Members diagnosed with TB disease who shall remain sputum positive after 30 days are required to submit the following:

- a. Income Benefit Claim
- b. Completed TB Benefit Form (Extension Section) with the following as attachments:

Pulmonary TB: results of sputum examination or culture taken three weeks from the previous sputum examination or culture, evidence of at least mild respiratory impairment by spirometry or peak flow and certification by a physician that he/she has at least Class 1 respiratory impairment.

Extrapulmonary TB: history and physical examination of attending physician, histopathology examination result of involved tissue or results of culture of fluid or tissue from involved site, and certification from the attending physician attesting to the diagnosis of TB of the extrapulmonary site concerned.

2.2 A GSIS physician shall evaluate the application and give the appropriate recommendation.

2.3 GSIS shall pay the approved benefit in the form of income benefit checks directly to the employee.

3. Permanent Partial or Total Disability

3.1. Members diagnosed with TB disease who shall remain sputum positive after 120 days are required to submit the following:

- a. Income Benefits Claim for Payment
- b. Other documents as attachments:

Pulmonary TB: results of sputum examination or culture taken at the end of the temporary total disability, respiratory impairment result by spirometry or peak flow and proof of at least 100 days of documented treatment.

Extrapulmonary TB: history and physical examination of attending physician, histopathology examination result of involved tissue or results of culture of fluid or tissue from involved site, certification from the attending physician attesting to the diagnosis of TB of the

extrapulmonary site concerned and proof of at least 100 days of documented treatment.

- 3.2. A GSIS physician shall evaluate the application and give the appropriate recommendation.

B. SSS

1. Temporary TB Disability (TB Sickness) Benefit

- 1.1. Members diagnosed with TB disease are required to submit the following:

- a. TB Sickness Notification Form for employed members or Sickness Benefit Claim for separated, self-employed, or voluntary members
- b. Sickness Benefit Reimbursement Application Form (for the employer)
- c. Completed TB Benefit (Initial Portion) Form with the following as attachments:

Pulmonary TB: official results of 3 AFB sputum examination, x-ray films and official results of mycobacterial or TB culture examination if available.

Extrapulmonary TB: history and physical examination of attending physician, histopathology examination result of involved tissue or results of culture of fluid or tissue from involved site and certification from the attending physician attesting to the diagnosis of TB of the extrapulmonary site concerned.

- 1.2. The application shall be evaluated by the SSS physician who shall return the basic TB Sickness Benefit form with the appropriate recommendation to the employee/employer except in the case of voluntary, self-employed or separated SSS members who shall receive the form directly.

- 1.3. The TB Sickness Benefit Form shall be collected by SSS and submitted to the Philippine Coalition Against Tuberculosis or other body designated to manage the National TB Data Base on a monthly basis

- 1.4. The employer shall advance the approved benefits and have this reimbursed by SSS.

2. Extension of Temporary TB Disability (TB Sickness) Benefit

- 2.1. Members diagnosed with TB disease who shall remain sputum positive after 30 days are required to submit the following:
 - a. TB Sickness Notification Form for employed members or Sickness Benefit Claim for separated, self-employed, or voluntary members
 - b. Sickness Benefit Reimbursement Application Form (for the employer)
 - c. Completed TB Benefit (Extension Portion) Form with the following as attachments:

Pulmonary TB: results of sputum examination or culture taken three weeks from the previous sputum examination or culture, evidence of at least mild respiratory impairment by spirometry or peak flow and certification by a physician that he/she has at least Class 1 respiratory impairment.

Extrapulmonary TB: history and physical examination of attending physician, histopathology examination result of involved tissue or results of culture of fluid or tissue from involved site and certification from the attending physician attesting to the diagnosis of TB of the extrapulmonary site concerned

- 2.2. The application shall be evaluated by the SSS physician who shall return the basic TB Sickness Benefit form with the appropriate recommendation back to the employee/employer except in the case of voluntary, self-employed or separated SSS members who shall receive the form directly.
23. The employer shall advance the approved benefits and have this reimbursed by SSS.

3. Permanent TB Disability, Partial or Total

- 3.1. SSS members with TB disease should submit the following:
 - a. Claim for Disability Benefit Form
 - b. Medical Certificate Form
 - c. Other documents that maybe required to support the disability claim:

Pulmonary TB: results of sputum examination or culture taken at the end of the temporary total disability, respiratory impairment result by spirometry or peak flow and proof of at least 100 days of documented treatment.

Extrapulmonary TB: history and physical examination of attending physician, histopathology examination result of involved tissue or results of culture of fluid or tissue from involved site, certification from the attending physician attesting to the diagnosis of TB of the extrapulmonary site concerned and proof of at least 100 days of documented treatment.

- 3.2. The application shall be evaluated by the SSS physician who shall give the appropriate recommendation

C. ECC

1. All claims shall be filed using the prescribed furnished by either the GSIS or SSS and endorsed by the employer or his duly authorized representative together with the following supporting documents:

- a. Completed TB Benefit Form (initial portion with the following as attachments:

- a.1. For application for Temporary Total TB disability (TB Sickness), Initial Claim

Pulmonary TB: official results of 3 AFB sputum examination, x-ray films and official results of mycobacterial or TB culture examination if available.

Extrapulmonary TB: history and physical examination of attending physician, histopathology examination result of involved tissue or results of culture of fluid or tissue from involved site and certification from the attending physician attesting to the diagnosis of TB of the extrapulmonary site concerned.

- a.2. For extension of Temporary Total TB Disability:

Pulmonary TB: results of sputum examination or culture taken three weeks from the previous sputum examination or culture, evidence of at least mild respiratory impairment by spirometry or peak flow and certification by the attending physician that he/she has at least Class 1 respiratory impairment.

Extrapulmonary TB: history and physical examination of attending physician, histopathology examination result of involved tissue or results of culture of fluid or tissue from involved site and

certification from the attending physician attesting to the diagnosis of TB of the extrapulmonary site concerned

a.3. For Permanent Total or Partial TB Disability:

Pulmonary TB: results of sputum examination or culture taken at the end of the temporary total disability, respiratory impairment result by spirometry or peak flow and proof of at least 100 days of documented treatment.

Extrapulmonary TB: history and physical examination of attending physician, histopathology examination result of involved tissue or results of culture of fluid or tissue from involved site, certification from the attending physician attesting to the diagnosis of TB of the extrapulmonary site concerned and proof of at least 100 days of documented treatment.

- b. Supporting documents: updated service record; statement of duties and responsibilities; pre-employment x-ray; official receipts in payment of laboratory bills, professional fees and medicines purchased from the drugstore
 - c. Proof of treatment a treatment record where the daily dose of the patient's anti-TB drugs taken under supervised treatment is recorded.
2. The GSIS/SSS physician shall evaluate the application within (20) calendar days from the submission of all required documents and shall render a decision denying or awarding compensation benefits.
 3. The claimant shall be notified in writing by the GSIS or SSS of its award or decision on the action taken on his claim. The claimant shall be informed of his right to appeal and that the decision shall become final and executory if no appeal or motion for reconsideration is filed within the reglementary period.
 4. The claimant shall file with the GSIS or SSS, as the case may be, only one motion for reconsideration within ten (10) calendar days from receipt of the decision. When a motion for reconsideration is denied by the GSIS or the SSS, the claimant may appeal to the Commission within thirty (30) calendar days from receipt of the decision or the notice of denial of the motion for reconsideration.
 5. The claimant shall file with the GSIS or the SSS, a notice of appeal within thirty (30) calendar days from receipt of the decision.

ANNEX 1

IMPAIRMENT CLASSIFICATION FOR RESPIRATORY DISEASE INJURIES

(Modified from American Thoracic Society Criteria)

CRITERIA	Class I 20% OB	Class 2 30% OB	Class 3 50% OB	Class 4 100% OB
I. History and P.E. Findings				
Functional Classification (DYS-PNEA)	Grade 1	Grade 2	Grade 3	Grade 4
	<i>and</i>	<i>and</i>	<i>and</i>	<i>and</i>
Pertinent Signs And Symptoms		Slight Constitutional symptoms	Moderate Constitutional symptoms	Marked Constitutional Symptoms with Cardio-pulmonary Embarrassment
In Injuries	Slight Constitutional symptoms, also Pain, discomfort on exertion; slight limitation of chest expansion/excursion, And/or chest deformity	Slight limitation of Chest expansion and/or chest deformity	Moderate restriction of chest expansion, deformities of chest	Marked restriction of chest expansion and/or deformities of chest, e.g. marked adhesions of diaphragm or pericardium
If present				
Anemia (Hgb)		81 to 100 g/l	70 to 80 g/l	<70 g/l
Weight loss		10% of IBW*	15% of IBW*	>15% of IBW*
Respiratory Impairment by spirometry		Mildly impaired	Moderately impaired	Severely impaired

Modified Tanhauser's formula for IBW for Filipinos = (height in cm – 100) x 10%

ATS FUNCTIONAL CLASSIFICATION (OF DYSPNEA)

Description	Grade	Degree
Not troubled by shortness of breath when hurrying on the level or Walking up a slight hill	0	None
Walks more slowly than people of same age on the level because of Shortness of breath	1	Mild
Has to stop for breath when walking at own pace on the level	2	Moderate
Stops for breath when walking about 100 yards or after a few minutes on the level	3	Severe
Too breathless to leave house, or breathless on dressing or undressing	4	Very severe

ATS RATINGS OF RESPIRATORY IMPAIRMENT BY SPIROMETRY

Rating	Pulmonary Function Parameters	Functional implication
Normal	FVC \geq 80% predicted, and FEV ₁ \geq 80% of predicted	No functional limitations
Mildly Impaired	FVC 60-79% of predicted or FEV ₁ 60-79% of predicted	Usually not correlated with Diminished ability to perform most jobs
Moderately impaired	FVC 51-59% of predicted, or FEV ₁ 41-59% of predicted	Progressively lower level of lung function correlated with diminishing ability to meet the Physical demands of many jobs
Severely Impaired	FVC \leq 50% of predicted, or FEV ₁ \leq 40% of predicted	Unable to meet the physical demands of most jobs including travel to work

TB BENEFIT FORM

Name _____ Age ____ Sex ____ Date of Referral _____
Occupation _____ Home Tel. No. _____
Company _____ Work Phone No. _____
Co. Address _____ Home Address _____

Attending Physicians' Report :

Symptomatic? Yes No

- Chronic cough
- Afternoon fever
- Hemoptysis
- Weight loss
- Chest and/or back pain
- Prior TB diagnosis or treatment (Attach clinical abstract if present)
- Others: _____

P.E. findings suggestive of TB? Yes No

Weight: _____

% of Ideal body weight

Pulmonary signs of TB: _____

Extrapulmonary signs of TB: _____

Sputum AFB smears done three times? Yes No

sputum 1: positive negative Date: _____

sputum 2: positive negative Date: _____

sputum 3: positive negative Date: _____

Sputum AFB Culture Positive? Yes No

Chest x-ray suggestive of TB? Yes No

Histopath. Suggestive of TB or fluid culture positive? Yes No

Sgd. _____, M.D.

License No. _____

SSS/GSIS/PHIC Accred. No. _____

PTR No. _____

Employers' Certification: Status: Employee Dependent

(For EC claims)

Employment history attached Job Description attached

Pre-employment chest x-ray : Normal
 Abnormal; please specify

Pre-employment P. E. : Normal
 Abnormal; please specify

Sgd.

_____ Name

_____ Position

_____ Company

SSS/GSIS/PhilHealth Verification:

Not qualified for benefits. Reason:

Complete requirements; approved for processing.

Incomplete requirements. Please submit the following before processing could proceed:

Sgd. _____

Name: _____

Official Designation: _____ Date: _____

Extension of Temporary Total Disability (TB Sickness) Benefits

Sputum AFB smears done three times? Yes No

sputum 1: positive negative Date: _____

sputum 2: positive negative Date: _____

sputum 3: positive negative Date: _____

Sputum AFB Culture Positive? Yes No

Impairment classification of class 1 or higher? Yes No

Certification from attending physician for Extrapulmonary TB? Yes No

Sgd. _____, M.D.

License No. _____

SSS/GSIS/PHIC Accred. No. _____

PTR No. _____

Permanent Total Disability**Pulmonary TB**

Met criteria for PTB? Yes No

Sputum AFB smears done three times? Yes No

sputum 1: positive negative Date: _____

sputum 2: positive negative Date: _____

sputum 3: positive negative Date: _____

Sputum AFB Culture Positive? Yes No

Impairment classification of class 1-3 for partial? Yes No
class 4 for total?

Proof of 100 days of documented treatment? Yes No

Extrapulmonary TB

Met criteria for extrapulmonary TB? Yes No

Satisfied functional impairment classification Yes No

And functional independence measure of organ involved?

Proof of 100 days of documented treatment? Yes No

Sgd. _____, M.D.

License No. _____

SSS/GSIS/PHIC Accred. No. _____

PTR No. _____

SOCIAL SECURITY SYSTEM

Disability Assessment Manual
Medical & Functional

Revised November 2000

RENE MANUEL T. PANGILINAN, MD.

SSS GUIDE to FUNCTIONAL ASSESSMENT

- I. Procedures for Scoring the Functional Independence Measure (FIM)
- II. Table: Relationship of Raw FIM Score to Impairment of the Whole-Person
- III. Description of the Levels of Function and their Scores
 - A. Self Care
 1. Eating
 2. Grooming
 3. Bathing
 4. Dressing – Upper Body
 5. Dressing – Lower Body
 6. Toileting
 - B. Sphincter Control**
 1. Bladder Management
 2. Bowel Management
 - C. Mobility**
 1. Transfers – Bed, Chair, Wheelchair
 2. Transfers – Toilet
 3. Transfers – Tub Shower
 - D. Locomotion**
 1. Walk/Wheelchair
 2. Stairs
 - E. Communication**
 1. Comprehension
 2. Expression
 - F. Special Cognition**
 1. Social Interaction
 2. Problem Solving
 3. Memory

PROCEDURE FOR SCORING THE FUNCTIONAL INDEPENDENCE MEASURE (FIM) *

Each of the 18 items comprising the FIM has a maximum score of 7, and the lowest score on each item is 1. The highest total score is 126 and the lowest total score is 18. The clinicians in the field have been adamant in their conviction that a seven-level scale is necessary for showing claimant function change with sufficient sensitivity. The original four-level scale was superseded in 1987 and the seven-level scale is recommended for all items.

Comment:

The social cognition items: social interaction, problem solving, and memory are estimates of function in three important areas of a person's daily activity. Unlike the other areas of function assessed with the FIM, which have been in clinical use for years, consensus is not yet clear among behaviorists and rehabilitation clinicians about how to quantify these activities at the level of disability. The social cognition items in the FIM have very acceptable reliability. They have been refined as a result of comments made by users during the trial and implementation phases and will continue to be refined as more clinical and research experience is gained by the field.

STEP 1. Record the number which best describes the subject's level of function for every FIM item on the coding sheet.

If the subject would be put at risk for injury if tested, then enter 1. Leave no FIM item blank.

When two helpers are required in order for the patient to perform the behaviors described in an item, enter level 1. Set-up is uniformly scored a level 5 for all items.

STEP 2. Convert the raw FIM score to the equivalent whole-person impairment estimate (% OB). Refer to 'Table – Relationship of Raw FIM Score to Impairment of the Whole – Person' below.

* UNIFORM DATA SET FOR MEDICAL REHABILITATION . The Uniform Data System for Medical Rehabilitation was developed with support from the US Department of Education, National Institute on Disability and Rehabilitation Research (NIDRR), grant number G008435062, and was conducted by the State University of New York at Buffalo, School of Medicine, Department of Rehabilitation Medicine, 1990

**Table on:
Relationship of Raw FIM Score to Impairment of the Whole – person (OB)**

FIM Score	OB Impairment (%)	FIM Score	OB Impairment (%)	FIM Score	OB Impairment (%)	FIM Score	OB Impairment (%)
126	0	98	26	70	52	42	78
125	1	97	27	69	53	41	79
124	2	96	28	68	54	40	80
123	3	95	29	67	55	39	81
122	4	94	30	66	56	38	81
121	5	93	31	65	56	37	82
120	6	92	31	64	57	36	83
119	6	91	32	63	58	35	84
118	7	90	33	62	59	34	85
117	8	89	34	61	60	33	86
116	9	88	35	60	61	32	87
115	10	87	36	59	62	31	88
114	11	86	37	58	63	30	89
113	12	85	38	57	64	29	90
112	13	84	39	56	65	28	91
111	14	83	40	55	66	27	92
110	15	82	41	54	67	26	93
109	16	81	42	53	68	25	94
108	17	80	43	52	69	24	94
107	18	79	44	51	69	23	95
106	19	78	44	50	70	22	96
105	19	77	45	49	71	21	97
104	20	76	46	48	72	20	98
103	21	75	47	47	73	19	99
102	22	74	48	46	74	18	100
101	23	73	49	45	75		
100	24	72	50	44	76		
99	25	71	51	43	77		

DESCRIPTION OF THE LEVELS OF FUNCTION AND THEIR SCORES

Independent (No Helper) Another person is not required for the activity		
7	Complete Independence	All of the tasks described as making up the activity are typically performed safely, without modification, assistive devices, or aids, and within reasonable time.
6	Modified Independence	Activity requires any one or more than one of the following: an assistive device, more than reasonable time, or there are safety (risk) considerations.
Dependent (Requires Helper) Another person is required for either supervision, or physical assistance in order for the activity to be performed, or it is not performed.		
Modified Dependence – the subject expands half (50%) or more of the effort. The levels of assistance required are:		
5	Supervision Or Set-up	Subject requires no more help than standby, cuing, or coaxing without physical contact. Or, helper sets up needed items or applies orthoses.
4	Minimal Contact Assistance	With physical contact the subject requires no more help than touching, and subject expends 75% or more of the effort.
3	Moderate Assistance	Subject requires more help than touching, or expends half (50%) or more (up to 75%) of the effort.
Complete Dependence – The subject expends less than half (<50%) of the effort. Maximal or total assistance is required, or the activity is not performed. The levels of assistance required are:		
2	Maximal Assistance	Subject expends <50% of the effort, but at least 25%
1	Total Assistance	Subject expends <25% of the effort.

A. SELF CARE

<p>1. EATING</p> <p>Includes use of suitable utensils to bring food to the mouth, Chewing and swallowing, once the meal is appropriately prepared.</p>		
No Helper		
7	Complete Independence	Eats from a dish, while managing all consistencies of food, and drinks from a cup or glass with the meal presented in the customary manner on a table or tray. The subject uses a spoon or fork to bring food to the mouth: food is chewed and swallowed.
6	Modified Independence	Requires an adaptive or assistive device such as a straw, spork, rocking knife, requires more than a reasonable time to eat, or requires modified food consistency or blenderized food, or there are safety considerations. If the individual relies in part on other means of alimentation, such as parenteral or gastrostomy feedings, then he/she administers the feedings him/herself.
Helper		
5	Supervision or Set-up	Requires supervision (e.g. standing by, cuing, or coaxing) or setup (application of orthoses); or another person is required to open containers, cut meat, butter bread or pour liquids.
4	Minimal Contact Assistance	Subject performs 75% or more of feeding tasks.
3	Moderate Assistance	Performs 50% to 74% of feeding tasks
2	Maximal Allowance	Performs 25% to 49% of feeding tasks
1	Total Assistance	Performs <25% of feeding tasks. Or, the individual does not eat or drink full meals by mouth but must rely in part on other means of alimentation, such as parenteral or gastrostomy feedings, and does not administer the findings him/herself.

2. GROOMING

Indicates oral care, hair grooming, washing hands and face, and either shaving or applying make-up. If there is no preference for shaving or applying make-up, then disregard.

No Helper

7	Complete Independence	Cleans teeth or dentures, combs or brushes hair, washes hands and face, shaves or applies make-up, including all preparations.
6	Modified Independence	Requires specialized equipment (including prosthesis, or orthosis) or takes more than a reasonable time, or there are safety considerations.

Helper

5	Supervision or Set-up	Requires supervision (e.g. standing by, cuing, or coaxing) or set-up (application of orthoses, setting out grooming equipment, and initial preparation such as applying toothpaste to brush, opening make-up containers).
4	Minimal Contact Assistance	Subject performs 75% or more of grooming tasks
3	Moderate Assistance	Performs 50% to 74% of grooming tasks
2	Maximal Assistance	Performs 25% to 49% of grooming tasks
1	Total Assistance	Performs <25% of grooming tasks

3. BATHING

Indicates bathing the body from the neck down (excluding the back), either tub, shower or sponge/bed bath. Performs safely.

No Helper

7

Complete Independence

Baths and dries the body.

6

Modified Independence

Requires specialized equipment (including prosthesis, or orthosis) or takes more than a reasonable time, or there are safety considerations.

Helper

5

Supervision or Set-up

Requires supervision (e.g. standing by, cuing, or coaxing) or set-up (setting out bathing equipment, and initial preparation such as preparing the water or washing materials).

4

Minimal Contact Assistance

Subject performs 75% or more of bathing tasks

3

Moderate Assistance

Performs 50% to 74% of bathing tasks

2

Maximal Assistance

Performs 25% to 49% of bathing tasks

1

Total Assistance

Performs <25% of bathing tasks

4. DRESSING – UPPER BODY

Indicates dressing above the waist as well as donning and removing prosthesis or orthosis when applicable.

No Helper

7	Complete Independence	Dresses and undresses including obtaining clothes from their customary places such as drawers and closets; manages zippers, buttons, and snaps; dons and removes prosthesis or orthosis when applicable.
6	Modified Independence	Requires special adaptive closure such as Velcro, or assistive device (including prosthesis or orthosis) or takes more than a reasonable time.
Helper		
5	Supervision or Set-up	Requires supervision (e.g. standing by, cuing, or coaxing) or set-up (application of orthosis, setting out clothes or dressing equipment).
4	Minimal Contact Assistance	Subject performs 75% or more of dressing tasks
3	Moderate Assistance	Performs 50% to 74% of dressing tasks
2	Maximal Assistance	Performs 25% to 49% of dressing tasks
1	Total Assistance	Performs <25% of dressing tasks

5. DRESSING – LOWER BODY

Indicates dressing from the waist down as well as donning and removing prosthesis or orthosis when applicable.

No Helper

7	Complete Independence	Dresses and undresses including obtaining clothes from their customary places such as drawers and closets; manages underpants, slacks, skirt, belt, stockings, and shoes; manages zippers, buttons, and snaps; dons and removes prosthesis or orthosis when applicable.
6	Modified Independence	Requires special adaptive closure such as Velcro, or assistive device (including prosthesis or orthosis) or takes more than a reasonable time.
Helper		
5	Supervision or Set-up	Requires supervision (e.g. standing by, cuing, or coaxing) or set-up (application of orthosis, setting out clothes or dressing equipment).
4	Minimal Contact Assistance	Subject performs 75% or more of dressing tasks
3	Moderate Assistance	Performs 50% to 74% of dressing tasks
2	Maximal Assistance	Performs 25% to 49% of dressing tasks
1	Total Assistance	Performs <25% of dressing tasks

6. TOILETING

Includes maintaining perineal hygiene and adjusting clothing before and after toilet or bedpan use. Performs safely.

No Helper

7	Complete Independence	Cleanses self after voiding and bowel movement; puts on sanitary napkins/inserts tampons; adjusts clothing before and after using toilet.
6	Modified Independence	Requires specialized equipment (including prosthesis or orthosis) or takes more than a reasonable time, or there are safety considerations.

Helper

5	Supervision or Set-up	Requires supervision (e.g. standing by, cuing, or coaxing) or set-up (application of adaptive devices or opening packages).
4	Minimal Contact Assistance	Subject performs 75% or more of toileting tasks
3	Moderate Assistance	Performs 50% to 74% of toileting tasks
2	Maximal Assistance	Performs 25% to 49% of toileting tasks
1	Total Assistance	Performs <25% of toileting tasks

B. SPHINCTER CONTROL

1. BLADDER MANAGEMENT Includes complete intentional control of urinary bladder and use of equipment or agents necessary for bladder control.		
No Helper		
7	Complete Independence	Controls bladder completely and intentionally and is never incontinent.
6	Modified Independence	Requires a urinal, bedpan, commode, catheter, absorbent pad, diaper, urinary collecting device or urinary diversion or uses medication for control; if catheter is used, the individual instills or irrigates catheter without assistance; cleans, sterilizes, and sets up the equipment for irrigation without assistance. If the individual uses a device, he/she assembles and applies condom drainage or an ileal appliance without assistance of another person; empties, puts on, removes, and cleans leg bag or empties and cleans ileal appliance bag. No accidents.
Helper		
5	Supervision or Set-up	Requires supervision (e.g. standing by, cuing, or coaxing) or set-up (placing or emptying) of equipment to maintain a satisfactory voiding pattern or to maintain an external device; or because of the lapse of time to get to bedpan or the toilet the individual may have occasional bladder accidents, or bedpan or urinal spills, but <u>less often than monthly</u> .
4	Minimal Contact Assistance	Requires minimal contact assistance to maintain an external device; the individual performs 75% or more of bladder management tasks; or may have occasional bladder accidents, but <u>less often than weekly</u> .
3	Moderate Assistance	Requires moderate contact assistance to maintain an external device; the individual performs 50% to 74% of bladder management tasks, or may have occasional bladder accidents, but <u>less often daily</u> .
2	Maximal Assistance	Despite assistance the individual is wet on a frequent or almost daily basis, necessitating wearing diapers or other absorbent pads, whether or not a catheter or ostomy device is in place. The individual performs 25% to 49% of bladder management tasks.
1	Total Assistance	Despite assistance the individual is wet on a frequent or almost daily basis, necessitating wearing diapers or other absorbent pads, whether or not a catheter or ostomy device is in place. The individual performs <25% of bladder management tasks.

Comment: The functional goal of bladder management is to open the bladder sphincter only when that is needed and to keep it closed the rest of the time. This may require devices, drugs or assistance in some individuals. This item, therefore, deals with two variables: 1) level of success in bladder management and 2) level of assistance required. Usually the two follow each other, e.g. when there are more accidents usually more assistance is required. However, should the two levels not be exactly the same, always record the lower level.

2. BOWEL MANAGEMENT
**Includes complete intentional control of bowel movement
and use of equipment or agents necessary for bowel control.**

No Helper		
7	Complete Independence	Controls bowels completely and intentionally and is never incontinent
6	Modified Independence	Requires bedpan or commode, digital stimulation or stool softeners, suppositories, laxatives, or enemas on a regular basis, or uses other medication for control. If the individual has a colostomy, he/she maintains it. No accidents.
Helper		
5	Supervision or Set-up	Requires supervision (e.g. standing by, cuing, or coaxing) or set-up of equipment necessary for the individual to maintain a satisfactory excretory pattern or to maintain an ostomy device; or the individual may have occasional bowel accidents, but <u>less often than monthly</u> .
4	Minimal Contact Assistance	Requires minimal contact assistance to maintain a satisfactory excretory pattern by using suppositories or enemas or an external devise; the individual performs 75% or more of bowel management tasks; or may have occasional bowel accidents, but <u>less often than weekly</u> .
3	Moderate Assistance	Requires moderate contact assistance to maintain a satisfactory excretory pattern by using suppositories or enemas or an external devise; the individual performs 50% to 74% of bowel management tasks, or may have occasional bowel accidents, but <u>less often than daily</u> .
2	Maximal Assistance	Despite assistance the individual is soiled on a frequent or almost daily basis, necessitating wearing diapers or other absorbent pads, whether or not an ostomy devise is in place. The individual performs 25% to 49% of bowel management tasks.
1	Total Assistance	Despite assistance the individual is soiled on a frequent or almost daily basis, necessitating wearing diapers or other absorbent pads, whether or not an ostomy devise is in place. The individual performs <25% of bowel management tasks

Comment: The functional goal of bowel movement is to open the anal sphincter only when that is needed and to keep it closed the rest of the time. This may require devices, drugs or assistance in some individuals. This item, therefore, deals with two variables: 1) level of success in bowel management and 2) level of assistance required. Usually the two follow each other, e.g. when there are more accidents usually more assistance is required. However, should the two levels not be exactly the same, always record the lower level.

C. MOBILITY

1. TRANSFERS – BED, CHAIR, WHEELCHAIR

Includes all aspects of transferring to and from bed, chair, and wheelchair, and coming to a standing position, if walking is the typical mode of locomotion.

No Helper

7	Complete Independence	<p>... <u>If walking</u>. Approaches, sits down and gets up to a standing position from a regular chair; transfers from bed to chair. Performs safely.</p> <p>... <u>If in a wheelchair</u>. Approaches a bed or chair, locks brakes, lifts foot rests, removes arm rest if necessary, and performs either a standing pivot or sliding transfer and returns. Performs safely.</p>
6	Modified Independence	Requires adaptive or assistive device (including prosthesis or orthosis) such as a sliding board, a lift, grab bars, or special seat or chair or brace or crutches; takes more than a reasonable time, or there are safety considerations.
Helper		
5	Supervision or Set-up	Requires supervision (e.g. standing by, cuing, or coaxing) or set-up (positioning sliding board, moving foot rests, etc.)
4	Minimal Contact Assistance	Subjects performs 75% or more of transferring tasks
3	Moderate Assistance	Performs 50% to 74% of transferring tasks.
2	Maximal Assistance	Performs 25% to 49% of transferring tasks.
1	Total Assistance	Performs <25% of transferring tasks.

Comment: When assessing bed to chair transfer, the subject begins and ends in the supine position.

2. TRANSFERS - TOILET

Includes getting on and off a toilet.

No Helper

7	Complete Independence	<p>... <u>If walking</u>. Approaches, sits down and gets up from a standard toilet. Performs safely.</p> <p>... <u>If in a wheelchair</u>. Approaches toilet, locks brakes, lifts foot rests, removes arm rests if necessary, and does either a standing pivot or sliding transfer and returns. Performs safely.</p>
6	Modified Independence	Requires adaptive or assistive device (including prosthesis or orthosis) such as a sliding board, a lift, grab bars, or special seat; takes more than a reasonable time, or there are safety considerations.
Helper		
5	Supervision or Set-up	Requires supervision (e.g. standing by, cuing, or coaxing) or set-up (positioning sliding board, moving foot rests, etc.)
4	Minimal Contact Assistance	Subjects performs 75% or more of transferring tasks
3	Moderate Assistance	Performs 50% to 74% of transferring tasks.
2	Maximal Assistance	Performs 25% to 49% of transferring tasks.
1	Total Assistance	Performs less than 25% of transferring tasks.

3. TRANSFERS - TUB OR SHOWER

Includes getting into and out of a tub or shower stall.

No Helper

7	Complete Independence	... <u>If walking</u> . Approaches, enters and leaves a tub or shower stall. Performs safely. ... <u>If in a wheelchair</u> . Approaches tub or shower, locks brakes, lifts footrests, removes armrests if necessary, and does either a standing pivot or sliding transfer and returns. Performs safely.
6	Modified Independence	Requires adaptive or assistive device (including prosthesis or orthosis) such as a sliding board, a lift, grab bars, or special seat; takes more than a reasonable time, or there are safety considerations.
Helper		
5	Supervision or Set-up	Requires supervision (e.g. standing by, cuing, or coaxing) or set-up (positioning sliding board, moving foot rests, etc.)
4	Minimal Contact Assistance	Subjects performs 75% or more of transferring tasks
3	Moderate Assistance	Performs 50% to 74% of transferring tasks.
2	Maximal Assistance	Performs 25% to 49% of transferring tasks.
1	Total Assistance	Performs < 25% of transferring tasks.

D. LOCOMOTION

1. WALK / WHEELCHAIR

Includes walking, once in a standing position, or using a wheelchair, once in a seated position, on a level surface. Check most frequent mode of locomotion. If both are about equal, check both W and C.

W = walking C = wheelchair

No Helper		
7	Complete Independence	... <u>Walks</u> a minimum of 150 feet without assistive device. Does not use a wheelchair. Performs safely.
6	Modified Independence	Walks a minimum of <u>150</u> feet but uses a brace (orthosis) or prosthesis on leg, special adaptive shoes, cane, crutches, or walkalette: takes more than a reasonable time, or there are safety considerations. <u>If not walking</u> , operates manual or electric wheelchair independently for a minimum of <u>150</u> feet; turns around; maneuvers the chair to a table, bed, toilet; negotiates at least a 3% grade; maneuvers on rugs and over doorsills.
5	Exception (Household Ambulation)	Walks only short distances (a minimum of 50 feet) with or without a device. Could take more than reasonable time, or there are safety considerations, or operates a manual or electric wheelchair independently only short distances (a minimum of 50 feet)
Helper		
5	Supervision or Set-up	<u>If walking</u> , requires standing by supervision, cuing, or coaxing to go a minimum of <u>150</u> feet. <u>If not walking</u> , requires standing by supervision, cuing, or coaxing to go a minimum of <u>150</u> feet in wheelchair.
4	Minimal Contact Assistance	Subject performs 75% or more of locomotion effort to go a minimum of <u>150</u> feet.
3	Moderate Assistance	Performs 50% to 74% of locomotion effort to go a minimum of <u>150</u> feet.
2	Maximal Assistance	Performs 25% to 49% of locomotion effort to go a minimum of <u>50</u> feet. Requires assistance of one person only.
1	Total Assistance	Performs < 25% of effort, or requires assistance of two people, or does not walk or wheel a minimum of <u>50</u> feet.

2. STAIRS

Goes up and down 12 to 14 stairs (one flight) indoors.

No Helper

7	Complete Independence	Goes up and down at least one flight of stairs without any type of handrail or support. Performs safely.
6	Modified Independence	Goes up and down at least one flight of stairs requiring side support or handrail, cane or portable supports; takes more than a reasonable time, or there are safety considerations.
5	Exception (Household Ambulation)	Goes up and down 4 to 6 stairs independently, with or without a devise. Could take more than reasonable time or there are safety considerations.

Helper

5	Supervision or Set-up	Requires standing by supervision, cuing, or coaxing to go up and down one flight.
4	Minimal Contact Assistance	Subject performs 75% or more of effort to go up and down one flight.
3	Moderate Assistance	Performs 50% to 74% of the effort to go up and down one flight.
2	Maximal Assistance	Performs 25% to 49% of stair climbing effort to go up and down 4 to 6 stairs. Requires assistance of one person only.
1	Total Assistance	Performs < 25% of the effort, or requires assistance of two people, or does not go up and down 4 – 6 stairs, or is carried.

E. COMMUNICATION

1. COMPREHENSION Includes understanding of either auditory or visual communication (e.g. writing, sign language, gestures). Check and evaluate the most usual mode of comprehension. If both are equally used, check both A and V. A = Auditory V = Visual		
No Helper		
7	Complete Independence	Understands directions and conversation that are complex or abstract; understands either spoken or written native language.
6	Modified Independence	Understands directions and conversations that are complex or abstract in most situations or with mild difficulty. No prompting is needed. May require a hearing or visual aid, other assistive device, or extra time to understand the information.
Helper		
5	Standby Prompting	Understands directions and conversation about basic daily needs more than 90% of the time. Requires prompting (slowed speech rate, use of repetition, stressing particular words or phrases, pauses; visual or gestural cues) less than 10% of the time.
4	Minimal Prompting	Understands directions and conversation about basic daily needs 75% to 90% of the time.
3	Moderate Prompting	Understands directions and conversation about basic daily needs 50% to 74% of the time.
2	Maximal Prompting	Understands directions and conversation about basic daily needs 25% to 49% of the time. May understand only simple questions or statements. Requires prompting more than half the time.
1	Total Assistance	Understands directions and conversation about basic daily needs < 25% of the time, or does not understand simple questions or statements or may not respond appropriately or consistently despite prompting.

Comment: Comprehension of complex or abstract information includes, but is not limited to understanding: group conversation, current events appearing in television programs or newspaper articles, or abstract information such as religion, humor, math, or finances used in daily living. Information about basic daily needs refers to conversation, directions, question or statements related to the subject's need for nutrition, fluids, elimination, hygiene, sleep (physiological needs).

1. EXPRESSION

Includes clear vocal or non-vocal expression of language. This item includes both intelligible speech and expression of language using writing or a communication device. Check and evaluate the most usual mode of expression. If both are about equally used, check both V and N.

V = Vocal N = Non-vocal

No Helper

7	Complete Independence	Expresses complex or abstract ideas clearly and fluently.
6	Modified Independence	Expresses complex or abstract ideas in most situations, or with mild difficulty. No prompting is needed. May require an augmentative communication device or system.

Helper

5	Standby Prompting	Expresses basic daily needs and ideas more than 90% of the time. Requires prompting (e.g. frequent repetition) less than 10% of the time to be understood.
4	Minimal Prompting	Expresses basic daily needs and ideas 75% to 90% of the time.
3	Moderate Prompting	Expresses basic daily needs and ideas 50% to 74% of the time.
2	Maximal Prompting	Expresses basic daily needs and ideas 25% to 49% of the time. May use only single words or gestures. Needs prompting more than half the time.
1	Total Assistance	Expresses basic daily needs and ideas < 25% of the time, or does not express basic needs appropriately or consistently despite prompting.

Comment: Examples of complex or abstract ideas include, but is not limited to, discussing current events, religion, or relationships with others. Expression of basic needs and ideas refers to the subject's ability to communicate about necessary daily activities such as nutrition, fluids, elimination, hygiene, and sleep (physiological needs).

F. SPECIAL COGNITION

1. SOCIAL INTERACTION

Includes skills related to getting along and participating with others in therapeutic and social situations. It represents how one deals with one's own needs together with the needs of others.

No Helper

7	Complete Independence	Interacts appropriately with staff, other patients, and family members (e.g. controls temper, accepts criticism, is aware that words and actions have an impact on others).
6	Modified Independence	Interacts appropriately with staff, other patients, and family members in most situations or with mild difficulty. No supervision is required. May require more than a reasonable time to adjust in social situations or may require medication for control.

Helper

5	Supervision	Requires supervision (e.g. monitoring; verbal control; cuing, or coaxing) only under stressful or unfamiliar conditions, but no more than 10% of the time. May require encouragement to initiate participation.
4	Minimal Direction	Subject interacts appropriately 75% to 90% of the time.
3	Moderate Direction	Interacts appropriately 50% to 74% of the time.
2	Maximal Direction	Interacts appropriately 25% to 49% of the time. May need restraint.
1	Total Assistance	Interacts appropriately less than 25% of the time, or not at all. May need restraint.

Examples of socially inappropriate behaviors: temper tantrums; loud, foul or abusive language; excessive laughing, crying; physical attack; or very withdrawn or non-interactive.

2. PROBLEM SOLVING

Includes skills related to solving problems of daily living. This means making reasonable, safe, and timely decisions regarding financial, social and personal affairs and initiating, sequencing and self-correcting tasks and activities to solve the problems.

No Helper

7	Complete Independence	Consistently recognizes a problem, makes appropriate decisions, initiates and carries out a sequence of steps to solve complex problems until the task is completed, and self-corrects if errors are made.
6	Modified Independence	Recognizes a problem, makes appropriate decisions, initiates and carries out a sequence of steps to solve complex problems in most situations, or with mild difficulty, or requires more than a reasonable time to make decisions about or solve complex problems.

Helper

5	Supervision	Requires supervision (e.g. cuing, or coaxing) to solve routine problems only under stressful or unfamiliar conditions, no more than 10% of the time.
4	Minimal Direction	Subject solves routine problems 75% to 90% of the time.
3	Moderate Direction	Solves routine problems 50% to 74% of the time.
2	Maximal Direction	Solves routine problems 25% to 49% of the time. Needs direction more than half the time to initiate, plan or complete simple daily activities. May need restraint for safety.
1	Total Assistance	Solves routine problems < 25% of the time. Needs direction nearly all the time, or does not effectively solve problems. May require constant 1:1 direction to complete simple daily activities. May need a restraint for safety.

Examples of problems: Complex problem solving includes activities such as: managing a checking account, participating in discharge plans, self-administration of medications, confronting impersonal problems, and making employment decisions. Routine problems include successfully completing daily tasks or dealing with unplanned events or hazards that occur during daily activities.

3. MEMORY

Includes skills related to recognizing and remembering while performing daily activities in an institutional or community setting. It includes ability to store and retrieve information, particularly verbal and visual. A deficit in memory impairs learning as well as performance of tasks.

No Helper

7	Complete Independence	Recognizes people frequently encountered and remembers daily routines: executes requests of others without need for repetition.
6	Modified Independence	Recognizes people frequently encountered, remembers daily routines and requests of others with mild difficulty. May use self-initiated or environmental cues, prompts or aids.

Helper

5	Standby Prompting	Requires prompting (e.g. cuing, repetition, reminders) only under stressful or unfamiliar conditions, but no more than 10% of the time.
4	Minimal Prompting	Subject recognizes and remembers 75% to 90% of the time.
3	Moderate Prompting	Recognizes and remembers 50% to 74% of the time.
2	Maximal Prompting	Recognizes and remembers 25% to 49% of the time. Needs prompting more than half the time.
1	Total Assistance	Recognizes and remembers < 25% of the time, or does not effectively recognize and remember.

THE PHILIPPINE HEALTH INSURANCE CORPORATION (PHIC) TB TREATMENT BENEFIT PACKAGE

INTRODUCTION

PHIC aims to provide its members with additional outpatient benefit items. Tuberculosis (TB) is one highly considered since although the disease is mainly managed on an out-patient basis, TB as a disease can only be reimbursed as in-patient in PhilHealth's present set-up. The challenge will come in as we develop an appropriate provider payment scheme. The DOTS (Directly Observed Treatment, Short-course) strategy, which is reported to have an 85-96% cure rate, is highly considered to effectively deliver this benefit package.

DEFINITIONS

1. **Tuberculosis or TB** is an infectious disease caused by the microorganism called Mycobacterium tuberculosis. The microorganism enters the body by inhalation through the lungs. They spread from the initial location in the lungs to other parts of the body via the blood stream, the lymphatic system, via the airways or by direct extension to other organs.
2. **Pulmonary Tuberculosis** refers to disease involving the lung parenchyma. It is the most frequent form of the disease, occurring in over 80% of cases. This form of tuberculosis may be infectious.
 - 2.1. **Symptomatic Pulmonary TB Case** refers to an individual with symptoms of pulmonary TB and is found to have one of the following:
 - a. At least two sputum specimens positive for AFB, with or without radiographic abnormalities consistent with active TB, OR.
 - b. One sputum specimen positive for AFB and with radiographic abnormalities consistent with TB, OR.
 - c. One sputum specimen positive for AFB with sputum culture positive for M. tuberculosis, OR.

- d. All three sputum specimens negative for AFB with radiographic abnormalities consistent with active TB, with no history of anti-TB treatment and with a normal previous chest x-ray.

fever

sputum expectoration

significant weight loss

hemoptysis or recurrent blood streaked sputum

chest and/or back pains not referable to any musculo-skeletal disorders

other symptoms such as chills, fatigue, body malaise, shortness of breath

- 2.2. **Asymptomatic Pulmonary TB Case** refers to an individual without symptoms of pulmonary TB and is found to have one of the following:

- a. Radiographic abnormalities consistent with PTB and at least one sputum specimen positive for AFB, OR.
- b. Previous chest x-ray normal and current chest x-ray show abnormalities consistent with PTB, OR.
- c. Previous chest x-ray showed abnormality consistent with PTB, 3 sputum AFB smears previously negative, current chest x-ray shows progression of radiographic abnormality.

N.B. If current CXR shows abnormality consistent with TB and 3 sputum specimens are negative for AFB, but no previous CXR is available and the patient does not fulfill the criteria for PTB, follow-up CXR and sputum examination should be done at least a month after.

3. **Extra-pulmonary tuberculosis** is tuberculosis affecting organs other than the lungs, most frequently pleura, lymph nodes, spine, joints, genitourinary tract, nervous system or abdomen. Tuberculosis may affect any part of the body.

4. **Qualified TB Patient**

A patient who falls under any of the above TB cases (except Extra-pulmonary) after being worked-up by a qualified provider TB is a qualified TB Patient to avail of this package.

5. Qualified Provider

A medical specialist or General Practitioner Accredited by PHIC to be a provider of this benefit package.

6. Drop-out

Qualified TB patient who starts the treatment but who for any reason discontinues treatment is considered a drop-out.

THE POLICY

1. The TB treatment package will be based on the Revised National Tuberculosis Control Program Guidelines. The package will cover diagnostic work-up, consultation and TB drugs. Only pulmonary TB will be covered. Only PHIC accredited outpatient clinics capable of delivering DOTS will be the main and only providers.
2. The package will cover symptomatic cases and asymptomatic cases as well. The goal is to capture not only active TB cases but the non-active cases but proven to have TB in order not to duplicate the existing National TB Program.
3. The package will not include extra-pulmonary TB.
4. PHIC will assure provision of a defined TB Treatment Benefit Package.

THE TB BENEFIT PACKAGE

A. COVERAGE

- v All qualified PhilHealth members and their dependents including the Indigent program members will be covered.
- v PHIC will provide a comprehensive package that will cover diagnostic work-up, consultation and TB drugs for all members diagnosed with TB as defined above.

B. PROVIDERS

- v DOTS Centers and qualified providers can be the only providers of this package.
- v DOTS centers certified by PhilCAT such as those but not limited to a hospital, HMO, LGU health units, factory clinic, church based-clinics, school clinics are qualified to become providers after duly certified by PhilCAT.

C. ACCREDITATION

- v The PhilCAT will certify providers to ensure trainings and technical capability of the clinics are appropriate.
- v Standards for accreditation of providers will be based on the new PHIC Benchbook on Performance of Improvement of Health Services and all other necessary claims processing requirements.

D. PAYMENT

- v Drugs, consultation fees and laboratory fees will be covered by a single flat rate per case.
- v A fixed amount of co-payment will be required from each member. The amount will be agreed upon by the corporation.
- v A co-payment scheme will be applied for purposes of this program only.
- v Reimbursement payment will be paid per defined schedule assigned by PHIC.
- v Reimbursement requirements will be in accordance with PHIC claims reimbursement guidelines.
- v Qualified TB patients who will drop outs from the treatment package will not be reimbursed by PHIC if he/she decides to go back to the program. This is to ensure that all DOTS centers will take full responsibility of patient compliance and at the same time ensure this program's success rate.

E. REFERRAL SCHEME

- v Referral Guidelines will be developed to ensure that all providers whether accredited or not will refer patients/members to the qualified provider and DOTS centers. The guideline will likewise stipulate the process by which portability issues are addressed.

F. NATIONAL TB REGISTRY

- v All DOTS centers will be linked to the National TB Registry. This registry will provide all the information and utilization of the benefit package. Likewise, the National TB Registry will collect and process the basic information on the patient's treatment, provider update and referral status.

G. MONITORING

- v Monitoring of this program will be spearheaded by the Health Finance and Policy Sector.
- v A committee composed of Quality Assurance Research and Policy development Group, Accreditation Department and Fraud Unit will develop the monitoring tool in collaboration with PhilCAT.

H. IMPLEMENTING GUIDELINES

- v The TB Technical Working Group will create the Implementing Guidelines for this package.
- v Each stakeholders of this benefit package will represent the TWG.