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Department of Education
REGION III
SCHOOLS DIVISION OFFICE OF BATAAN

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In compliance with DepEd Order (DO) No. 8, s. 2013 this advisory is issued not for endorsement per DO 28, s. 2001, but only for the information of DepEd officials, personnel/staff, as well as the concerned public.
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PROVINCIAL ORDINANCE NO. 05 SERIES OF 2026

This Office informs all concerned of **Provincial Ordinance No. 05, Series of 2026**, entitled "**An Ordinance Revising Provincial Ordinance No. 01-2014, Entitled 'An Ordinance Adopting the Implementation of the Tuberculosis Control Program in the Province of Bataan to Strengthen and Support All Activities of the Program to Attain a Tuberculosis-Free Community.'**"

Attached to this Advisory is a copy of **Provincial Ordinance No. 05, Series of 2026**, for reference.

Immediate dissemination of this Advisory is desired.

For:

CAROLINA S. VIOLETA, EdD, CESO V
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S04
6/16/2026



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Sangguniang Panlalawigan

BATAAN CAPITOL, BALANGA CITY



EXCERPT FROM THE MINUTES OF THE 34TH REGULAR SESSION OF THE SANGGUNIANG PANLALAWIGAN OF BATAAN ON MARCH 16, 2026 HELD AT THE SESSION HALL, THE BUNKER, @ THE CAPITOL COMPOUND, TENEJERO, BALANGA CITY, BATAAN 2100

PRESENT:

Hon. Maria Margarita R. Roque, Board Member & Temporary Presiding Officer

FIRST DISTRICT:

Hon. Jomar L. Gaza J.D., Board Member
Hon. Mylene A. Serrano, Board Member
Hon. Godofredo B. Galicia, Jr., M.D., Board Member

SECOND DISTRICT:

Hon. Noel Joseph L. Valdecañas, Board Member
Hon. Victor A. Baluyot, Jr., Board Member

THIRD DISTRICT:

Hon. Romano L. Del Rosario, MPA, Board Member
Hon. Angelito M. Sunga, Board Member
Hon. Jorge S. Estanislao, M.D., Board Member
Hon. Roman Harold R. Espeleta, OP, Board Member

Hon. Jovy Z. Banzon, Board Member (PCL President)
Hon. Romeo A. Austria, Board Member (FABC President)
Hon. Lovely Joy A. Poblete, Board Member (SKF President)
Hon. Feliciano G. Magay, Jr., Board Member (IPMR)

ABSENT:

Hon. Ma. Cristina M. Garcia, Vice Governor (O.B.)

PROVINCIAL ORDINANCE NO. 05 Series of 2026

AN ORDINANCE REVISING PROVINCIAL ORDINANCE NO. 01-2014, ENTITLED "AN ORDINANCE ADOPTING THE IMPLEMENTATION OF THE TUBERCULOSIS CONTROL PROGRAM IN THE PROVINCE OF BATAAN TO STRENGTHEN AND SUPPORT ALL ACTIVITIES OF THE PROGRAM TO ATTAIN A TUBERCULOSIS-FREE COMMUNITY."

**AUTHORED & SPONSORED BY:
HON. JORGE S. ESTANISLAO, M.D.**

WHEREAS, the Sangguniang Panlalawigan of Bataan enacted Provincial Ordinance No. 01-2014, or Tuberculosis Control Program Ordinance, with the primary objective of reducing the Tuberculosis (TB) burden through active case finding, enhanced treatment compliance, and strengthened local health system capacity which were aligned with the 2010-2016 National Plan of Action to Control TB;

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WHEREAS, Republic Act (RA) No. 10767, or the Comprehensive Tuberculosis Elimination Plan Act enacted in 2016 to eradicate TB as a public health issue by creating a national health action plan, increasing funding for prevention and treatment, mandating case reporting, integrating TB education into school curriculum and expanding PhilHealth benefits for TB patients;

WHEREAS, RA No. 10767 stipulated that all public and private health care providers shall report all diagnosed TB cases in accordance with the guidelines issued by the National TB Control Program (NTP) of the Department of Health (DOH);

WHEREAS, the DOH has reported that nearly 200,000 TB cases were recorded nationwide during the first half of 2025. In 2023, approximately 739,000 were confirmed, with around 37,000 TB-related deaths, highlighting a significant gap between estimated and registered cases and underscoring the need for intensified detection and treatment efforts;

WHEREAS, according to the World Health Organization (WHO) Global TB 2025 Report, the Philippines remains among the countries with the highest TB burden globally, accounting for approximately 6.8% of total global TB cases, with the disease driven largely by poverty, overcrowded living and working conditions, malnutrition, smoking, and HIV infection;

WHEREAS, in the practice of sustainable health detection, care, treatment, and governance, the Provincial Government of Bataan (PGB) commits to support the national government's efforts to institutionalize efficient and effective program implementation of the NTP;

WHEREAS, to achieve this, a whole-of-community approach is essential. All local sectors shall be engaged, including non-government organizations (NGOs), private sector partners, health facilities and hospitals, schools, day care centers, hotels, drugstores and pharmacies, community-based organizations (CBOs), transport groups (TODA and JODA), senior citizens, persons with disabilities, workplaces, barangays, barangay health workers and volunteers, and vulnerable and marginalized groups such as the urban and rural poor, 4Ps beneficiaries, and residents of resettlement areas. These sectors shall actively participate in intensified case finding, monitoring and evaluation, and patient care and case-holding to ensure sustained and effective TB control across the Province of Bataan;

WHEREAS, the PGB has demonstrated a strong multi-sectoral commitment to the eradication and control of TB through intensified, localized, and innovative health programs. The 1Bataan Seal of Healthy Barangays is an incentive-based program launched in 2019 to improve life expectancy by reducing and preventing communicable diseases, including TB, at the community level;

WHEREAS, the Office of the Provincial Health Officer (OPHO) actively promotes TB awareness, encouraging screening even for asymptomatic individuals. These efforts are supported by the 1Bataan vision of improving health care access, utilizing the OPHO to coordinate with Local Government Units (LGUs) and partners to achieve a TB-free province;

WHEREAS, RA No. 11332, or the Mandatory Reporting of Notifiable Diseases and Health Events of Public Health Concern Act, mandates the prompt reporting of notifiable diseases, emerging/re-emerging infections, and other health threats by public and private health personnel, hospitals and establishments;


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WHEREAS, there is a need to pass necessary ordinance to ensure achieving the objectives in improving healthy behavior, bolstering patient-centered TB and Drug-Resistant TB (DRTB) treatment, and expanding local health system capacity to effectively deliver TB and DRTB services to target populations;

NOW, THEREFORE, be it ordained, as it is hereby ordained by the Sangguniang Panlalawigan of the Province of Bataan, in session assembled, that:

SECTION 1. SHORT TITLE. – This Ordinance shall be known and cited as "The Revised Bataan Tuberculosis Elimination Act Ordinance of 2026."

SECTION 2. OBJECTIVES. – This Ordinance aims to establish a comprehensive and unified policy for the TB Control Program in the PGB. It is designed to foster targeted advocacy, eliminate stigma, and enhance case detection, including TB infection and disease, through robust community engagement.

Furthermore, it strengthens case holding, management, evaluation, and prevention strategies across all age groups to significantly reduce the TB burden in the province.

SECTION 3. DECLARATION OF POLICY. – It is hereby declared the policy of the PGB to institutionalize an integrated, comprehensive, sustainable, and unified policy for the TB Control program through suitable strategies:

- A. The PGB joins the National Government's efforts to institute an effective TB Control Program through the NTP delivery of TB services and strategies such as Mandatory TB Case Notification (RA No. 10767) and Patient-centered Care (Universal Health Law or RA No. 11223);
- B. The PGB shall promote public awareness about the causes, modes of transmission, consequences, and means of prevention and control of TB through a comprehensive province-wide education and information campaign organized and conducted by the OPHO. Such campaigns shall promote value formation and employ scientifically proven approaches, focus on the family as a basic social unit, and be carried out in all schools and training centers, health centers, hospitals, workplaces, and communities. This program shall involve affected individuals and the risk groups, including support groups;
- C. The PGB shall involve stakeholders from public and private sectors in the TB Control Program implementation, including, but not limited to, those organizations identified in Executive Order No. 187;
- D. The PGB recognizes the vital role of affected and cured individuals in promoting TB awareness. Their lived experiences shall be harnessed to effectively disseminate accurate information, reduce stigma, and educate the public about the prevention, treatment, and control of TB;
- E. Consistent with the above-mentioned policies and in consonance with the NTP Strategy, the PGB recognizes THAT:
 1. Multi-sectoral involvement is essential to local responses to TB infection;
 2. Bataños should be empowered to prevent further spread of TB through access to appropriate information and resources for prevention;


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3. The formulation of socio-economic development policies and programs should include the consideration of the impact of TB in the unique vulnerabilities of high-risk groups;
 4. Continued efforts should be made to constantly improve the performance and assure the quality of TB-related programs;
 5. Discrimination in any form, from pre-employment to post-employment, including hiring, promotion or assignment based on the actual, perceived, or suspected TB status, is prohibited, unless under the infective stage upon the determination of the medical specialist; and
 6. No educational institution shall refuse admission to any prospective student or discipline, segregate, deny participation, benefits, or services to, or expel any current student on the basis of his/her actual, perceived, or suspected TB status. Unless under the infective stage upon determination of a medical specialist, this shall include any perception of suspicion of TB status that may arise from a person being a friend, relative, or associate.
- F. To ensure and strengthen the smooth implementation of FAST-Find TB cases Actively, Separate Safely, and Treat effectively across all public and private health facilities, including DOTS centers and hospitals;
- G. To institutionalize the NTP, a functional Service Delivery Network (SDN) with a two-way referral system shall be established and strengthened. A standard referral form with a feedback mechanism shall be utilized to ensure continuity of care. Additionally, tracking systems for patients lost to follow-up shall be implemented in all health facilities providing DOTS services to strengthen a positive environment for TB disease and to encounter the stigma attached to it, thereby promoting health-seeking behavior of the population at large;
- H. To ensure compliance to TB infection control guidelines, all health (DOTS) facilities, hospitals and TB laboratories shall institutionalize appropriate infection control measures at all times following the order of hierarchy: administrative, environmental, and respiratory control;
- I. To ensure that all Pharmacies in the province shall be enjoined to enforce "No Prescription, No Dispensing" policy of TB Control for their implementation and compliance in accordance with DOH and Food and Drug Administration (FDA) regulations;
- J. The PGB shall allocate and provide at least ten percent (10%) of the projected drug requirements for both drug-susceptible and drug-resistant tuberculosis, laboratory supplies, and commodities to supplement national procurement, subject to the availability of funds and compliance with applicable procurement laws. This allocation shall serve as buffer support, particularly during unforeseen supply interruptions;
- K. The PGB shall ensure that all identified TB cases from all public and private healthcare providers, facilities, and hospitals are reported, monitored, and treated properly. In cases of non-compliance, a formal notice of violation shall first be issued by the OPHO. Continued failure to comply may warrant a recommendation to the city/municipal mayor for the revocation of the establishment's business permit;


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- L. To ensure compliance to DOH Administrative Order No. 2015-0039-Guidelines for Managing Tuberculosis Control Program during Emergencies and Disasters and to provide support for NTP emergency/disaster preparedness and response; and
- M. To ensure that all health centers are certified and accredited TB DOTS centers.

SECTION 4. DEFINITION OF TERMS. -

- A. **SYSTEMATIC SCREENING FOR ACTIVE TB** - refers to the systematic identification of presumptive TB in a predetermined target group, using examinations or other procedures that can be applied rapidly.
- B. **PRESUMPTIVE PULMONARY TUBERCULOSIS** - refers to any person having: i) two weeks or longer of any of the following - cough, unexplained fever, unexplained weight loss, night sweats; or ii) a chest X-ray finding suggestive of TB.
- C. **PRESUMPTIVE EXTRAPULMONARY TUBERCULOSIS** - refers to anyone having signs and symptoms specific to the suspected extrapulmonary site with or without general constitutional signs and symptoms such as unexplained fever or weight loss, night sweats, fatigue, and loss of appetite.
- D. **SYMPTOM-BASED SCREENING** - refers to screening using any of the four cardinal TB signs and symptoms. The four cardinal signs and symptoms of TB are at least two weeks' duration of cough, unexplained fever, unexplained weight loss, and night sweats.
- E. **SCREENING BY CHEST X-RAY** - refers to using chest X-ray to identify presumptive pulmonary TB (PTB), which will manifest with common abnormalities that are suggestive of PTB.
- F. **PRIMARY SCREENING TOOL** - refers to the test or tool that is used initially to detect presumptive TB in the systematic screening of TB. It may be symptom-based or a chest X-ray.
- G. **HEALTH FACILITY WITH TB SERVICES** - a health-care facility, whether public or private, that provides the entire spectrum of TB services in accordance with the policies and guidelines of the National Tuberculosis Control Program (NTP), Department of Health (DOH). This was formerly referred to as a directly observed treatment, short course (DOTS) facility.
- H. **CLOSE CONTACT** - a person who shared an enclosed space, such as the household, a social gathering place, workplace, or facility, for extended periods within the day with the index case during the three months before diagnosis of TB.
- I. **INDEX CASE** - the initially identified TB case of any age in a specific household or other comparable setting in which others may have been exposed.
- J. **INDIVIDUALIZED TREATMENT AND CARE PLAN** - a personalized treatment plan to be completed and mutually agreed upon by both the health-care provider and the patient throughout the course of treatment, encompassing: (1) literacy competency of the patient; (2) nutritional


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support; (3) comorbid condition management; (4) psycho-emotional support; (5) familial and social support; and (6) financial support.

- K. **STIGMA** – a disapproving renown or distinction commonly perpetuated from misconception and scant knowledge on TB disease and treatment.
- L. **DISCRIMINATION** – prejudicial perception of TB patients leading to unjust distribution or deprivation of services and non-acknowledgement of their rights.
- M. **ACTIVE TB DISEASE** – a presumptive TB case that is either bacteriologically confirmed or clinically diagnosed by the attending physician.
- N. **PULMONARY TB (PTB)** – refers to a case of tuberculosis involving the lung parenchyma. A patient with both pulmonary and extrapulmonary tuberculosis should be classified as a case of pulmonary TB.
- O. **EXTRAPULMONARY TB (EPTB)** – refers to a case of tuberculosis involving organs other than the lungs (e.g., larynx, pleura, lymph nodes, abdomen, genito-urinary tract, skin, joints and bones, and meninges).
- P. **BACTERIOLOGICALLY CONFIRMED TB (BCTB)** – refers to a patient from whom a biological specimen, either sputum or a non-sputum sample, is positive for TB by smear microscopy, culture, or rapid diagnostic tests (such as Xpert MTB/RIF, line probe assay for TB, or TB LAMP).
- Q. **CLINICALLY DIAGNOSED TB (CDTB)** – refers to a patient for whom the criterion for bacteriological confirmation is not fulfilled, but diagnosis is made by the attending physicians on the basis of clinical findings, X-ray abnormalities, suggestive histology, and/or other biochemistry or imaging tests.
- R. **NEW** – refers to a patient who has never had treatment for TB or who has taken anti-TB drugs for less than one month. Preventive treatment is not considered as previous TB treatment.
- S. **PREVIOUSLY TREATED FOR TB** – refers to a patient who had received one month or more of anti - TB drugs in the past. Also referred to as retreatment.
- T. **HIGH RISK FOR MULTIDRUG-RESISTANT TUBERCULOSIS (MDR-TB)** – previously treated for TB, new TB cases that are contacts of confirmed DR-TB cases, or non-converters among patients on DS-TB regimens.
- U. **RIFAMPICIN-RESISTANT TB (RR-TB)** – resistance to rifampicin detected using phenotypic or genotypic methods, with or without resistance to other anti-TB drugs. It includes any resistance to rifampicin, whether monoresistance, multidrug resistance, polydrug resistance, or extensive drug resistance.

SECTION 5. NATIONAL TUBERCULOSIS CONTROL. - The NTP now uses the Manual of Procedures (MOP), 6th edition, which was last modified in 2021–2022. It was released in 2020. It features updated, patient-centered guidelines on TB screening, diagnosis (Xpert MTB/RIF), and therapy, replacing the Fifth Edition (2015).

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A. PATIENT-CENTERED SUPPORT AND CARE FOR TUBERCULOSIS

1. Health care workers (HCWs) must respect patient autonomy and encourage self-efficacy along the TB care continuum.
2. By offering evidence-based integrated care for TB and associated co-morbidities, the patient's physical comfort, safety, and health will be maximized.
3. To lessen stigma, all TB patients must get psycho-emotional care as well as protection from discrimination and social exclusion.
4. By connecting TB patients to social protection programs, the effects of poverty and food insecurity on TB diagnosis and treatment will be acknowledged and addressed.

B. SCREENING AND DIAGNOSIS OF TUBERCULOSIS

1. All health facilities shall implement systematic screening for TB.
2. The primary screening tool for systematic screening in health facilities among all consultations, including immunization, maternal health, and child health, shall be symptom screening using any of the four cardinal signs and symptoms (cough lasting at least two weeks, fever with no known cause, weight loss without explanation, and night sweats). Persons accompanying the patient will also undergo screening by inquiring about TB signs and symptoms.
3. Consultations at health facilities should include annual chest X-ray screening as a recommendation.
4. Instead of depending only on sputum smear microscopy, active case finding will be implemented in congregate settings, targeted communities, and workplaces using chest X-rays as the primary screening tool and the adoption of molecular diagnostic rapid tests, such as Xpert and MTB/RIF, as the primary diagnostic test for everyone.
5. Every person living with HIV (PLHIV) needs to get their TB co-infection checked.
6. Every year, all healthcare facilities must use both symptom and chest X-ray screening to check for tuberculosis in their employees.
7. A chest X-ray and symptoms should be used to screen household members and close contacts of any age who have been diagnosed with tuberculosis.

C. DIAGNOSIS OF TUBERCULOSIS DISEASE

1. The primary diagnostic test for PTB and EPTB in adults and children should be a rapid diagnostic test (RDT), such as Xpert MTB/RIF.
2. Referrals for Xpert MTB/RIF testing are required for all presumed TB patients who are at high risk of MDR-TB. If not available, the patient will be transferred to the closest medical facility that offers DR-TB services for screening.
3. The bodily fluid or biopsy samples suitable for Xpert MTB/RIF testing must be collected for presumed EPTB cases.


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4. If Xpert is not available, the other diagnostic tests will be smear microscopy (whether brightfield or fluorescence microscopy) or loop mediated isothermal amplification (TB LAMP) and the Truenat test.

The Xpert MTB/RIF test's unavailability shouldn't prevent a bacteriological diagnosis of tuberculosis.

5. Large sample loads can be processed using TB LAMP, particularly in ACF efforts, but not for children, PLHIV, or MDR-TB risk groups.
6. In the event that bacteriologic testing yields negative results or is unavailable or inaccessible, patients will be assessed by the medical facility's physician, who will use best clinical judgment to determine a clinical diagnosis.
7. When a clinical diagnosis of TB in children is uncertain, the tuberculin skin test (TST), also called the pure protein derivative (PPD) test or the Mantoux test, should only be used as an adjuvant. You can use either 5-TU or 2-TU strength.
8. TST testing and reading will be performed by qualified health workers. A positive TST reaction is defined as an induration of at least 10 mm, regardless of the status of the Bacille Calmette-Guerin (BCG) immunization, or 5 mm in immunocompromised children (such as those who are very malnourished).
9. Every laboratory, whether public or commercial, that offers TB diagnostic tests must take part in the NTP's quality assurance program.
10. For the purpose of diagnosing clinically diagnosed DR-TB and managing challenging DS-TB and DR-TB cases, each RHU/health facility shall have a TB Core Team.

D. TREATMENT OF TUBERCULOSIS

1. Within five (5) working days from sputum collection, all diagnosed drug-susceptible TB (DS-TB) cases must get the proper anti-TB medication.
2. The findings of the Xpert MTB/RIF test or any other DST will determine the standard treatment for DS-TB; if the test is not performed, the regimen will be based on treatment history.
3. Ordering from a supplier who has a history of manufacturing first-line medications in accordance with national quality standards established by the FDA can guarantee the quality of anti-TB medications.
4. Patient-centered methods will be used to guarantee treatment adherence. Health professionals, community volunteers, or family members must offer treatment assistance.
5. Clinical evaluation and follow-up smear microscopy will be used to track treatment response.
6. Every adverse drug reaction (ADR) must be documented using the FDA's official reporting form and handled appropriately.


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7. According to the phased implementation of the TB-HIV partnership, all TB patients who are 15 years of age or older must be offered provider-initiated HIV counseling and testing.
8. Diabetes screening is required for all TB patients who are 25 years of age or older.

E. TREATMENT OF DRUG RESISTANT (DR) TUBERCULOSIS

1. Treatment for RR-TB and MDR-TB must be started within seven (7) days after diagnosis.
2. According to patient eligibility and exclusion criteria, standard treatment regimens for Multi-Drug Resistant-TB (MDR-TB) and Rifampicin-Resistance TB (RR-TB) will be administered. Patients who are not eligible for any of the conventional regimens will receive individualized treatment.
3. Prior to MDR-TB and RR-TB therapies, as well as before Extensive Drug Resistant-TB (XDR-TB) and XDR-TB treatments, first- and second-line Line Probe Assay (LPA) tests must be performed. Results must be available within 14 days of submission, and if a patient is resistant to fluoroquinolones (FQ) or both high-dose isoniazid and protionamide, treatment must be promptly adjusted.
4. Frequent adherence counseling will start prior to treatment, continue for two weeks following treatment, and be conducted once a month during therapy. Every medical facility that provides TB services must set up a responsive treatment adherence system that enables timely patient follow-up for those who discontinue treatment.
5. In order to improve treatment adherence, patients will receive assistance. This covers conditional cash transfers, transportation allowances, and community-based care, among other things.
6. A treatment supporter—a medical professional, a trained lay volunteer, or a family member—must be allocated to each patient in order to guarantee daily intake at home, in a designated community location, at work, or in a medical facility. If possible, self-administered treatment may be aided by the use of digital adherence technologies (such as video-based therapy, 99 DOTS, or Artificial Intelligence (AI) but supported by appropriate and consistent adherence counseling and support.
7. Clinical, microbiological, smear microscopy (SM) and culture, and laboratory investigations will monitor treatment in accordance with approved schedules and as needed.
8. Adverse circumstances must be promptly managed. In the event of drug intolerance (e.g., persistent nausea and vomiting), treatment must be modified. Patients who require hospital care due to serious adverse events or other comorbidities must be referred as soon as possible.
9. The FDA standard report form for adverse drug reactions (ADRs) or the Pharmacovigilance Information Management System (PViMS) must be used to record and report any severe adverse events or adverse events of special interest.


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10. Before and during treatment, patients and their families must receive treatment education, including instruction on infection prevention.
11. When necessary, patients' situations should be promptly discussed with the BPTC.

F. TUBERCULOSIS PREVENTIVE TREATMENT

1. TB contacts, PLHIV, and TB risk groups should be evaluated for eligibility to receive TB preventive treatment.
2. The following eligible persons will not need to undergo an interferon-gamma release assay (IGRA) or a tuberculin skin test (TST) before beginning preventive treatment:
 - a. PLHIV
 - b. children under five (5) who live with household contacts of PTB that has been bacteriologically verified; and
 - c. those with other TB risk factors and household contacts of bacteriologically proven PTB who are five years of age or older.
3. Other people must undergo TST (or IGRA) before receiving TB preventative treatment. When it comes to developing the induration characteristic of tuberculosis infection, either 5-TU or 2-TU strength is thought to be comparable.
4. Before starting TPT, a chest X-ray and symptom screening must rule out active TB.
5. Contacts of MDR-TB and RR-TB are not eligible for preventive treatment.
6. The completion of preventive therapy is the responsibility of all healthcare providers.

G. RECORDING AND REPORTING

1. To guarantee the delivery of sufficient and high-quality services, patient data must be gathered, examined, and used.
2. All healthcare facilities, whether public or private, that offer TB services (screening, testing, diagnosis, treatment, and/or prevention) or portions of them must implement NTP recording and reporting.
3. According to RA No. 10767, also referred to as the TB Law, all diagnosed active TB cases must be recorded and reported, and all treated latent TB cases must be categorized using globally recognized case definitions.
4. Healthcare personnel must receive training on completing NTP recording forms and reporting.
5. In accordance with RA No. 10173, also known as the Data Privacy Act of 2012, patient privacy must always be protected by maintaining the confidentiality of patient records.


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6. Before being properly disposed of, all paper-based records must be retained for seven (7) years. After 20 years, electronic records will be archived.
7. The official electronic TB information system will be called ITIS. The official TB and TPT registers must be kept up-to-date at medical establishments.
8. The DOH must receive all NTP reports via the Integrated TB Information System (ITIS) within the allotted time frame. Feedback on the reports that have been submitted must be given in accordance with the guidelines and schedule.
9. All levels of facilities (municipality, city/province) are required to conduct routine on-site data quality review and validation within the National Tuberculosis Control Program.
10. The information gathered will enable the computation of the primary metrics for program assessment.
11. The NTP shall release official data annually based on the key program indicators. Performance on screening, testing and diagnosis, treatment, and TB preventive treatment will likewise be available to the public via the TB dashboard.

SEC. 6. CREATION AND COMPOSITION OF THE BATAAN PROVINCIAL TUBERCULOSIS COUNCIL (BPTC). - The PGB shall create the Bataan Provincial TB Council as a vehicle for consolidation and unification of efforts on TB and consistent with existing mandates in the Local Government Code, which will be composed of the following:

Chairperson - Governor

Vice Chairperson - Chapter President, League of Municipality

Members:

- Provincial Health Officer
- Sangguniang Panlalawigan Committee Chairperson on Health and Sanitation
- Provincial Tuberculosis Program Coordinator
- Provincial Tuberculosis Medical Technologist Coordinator
- Liga ng Barangay President
- Representative of DOH Regional Office
- Representative of Local Finance Committee
- DILG Provincial Director
- DepEd Bataan Medical Officer
- Representative of Accredited Civil Society Organizations (NGO's)
- Representative of PhilHealth
- Bataan Medical Society - President

The Provincial Governor is authorized to determine and modify the composition of the BPTC as may be appropriate for the performance of its functions and the effective implementation of this Ordinance. The OPHO is hereby designated as the Secretariat, which shall provide administrative, clerical, and operational support to the Council.

National government offices represented in the Council shall not be counted for purposes of determining a quorum.


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The PGB may determine the feasibility of designating a TB Control Coordinator who shall function as the dedicated personnel for the implementation of the Comprehensive TB Elimination Plan Act of the province.

The roles and functions of the BPTC include:

1. To identify and establish the roles and responsibilities of the partners in the organization and delivery of TB care as per NTP guidelines;
 - A. To establish a secretariat for the TB Council;
 - B. To ensure the socio-economic development policies and programs and to include consideration of the impact of TB infection to the community;
 - C. To work for the prioritization in the allocation of resources for the TB Program; and
 - D. Spearhead activities and advocacy on TB Celebrations.
2. To coordinate with the different sectors involved in the NTP implementation and ensure that the NTP policies and the DOTS strategy are implemented, thereby ensuring case detection rate of at least 90% and treatment success rate of 90%;
 - A. To strengthen partnership with other government agencies, NGOs and private entities and international agencies for a more comprehensive NTP implementation;
 - B. To support local community health volunteers and TB Diagnostic Committee activities to sustain private sector interest and participation in the NTP; and
 - C. To gather sources and additional support (financial and material) for the continuous implementation of the program.
3. To ensure that efforts and resources are generated and geared towards achieving the goal of having a community where TB is no longer a public health problem; and
 - A. To ensure that the collection for the budget requirements for the TB Program for the province is sufficient;
 - B. To ensure that the LGU regularly support the monitoring, supervision, evaluation, training requirements, NTP drugs and supplies; and
 - C. To advocate the continuous investment for quality improvement and certification and accreditation of the LGU health facilities as DOTS centers.
4. To create a TB Taskforce in the PGB (from OPHO);
 - A. To assist in all the activities of the Health Centers towards an efficient and effective implementation of the program;
 - B. To help raise awareness and provide information campaigns and house-to-house orientation about TB;
 - C. To assist in data gathering, recording and monitoring of TB cases in the province; and


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- D. To directly report to the Provincial TB Area coordinator and work hand in hand with the barangay to ensure smooth implementation of the program.

SECTION 7. ALLIANCES AND NETWORKING. - A multi-sectoral alliance shall be included in the BPTC to initiate other measures necessary to establish networks, inter-agency links, and partnerships with key stakeholders. This will strengthen partnerships with different sectors involved in the program, such as government agencies, NGOs, civil societies, private sectors, donor institutions, and other cooperating agencies, for a more cooperative NTP implementation.

All public and private health facilities, including hospitals, laboratories, pharmacies, private diagnostic clinics/centers, workplaces, transport groups, day care centers, and schools in the province shall be engaged in TB control and prevention.

All practicing physicians and other healthcare workers essential in the implementation of NTP in the Province of Bataan shall be oriented, updated, and trained to ensure key participation in TB control.

SECTION 8. TB AWARENESS CAMPAIGN. - A continuous promotion of TB awareness, active case finding, and care shall be actively conducted through collaborations between the DOH, OPHO, and local municipal health office. These initiatives focus on early detection, community education, and reducing the stigma associated with TB.

The PGB launched the "1Bataan Seal of Healthy Barangay," an incentive-based program to encourage local government units to actively participate in health initiatives, including TB prevention.

SECTION 9. APPROPRIATIONS. - The PGB shall allocate such funds as may be necessary for the effective implementation of this Ordinance, subject to applicable laws, rules, and regulations.

- a) To ensure that the allocation for the budget requirements for the TB program of the PGB is sufficient;
- b) To ensure the support of the creation of BPTC, TB Task Force and its activities;
- c) To ensure that efforts and resources are geared towards achieving the goal of having a community where TB is no longer a public health problem;
- d) To ensure that the NTP policies and the DOTS strategies are implemented, thereby ensuring a case detection of at least 90% and a treatment success rate of at least 90%;
- e) To advocate for the continuous investment for quality improvement, certification, and accreditation of the LGU health facilities as DOTS centers. To strengthen and capacitate local community health volunteers on TB DOTS programs; and
- f) To ensure that the LGU regularly supports the Advocacy, Communication, and Social Mobilization monitoring, supervision, evaluation, training requirements, NTP drug supplies contingencies, and other incidental expenses.


JOSE ENRIQUE S. GARCIA III
Provincial Governor

SECTION 10. IMPLEMENTING RULES AND REGULATIONS. - The Provincial Governor may issue the necessary Implementing Rules and Regulations for the effective implementation of this Ordinance.

SECTION 11. SEPARABILITY CLAUSE. - If any provision of this Ordinance is declared invalid or unconstitutional, the remaining provisions not affected shall continue in full force and effect.

SECTION 12. REPEALING CLAUSE. - All ordinances, rules, regulations, and other issuances or parts thereof inconsistent with this Ordinance are hereby repealed or modified accordingly.

SECTION 13. EFFECTIVITY. - This Ordinance shall take effect after compliance with the relevant provisions of the Local Government Code of 1991.

UNANIMOUSLY ENACTED this 16th day of March 2026.

I HEREBY CERTIFY to the enactment of the foregoing ordinance.

MARY ANN R. DE JESUS, MPA
Acting Secretary to the Sangguniang Panlalawigan

ENACTED:

JOMAR L. GAZA J.D.
Board Member

NOEL JOSEPH L. VALDECAÑAS
Board Member

MYLENE A. SERRANO
Board Member

VICTOR A. BALUYOT, JR.
Board Member

GODOFREDO B. GALICIA, JR., M.D.
Board Member

JORGE S. ESTANISLAO, M.D.
Board Member

ROMANO L. DEL ROSARIO, MPA
Board Member

ROMAN HAROLD R. ESPELETA, OP
Board Member

ANGELITO M. SUNGA
Board Member

ROMEO A. AUSTRIA
Board Member
(FABC President)

JOVY Z. BANZON
Board Member
(PCL President)

LOVELY JOY A. POBLETE
Board Member
(SKF President)


JOSE ENRIQUE S. GARCIA III
Provincial Governor


FELICIANO G. MAGAY, JR.
Board Member
(IPMR)

ATTESTED:


MARIA MARGARITA R. ROQUE
Board Member & Temporary Presiding Officer

APPROVED:


JOSE ENRIQUE S. GARCIA III
Provincial Governor
Date: 3-24-2026 *rf*





