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Barriers to tuberculosis care in the Philippines

In their Series paper in *The Lancet Respiratory Medicine*, Dheda and colleagues¹ reported a discrepancy between expected and reported tuberculosis cases during the COVID-19 pandemic. We write from the Philippines, the fourth largest contributor to the number of tuberculosis cases worldwide, with 500 people affected per 100 000.² Despite plans to improve tuberculosis programmes, aggregate tuberculosis notification decreased by 78.7% following community quarantine implementation.^{1,3} Multiple factors, including public perceptions about respiratory illnesses, limited health-care access, and a decentralised COVID-19 response, hindered progress for tuberculosis during the pandemic in the Philippines.

The pandemic increased precautions against respiratory illnesses, yet tuberculosis incidence is predicted to increase by 130% between 2021 and 2025.² A survey by Lau and colleagues⁴ showed that more than 60% of Filipinos avoided crowds and people with influenza-like symptoms as part of the response to COVID-19. Although compliance was high, only a third of respondents demonstrated understanding of these practices as preventive measures. Higher educational attainment and

telephone ownership were related to understanding of disease prevention; however, 80% and 20% of Filipinos, respectively, lack access to these.⁴

The decline in case notification, together with restricted access to tuberculosis programmes, has left substantial gaps in the continuum of care. In effect, deaths due to tuberculosis are predicted to increase by 170% owing to the effects of COVID-19.² The National Tuberculosis Program (NTP) has formulated a tuberculosis adaptive plan in the context of COVID-19. Interventions include video-observed treatment, digital adherence technologies, and support from other household members for patient treatment adherence in preference to traditional, directly observed therapy in the clinic.⁵ These interventions have delivered promising results: a 75% relative reduction in loss to follow-up after 6 months of treatment.⁵ However, these measures are limited to two regions and are still inaccessible to most Filipinos.

Despite the establishment of a national task force, the Philippine Government's pandemic response was largely decentralised.⁵ Early directives such as enhanced community quarantine occurred only in Luzon island. Lockdown and testing protocols varied by city. Local government units assigned their limited workforce to COVID-19

services, impacting primary health care resources available for other diseases. This shift halted tuberculosis surveillance, especially in urban centres where COVID-19 was rampant.²

We agree with the authors that the pandemic has impeded tuberculosis care, especially in countries with a high tuberculosis burden, and that a novel approach is now imperative. Support for the Philippines' first national inventory study in 2022 is crucial in quantifying under-reported tuberculosis cases. With this information, structured implementation of the NTP will improve identification, diagnosis, and treatment of tuberculosis. Overall, a centralised strategy will enhance surveillance and service delivery to reduce the burden of tuberculosis in the Philippines.

We declare no competing interests.

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