



# HEALTHbeat

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**25 Years of  
GENERIC  
LAW**

*FDA Acting Director General Kenneth Y. Hartigan-Go, MD*

# Trust the Regulators



*Christian or Muslim, rich or poor, city dweller or mountain dweller, Filipinos are assured of quality health care. DOH provides the same attention and the same services to Filipinos regardless of religious beliefs, ethnic background or ancestry and economic standing.*





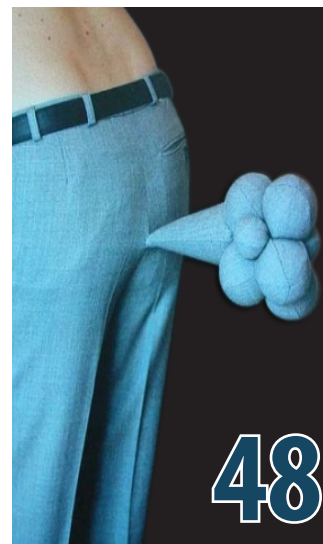
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## 25 Years of Generics Law

On September 13, 1988, Republic Act. No. 6675 or the Generics Act of 1988 was signed into law by then President Corazon C. Aquino. The title of the law clearly states its purpose – “to promote, require and ensure the production of an adequate supply, distribution, use and acceptance of drugs and medicines identified by their generic names.” An important provision of the law is to ensure adequate supply of drugs with generic names at the lowest possible cost and make them accessible and available especially to the poorest sector of society.

The Generics Law was hailed as a landmark law that could benefit the public. It also laid the groundwork for establishing a local drug industry in the Philippines. The good law, of course, came with strong opposition particularly from multinational drug companies as well as from many doctors. Twenty five years ago until now, the premise that branded medicines are far better than their generics counterparts is still being debated. Efforts to bring down the prices of drugs and medicines and make them accessible to all remain obscure.

Another law to support the Generics Law came – the Universally Accessible Cheaper and Quality Medicines Act of 2008 – enacted on April 29, 2008. It amended some provisions of the Intellectual Property Code, the Pharmacy Law and the Generics Law. However and as expected, the “generics only” and “price regulatory board” clauses in the House version were scrapped in the law. These two provisions could have made a bigger impact in drug price reduction.

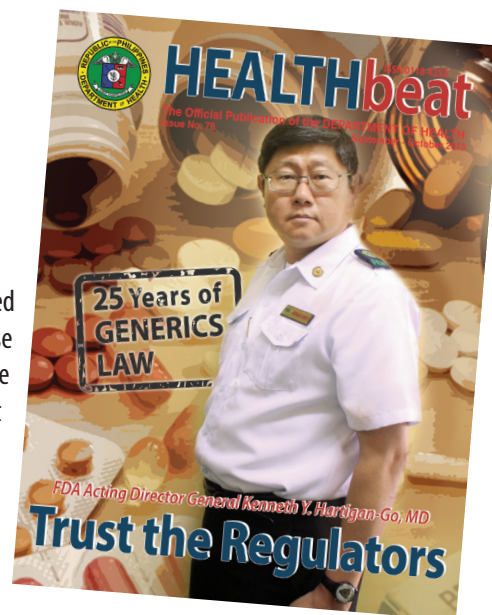
One of the major criticisms why access to medicines still cannot be attained is the “health department’s incompetence.” During a policy dialogue on universal health care and access to medicines at the Asian Institute of Management on July 25-26, 2013, Food and Drug Administration (FDA) Acting Director General, Dr. Kenneth Y. Hartigan-Go, admitted that his agency cannot guarantee the quality, safety, and efficacy of generic drugs due to lack of resources to test the drugs. But he was quick to add that the FDA is now working on requiring bioavailability and bioequivalence analyses for generic drugs. Go also called on the much needed support and resources for the FDA to fulfil its duties, and more importantly to trust the FDA as a health regulator.

The issue on providing quality and low-cost medicines to all is still a continuing saga in the Philippines. The Department of Health is committed to work on this goal, together with its complex details, to achieve **Kalusugan Pangkalahatan**. The DOH enjoins everyone's support and action in this endeavor.

- The Editors

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Cover Photo **Adell R. Azuelo**

Graphics Design **Rhoderic N. Domingo**  
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Contributors  
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**Cecilia Q. Cañiza**  
**Joyce Anne Ceria, RPh**  
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(Photos) **Romeo S. Caparas**  
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# Trust the Regulators

by  
**ABRAM JOSEPH MAGNAYE**  
DOH Research Fellow

Food and Drug Administration (FDA) Acting Director General Dr Kenneth Y. Hartigan-Go stressed the important role of regulators in achieving **Kalusugan Pangkalahatan** (universal health care) and access to medicines guaranteeing the quality, efficacy and safety of medicines which entails monitoring the whole life cycle of drugs starting from manufacturing up to consumption.

He said this during the Policy Dialogue on Universal Health Care and Access to Medicines at the Asian Institute of Management on July 25-26, 2013, and emphasized the key functions of FDA which include: the creation of regulatory standards; inspection and licensing of drug establishment; levying penalties for violators; conducting laboratory tests for health products; and post-marketing surveillance.

Borrowing the World Health Organization's concept of health system strengthening, Go emphasized that **Kalusugan Pangkalahatan** cannot be dissociated with strengthening health systems – human resource health, logistics, good governance, information and communication technology, health products, and healthcare financing – and challenges can be best addressed with a holistic community approach which encourages the engagement of every stakeholder from other government agencies to the industry as well as health professionals and consumers.

First, compliance to good manufacturing practice (GMP) needs to be strictly enforced in order to ensure the



*Food and Drug Administration (FDA) Acting Director General Dr. Kenneth Y. Hartigan-Go calls on stakeholders to "trust the regulators." (Photo by Romeo Caparas)*

quality, efficacy, and safety of drugs. The FDA is now more than ever vigilant in meeting this obligation to safeguard public health. However, the FDA would want to be more proactive by conducting on-site GMP inspections of drug manufacturers abroad in order to guarantee the quality, safety, and efficacy of imported medicines.

On changing irrational and improper prescribing behavior of medical practitioners, the FDA is fully aware of the need to address the unethical marketing promotions. Accurate information on drugs is very essential as these pieces of information influence the choice of medicines. Likewise, prescriptions also have a great influence in



the choice of medicines. The FDA takes full responsibility of monitoring the unethical marketing practices. In the coming months, the FDA will implement the Asia-Pacific Economic Cooperation (APEC) Declaration of Ethical Marketing Practices in the country to address this issue.

The prescription of generic drugs is also an issue. Recent data show that the Philippines is still a branded market when it comes to drugs. This is alarming given that the Generics Law of the Philippines, marks its 25th anniversary this year. However, a more pressing issue is the question on the quality of generic drugs. To date, the FDA cannot guarantee the quality, safety, and efficacy of generic drugs due to lack of resources to test the drugs, but the FDA is not stopping there. The FDA is now working on requiring bioavailability and bioequivalence (BA/BE) analyses for generic drugs.

To continuously monitor the quality of drugs available in the market, the FDA is strengthening its post-marketing surveillance. The FDA has already established its Regulatory Enforcement Unit which now requires companies to provide risk management plans, including the voluntary recall of products if proven unsafe, substandard and ineffective.

The FDA has already established

an e-reporting system for adverse drug reactions (ADR) providing an avenue for consumers to lodge their complaints on the safety, quality, and efficacy of medicines. It is also complemented with the continuous advocacy on pharmacovigilance and the ongoing education and promotion efforts to increase awareness on ADR.

Moreover, the FDA is also laying down other innovations in regulatory reform, like a Micro, Small and Medium Enterprises unit that will be closely working with the Department of Trade and Industry to help address the compliance and investment issues of the pharmaceutical sector. In addition, the FDA is challenging the Pharmacy Law with regard the deregulation of the requirement for pharmacists in drugstores. The significant mismatch between the number of drugstores and licensed pharmacists poses a challenge to access to medicines with drugstores facing closure with this stringent requirement and potentially reducing the accessibility of medicines especially in remote areas.

However, it must be noted that FDA's role in **Kalusugan Pangkalahatan** spans many other health product categories under its remit such as food, cosmetics, and medical devices. This amounts to about Php 2.2 trillion of household expenditures

on the products directly monitored by the agency, and may even reach Php 3.3 trillion of household expenditures if other sectors that are indirectly monitored by the FDA are included. Thus, the FDA is actually in the frontline and bottleneck of access to medicines, inclusive growth and sustainable development.

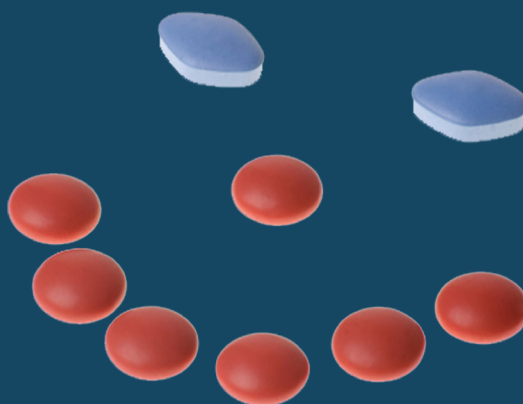
Go said that the FDA dutifully accepts its mandate, but without the support and the resources to fulfil its duties, it may turn into a 'white elephant.' Amidst the financial constraints of the agency, he believes that the agency is not being a very effective regulator. There is still so much to be done. The regulator needs to be equipped, but there is no school for regulators to equip them with the science of regulation. Also, the regulator needs to be protected from any political and economic agenda that can compromise its regulatory obligation to the public. Finally, the FDA must be strengthened with improved science, equipment, and facilities in order to register better products, in turn, gaining credibility as a regulator.

Finally, Go called on stakeholders to trust the regulators. Amidst all the financial challenges the FDA faces, it has been showing resiliency and is making a statement that it will not back down in doing its mandate.

## Mahal ang Gamot

*Mister at Misis sa botika...*

PHARMACIST: P2,500 po lahat ang presyo ng gamot ninyo.  
DINKY: Ang mahal naman, n'yan. Tanggalin mo lahat ng hindi mo kailangan.  
TERE: Okay, Hon...  
PHARMACIST: P500 nalang po ito.  
DINKY: Ang laki ng nabawas. Ano ba ang tinanggal mo?  
TERE: Eh 'di 'yung mga gamot mo. Sabi mo kasi tanggalin ko ang hindi ko kailangan.







*Health Undersecretary Madeleine Valera presents the Philippines' response on universal health care and access to medicines during the policy dialogue at the Asian Institute of Management on July 25-26, 2013. (Photo by Romeo Caparas)*

## Financing Access to Medicines

by

**GLORIA NENITA VELASCO**

National Center for Pharmaceutical Access and Management

Ensuring that Filipinos have access to safe, efficacious, and quality essential medicines is an integral part of **Kalusugan Pangkalahatan** (universal health care) focusing on three strategic thrusts - rapidly expanding enrolment and utilization of the national health insurance program, improving access to quality health services, and attaining the health-related Millennium Development Goals (MDGs).

Financing is important to ensure the availability and affordability of medicines, as it is for other health care services. Access to medicines is an old issue, but has recently surged in global attention and significance even to the point as saying that universal health care in unachievable

without ensuring access to medicines.

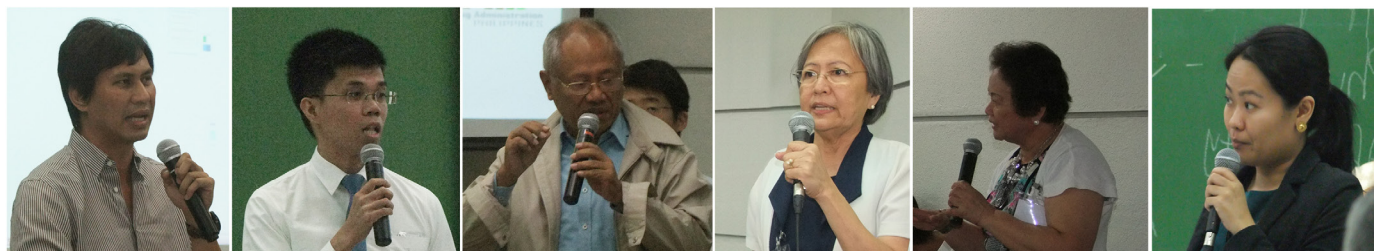
Access to medicines figures a sizeable role in improving access to health services, (i.e., a quality experience in a hospital or health facility includes having access to the safe, efficacious, and quality medicines) and in achieving the MDGs (i.e., a number of the identified health problems like tuberculosis, malaria, and HIV/AIDS requires people to have access to the medicines they need.

On July 25-26, 2013, a policy dialogue on universal health care and access to medicines was held to identify gaps and solutions in ensuring universal access to medicines in the Philippines. The dialogue involved numerous stakeholders from both

the public and private sectors, including local and multinational pharmaceutical companies, health maintenance organizations (HMOs), and civil society groups. It was organized by the Department of Health, Philippine Health Insurance Corporation (PhilHealth), and the Food and Drug Administration with support from the Dr. Stephen Zuellig Center for Asian Business Transformation and Management Sciences for Health. The dialogue was held at the Asian Institute of Management in Makati City.

One way of promoting increased access to medicines is bringing down the prices of medicines. Prices of medicines in the country can be prohibitive that patients





**Stakeholders share their views to identify gaps and solutions in ensuring universal access to medicines in the Philippines. (Photos by Romeo Caparas)**

cannot afford and unable to buy them. This reality clearly affects the achievement of *Kalusugan Pangkalahatan*. This is most relevant for patients with chronic illnesses who require chronic medication, the end result of which would be a worsening condition or even death. In the policy dialogue, rational drug pricing with the establishment of a drug price reference index and tailored procurement were presented as strategies to ensure affordability of medicines.

Dr Melissa Guerrero of the DOH-National Center for Pharmaceutical Access and Management (NCPAM) emphasized the need for ensuring the cost-effectiveness and value for money of pharmaceuticals that consumers buy and benefit with improved health outcomes. She underscored the additional benefit of rational drug pricing which is savings for the government that can be allotted towards more drugs and health services for patients, especially the poor. Alex Haasis, also from NCPAM, went further into the establishment of a drug price reference index which can be used in rational drug pricing. He presented preliminary results of a drug price scan that is currently being conducted by the DOH. Though still in the works, the drug price reference index can change the way medicines will be priced in the future especially in the public health sector.

The additional benefit of savings for the government was also cited by Bienvenido Bautista, president of Philippine International Trading Corporation (PITC)

Pharma, and said that tailored procurement should be practiced by government agencies because prices of medicines can be brought down significantly. This reduction in procurement price translates into larger savings which can be earmarked for other government programs and projects. Bautista has effected positive changes in the procurement processes of PITC Pharma, using his knowledge and experiences from the private sector. He hopes that PITC Pharma will soon become a major contributor in bringing down medicine prices in the public sector.

Medicines in the Philippines are available through numerous channels such as privately-owned pharmacies, hospitals, and health facilities, as well as through government health facilities such as rural health units, health centers, and hospitals. Though majority of medicines are accessed through privately-owned pharmacies, other privately-owned organizations, PhilHealth, and public-private partnerships can increase the availability of medicines. By having more channels for medicines to be available, Filipinos can anticipate to have more chances to access the medicines they need.

Carlos da Silva, executive director of the Association of Health Maintenance Organizations of the Philippines, Inc. spoke on the industry's role as arrangers of health and in increasing access to health care through risk pooling – the current practice of most HMOs. On the other hand, Dr Francisco Soria, PhilHealth senior vice president, shared the agency's efforts at risk

pooling and pointed out that PhilHealth can increase Filipinos' access to medicines through increasing enrolment, expanding accreditation of health care providers, expanding benefits, and shifting the payment mechanism from fee-for service to case-based payment. HMOs and PhilHealth cover both in-patient and out-patient health care, although ensuring access to medicines is limited. However, there is great potential for both to contribute to increased access to medicines especially for out-patient health care.

A public-private partnership project on improving access to medicines is currently being piloted in Palawan and it appears to be promising. This project is the result of a collaboration between the Bill and Melinda Gates Foundation, four multinational pharmaceutical companies, the DOH, PhilHealth, and the local governments of the Province of Palawan and Puerto Princesa City. It aims to improve access to medicines by improving the availability, accessibility, and affordability of medicines. Dr Anthony Faraon, head of the project, said it will "allow the identified target patients to take advantage of a public policy environment that facilitates the provision of differentially priced medicines at participating access points, which will be the provincial hospital pharmacies."

Ensuring access to medicines is a complex issue that cannot be solved at once. The policy dialogue, however, revealed a willingness and commitment of all stakeholders to solving this problem.



# Philippine National Formulary System

by

**JOYCE ANNE P. CERIA, RPh** and **IRENE V. FLORENTINO-FARIÑAS, RPh, MD**

National Center for Pharmaceutical Access and Management

A year after the enactment of Republic Act 6675 otherwise known as the Generics Act of 1988, the very first edition of the Philippine National Drug Formulary (PNDF) Volume I was printed and published. This contained a list of medicines deemed essential and ethical to be prescribed by health practitioners nationwide. It is likewise considered as one of the important tools to promote rational drug use, one of the five pillars of the National Drug Policy, by making essential affordable medicines of proven efficacy, safety and quality accessible at all times. The Formulary, which undergoes revision every three years, also serves as the basis for procurement of government agencies and health facilities as well as the reimbursement of medicines by Philhealth.

## From PNDP to PNF

In 2008, the 7th edition of the PNDP Volume I was published, which included a total of 627 essential medicines. The National Formulary Committee (NFC) was then chaired by Dr. Estrella Paje-Villar and comprised of expert members from different medical fields. In 2011, the NFC was reconstituted and renamed as the Formulary Executive Council (FEC) by virtue of Administrative Order No. 2012-0023 or the Revised Implementing Guidelines for the Philippine National Formulary



System (PNFS). The composition of this Council includes experts from the fields of pharmacology, medical anthropology, toxicology, clinical epidemiology, pharmacy, clinical medicine, public health, law and medicine, health economics and health social science. This issuance has also referred to the PNDP as the Philippine National Formulary (PNF) with its processes and governance framework collectively named as the PNF System. Currently, the FEC is chaired by Undersecretary Madeleine De Rosas Valera and co-chaired by Food and Drug Administration (FDA) Acting Director-General Kenneth Hartigan-Go.

The year 2011 marked the start of refinement and innovations on how

the Formulary should be developed and how its corresponding policies are implemented. The incorporation of health technology assessment (HTA) and economic evaluations (e.g., cost-effectiveness analysis, cost-utility analysis) are among these improvements.

To support the FEC in the evaluation process, the Evidence Review Group (ERG), an independent body of academics and researchers, is contracted separately from the FEC. The ERG is responsible for analyzing, appraising and synthesizing the evidence on the overall risk-benefit of drugs based on results of controlled clinical trials and sound epidemiologic studies. The methods of the ERG continue to be reviewed and enhanced to ensure an objective and independent quality assessment of the existing evidence that will guide the FEC in making sound recommendations on new and old drugs including their proper use and place in clinical therapy. By 2014, national guidelines on the clinical and economic evaluation of vaccines and other essential medicines will be launched by the Department of Health with its academic partners. Likewise specialty experts are also summoned during meetings to help the FEC during deliberations. In-house capacity to technically review drug submissions for the national formulary is also being built at the National Center for Pharmaceutical Access and Management (NCPAM), the Office within DOH tasked to act as the technical

Secretariat for the FEC.

In the advent of the revised guidelines, new forms and documentary requirements are being asked from the proponents to support their submissions. The proponents may not only be from the pharmaceutical industry but also include those from the hospital, civil society, consumer and patient groups or practically everyone who has a stake in the utilization of medicines.

Applications to the national formulary are classified into major submissions (i.e., new medicine not listed in the formulary; new dosage form, new indication, or new route of administration for a medicine already listed in the current edition of the PNF; re-inclusion; or resubmission) and minor submissions (i.e., new dosage strength; net content; or immediate packaging for medicines already listed in the current Formulary). Since 2011,

32 minor and 16 major submissions have been approved for inclusion in the PNF. These are posted together with the other PNFS updates in the NCPAM website <[http://uhmis2.doh.gov.ph/doh\\_ncpam](http://uhmis2.doh.gov.ph/doh_ncpam)>.

### The Way Forward

NCPAM has been in partnership with the Thailand Ministry of Health's Health Intervention and Technology Assessment Program (HITAP) and the United Kingdom National Institute for Health and Care Excellence (NICE) since 2012 for the continuous improvement of the methods, processes and governance of the PNFS as well as DOH capacity-building for HTA. The new PNF Manual will soon be published with a more user-friendly format which will include the following clinical information on all drugs in the formulary: 1) dose (formulation and strength) and indication; 2) special

precaution; 3) adverse drug reaction; 4) drug interaction; 5) warning; and 6) list price to the government. A Medicines Price Board will also be created within the PNFS tasked to negotiate with the industry on the pricing of pharmaceutical products guided by pharmaco-economic studies demonstrating the value for money of new drugs to DOH, PhilHealth and the bigger national health system. This is to ensure that the limited resources of the government are efficiently used toward drugs and technologies that provide significant clinical value to patients and the healthcare system as part of the overall agenda of universal healthcare.

This year, the PNF for Primary Healthcare will be published and distributed to all primary care facilities in the country. For more information and updates, please visit the NCPAM website or email the PNFS Secretariat at <[pndfs.secretariat@gmail.com](mailto:pndfs.secretariat@gmail.com)>.



The image shows two men in green uniforms and hard hats, likely healthcare workers, looking at a magazine titled "HEALTHbeat". The magazine is the 17th Anniversary Issue, dated August 2013, and features a portrait of President Benigno S. Aquino III. The magazine also mentions "115 Years of DOH". The man on the left is wearing a white hard hat with a logo and a name tag that says "DPOS-QC". The man on the right is wearing a black hard hat with "DPOS" written on it and a name tag that says "BURCE J G".

Pahinga Muna, Mag HEALTHbeat Online  
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Photo by Joerem P. Ceria



## *FDA Raising the Alarm Anew on* **Misleading Claims of Food/Dietary Supplements**

The Department of Health - Food and Drug Administration (FDA) raised anew its concerns over the massive advertisement, promotion and marketing of food/dietary supplements (F/DS) which may have often misled some consumers to buy them as drugs or medicines, and issued FDA Advisory No. 2013-020 s on July 17, 2013. Consumers are advised to read F/DS product labels and to use the FDA website **www.fda.gov.ph** to validate information and health claims .

F/DS are processed food in the form of capsules, tablets, liquid, gels, powders or pills and are intended to increase the total daily food energy or nutrient intake. However, F/DS are often advertised, promoted and marketed as agents that can cure or treat people who are suffering from various diseases and disorders. FDA strongly advises the public that F/DS are merely adjunct nutritional substance to support food intake and are NOT meant to replace prescribed drugs and medicines especially those that are supposed to be taken as maintenance medicine (e.g. for hypertension, dyslipidemia, diabetes, cancer, etc.).

FDA Acting Director General Dr Kenneth Y. Hartigan-Go reiterated, "If you intend to take food/dietary supplements, please inform your physician."

All F/DS are regulated by the FDA Center for Food Regulation and Research and all registered food products have certificates of product registration (CPR) as food products issued by the center.

Recently, the FDA Inspectorate discovered an unregistered F/DS product in the market containing raw 500 milligram (mg) cayenne (chili pepper) powder per capsule of 100/plastic container. Upon closer inspection of the principal display panel of the packaging, the product is an "appetite suppressant and fat metabolizer," which are drug therapeutic claims not substantiated by any clinical trial data to establish safety and efficacy. The side panel of the label shows that a cosmetic distributor owns the unregistered product, which was manufactured by a food supplement corporation licensed as food manufacturer. The product is also available through the Internet.

The FDA Advisory urged consumers to be vigilant and always read the product labels. The phrases "food supplement" and "No Approved Therapeutic Claims" should always be printed on the principal display panel. Likewise, the names of the manufacturer, trader or distributor, date of manufacture and expiration date of the product should be found on the label. All F/DS should have no indication to treat or cure any type of medical conditions.

All consumers are also enjoined to validate all information and product label claims, especially those with curative and therapeutic effects, by simply accessing the FDA website and taking the following steps:

- To verify if the product has CPR, simply click the tab CONSUMER CORNER and then Click REGISTERED FOOD SUPPLEMENTS. The names of the F/DS products are arranged

in alphabetical order. A faster way is to use the SEARCH tab found in the upper right hand corner of the website. Type the product name and wait until the name of the product appears. The product name will appear if a CPR has been issued by the FDA. If the product name is clicked, the following information will appear: a) Product Name; b) Company Name; c) Registration No.; and d) Date Issued and Expiry Date (of the CPR).

- To verify if the health or nutritional claims of the product have been authorized by the FDA to be placed on the label, email the FDA at **report@fda.gov.ph** or visit its website and click the **eReport** tab. Under the **Contact Form**, fill in the information requested: a) Name; b) Email; c) Subject; and d) Message (type in the query about the product). The message will be received by the FDA, and expect a reply within 24 hours.

- To validate if the food manufacturer or distributor has a valid License to Operate (LTO), click on the **Industry Corner** tab. Under the Food Industry, click Food Manufacturer or Food Distributor. The names of the food establishment are arranged in alphabetical order. The following information will appear when the name of the establishment is clicked: a) Company Name; b) Address; c) Owner; d) LOT No.; e) Date Issued (of the LTO); and f) Expiry Date (of the LTO).

- To report any adverse reactions for using a specific cosmetic product, email the FDA at **report@fda.gov.ph**.



Go reiterated, "Always read product labels or check out their website, Before buying any food supplement, particularly those that have curative and therapeutic claims or are priced exorbitantly high."

In 2010, the DOH attempted to protect the public from F/DS by issuing an Administrative Order (AO) 2010-2008 mainly to inform that these supplements are not drugs and should not be used to treat diseases. The AO would require F/DS manufacturers and distributors to translate in Filipino the "No Approved Therapeutic Claim" tagline in their promotion and advertising and use the statement "HINDI ITO GAMOT AT HINDI DAPAT GAMITING PANGGAMOT SA ANUMANG URI NG SAKIT."

The AO raised howls of protest from the multi-billion peso herbal and food supplement industry and they responded by dragging then Health Secretary Esperanza Cabral before the Court as well as the Office of the Ombudsman. The industry eventually has been granted an injunction by the Court that stalled the implementation of the AO.

Filipino consumers do not really need these F/DS supplements for health and well-being. If a person wants to improve and protect health, he/she must think of real food. A person who depends on supplements than eating a variety of foods will miss the potential benefits of antioxidants, fiber and other nutrients that only whole, unprocessed foods can provide. For example, a person can get vitamin C from a pill or from an orange. But the orange is still the better choice because it also provides fiber, beta carotene, calcium and other nutrients.

The best way to stay healthy and avoid most diseases is still to adopt a healthy lifestyle by doing physical activity or exercise, eating the right kind and amount of food, no smoking, responsible drinking, and having a regular medical check-up.

## beatBOX



## Smile Ka Din

Smiling, even when you fake one, can reduce stress levels, lower the heart rate while performing difficult task, and even make people more lenient when you have been naughty.

Go ahead, try it. Turn the corners of your mouth up into a smile and then give a laugh, even if it feels a little forced. Once you've had your chuckle, take stock of how you're feeling. Are your muscles a little less tense? Do you feel more relaxed or buoyant? That's the natural wonder of laughing at work. It does your body good.

Smile 'though your heart is aching. Laugh and the world laughs with you.

### ABOUT THE PHOTO

Since there is no photo contribution from readers yet, the National Center for Health Promotion is filling in this section with funny photos of the staff. Here, Jerry de Leon (left) and Romy Caparas (right) do a spoof of a fastfood advertisement. (Photo by Rowena Bunoan, design by Frederick Pereña)

Do you have funny (but not offensive) photo you want to publish in **HEALTHbeat**. Just email your high resolution photo with caption at <healthbeat@ymail.com>. Include the name and office of the photographer. Make sure you also get the permission of your subject/s.

We will create some health tidbit the way we see your photo.





# Epilepsy Awareness Begins in Communities

*Prepared by the*  
**PHILIPPINE LEAGUE AGAINST EPILEPSY**

September 1-7, 2013 is National Epilepsy Awareness Week. This year's advocacy with the theme "Epilepsy ABC: Awareness Begins in Communities (Kaya Natin 'To!)," which started in August,

travelled around 150 schools nationwide to promote not just awareness on epilepsy but more importantly inclusion of persons with epilepsy (PWEs) in various levels of engagement, in health, education, welfare

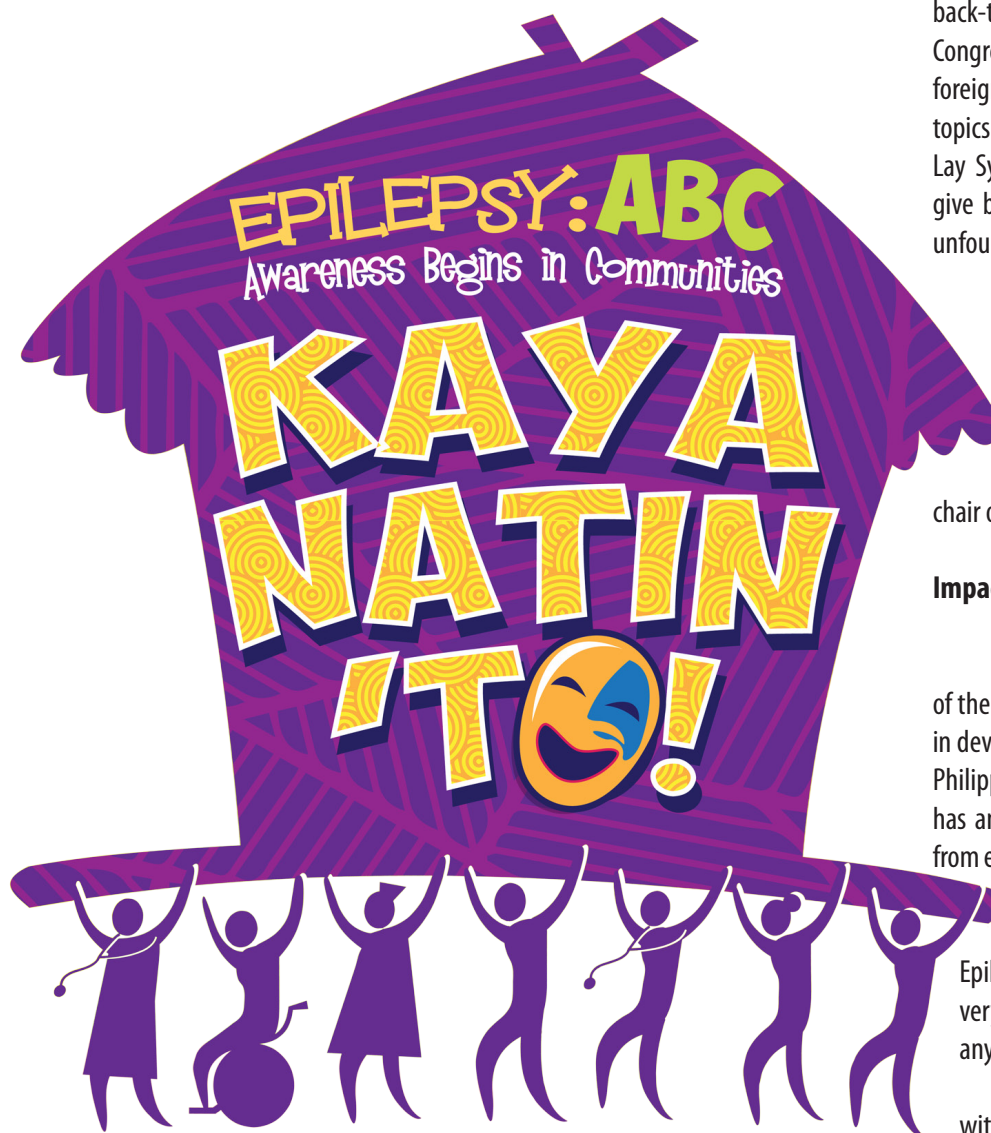
and development through community-centered activities.

The week's activity culminated with the country's hosting of the Asian Epilepsy Academy EEG Training Course back-to-back with the 7th National Epilepsy Congress in Tagbilaran, City, Bohol where foreign and local experts discussed relevant topics on the treatment of epilepsy. A National Lay Symposium was also held in Bohol to give basic information on epilepsy, discard unfounded beliefs and fallacies, and prevent stigmatization and discrimination in communities. All these activities were spearheaded by the Philippine League Against Epilepsy (PLAE), led by Dr. Hazel Paragua (president) and Dr. Fe Abarcar-Delos Reyes (overall chair of the organizing committee).

## Impact of Epilepsy

Epilepsy is present in around 1% of the global population, and may be higher in developing countries. This means that the Philippines, with a population of 93 million, has an estimated 930,000 people suffering from epilepsy. A local prevalence study in the country estimates 230 persons with epilepsy per 100,000 population. Epilepsy strikes most often among the very young and the very old, although anyone can get it at any age.

The mortality rate among people with epilepsy is two to three times



higher than the general population and the risk of sudden death is 24 times greater. People with epilepsy can die of seizures and related-causes, including status epilepticus (non-stop seizures), sudden unexpected death in epilepsy (SUDEP), drowning and other accidents. Twenty (20) to 30 percent of people with epilepsy are severely affected and continue to have seizures despite treatment.

Of major chronic medical conditions, epilepsy is among the least understood even though one in three adults know someone with the disorder. Lack of knowledge about proper seizure first aid exposes affected individuals to injury from

unnecessary restraint and from objects needlessly forced into the mouth. The leading non-medical problem confronting people with epilepsy is discrimination in education, employment, social acceptance and extreme poverty.

The association between epilepsy and depression is especially strong. More than one of every three persons with epilepsy are also affected by the mood disorder, and people with a history of depression have a 3 to 7 times higher risk of developing epilepsy. From studies abroad, depression is reported by 24-74% of patients with epilepsy; anxiety in 10-25%. Around 64% of people with epilepsy in the Philippines suffer from

anxiety and 51% from depression.

Living with epilepsy presents challenges affecting many aspects of life, including relationships with family and friends, school, employment and leisure activities.

## Diagnosis and Treatment

Epilepsy should be accurately diagnosed so that an effective treatment can be given. Diagnosis is by a good clinical evaluation from a doctor who is familiar with the disease. In addition, other tests like an EEG (electroencephalogram, recording of brain waves) may be requested to confirm

# Facts and Fallacies about Epilepsy

***It is a mental condition and leads to insanity.***

**FACT:** Epilepsy is a brain condition characterized by recurrent seizures. Seizures are sudden, brief abnormalities of behavior, thought, movement or sensation generally lasting for a few minutes. Seizures are caused by a hyperactive, disorganized electrical activity from the brain. Although psychosis may be found in only 2-7% of persons with epilepsy, it is the exception rather than the rule.

***It is caused by spirit possession or "pagsasapi."***

**FACT:** Although movies, literature and folklore refer to seizures as arising from a spirit possession because of some similarities in their manifestations, seizures can be documented scientifically as abnormal brain activity on EEG, unlike demon possession. Seizures are not

dealt with by exorcism or prayer; only by medications and in other cases, brain surgery and a special diet (ketogenic diet, doctor prescribed).

***It is contagious or can be inherited. (In the past decades, this fallacy has caused many patients with epilepsy to be shunned from society and from pursuing marriage and having a family.)***

**FACT:** Many conditions can cause epilepsy. In a small number of patients (10-15%), the susceptibility or predisposition to develop seizures may be inherited. However, for the most number of patients, it can be due to other brain insults. It may happen in those with a history of head injury. It may also happen to those with hypoxic brain injury sustained from a birth complication (lack of brain oxygen in the baby during child birth – ex. due to coiled cord around neck of baby, difficult labor, maternal

complications leading to fetal distress). It may also result from an infection of the brain (meningitis, encephalitis), brain tumors, strokes, prolonged convulsions in childhood. The cause may be unknown in around 40% of cases.

This leads us to another interesting question: Can Epilepsy be Prevented? Epilepsy can be prevented by wearing seatbelts and bicycle helmets, putting children in car seats, and other measures that prevent head injury. Prescribing medication after first or second seizures or febrile seizures also may help prevent epilepsy in some cases. Good prenatal care, including treatment of high blood pressure and infections during pregnancy, can prevent brain damage in the developing baby that may lead to epilepsy and other neurological problems later. Treating cardiovascular disease, high blood pressure, infections, and other disorders that can affect the brain during adulthood and aging also may prevent



and classify the epilepsy; as well as a CT (computerized tomography) Scan or MRI (magnetic resonance imaging) of the brain, to find out what is causing it. An EEG costs from between 800- 2500 pesos; while an CT scan costs 5,000- 6,000 pesos; an MRI 7,000 – 12,000 pesos.

Once epilepsy is diagnosed, it is important to begin treatment as soon as possible. Research suggests that medication and other treatments may be less successful in treating epilepsy when delayed and when seizures and their consequences have become established. Doctors who treat epilepsy come from many different fields of medicine. They include neurologists, pediatricians,

pediatric neurologists, internists, and family physicians, as well as neurosurgeons and doctors called epileptologists who specialize in treating epilepsy.

People who need specialized or intensive care for epilepsy may be treated at large Epilepsy centers (at St Luke's Medical Center, Makati Medical Center, Philippine General Hospital, Medical City, Philippine Children's Medical Center) and neurology clinics at hospitals or by neurologists in private practice.

Medications and other treatments help manage seizures. More than 12 different antiepileptic drugs are now on the market in the Philippines, all with different benefits

and side effects. The choice of which drug to prescribe, and at what dosage, depends on many different factors, including the type of seizures a person has, the person's lifestyle and age, how frequently the seizures occur, and, for a woman, the likelihood that she will become pregnant. People with epilepsy should follow their doctor's advice and share any concerns they may have regarding their medication.

For most people with epilepsy, seizures can be controlled with just one drug at the right dose. Using too many drugs in combination can worsen or aggravate side effects such as fatigue and decreased appetite, so doctors usually prescribe

many cases of epilepsy. Finally, identifying the genes for many neurological disorders can provide opportunities for genetic screening and prenatal diagnosis that may ultimately prevent many cases of epilepsy.

### ***Epilepsy patients are retarded.***

**FACT:** This is a misperception because epilepsy is highly prevalent among other disability groups such as autism (25.5%), cerebral palsy (13%), Down syndrome (13.6%) and mental retardation (25.5%). However, if one looks at the entire population of people suffering from epilepsy, majority of them have normal IQs, are able to go to school and sustain gainful employment.

### ***Patients with epilepsy shouldn't get stressed so they should not study or work or indulge in sports and leisure activity.***

**FACT:** The relationship between the occurrence of psycho-mental stress and seizures is at present unstudied. Patients

associate stressful periods with an increase in seizures. Many experts believe it is the effects of stress such as disturbed sleep and missing meals and medications that bring about an increase in seizures rather than the psychological or mental preoccupation itself.

The fact that there are philosophers, world leaders, artists, writers, politicians and athletes who have epilepsy prove that epilepsy should not pose a limitation to mental and physical activities.

### ***When a patient starts to have a seizure, the best first aid is to stick a spoon inside his mouth.***

**FACT:** When a person goes into a seizure, there are very powerful muscle contractions that suddenly cause him to fall, stop breathing, bite his tongue and clamp his jaw. Inserting an object into his mouth has been found to be more detrimental to the patients and has caused dental fractures, mouth lacerations and suffocation. It is not encouraged.

Rather, one should: 1) cushion

the patient's head with a soft pillow; 2) loosen his clothing around the neck; 3) remove harmful objects around him which can hurt or injure him; 4) turn him to his side to prevent suffocation and allow drainage of saliva; and 5) time the seizures. If seizures last five minutes or more or the patient has been injured, the patient should be brought immediately to the emergency room.

### ***Antiepileptic medications are toxic ("naluluto ang utak") and should not be taken for a long time.***

**FACT:** Epilepsy is a chronic condition and needs long term intake of antiepileptic drug, the minimum of which is 2-5 years, depending on its cause. Patients are always advised to take their medications daily to prevent seizures from recurring each day. There are minor side effects with long term intake, esp. on the bone, cognition, blood elements or liver but these can be monitored by the doctor on regular follow-up.

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monotherapy, or the use of just one drug, whenever possible. Combinations of drugs are sometimes prescribed if monotherapy fails to effectively control a patient's seizures. Patients have to take medications one to three times a day, every day for several years, and in other cases, for their lifetime. Most side effects of antiepileptic drugs are relatively minor, such as fatigue, dizziness, or weight gain. However, severe and life-threatening side effects such as allergic reactions can occur.

Epilepsy medication also may predispose people to developing depression or psychoses. People with epilepsy should consult a doctor immediately if they develop any kind of rash while on medication, or if they find themselves depressed or otherwise unable to think in a rational manner.

If seizures are controlled within 2-5 years of medications, medications are eventually tapered and discontinued upon the advise of the doctor. Some 20-30% of patients continue to have seizures that impact their daily lives in spite of medications. People taking epilepsy medication should be sure to check with their doctor and/or seek a second medical opinion if their medication does not appear to be working or if it causes unexpected side effects.

## State of Epilepsy Care in the Philippines

There are presently 358 certified neurologists in the country. These are doctors who are specially trained to handle diseases of the brain, such as epilepsy.

With the population in the Philippines, this gives a neurologist to patient ratio of 258,000 Filipinos to one neurologist. Taking the estimated number of persons with epilepsy for each neurologist, the ratio would be 2,568 epilepsy patients per neurologist. However, the distribution of specialists/neurologists in the country is uneven — most specialists practice in the National Capital Region, leaving a lot of areas in the country with no access to a neurologist. In these areas, government doctors, internists, pediatricians or family or general practitioners are the ones handling epilepsy, and most of them admit to lacking confidence in handling the condition.

There are 20 epileptologists, neurologists/neurosurgeons with special training or interests in epilepsy care and management. Only two neurosurgeons in the country are specially trained in epilepsy surgery, and this is underutilized in the country. Utilization rate is only 18%.

In the Philippines, 12 antiepileptic

drugs are available; several generic versions of these drugs make treatment more affordable for patients.

Epilepsy has received very little government attention in the past decades mainly due to high priority being given to urgent problems like heart disease, cancer, dengue fever, pulmonary tuberculosis and other infectious diseases.

Epilepsy has been included among the six diseases of concern under the National Mental Health Policy formulated by the Department of Health in 2002. It is also one of eight priority areas for primary mental health care by the 2008 World Health Organization (WHO) Mental Health Gap Action Programme which needs to be given attention and integrated in the primary health care at the community level.

The efforts of WHO goes along with the most recent statement of the International League Against Epilepsy (ILAE) to "CLOSE THE TREATMENT GAP AND SAVE LIVES." For physicians, the call is to optimize treatment using essential medications, affordable, and accessible for persons with epilepsy across economic levels. For epilepsy advocates it is bringing the battle against epilepsy where it matters, taking in one community at a time.

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## 'Wag Mag Baboy...

JERRY: Miss, para kang chicharon.

AU: Bakit?

JERRY: Ang sarap mong papakin!

*Umepal ang isang matrona...*

BECCA: Ako rin parang chicharon!

JERRY: Oo. Nakaka-high blood ka!

DENNIS: Kapag sexy ang kakain ng

apple, ang tawag ay

SNOW WHITE.

GLEN: Kapag mataba naman,

'Pre, ano ang tawag?

DENNIS: Eh 'di, LECHON!

Wala akong pakialam kung mataba ka...

Kasi, I love you just the WEIGH you are!





# WANTED: FETP Fellows

## Be One of the Philippines Disease Detectives

**APPLY NOW!**

*The Field Epidemiology Training Program (FETP) opens its doors to interested candidates who understand the country's public health infrastructure and issues, possess excellent interpersonal skills, are committed to public health as a career and wish to enhance their knowledge and skill in applied public health and field investigation.*



**We welcome applications from persons who meet the following screening criteria:**

- ▶ Health Professionals (physicians, nurses, veterinarians, medical technologists, dentists or any other health related courses)
- ▶ At least two (2) years experience in public health service
- ▶ Must be willing to travel and be deployed ANYWHERE in the Philippines and abroad and able to adapt to any public health events and emergency
- ▶ Must be willing to provide 4-year return service to the Philippine government after completion of the two-year FETP course
- ▶ Age preferably 25 to 45 years old
- ▶ Should completely accomplished the FETP Application Form and requirements (DOH-NEC-QMOP-01-FORM1.REV.1)

**The next batch of FETP training will begin in April 2014. The final selection and screening of applicants will be on November 4, 2013 (Monday). Those who are interested may contact:**

**Mr. Gilbert D. Santos**  
FETP Advocacy Officer  
Tel. No.: (02) 6517800 loc.2954  
E-mail: fetp\_philippines@yahoo.com

**Vikki Carr delos Reyes, MD, PHSAE**  
FETP Training Officer  
(02)651-7800 x. 2929  
vcdelosreyesmd@yahoo.com

**Ma. Nemia L. Sucaldito, MD, PHSAE**  
OIC, Applied Public Health Division  
(02) 651-7800 x. 2929  
manemia\_sucaldito@yahoo.com

**The following requirements should be submitted together with the application form:**

1. Letter of intent addressed to Director of the National Epidemiology Center, DOH
2. Letters of endorsement from Head of Office (2 Professional Supervisor)
3. Photocopy of Diploma (please bring original during the interview)
4. Photocopy of Board Exam Results (please bring the original copy during the interview); and
5. Two (2) Passport-size picture

**The deadline for application is on October 18, 2013, 5:00pm.**

Building 19, Room 304, 3rd Floor  
Department of Health, San Lazaro Compound, Rizal Avenue,  
Sta. Cruz, Manila, Philippines 1003  
fetp\_philippines@yahoo.com



National  
Epidemiology  
Center



*Health Undersecretary Teodoro Herbosa (center in white barong) leads the wreath laying ceremony at the Rizal Monument culminating the Walk for Sight that started at the Cultural Center of the Philippines grounds participated by 300,000 people to kick off the Sight Saving Month on August 4, 2013. (Photos by Joerem Ceria)*

## For Your Eyes Only

On August 4, 2013, the Department of Health and the National Committee on Sight Preservation led more than 3,000 people who joined the Walk for Sight from the Cultural Center of the Philippines grounds to Luneta Park to kick off the observance of Sight Saving Month with the theme, "Alagaan Ang Mata Mula Bata Hanggang Pagtanda." The walk culminated in a wreath

laying and gun salute at the monument of Dr. Jose Rizal, the country's national hero who was also an ophthalmologist.

The DOH encourages all Filipinos aged 12 years and above to undergo an eye examination. According to a World Health Organization (WHO) report in June 2012, approximately 285 million people worldwide are visually impaired, with 39

million blind and 246 million with low vision. Of all visual impairment, 80% can be avoided or cured, which includes avoidable and treatable conditions like cataract, error of refraction, and childhood blindness.

Avoidable blindness and visual impairment is a serious global health issue. It imposes a significant health, social, and economic burden on individuals and



communities. With the aim of eliminating the main causes of avoidable blindness by the year 2020, the global initiative 'VISION 2020: The Right to Sight' was launched in 1999 by the WHO in partnership with the International Agency for the Prevention of Blindness, which promoted the development of sustainable eye care programs based on the three core strategies of disease control, human resource development and infrastructure and technology, incorporating the principles of primary health care.

The goal of eliminating avoidable blindness would be best achieved by integrating an equitable, sustainable, comprehensive eye care system into national health systems, to ensure provision of the best possible vision for all people and improve their quality of life. The VISION 2020 initiative is intended to strengthen national health care system and facilitate national capacity building. Similarly, the DOH **Kalusugan Pangkalahatan** (universal health care) agenda mandates that every Filipino should have access to affordable and

quality health care.

Globally, uncorrected refractive errors are the main cause of visual impairment, while cataract remains the leading cause of blindness. Furthermore, 65% of visually-impaired and 82% of blind people are over 50 years old. The top three causes of visual impairment are uncorrected refractive errors, cataract, and glaucoma. On the other hand, the top three causes of blindness are cataract, glaucoma, and age-related macular degeneration.

In the Philippines, the current estimated number of persons who are bilaterally blind is 569,072, of which 62.1% is due to cataract, 10.3% due to uncorrected refractive errors, 8% due to glaucoma, and 4% due to retinopathies. The current estimated number of persons who have low vision (moderate to severe visual impairment) is 1,962,317, of which 53% is due to errors of refraction, 40.8% due to cataract, 2.2% due to maculopathy, and 2% due to retinopathy.

In support of the new Global

Action Plan for Avoidable Blindness and Visual Impairment 2014-2019 adapted recently by the World Health Assembly in May 2013, with the theme is 'Universal Eye Health', the DOH is pleased to announce that a five-year strategic plan for prevention of blindness 2013-2017 was recently completed by the national Center for Disease Prevention and Control, as an integral part of the overall strategic plan for non-communicable diseases, based on a health systems strengthening framework and universal health care.

Health Secretary Enrique T. Ona explained that the current thrust of the DOH's blindness prevention program is strengthening the government eye health services at the hospitals and field health service delivery network, anchored on achieving **Kalusugan Pangkalahatan** for all Filipinos. He said, "Good eyesight is a basic right that should be accorded to everyone without discrimination as to age, sex, gender, religion, race or social standing."

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# Adopt-A-Hospital

Health Secretary Enrique T. Ona congratulated Dr. Juan M. Montero II of the Montero Medical Missions as the first foreign-based medical mission to respond to the Department of Health's (DOH) program "Adopt-A-Hospital" during the "Adopt Adela Serra Ty Memorial Medical Center Project-Memorandum of Agreement Signing and Cataract-Pterygium Surgical and Eye Care Mission" held in Tandag City, Surigao del Sur on On July 23, 2013..

A Memorandum of Agreement (MOA) was signed among the DOH, Adela Serra Ty Memorial Medical Center (as recipient), Montero Medical Missions (as partner Non-Government Organization), Beach Eye Care and Virginia Center for Eye Surgery (as partner NGO), Community United Methodist Church (as partner NGO), Loving Presence Foundation, Inc. (as partner NGO), Rotary Club of Central Tandag (as partner NGO), the City Government of Tandag (as partner city Local Government Unit), and the Provincial Government of Surigao del Sur (as partner provincial LGU).

The event was also attended by

officials from the Provincial Eyesight Board, the DOH-Center for Health Development Caraga Region, the National Committee on Sight Preservation, Philippine Medical Association of Southeast Virginia (USA), and other partner organizations.

FSMMs are activities where medical interventions and/or surgical services are provided to select underserved areas and communities by a foreign individual or organization in partnership with the local government unit, non-government organization, hospital, or medical society. It can either be a one-time conduct of medical mission or the longer term "Adopt-A-Hospital" program.

The "Adopt-A-Hospital" program is the DOH intervention for some of the challenges brought about by these FSMMs which are usually short-term in nature and identification of deserving areas where these missions' services are most needed are inappropriately done.

There were also concerns on the lack of structured programs for sustainability and continuity of care, especially for the pre-

and post-mission activities.

Thus, the "Adopt-a-Hospital" Program was born. Under this, the foreign-based medical mission is now required to identify and collaborate with a local public hospital from a list provided by the DOH. Their collaboration is made official with a MOA among all parties, that is, the DOH, the medical mission group and other partner NGOs, the recipient hospital, the city/municipal and provincial governments where the hospital is located.

The MOA provides for a more sustainable and longer-term delivery of health services by a foreign-based organization or non-profit medical mission group or foreign-based hospital to underserved communities through a local public hospital.

In the case of the Adela Serra Ty Memorial Medical Center (ASTMMC) adoption, the Montero Medical Mission (MMC) agrees to provide voluntary health services to the hospital through the annual conduct of medical missions. These yearly visits include clinical/operative services,



conduct of teaching programs or medical education lectures, and provide/donate medicines, medical supplies and/or equipment to ASTMMC.

Also, the MMC shall establish its specialized health programs, such as EyeSight2020, Prosthetic and Dental Care, at the hospital so that these are accessible to indigent residents of Surigao del Sur.

As the recipient hospital, the first in the "Adopt-a-Hospital" program, the ASTMMC will provide logistics and health personnel, help identify and screen patient beneficiaries, take care of the post-mission follow-up patient care and referrals in case of complications after an operation.

The Province of Surigao also commits to support the ASTMMC through finance and in-kind resources to improve or complement the infrastructure, health personnel, and equipment needs of the hospital, especially in preparation and during the annual surgical missions, and provide transportation and accommodations to MMM while they are in the country during the medical mission.

Meanwhile, the City of Tandag where ASTMMC is located, mobilized the local financial and in-kind resources and community clubs, such as the Rotary Club, during the medical mission's stay.

The ASTMMC is a Level 2 hospital (with pharmacy, radiology, laboratory, and dental services) authorized to have 200 beds but only has 100 beds due to budgetary constraints. Its bed occupancy rate is 106%, which means that it is always full. Its hospital chief is Dr. Ponciano S. Limcangco.

Its leading cause of consultations is dental examination with 1,511 recorded cases last year. Out of the 2,884 total admissions since January up to June this year, fifty percent (50% or 1,438) belonged to the National Household Targeted Service list.

## quality MANAGEMENT



# QMMC is ISO Certified

Quirino Memorial Medical Center (QMMC) becomes the first Department of Health-retained hospital to be ISO 9001-2008 certified for Quality Management System (QMS). It received the certification from AJA Registrars, Inc., which covers all the medical, nursing, ancillary and administrative support services.

Health Secretary Enrique T. Ona said, "We would love to see all the DOH-retained hospitals being recognized as centers of excellence on quality management system. And we are working towards it."

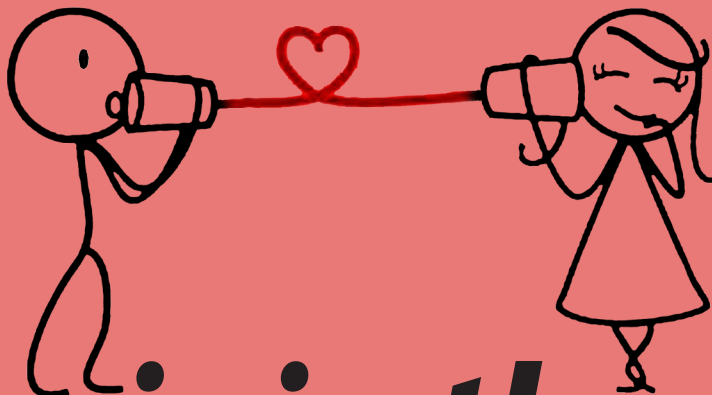
The awarding of the ISO certification, which coincided with the celebration of the 60th hospital anniversary, served as a testament to QMMC's commitment to quality health care in support of **Kalusugan Pangkalahatan** (Universal Health Care), the Aquino administration's health agenda.

During the awarding of the

ISO certification, Medical Center Chief Dr. Angeles de Leon acknowledged the contribution of the trailblazers of QMMC who have exhibited selfless service to the Filipino people and the present staff who continue to practice excellent health care through quality assurance with humility, dedication and professionalism. "At 60 years, everyone made a significant contribution towards ISO certification", she quipped.

The ISO certification was a collaborative effort of the QMMC Management Committee (ManCom) and the Quality Management Unit which included the conduct of several awareness campaigns and workshops on Document Writing and Internal Quality Audit, among others.

Prior to the ISO certificate awarding, the QMMC officers and staff hurdled months of intense preparation through teamwork and openness to change, as transitions were implemented towards improved QMS.



## *Love is in the Air*

### Hangin

JAK: Sabi nila, love is in the air.  
YUL: Hindi nga ba, 'Pre?!?  
JAK: Eh, nasinghot ko na ang lahat ng klase ng hangin, bakit wala pa rin akong lovelife?

### 'Di Gwapo

CLARENZ: Alam kong hindi ako gwapo.  
LIZELLE: Buti alam mo.  
CLARENZ: Pero pag ako ang minahal mo, lahat ng gwapo papangit sa paningin mo.

### Bastos

DANNY: Sex tayo?!?  
JOJIE: Bastos!!!  
DANNY: Bakit, ano ba ang sinabi ko?  
JOJIE: Sex tayo?!  
DANNY: 'Tara na.

### Text

ROMMEL: (*Nagtext...*) "Matagal ko nang tinatago ang nararamdaman ko para sa 'yo. MAHAL NA MAHAL KITA."  
ALEX: "Akala mo ba ikaw lang ang nagtatago ng nararamdaman? LABIS-LABIS DIN KITANG MAHAL, ROMMEL."  
ROMMEL: "Pare, wrong send ako. KADIRI KA!"

### 'Di Maganda

AVIC: Pangit ba ako?!?  
NOEL: Walang ginawang pangit si Lord.  
AVIC: Salamat ha.  
NOEL: Kaya nga nagtataka ako kung sino talaga ang gumawa sa 'yo!

### Proteksyon

DIANA: Sister, ang sex nang walang proteksyon ay parang MAGIC!  
JOAN: Totoo ba 'yan, Sis?  
DIANA: Oo. Kasi nga mag-a-APPEAR ang baby at magdi-DISAPPEAR naman ang daddy!

### Ipaglaban Mo

JOEREM: Pare, kapag may mahal ka, ipaglaban mo.  
FRED: Ganun ba talaga 'yun, 'Pre?!?  
JOEREM: Oo naman. At kapag dalawa ang mahal mo, paglabanin mo sila. Tapos sabihin mo, matira ang matibay!

### Mangga

JUN: Mangga ka ba?  
LITA: (*Kinikilig*) Bakit? Dahil may asim ako o sweet ako?  
JUN: Hindi. Mukha ka kasing kalabaw!

### Bakla!

CHARI: Bakla! Bakla! Bakla!  
BORGY: Hoy, kahit anong gawin mo, hindang-hindi kita hahalikan! Asa ka pa!

### Yosi Break

JED: (*Galit.*) Ako o 'yang yosi mo?!? Kung hindi mo kayang itigil 'yan, break na tayo!!!  
IAN: Ganyan ka ba kababaw? Dahil lang sa sigarilyo iiwan mo ako?  
JED: Ikaw na kasi ang gusto kong makasama habambuhay. At hindi ko kaya na habang hinihitit mo 'yang yosi mo, nababawasan ang mgaaraw na dapat ay magkasama tayo!





*Dr. Carmela Granada (left photo), program manager of cardiovascular diseases and cancer, and Dr. Emmanuel Tiongson (right photo), program manager of medical tourism, are the female and male "biggest losers" of the six-month waist circumference reduction challenge dubbed as "Belly Gud for Health: The Executive Edition." Health Secretary Enrique T. Ona and Undersecretary Janet Garin award their prizes in simple rites during the regular flag raising ceremony on August 12, 2013. (Photos by Rhoderic Domingo)*

# DOH Reveals Executives who are "Biggest Losers"

by

**ANTHONY R. RODA, MaHeSoS**  
HEALTHbeat Staff

On August 12, 2013, in simple rites during the regular flag raising ceremony, the Department of Health - Central Office revealed its executives who are considered biggest losers, in terms of waist circumference reduction, to culminate the six-month "Belly Gud for Health: The Executive Edition" Challenge where DOH top executives, directors, division chiefs and program managers volunteered themselves to healthy lifestyle interventions to lose some fats, from February to July 2013.

Health Secretary Enrique T. Ona said, "This is one of the few moments in life when losers are winners. We wanted all DOH staff, from the executives to the rank-and-file, to practice what they preach in maintaining good health. We don't want

them to suffer the consequences of non-communicable diseases (NCDs) that could result from work stress, binge eating and lack of physical activity."

Waist circumference is a simple and easy measure of central obesity which is the amount of visceral fat (the fat that surrounds the inner organs) among adults and a significant indicator of risk for NCDs particularly heart disease and stroke. The desirable waist circumference for adults is less than 90 centimeters (cm) for males and less than 80 cm for females.

Declared grand winners and the biggest losers are: Dr. Carmela Granada of the National Center for Disease Prevention and Control who lost 15.70 centimeters (cm) from 108.20 cm to 92.50 cm; and Dr.

Emmanuel Tiongson of the Office for Special Concerns who lost 10.50 cm from 108.40 cm to 97.90 cm. Tiongson also received a special award in perfect attendance to the various healthy lifestyle intervention activities provided for the Challenge.

The eight "good performing participants" or runners-up are: Dr. Vilma Diez of the National Epidemiology Center losing 9.70 cm; Dr. Rodolfo Albornoz of Environmental and Occupational Health Office (EOHO) losing 8.55 cm; Dr. Cecile Magturo of EOHO losing 8.50 cm; Engr. Luis Cruz of EOHO losing 8.30 cm; Assistant Secretary Enrique "Eric" Tayag losing 7.80 cm; Rosemarie Aguirre of the National Center for Health Promotion losing 7.05 cm; Undersecretary Madeleine Valera losing 5.50

## TOP 10 BIGGEST LOSERS

*"Belly Gud for Health: The Executive Edition," 6-Month Waist Circumference (WC) Reduction Challenge*

RANK	NAME	POSITION/OFFICE	INITIAL WC (Feb. 2013)	FINAL WC (July 2013)	TOTAL WC REDUCTION
1.	<b>Dr CARMELA GRANADA</b> (Female Grand Winner)	Medical Specialist II National Center for Disease Prevention and Control (NCDPC) Degenerative Disease Office (DDO)	108.20 cm	92.50 cm	15.70 cm
2.	<b>Dr EMMANUEL TIONGSON</b> (Male Grand Winner)	Medical Specialist III Philippine Medical Tourism Program, Office of Special Concerns	108.40 cm	97.90 cm	10.50 cm
3.	<b>Dr VILMA DIEZ</b>	Provincial Health Officer, Cavite (detailed at National Epidemiology Center)	93.00 cm	83.30 cm	9.70 cm
4.	<b>Dr RODOLFO ALBORNOZ</b>	Medical Officer V (Division Chief) NCDPC - Environmental and Occupational Health Office (EOHO)	116.35 cm	107.80 cm	8.55 cm
5.	<b>Dr CECILE MAGTURO</b>	Medical Specialist IV NCDPC - EOHO	91.30 cm	82.80 cm	8.50 cm
6.	<b>Engr LUIS CRUZ</b>	Supervising Health Program Officer NCDPC - EOHO	113.30 cm	105.00 cm	8.30 cm
7.	<b>ASec ENRIQUE TAYAG, MD</b>	Head, Support to Service Delivery and Technical Cluster II and Director IV, National Epidemiology Center	111.10 cm	103.30 cm	7.80 cm
8.	<b>ROSEMARIE AGUIRRE</b>	Health Education and Promotion Officer V (Division Chief) National Center for Health Promotion	91.65 cm	84.60 cm	7.05 cm
9.	<b>USec MADELEINE VALERA, MD</b>	Head, Health Policy Finance and Research Development Cluster	88.20 cm	82.70 cm	5.50 cm
10.	<b>REMEDIOS GUERRERO</b>	Supervising Health Program Officer NCDPC - DDO	93.75 cm	88.50 cm	5.25 cm



**LEFT PHOTO:** Health Undersecretary Teodoro Herbosa (extreme right) presents the certificate of appreciation to representatives of the Slimmers World, the major sponsor of the Belly Gud for Health Challenge. USec Herbosa, ended 11th place losing 4.40 cm waist circumference. **RIGHT PHOTO:** Health Assistant Secretary Enrique Tayag leads the DOH staff to his popular Dance for Health moves. ASec Tayag landed 7th place, losing 7.80 cm. (Photos by Rhoderic Domingo)





**Other top winners who were present to receive their awards from Undersecretary Nemesio Gako, Assistant Secretary Paulyn Jean Rossel-Ubial and Assistant Secretary Gerardo Bayugo. LEFT PHOTO: Dr. Vilma Diez of National Epidemiology Center (3rd place); MIDDLE PHOTO: Dr. Rodolfo Albornoz of Environmental and Occupational Health Office (4th place); RIGHT PHOTO: Rosemarie Aguirre of the National Center for Health Promotion (8th place). Note that USec Gako and ASec Bayugo are exempted from the Belly Gud for Health: The Executive Edition Challenge because they already have a "desirable waist circumference." (Photos by Rhoderic Domingo)**

cm; and Remedios Guerrero of Degenerative Disease Office losing 5.25 cm.

Meanwhile, Undersecretary Teodoro Herbosa who is considered as the "most-challenged" participant at the start of the Challenge in February with his 118.30 cm waist circumference ended up in the 11th place, losing a total of 4.40 cm.

During the six-month challenge, the participants worked on their own healthy lifestyle interventions in accordance to their preference, schedule and convenience. The DOH Challenge also provided the participants with laboratory/screening tests, nutrition counseling and aerobics exercise sessions, therapeutic massage services, and one-week Fitness Camp. The participants, however, were prohibited the use of slimming drugs or herbal products and other formulations, including liposuction or other

artificial interventions in the course of the Challenge.

Each grand winner received P10,000 cash, a trophy and a gift certificate for unlimited use of gym facilities for three months from Slimmers World, while each runner-up received P2,000 cash, a trophy and a gift certificate for one free visit for facial or massage service from Slimmers World.

During the awarding ceremony, the DOH acknowledged its major partners, namely: Slimmers World International for providing the participants and DOH employees with body mass index, body fat analysis, nutrition counseling and diamond peeling as part of its Great Body and Great Skin campaign; Pfizer, Inc. for providing risk factor screening, specifically blood glucose and cholesterol screening, urine test and

bone density scan; and the Philippine Association of Licensed Massage Therapists for providing therapeutic massage services.

The DOH also acknowledged Felicidad Velandria of the Nutritionist-Dieticians' Association of the Philippines and Natalia Uy Chan of the University of the Philippines - College of Human Kinetics for being resource speakers for the monthly nutrition and physical activity sessions and in the Fitness Camp.

Ona announced that the DOH will start implementing the "Belly Gud for Health" Challenge in the following requesting government agencies: Commission on Audit; Government Service Insurance System, Department of Labor and Employment, and Department of Environment and Natural Resources.

- o o o -

## Two-Piece

Ang mga babaeng sexy nagtu-two-piece bikini...  
'Yun naman hindi sexy, nagtu-two-piece chicken!





*Balanga City Mayor Jose Enrique "Joet" S. Garcia III (center) raises the Pilipinas Go4Health logo signifying the city's adoption of the new DOH healthy lifestyle movement. Also in photo are Health Assistant Secretary Enrique A. Tayag, Bataan Governor Albert Garcia, DOH-Central Luzon Regional Director Leonita Gorgolon and other Balanga City officials.*

## Balanga City Go4Health

by

**SHEILA BANZON ZABALA, RN**

Balanga City Health Office

Balanga City, Bataan – the fast emerging educational and commercial city where cigarette smoking has been banned since 2008 set another milestone by launching its local version of the Department of Health's "Pilipinas Go4Health" movement at the Plaza Mayor de Balanga on July 26, 2013.

Balanga is the first city in the country to launch this new healthy lifestyle movement. DOH officials headed by Health Assistant Secretaries Enrique "Eric" Tayag

and Pauly Jean Rosell-Ubial, DOH Center for Health Development-Central Luzon Director Leonita Gorgolon and DOH-National Center for Health Promotion Director Ivanhoe Escartin, and World Health Organization-Philippines Office representative Dr. Florante Trinidad graced the occasion organized by Bataan Provincial Governor Albert Garcia, Balanga City Mayor Jose Enrique "Joet" S. Garcia III, and City Health Officer Dr. Mart T. Banzon.

It was an afternoon of fun for more

than 1,000 government employees, private sectors and non-government organization representatives who converged at the city plaza to rally the cause of the program as they energetically imitated Tayag's popular zumba dance moves. Pilipinas Go4Health aims to inform and encourage Balangueños from all walks of life to practice a healthy lifestyle by making a personal commitment to physical activity, proper nutrition, prevention of the harmful use of alcohol and no smoking (Go Sigla, Go Sustansiya, Go





**TOP:** Health Assistant Secretary Paulyn Jean Rossel-Ubial turns over the P500,000 cash grant to Balanga City Mayor Jose Enrique "Joet" S. Garcia III and Vice Mayor Noel Valdecañas for winning the DOH Red Orchid Hall of Fame Award. **ABOVE:** Dancing is fun in Balanga City!

Slow sa Tagay, and Go Smokefree).

Ubial, who is also the chair of the DOH Red Orchid Awards, took this opportunity to formally turn over to Mayor Garcia and Vice Mayor Noel Valdecañas the check amounting to P500,000 as prize for bagging the DOH Red Orchid Hall of Fame Award for implementing a 100% tobacco-free environment for three consecutive years. The cash grant is intended to support programs/projects that will support the city's implementation of tobacco-free initiatives.

In 2008, the Balanga City council passed an ordinance banning smoking in public places, public utility vehicles and business establishments. At first, a number of smokers objected to the anti-smoking drive but they were eventually convinced that the campaign was good for the city. In support of the city's initiative, Governor Garcia, Vice Governor Efren Pascual and the provincial board members presented to the public the provincial anti-smoking ordinance which aims to make the whole province of

Bataan smokefree as well.

Tagay, known for his dance moves to campaign for various health programs, expressed appreciation to the Balanga folks and thanked the local government for the successful strict implementation of anti-smoking campaign. *"Sasayaw ako kahit long playing pa basta para sa kalusugan at healthy lifestyle,"* he said.

**Visit**

**<[www.go4health.ph](http://www.go4health.ph)>**



# Kababalaghan

## Maikling Kuwento

TITSER: Magsulat ng isang maikling kuwento na hindi hihigit sa 100 salita na tumatalakay sa mga temang Relihiyon, Sekswalidad at Kababalaghan.

ISINULAT NI LORIE: Diyos ko! Buntis ako! Sino kaya ang ama nito?

## Multo

MULTO: Awooooooooooooh!

TOTOY: Huwag poooh!

MULTO: Okay.

TOTOY: N'yay!

## Drakula

JOJO: Pare, paano ka uutang kay Drakula?

ANTE: Paano, 'pre?

JOJO: Eh di sabihin mo, 'Meron ka BAMPIRA?'

## 'Di Lahat

TITSER: Hindi lahat ng estudyante tamad.

ERIKA: Opo naman, Ma'am.

TITSER: 'Yung iba naman kasi talagang nagsisipag... NAGSISIPAGLANDIAN!

## Papatayin Ka

OBET: 10 plus 10?

DENPOT: 'Di ko po alam.

OBET: Ang dali lang ng tanong 'di mo pa masagot. Papatayin ka ng kabobohan mo.

DENPOT: 'Tay kung makakakita ka ng P1,000 at P500 sa kalye, alin ang pupulutin mo?

OBET: Siyempre 'yung isang libo!

DENPOT: Pwede mo naman pulutin pareho, 'Tay. Papatayin ka ng katangahan mo!

## Nasa Akin Lahat

ERNIE: Ang saklap talaga ng buhay. Nasa akin na ang lahat – pera, malaking bahay, mamahaling kotse, magandang babae na nagmamahal sa akin – tapos, poof... biglang nawala lahat!

FRANK: Bakit pare, anong nangyari?

ERNIE: Nalaman ng asawa ko.

## Mundo

BETH: Mare, kamusta na kayo ng Mister mo?

ABBY: Hiwalay na kami.

BETH: Ha? 'Di ba dati ikaw ang

MUNDO niya? Anong nangyari?

ABBY: Hayun, nangibang PLANETA!

## Talaba

MIGZ: Dok, masakit po ang tiyan ko...

DOK: Kelan pa ba nagsimula yan?

MIGZ: Simula po nung kumain ako ng talaba!

DOK: Baka naman sira 'yung nakain mo? Nang buksan mo 'yung talaba, hindi ba mabaho?

MIGZ: Ay, binubuksan po ba 'yun?

## Asin

LUZ: Anak, bumili ka nga ng asin sa kanto.

KRISTAL: Ayoko nga! Ang dilim kaya. Nakakatakot nang lumabas.

LUZ: 'Wag ka mag-alala, kasama mo naman ang angel mo eh.

KRISTAL: Eh 'di siya nalang ang utasan n'yo. Para asin lang ang bibilhin, dalawa pa kami?

## Naloko

BATA: Dyaryo! Dyaryo! Dalawang bakla ang naloko!!!

CHRIS: Dyaryo! Magkano?!?

BATA: Dose po.

CHRIS: (*Hinalungkat ang mga pahina...*)

Wala namang balitang may dalawang baklang naloko ah!

BATA: Dyaryo! Dyaryo kayo dyan!

Tatlong bakla ang naloko!!!





*Dr. Emmanuel M. Bueno (center) and his medical team ride a bulldozer to reach the mudslide site at St. Bernard, Guinsaugon, Southern Leyte in February 2006.*

## *Dr. Emmanuel M. Bueno Story* **A Disaster Survivor**

by

**SUSAN G. JUANGCO**

DOH Health Emergency Management Staff

**DONATO DENNIS B. MAGAT**

HEALTHbeat Staff

### **From HEMS Coordinator to Medical Center Chief**

Dr Emmanuel M. Bueno, the medical center chief of the Amang Rodriguez Memorial Medical Center (ARMMC), is a Health Emergency Management Staff

(HEMS) coordinator since 2003. As such he has been in various disaster scenes not only in the country, but also in various parts of the globe where the Philippines has sent humanitarian teams to assist in medical missions.

In July 2004, Bueno was team

leader of the joint Armed Forces of the Philippines (AFP) and Department of Health rescue and response team to General Nakar, Quezon that was ravaged by flashflood and landslide brought about by Typhoon Winnie (international name Muifa) and Typhoon Yoyong (Nanmadol). In February

2006, he was team leader of another AFP-DOH rescue and response team to mudslide that wiped out an entire barangay (village) in Guinsaugon, Southern Leyte. A few months later, in May and June 2006, he was a team leader of the AFP-DOH Philippine international humanitarian team sent to the strong earthquake-stricken Yogyakarta, Indonesia. And in January 2010, he was again team leader of the humanitarian team that was sent to Haiti that was destroyed by a catastrophic earthquake.

As team leader to several disasters, Bueno specializes in General Surgery and Trauma. He is a fellow both of the Philippine Society of General Surgeons, Inc and the Philippine College of Surgeons, and a diplomate of the Philippine Board of Surgery. He is at present the Deputy Brigade Commander of the 1st Technical and Administrative Brigade (1st TASB) of the AFP Reserve Command, with the rank of Colonel.

Bueno, who hails from Rizal, Bansalan, Davao del Sur, earned his Doctor of Medicine degree in 1980 at the University of the East Ramon Magsaysay Memorial Medical Center, College of Medicine. In 1981, he passed the Philippine Medical Licensure Examination and in 1987, the DOH certifying examination in General Surgery.

He started his career as medical director of the Zarsona Medical Clinic in Davao del Sur in 1982. He became the chief resident of the Department of Surgery at the East Avenue Medical Center (EAMC) in 1986. In 1998-2010, he was Medical Director of the St. Vincent and Sta Monica Hospitals in 1998-2010. He was chairman of the EAMC Emergency Room-Trauma Department since 2006 until he was appointed to Amang Rodriguez Memorial Medical Center in February 2013 as officer In-charge initially, and subsequently as Medical Center Chief II.

He said, "It was during my stint as HEMS Coordinator and chair of the EAMC Emergency Room - Trauma Department that best prepared me for my present job as ARMMC chief." He added that being part of a constant contingent to several disasters here and abroad broadened his horizons on rescue and humanitarian missions.

### **2006: Guinsaugon Mudslide**

In February 2006, Bueno headed the search and rescue mission to Guinsaugon, Southern Leyte where a series of mudslides erased the whole barangay of St. Bernard. It resulted to the recovery of more than 200 cadavers and body parts

in the area and more than 2,500 residents buried and missing.

The disaster struck at around 10:30 am when the cliff of a ridge collapsed subsequently burying a local elementary school with about 246 students at that time and about 80 women attending the 5th anniversary celebration of Guinsaugon Women's Health Association. Reports stated that up to 10 smaller landslides occurred before the tragic event on February 17, 2006.

Bueno, upon the order of DOH-HEMS Director Carmencita A. Banatin, organized a 20-member team for the Guinsaugon tragedy. This team was composed of 6 surgeons, 4 internists 3 anaesthesiologists, 6 nurses, 1 psychiatrist for debriefing sessions. He recalled that part of the team took a commercial flight to Tacloban. Others took the Philippine Air Force (PAF) C-130 plane flight.

The landslide site was hard to reach because several minor landslides occurred and people were displaced. They arrived at the area using a private transport. After a short courtesy visit to Gov. Rosette Yñiguez-Lerias, the team went to the Anahawan District Hospital to organize. Half of the team would take care of patients while half would



*in 2006, the Guinsaugon mudslide area turned into a mass grave.*





be deployed to the impact zone.

"I was always at the landslide site, while Dr. Benson Mangubat was manning the district hospital in close coordination with the military, local government, Director. Banatin and then DOH Secretary Duque," Bueno explained. He added, "We requested that a mass burial be done in order to prevent the spread of diseases and get rid of the foul odor coming from cadavers." Gov. Lerias was always present at the site from sunrise to sunset, he said.

We stayed at Guinsaugon for two weeks. Initially, we were on a rescue mission but as days passed and the chance of finding a survivor from the landslide went down, our task was reduced to retrieval of dead bodies.

The Guinsaugon experience taught Bueno a lot of lessons – the value of communication with his teammates. "*Kahit tuwing gabi lang kami lahat nagkikita at nagkakakwentuhan, updated kami lahat sa mga nangyayari.*" In that way, we can better prepare our moves for the coming days," he said. He added, everyone needed to prepare his/her own supplies and be self-sufficient.

Bueno emphasized that, while in Guinsaugon, they became very much aware that they represented the DOH in all their decisions and undertakings, hence there was no room for inaccuracies.

## 2006: Yogyakarta Earthquake

During the 2006 mission to the earthquake-ravaged Yogyakarta, Indonesia, Bueno and his team took the PAF C-130 to get there. It was also a 20-member humanitarian team with Dr. Romeo Bituin as assistant team leader. The team was composed of 20 specialist physicians, operating room nurses, nurse psychologist and an engineer. The flight took seven hours, and at the airport, they were met by Vice Consul Voltaire Pingcol, and were later



**In 2009 during the earthquake that devastated Yogyakarta, Indonesia, the 20-member Philippine humanitarian team was divided into the hospital team and public health team.**

taken to a 100-bed Sleman Trauma Hospital. Several equipment were brought to the site: surgical instruments and orthopedic implants, operating room supplies, and a complete complement of medicines.

Again, the team was divided in two groups, the hospital team and public health team. Every night, the two teams held a meeting, updating of cases and planning for the next day assignment. Language barrier

has been the biggest problem encountered by the team. Whenever the group made patient rounds, an interpreter was always with them. The team emphasized to the hospital director that the Philippine humanitarian team is under their jurisdiction and that they are there to support them.

The team provided humanitarian and medical services there for about a month. The Indonesians respected the team

and they were all happy with the treatment that they were providing. There was also some conflicts among the team members but were only minor ones.

"As a leader, I always looked after the team's safety. This has endeared me to them," Bueno said.

## 2010: Haiti Earthquake

And finally, on January 15, 2010, upon instructions from then President Arroyo, the DOH-HEMS organized a medical team to assist the relief efforts in the aftermath of the catastrophic earthquake in Haiti. Given its wealth of experience in dealing with internal disasters, the Philippines was in a unique situation to reach out and provide assistance to Haiti.

Bueno was again asked to lead the team. EAMC Chief Cortez gave him free hand in preparing the needed medical equipment and supplies. "The trust that Dr. Cortez had on me is a motivating and compelling factor that I should not perform below par," he said, adding that he always provided Cortez updates on his team's development until they left for Haiti.

Based on experience, the aftermath of the earthquake would call for more than just medical services. Needs for psychosocial support, water and sanitation became apparent in the weeks following the quake. The Philippines team was assembled with this in mind. The members were selected from a current pool of professionals and specialists based on training and experience. The team was composed of 3 general surgeons, 2 orthopedic surgeons, 2 anesthesiologists, 1 internist,

1 pediatrician, 5 nurses, 1 psychologist, 1 social worker, 3 epidemiologists, and 2 sanitary engineers. In 48 hours, everything was ready.

The team brought with them operating room equipment like anesthesia machines, electro-cautery machines, suction machines, electrocardiogram machines, cardiac monitors, orthopedic implants, anesthesia supplies, drugs and medicines and operating room supplies, worth Php 20M. As in previous disaster experiences, Bueno asked his team to be self-sufficient in order to deliver the needed humanitarian services.

The team took a Philippine Airlines flight from Manila to San Francisco to Miami, then to Sto. Domingo in the Dominican

Republic. At the airport, the team was met by the Philippine Honorary Consul to The Dominican Republic Lemuel V. Dadulo and Philippine Ambassador to the Caribbean Countries Macarthur F. Corsino, and they were escorted by three United Nations (UN)-Philippines contingents - the 10th Philippine Contingent to Haiti (10th PCH) Philippine Air Force and Philippine National Police - in passing the Dominican Republic-Haiti border.

Upon arriving in Haiti, the team was met by Lt. Colonel Lope Dagoy, Commander of the 10th PCH and was accommodated in the Guatemalan Camp within the UN Base. They immediately went into briefing sessions with officials from the UN, World Health Organization and Pan American Health Organization to plan for the order of battle. Every morning, all members of the team had to take a heavy meal because the next meal will be in the afternoon or dinner. They could not eat in disaster sites because the earthquake victims would either beg or get their food.

Supplies and equipment arrived a few days late because these were sent through air cargo and had to pass through a different route. Fortunately, there were enough unconsumed medicines and supplies from the American team, so they used whatever was available there. The Philippine team stayed there for about four weeks.

Three years after the earthquake, Haiti is still wallowing in rubbles, and recovery has been observed to be slow.

Bueno concluded, "I was never a victim of a disaster but I will always consider myself a disaster survivor because of the many rescue missions that I became part of."



*Dr. Emmanuel Bueno in a humanitarian mission in Haiti, amidst the rubbles caused by a catastrophic earthquake in 2010. He said, "I was never a victim of a disaster but I will always consider myself a disaster survivor because of the many rescue missions that I became part of."*





Photo grabbed from < [www.dzmm.abs-cbnnews.com](http://www.dzmm.abs-cbnnews.com) >

# Mercury Spill in Fabella Hospital

by  
**GLEN S. RAMOS**  
HEALTHbeat Staff

Call it an irony or a premonition, but the mercury spill in the Dr. Jose Fabella Memorial Hospital came in between the release of a report, “From the Backyard to the Frontline: Initiatives of Philippine Hospital Workers on Best Environmental Practices” showcasing exemplary practices in seven selected hospitals, including San Lazaro Hospital’s mercury-free dental services, by the Health Care Without Harm-Asia and the United Nations Development Program-Global Environment Facility Project on August 1, 2013 (*See related story next page. - Ed*), and the conduct of a workshop on the formulation of the three-year strategic plan for the phase-out of mercury in health facilities by the Department of Health-National Center for Health Facility Development on August 27 -30.

On August 8, at around 4pm, a

mercury spill occurred in the second floor of Fabella’s Property and Procurement building. The mercury spilled from a vial (which was used as dental amalgam), seeped into the wooden floor of the second floor and trickled into the ground floor. The ground floor was full of medical supplies while the second floor was used for the decommissioned mercury devices such as sphygmomanometers. The area was immediately isolated. There were 30 individuals exposed in the affected area, and were given instructions to decontaminate and immediately seek consultation when development of signs and symptoms occurred. A “code white” was also immediately ordered.

On August 9, Dr Ruben C. Flores, hospital chief, ordered the transfer of 40 pediatric patients from the Pediatric Ward, as a precautionary measure because they were

located near the Property and Procurement building. They were placed at the ward of the main building of the hospital. All exposed individuals who entered the building have undergone blood extraction procedure as initial evaluation. The DOH and Bureau of Fire Protection-Hazardous Materials Team (BFP-HAZMAT) organized a team to collect the spilled mercury for proper disposal. Flores also coordinated with Manila Health Department for the relocation of the residents near the hospital before the start of the mercury clean-up.

August 10, 2013, the BFP-HAZMAT started the clean-up of the mercury spill at 1 pm with the Fabella Medical team providing logistic and medical support for any untoward incident that might occur. DOH coordinated with the Department of

*Please turn to page 36...*

# Philippine Hospitals Show the Way to Health Care Waste Management

by

**SONIA G. ASTUDILLO\***

Health Care Without Harm - Asia

## Hospital Waste: A Growing Concern

The modernization of Philippine hospitals in the 20th century brought a vast improvement in the country's practice of health care. Today, with the Restructured Health Care Delivery System, primary services are provided at the local government level and are aimed at prevention and promotion of health. Secondary services are offered to patients requiring additional resources for treatment and are provided at the municipal to provincial hospital levels. Tertiary services are for patients needing highly technical and specialized skills which are found in medical centers, large hospitals, and national specialty hospitals. This system allows tertiary facilities to focus on complicated cases and provide their specialized services to a greater number of people needing those services.

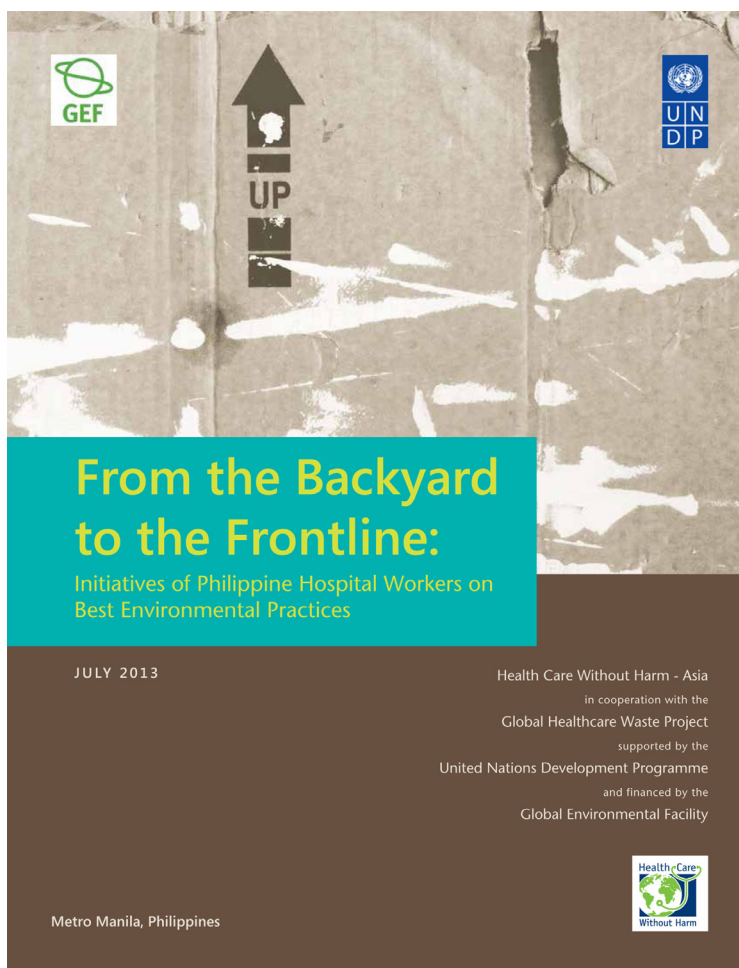
The expansion of the health care system, however, has resulted in new concerns. Emerging problems such as the

increase in biomedical waste meant a greater desire to resort back to traditional methods of treating waste, such as medical waste incineration, or to choose the newer so-called "waste-to-energy" technologies, both very expensive and with little or no

patients' overall health, but also the health and safety of health care workers and communities. Health care facilities produce a significant amount of not only general waste, but toxic wastes such as mercury and several hazardous chemicals ranging from

attention given to pollution control. Incineration, although initially aimed at preventing transmission of infectious diseases from medical waste, is under greater worldwide scrutiny from scientific experts and the general public because of the hazardous pollutants generated by incineration including the highly toxic and environmental persistent by-product of burning: dioxins. Toxic at extremely low concentrations, dioxins are a family of compounds classified as Known Human Carcinogens by the International Agency for Research on Cancer, an agency of the World Health Organization.

Ongoing evidence-based inquiries have also unearthed a list of other concerns in health care, concerns that not only impact



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\* The introduction of this article is reprinted from the report, "From the Backyard to the Frontline: Initiatives of Philippine Hospital Workers on Best environmental Practices." To read the complete report, please visit HEALTHbeat Online <[www.healthbeat.ph](http://www.healthbeat.ph)> and like us on Facebook <[www.facebook.com/DOH.HEALTHbeat.ph](http://www.facebook.com/DOH.HEALTHbeat.ph)> to help us grow.



disinfectants to expired medications.

In the 21st century, the Philippine government started to address concerns regarding dioxin release and mercury exposure of patients in health care settings. In 2000, the Philippine Clean Air Act was passed, which bans any form of incineration, including the burning of medical waste. In 2008, an administrative order was passed which mandated the use of mercury-free devices in health facilities. These initiatives gained international attention, primarily because both laws were among the first to have been passed globally. To date, however, no local policy or law regulates the management of hospital chemicals.

Three Health Care Waste Assessment Reports were conducted by Health Care Without Harm-Asia on Philippine hospitals: St. Paul de Chartres Hospital in Tuguegarao, Cagayan Valley; Saint Paul Hospital Cavite in Dasmarinas, Cavite; and General Santos Doctors Hospital in General Santos City. The reports gave similar conclusions, namely, that infectious and hazardous hospitals wastes (e.g., pathological waste, sharps) comprise only about 15-20% of total hospital waste, while the rest is composed of recyclable, residual and compostable/biodegradable waste.

Recognizing the need to address the issue, the United Nations Development Programme (UNDP) together with the World Health Organization and Health Care Without Harm (HCWH) worked on a "Global Healthcare Waste Project" funded by the Global Environment Facility (GEF). The primary goal was to protect public health and the global environment from the impacts of dioxin and mercury releases.

HCWH is an international coalition of more than 500 organizations in 53 countries, working to transform

the health care sector worldwide, without compromising patient safety or care, so that it is ecologically sustainable and no longer a source of harm to public health and the environment.

The UNDP GEF project, which started in 2008, was implemented in seven counties (Argentina, India, Latvia, Lebanon,

Senegal, Vietnam and Philippines) to develop, demonstrate, and sustain best health care waste management practices that are locally appropriate and globally replicable. In the Philippines, the project also demonstrated non-incineration technologies for the treatment of infectious waste.

### Best Environmental Practices in Philippine Hospitals

On August 1, 2013, at a meeting of 150 hospital administrators and staff in Alfonso, Cavite, HCWH-Asia and UNDP GEF Project on Global Healthcare Waste launched the report "From the Backyard to the Frontline: Initiatives of Philippine Hospital Workers on Best Environmental Practices." The report showcases - practices in seven (7) selected hospitals.

HCWH-Asia Director Merci Ferrer said, "Hospital waste management and the whole gamut of issues in hospitals from harmful chemicals, wastewater, to energy use remain big concerns that we continue to address. This report proves that good environmental practices exist and Philippine hospitals and hospital workers are already engaged in them."

Among the best practices featured are:

- Materials recovery and recycling, banning of polystyrene foam packaging, composting, and encapsulation of autoclaved sharps waste of the Hospital Waste Management Team at Maria Reyna-Xavier University Hospital in Cagayan de Oro City;
- Safe practices to prevent radiation exposure in General Santos Doctors Hospital led by the Radiology Technology team;
- Use of safer alternatives for surface cleaning and cleaning of non-



**San Lazaro Hospital's Mercury Storage.** Newly constructed storage room for mercury-containing fluorescent lamps and bulbs, old storage room in an isolated area with precautionary signs in place, and properly sealed containers inside storage rooms. (Source: Dr. Karen Arago, San Lazaro Hospital, grabbed from the report, "From the Backyard to the Frontline...")

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critical items by the housekeeping staff, autoclaving of waste, and maximizing natural lighting at St. Paul Hospital – Tuguegarao City;

- Installation of the first Philippine hospital biodigester designed by a biomedical waste worker to convert food and garden waste into methane gas for the kitchen and laundry, solar panels for water heating, green walls for cooling, and vermicomposting at Perpetual Succor Hospital in Cebu City;

- Wastewater treatment and reuse of treated water for gardening led by the engineers of Philippine Heart Center and Our Lady of Peace Hospital in Paranaque City; and
- Mercury-free dental services from

the San Lazaro Hospital dentists.

“The report reminds us that the Philippines is a leader in environmental health practices in the region,” said Ferrer. The country is the first in Asia to have a national legislation mandating the phase-out of mercury in all health care facilities and institutions and the first in the world to have a national legislation banning medical waste incineration.

Dr. Jorge Emmanuel, chief technical advisor for the UNDP GEF Project, thanked the Sisters of St. Paul de Chartres Health Care Ministry, which owned or operated five of the seven model hospitals, and the two other hospitals for allowing HCWH-Asia to document their practices. “Reading the report reminds one of the importance of vision and leadership

by hospital administrators, the role of environmental champions among the staff, and the power of creativity and initiative,” said Emmanuel.

He challenged hospital administrators to follow the examples of the seven hospitals and to be part of the global network of hospitals sharing their good practices. Six of the seven hospitals in the report are part of the Global Green and Healthy Hospitals (GGHH) Network <[www.greenhospitals.net](http://www.greenhospitals.net)>. GGHH deals with environmental health leadership, safe chemical alternatives, waste minimization and safe disposal, energy efficiency and clean energy, water conservation, improved transportation, healthy food, pharmaceutical waste management, green building design, and green purchasing.

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## Mercury Spill in Fabella Hospital

*continued from page 33*

Social Welfare and Development (DSWD)-Manila for the temporary relocation of some 90 families who were living near the hospital. They were taken at Bascom covered court near Police Station 3 beside Manila City Jail during the clean-up operation and were asked return to their respective homes in the afternoon. The DOH collected and examined blood samples from all exposed individuals.

On this day, the DOH briefed media to confirm the mercury spill and report its actions on the incident. Health Assistant Secretary Enrique Tayag also clarified that Fabella Hospital no longer uses mercury and the chemicals were already for disposal. Meanwhile, Health Secretary Enrique T. Ona also appealed to other hospitals to review their system for the storage and disposal of mercury to prevent similar incidents.

On August 11, the supposed second phase of the clean-up operation was suspended due to high level of mercury

detected in the air inside the building. The building was immediately closed. The mercury spillage bin was sealed and given to Chevalier – a service provider accredited by the Department of Environment and Natural Resources to dispose hazardous materials.

A fact-finding committee was organized to investigate the incident. Exposed individuals were given acetylcysteine as prophylaxis. Meanwhile, Fabella Hospital still continued to accept and care for patients.

On August 12, the hospital staff underwent debriefing and orientation on mercury contamination by Dr. Visitacion Antonio, a toxicologist from East Avenue Medical Center, Engr. Anna Rivera of the DOH-Environmental and Occupational Health Office, and the Health Emergency Management Staff of Fabella. Blood samples were extracted to the eleven 11 exposed personnel and brought to East Avenue

Medical Center for laboratory analysis. The entire procurement building was sealed and secured. Spectrometer air testing for mercury was conducted three times a day.

Starting August 14, experts from the National Center for Mental Health conducted psychosocial processing to 92 hospital personnel. As of August 18, all test results for mercury contamination turned out negative for the affected hospital staff and civilians living near the hospital. Mercury level monitoring was recorded within normal range except in the affected area of the hospital. All exposed office equipment were turned-over to BFP for proper disposal.

On the global scale, all United Nations (UN) member states agreed to a new legally-binding treaty of the UN Environment Program (UNEP) to ban the production, export and import of all mercury containing products by 2020.

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# How's Our Oral Health Program?

by

**DR. EDWINA J. GO**

DOH Center for Health Development - CaLaBaRZon

The Family Health Office of the Department of Health - National Center for Disease Prevention and Control (DOH-NCDPC) conducted the Oral Health Program Mid-Year Implementation Review and 2011-2016 Strategic Plan Mid-Term Review on July 16-19, 2013 at Ciudad Christia, Rizal. As a first step, the program solicited input from the program's regional coordinators nationwide as well as key partners from Department of Education (DepEd) and other stakeholders with the purpose of assisting the DOH to have the greatest impact on oral health in the coming years. The DOH, considered as the authority on health, has its current thrust - Kalusugan Pangkalahatan (universal health care) - focused on the poor sectors of the country. Basically, the main goal is survival and health of the population mainly from diseases and illnesses, one of which is the promotion and protection of people's oral health.

In fulfilling its mandate to ensure quality, affordable, accessible and available oral health care delivery, the DOH has issued Administrative Order 101, s 2003 or the National Policy on Oral Health followed by Administrative Order 2007-0007 which prescribes the framework or guidelines to implement the oral health program for public health services. Capability enhancement program for public health dentists has also been developed to provide in-depth understanding of their different roles and functions in program management and delivery. Furthermore, the oral health program has taken its leap with the development and implementation

of the Orally Fit Child (OFC) Program and the integration of oral health in different family health programs using the life-cycle approach. However, its implementation could not be relied upon in as much as it all strongly depends upon prerogatives and priorities of local government chief executives and partner agencies on whether or not to give oral health equal importance vis-a-vis other health concerns.

So far, a number of strengths, weaknesses, issues/problems, gaps and good practices have been documented during the

implementation of the oral health program aside from the issues on the total execution of the 2011-2016 strategic plan that has yet to be settled. Concomitant with the recent change in leadership of some local government officials, this program implementation review is best fitting to address major concerns and to draw up a comprehensive oral health program for all Filipinos.

Dr. Irma L. Parajas,  
director of the University  
of the Philippines -  
Human Resource  
Development



Office and one of the principal researchers of the 2011 National Monitoring and Evaluation Dental Survey, presented the latest result of the said survey. Every five years (1977, 1982, 1987, 1992 and 1998), the DOH-NCDPC, in collaboration with the UP-National Institutes of Health, conducts a nationwide dental survey to determine the oral health status of the country. Data from surveys provided reliable estimates of oral diseases of the population, dependable information on the trends and changing patterns of oral health in the country as well as it served as critical inputs in formulating national policies and strategies to address dental problems in the country as well as in planning, implementing and evaluating oral health interventions that are aimed in improving the dental conditions of the populace.

According to Parajas, when compared to results of previous studies, the prevalence of dental caries (also known as tooth decay or cavity) decreased from 94.2% (1998) to 87.4% (2011), while periodontal disease (a condition in which the tissue – gums, deeper supporting tissue, and bone – around a tooth or teeth become infected and inflamed) decreased from 78% (1998) to 48.3% (2011). The two dental diseases show a fluctuating trend from 1977 to 2011, although years of interval varied greatly from 1998 to 2011. The data gathered by Department of Education (DepEd) in 2006 cannot be compared to the previous years as well as the most recent year of study because of the difference in criteria used.

To assess dental caries in a population, a "DMFT" index is used; it is a count of the number of "Decayed, Missing, Filled Tooth" surfaces in a person's mouth. The average DMFT at 12 years and 35-44 years age groups for the past 34 years as recorded in the seven studies show fluctuating trends.

The highest average DMFT of 12 years was in 1982 and 1992, while peak DMFT for the 35-44 years age group was in 1998. The occurrence of DMFT decreased from then on until 2011. When compared to our neighboring countries in the Western Pacific Region of the World Health Organization (WHO), the Philippines comes second to Brunei Darussalam with the highest average DMFT for 12-year old children. The countries with the lowest DMFT are China at 0.5 and Hongkong at 0.8 DMFT.

The prevalence of periodontal disease from 1982 to 2011 showed a dramatic decrease from 1998 to 2011 for all ages. Results are the same when evaluated by specific age. When compared with other countries in the Western Pacific Region, at 15-19 years age group, the Philippines together with Tonga obtained 4.5 healthy sextants. The mouth is divided into sextants defined by tooth numbers: 18-14, 13-23, 24-28, 38-34, 33-43, and 44-48. A sextant should be examined only if there are two or more teeth present and not indicated for extraction. The country ranked fourth to French Polynesia with 5.8 healthy sextant, followed by Korea at 5.1 and New Zealand at 4.8 sextants.

Likewise, the Philippines had low number of sextants with deep pockets, 0.08 for score 3 and 0.01 for score 4, compared to Tonga and Malaysia with no pockets. At 35-44 years age group, Korea had the most number of healthy sextants at 3.5. These are followed by New Zealand at 2.9 sextants, Japan at 2.7, the French Polynesia 2.6 and the Philippines at 2.22 sextants.

Since the full implementation of the Local Government Code of 1991, the DOH dental health services was reorganized and created a significant impact on the oral health situation in the country. However, in the early nineties, the DOH formulated a six-year (1993-1998) Comprehensive Dental

Health Program to respond to improving the nation's oral health. It attempted to operationalize innovations in preventive oral health care using a revitalized primary health care approach. Plans and actions are geared towards preventing and controlling oral health diseases and conditions so as to attain the highest possible level of oral health care. In 2005, oral health policies and guidelines on oral health were instituted and the DOH Orally Fit Child Program for under six-year old children and the DepEd Oral Health Program contributed greatly to the improvement of the oral health status of children, specifically for oral hygiene as evidenced by majority (93.3%) of the study population brushing their teeth. This may be the reason for the high decrease in periodontal disease in our country today. However, much effort should still be made to improve the status of dental caries to meet the WHO global goals.

Some of Parajas' recommendations to reach the WHO goals and parameters are for government agencies to work harder, to provide incentives for public health dentists to encourage them to visit remote barangays. Other recommendations include the implementation, regular monitoring and evaluation of the Orally Fit Child program in all the preschools of the country as well as adopting alternative approaches to solve the problem of health human resources. It is also recommended to study the water in communities to determine the fluoride level, the inclusion of oral health services in Philippine Health Insurance (PhilHealth), and implement programs for all the other age groups in coordination with other agencies.

Taking all these in consideration, all the regional oral health program coordinators came up with their plans of action.

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## ***Kahirapan Wakasan, Karapatan ng Bata Ipaglaban***

October is National Children's Month and in its 21st year celebration the Council for the Welfare of Children (CWC) - a focal inter-agency body of government, including the Department of Health, mandated to coordinate the implementation and enforcement of all laws; formulate, monitor and evaluate policies, programs and measures for children - focuses on poverty with the theme *"Kahirapan Wakasan, Karapatan ng Bata Ipaglaban."*

The World Bank defines poverty as pronounced deprivation in well-being, and comprises many dimensions. It includes low incomes and the inability to acquire basic goods and services necessary for survival with dignity. Poverty also encompasses low levels of health and education, poor access to clean water and sanitation, inadequate physical security, lack of voice, and insufficient capacity and opportunity to better one's life.

Child poverty is different from adult poverty because it has multiple dimensions. Child poverty is more than income poverty and manifests itself in deprivations that have consequences on a child's overall well-being and development.

The three main determinants of child poverty are: 1) children living in poor households; 2) deprivations of basic amenities such as electricity, potable water and sanitary toilet facilities; and 3) a child development index which is a composite of health, education, and quality of life indicators.

The Global Study on Child Poverty and Disparities by the United Nations Children's Fund (UNICEF) describes child poverty as an outcome of deprivation in the family, thus, as poverty incidence in families rise, more and more children are deprived of their basic needs and are pushed to join the labor force at an early age, becoming exposed to exploitation and abuse. Deprivation of basic needs because of poverty affects the growth and development of the child.

According to the 2009 Official Poverty Statistics in the Philippines by the National Statistical Coordination Board, children came in third to fisherfolks and farmers among the nine basic sectors with high poverty incidence. (The other sectors are: self-employed with unpaid family members; workers; women; youth; migrant and formal sector; senior citizens; and individuals residing in urban areas.) For the

basic sectors, poverty incidence for children is higher at 35.1% in 2009 from 34.8% in 2006, higher than the poverty incidence among the population in the Philippines at 26.5% in 2009. Poverty incidence for children residing in urban areas increased between 2006 and 2009, with 0.3 percentage point increases.

The 2009 statistics revealed a Filipino family of five needed Php 4,869 monthly income to meet the basic food needs and Php 7,017 to stay out of poverty. The magnitude of poor population increased by almost 970,000 Filipinos from 22.2 million in 2006 to 23.1 million in 2009. CARAGA, Autonomous Region in Muslim Mindanao and the Zamboanga Peninsula (Region IX) posted the highest poverty incidence among families.

There has been some progress though in areas of child health, particularly in the provision of expanded program on immunization and micronutrient supplementation, and the promotion of exclusive breastfeeding. A joint study by UNICEF and Philippine Institute for Development Studies (PIDS) noted that aside from child survival interventions, some progress has been made in the proportion of

children deprived of electricity and access to communication, and water and sanitary facilities. Nevertheless, the study also noted that a lot still needs to be done especially in the areas of education and maternal mortality. A roadmap for poverty reduction, in particular for the alleviation of the children's plight, therefore has to be crafted.

Data on Philippine education show all three indicators on children under the Millennium Development Goal (MDG) 2, i.e. net enrolment ratio in primary education, proportion of pupils starting Grade 1 who reach Grade 6, and primary completion rate, show low probabilities of achieving their target by 2015. Likewise, reducing maternal and neonatal mortality in the Philippines or MDG 5 remains a key development challenge.

One program in the anti-poverty strategy of government is the Pantawid Pamilyang Pilipino Program (4Ps) which attack the root causes of poverty – weak education, health and other human development characteristics

that disadvantage a poor person. One of its key interventions is the provision of conditional cash transfers (CCTs) to mothers, as long as they commit to investing in their children, such as by ensuring their children go to school, get health services and others. The target beneficiaries are those who are considered to be the poorest of the poor. The receipt of cash is based upon the behavior of recipients. In effect, CCTs are designed to discipline parents in assuming direct responsibility for the welfare of their children. The 4Ps now operates in 79 provinces covering 1,484 municipalities and 143 key cities in all 17 regions nationwide.

As of June 2013, the program covered almost 4 million households. The planned extension of the 4Ps will include an additional 2 million children to the current 8.5 million in the program. A special emphasis will be placed on providing additional support to children from poor families who would like to go to high school. By 2015, a quarter of the population is expected to be beneficiaries, including new

categories for coverage such as abandoned children, the disabled, and those displaced by calamities or conflict.

Despite criticisms that the billions invested in the 4Ps which could have been better spent on job creation, no other social protection program in Philippine history has ever reached a wide scale and has improved school attendance and health care coverage. The 4Ps can help ensure that the majority of children will grow up to be educated, healthy, and productive members of Philippine society, contributing to the country's economic competitiveness in the longer term. .

Poverty reduction starts with children. A roadmap for poverty reduction, in particular for the alleviation of the children's plight, therefore has to be crafted and implemented. Just as what an old adage says, "it takes a tribe to raise a child," everyone has a stake in contributing to poverty reduction and advocating for stronger holistic actions, particularly preventive measures to address the problems on poverty.

## ***Habagat Strikes, DOH Responds***



At the height of the heavy rains and floods caused by the southwest monsoon (habagat) induced by Typhoon Maring in most parts of Luzon, the Department of Health activated operation centers at the regional and local levels, and established an alternate national headquarters at the East Avenue Medical Center in Quezon City. Health Secretary Enrique T. Ona and the DOH Executive Committee members visited several affected areas including: Marikina; Mandaluyong; San Mateo, Rizal; Malolos, Bulacan; Sto. Tomas, Pampanga; Sta. Rita, Macabebe, Pampanga; and San Pedro, Laguna; among others. They provided logistical needs, assorted drugs and medicines, hygiene kits and health promotion materials. Leptospirosis monitoring also started on August 24 in all DOH hospitals.

Photo shows Secretary Ona, Health Undersecretary Teodoro Herbosa, World Health Organization Country Representative Dr Julie Hall, CALABARZON OIC-Director Dr Corazon Flores, San Pedro Mayor Lourdes Cataquiz and other local officials visiting the Landayan covered court in San Pedro, Laguna on August 24, 2013. The health chief advised evacuees to practice hygiene habits to prevent diseases and warned of dengue and leptospirosis which are common during rainy season. Ona also advised local officials to provide information to mothers on reproductive health, child health and nutrition and the importance of immunization.



# Stop Sepsis, Save Lives

by  
**CECILIA Q. CAÑIZA\***

On January 29, 2013, New York Governor Andrew M. Cuomo declared that all New York state hospitals were now required to “adopt best practices for the early identification and treatment of sepsis, a medical condition which is the number one killer in hospitals and the 11th leading cause of death in the United States.” Cuomo also proposed health regulations specifically targeted to protect pediatric patients, and to ensure the highest standards for patient care.

Cuomo's plan to reform the state's healthcare system follows the much publicized death of 12-year old Rory Staunton, who died of sepsis in April 2012 because he was not immediately diagnosed with the disease. “Rory's Regulations,” as the proposed reforms are called,

make New York the first state to legally recognize sepsis as a national medical emergency.

Sepsis cases among pediatric patients are common in the Philippines, but sepsis has yet to be declared a health burden. In 2008, however, there was an alarming rise in neonatal deaths at the Ospital ng Makati. Then Makati Mayor Jejomar Binay ordered an investigation into the deaths along with a separate investigation composed of officers from the Department of Health. It was discovered that substandard hygiene practices, hospital overcrowding, and negligence among several hospital staff were the reasons behind the contraction of sepsis in newborn infants. Newborn deaths in urban hospitals have been the subject of recent research, as many major metropolitan hospitals continue to struggle to control and take precaution against new sepsis cases.

“Every 3-4 seconds someone dies of sepsis,” according to the World Sepsis Day

website. Despite this fact, sepsis remains “the most common, but least recognized disease,” accounting for more deaths every year than certain cancers, heart conditions, and even HIV/AIDS. Mortality rates from sepsis keep rising each year among the elderly and children, especially in developing countries like the Philippines, despite major advances in medical care and research.

## The Silent Killer

Considered by medical professionals and researchers worldwide as “the silent killer,” sepsis is frequently described as blood poisoning, and is the body's often deadly response to an infection or injury.

The word sepsis comes from the Greek meaning “decay” or “to putrefy,” says Sepsis Alliance – a non-profit organization dedicated to sepsis awareness. In medical terms, sepsis is defined as either “the presence of pathogenic organisms or their toxins in the blood and tissues” or “the poisoned condition resulting from the presence of pathogens or their toxins as in septicemia.”

Patients are given a diagnosis of sepsis when they develop clinical signs of infections or systemic inflammation; sepsis is not diagnosed based on the location of the infection or by the name of the causative microbe. Physicians draw

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*\*The contributing writer is a registered supporter of World Sepsis Day. She taught at the Department of European Languages, College of Arts and Letters, University of the Philippines-Diliman. She is currently involved in efforts to enjoin the Philippine Government in recognizing World Sepsis Day.*

from a list of signs and symptoms in order to make a diagnosis of sepsis, including abnormalities of body temperature, heart rate, respiratory rate, and white blood cell count. Sepsis may be diagnosed in a 72-year old man with pneumonia, fever, and a high white blood count, and in a 3-month old with appendicitis, low body temperature, and a low white count.

Sepsis is defined as severe when these findings occur in association with signs of organ dysfunction. Nearly all victims of severe sepsis require treatment in an intensive care unit for several days or weeks. While most cases of sepsis are associated with disease or injury, many events follow routine, even elective surgery.

More frightening is that sepsis can range in response to incidents as seemingly benign as a playground scrape or a nicked cuticle from the beauty parlor." Almost half of patients diagnosed with severe sepsis do not survive due to multiple organ failure, or are more likely to die within several years as a result of complications from sepsis.

Because anyone at any age can contract sepsis, there are many causes of this little-known medical condition. Infected wounds or simple cuts may cause bloodstream infections that lead to sepsis. Underlying medical conditions such as pneumonia and abdominal and kidney disease are also high-risk factors for sepsis. Weakened immune systems among the elderly and infants are also a major cause of sepsis mortalities. Aside from these, drug-resistant bacteria, complications from invasive surgeries, and even bacteria in hospitals, especially in emergency rooms, may cause sepsis.

## Symptoms

According to the Mayo Clinic, the most recognized non-profit medical

organization for medical care, research, and education, most medical professionals consider sepsis a 3-stage condition: sepsis, severe sepsis, and finally, septic shock. The following are the symptoms for each stage, which are also symptoms for other illnesses and often make it difficult to correctly diagnose sepsis:

- **Stage 1: Sepsis.** Fever above 38.5°C or below 35°C; heart rate higher than 90 beats per minute; respiratory rate higher than 20 breaths a minute; and probable or confirmed infection;
- **Stage 2: Severe Sepsis.** Significantly decreased urine output; abrupt change in mental status; decrease in platelet count; difficulty breathing; abnormal heart pumping function; and abdominal pain;
- **Stage 3: Septic Shock.** Same symptoms as severe sepsis, and extremely low blood pressure that is unresponsive to fluid replacement.

## Treatment and Prevention

A majority of patients with sepsis are often diagnosed too late, as with the case of Rory Staunton, and may have contracted the disease outside of the hospital. Patients suspected of having sepsis should be brought immediately to the nearest hospital emergency room, where they will be placed in an intensive care unit.

Treatment consists of providing high flow oxygen, blood transfusions, the taking of blood cultures to determine the cause of sepsis, giving intravenous (IV) antibiotics, monitoring hemoglobin and urine levels, and dialysis. There is no vaccine for sepsis.

Recovery after sepsis often takes years and many survivors experience

muscular weakness, impairment of the senses, difficulty in speech, loss of memory and mental faculties, depression, symptoms similar to post-traumatic stress disorder, among others.

Some ways to prevent sepsis, include: vaccinating young children against disease; supervised care after invasive surgeries and cancer treatments like chemotherapy; and always practicing proper hygiene and sanitation at home, school, the workplace, and even in healthcare facilities. However, the best prevention of sepsis is still public awareness through health promotion activities like information campaigns or educational seminars.

## World Sepsis Day

Last year, September 13 was declared as "World Sepsis Day" by the Global Sepsis Alliance, an association of global healthcare professionals, seven international federations involved with critical and acute care medicine, and 43 national organizations. Like other worldwide days dedicated to health conditions, the first World Sepsis Day was declared in order to raise awareness about the condition among healthcare professionals and the general public, and to reduce the incidence of sepsis through specific prevention strategies that will hopefully be adopted worldwide.

This year, the founding members aimed to reduce the number of sepsis mortality rates by 20% by 2020, implement standardized prevention and treatment guidelines internationally, and make sepsis known worldwide.

For more information about sepsis and to learn how to support World Sepsis Day, visit <[www.world-sepsis-day.org](http://www.world-sepsis-day.org)>, <[www.globalsepsisalliance.org](http://www.globalsepsisalliance.org)> or <[www.sepsisalliance.org](http://www.sepsisalliance.org)>.

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# Dengue Control Goes to Church

*"Nasa Diyos ang awa, nasa tao ang gawa."* That's what the Filipino proverb tells us. It tells us not only to pray for our better health, but we need to act accordingly to prevent us from getting sick.

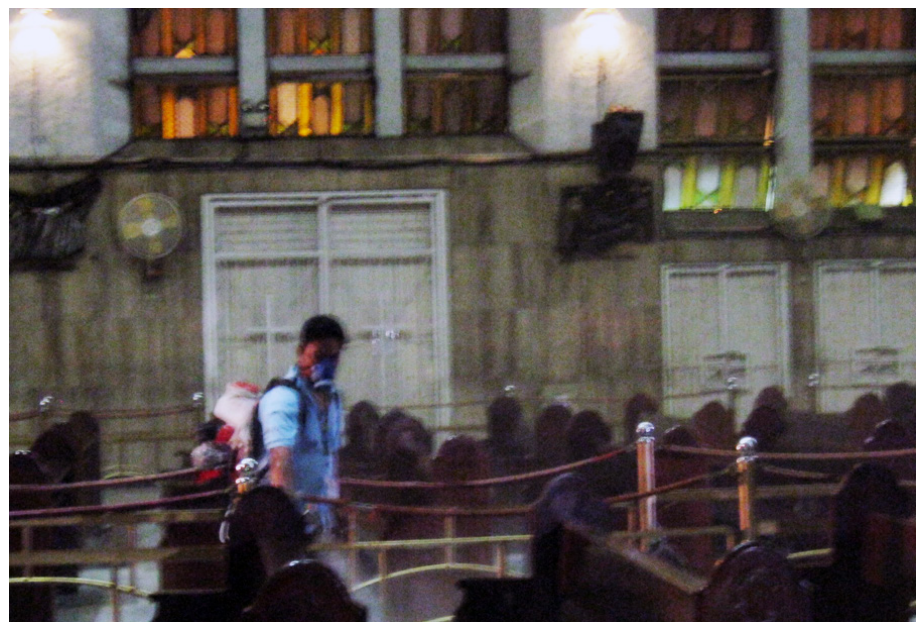
Thus, dengue control efforts of the Department of Health - National Capital Region (DOH-NCR) leave no stone unturned, so-to-speak. Aside from anti-dengue spraying in communities, schools, bus terminals and other public places where people congregate, the DOH-NCR is also targeting the Church – and its first stop was The Minor Basilica of the Black Nazarene or the Quiapo Church on July 29, 2013.

"The Quiapo Church is one of the biggest public areas that attracts thousands of crowds daily from all walks of life and this is the first time that the DOH will provide anti-dengue spraying to protect devotees from mosquito bites," said DOH-NCR Director Eduardo C. Janairo.

He added that this effort was not limited to the misting and larviciding operations for the prevention and control of dengue, the DOH-NCR also conducted disinfection inside and around the church's vicinity to prevent the spread of harmful bacteria that may cause illness and other health risks such as colds, cough and even influenza. This move complemented the clean-up drive of the Manila City government.

The activity was made in partnership with Msgr. Jose Clemente F. Ignacio, the present parish priest. The Quiapo Church is one of the most heavily populated churches in NCR especially on Fridays when devotees pay homage to the Black Nazarene.

As of end of July 2013, DOH-NCR



has disinfected and sprayed a total of 50 bus terminals along Avenida and EDSA. There are now a total of 12,470 households and 56 public and private schools sprayed and disinfected all over Metro Manila.

"Our anti-dengue and disinfection activities are continuously being done

to counter the spread of dengue and to eliminate mosquitoes and their breeding sites. We will not stop until dengue is eliminated in Metro Manila," Janairo said.

The next destination will be the National Shrine of Our Mother of Perpetual Help or the Baclaran Church.

# Chikungunya Outbreak

In a special session of the municipal council of San Nicolas in Ilocos Norte on July 25, 2013, a state of calamity was declared after the number of suspected chikungunya cases surged to more than 300, affecting at least four neighboring villages as well as to use the town's calamity funds for preventive measures against the spread of the disease.

Chikungunya is a viral disease (genus Alphavirus) which is transmitted to humans by infected mosquitoes – including *Aedes aegypti* and *Aedes albopictus*. The name chikungunya originates from a verb in the Kimakonde language of Tanzania and Mozambique, meaning "to become contorted." This refers to the "stooped" appearance of those suffering with joint pain.

Aside from joint pain, Chikungunya is also characterized by fever, headache, fatigue, nausea, vomiting, muscle pain and rash. Symptoms appear between 4 and 7 days after the patient has been bitten by the infected mosquito.

Acute chikungunya fever typically lasts a few days to a few weeks and some patients have prolonged fatigue lasting several weeks. Additionally, some patients have reported incapacitating joint pain, or arthritis which may last for weeks or months, and this is not typical of dengue. Chikungunya shares some clinical signs with dengue and can be misdiagnosed in areas where dengue is common, therefore the incidence of chikungunya could be much higher than what has been previously reported.

Pregnant women can become infected with chikungunya virus during all stages of pregnancy and have symptoms similar to other individuals. Most infections

occurring during pregnancy will not result in the virus being transmitted to the fetus. The highest risk for infection of the fetus/child occurs when a woman has virus in her blood (viremic) at the time of delivery. There are also rare reports of first trimester abortions occurring after chikungunya infection.

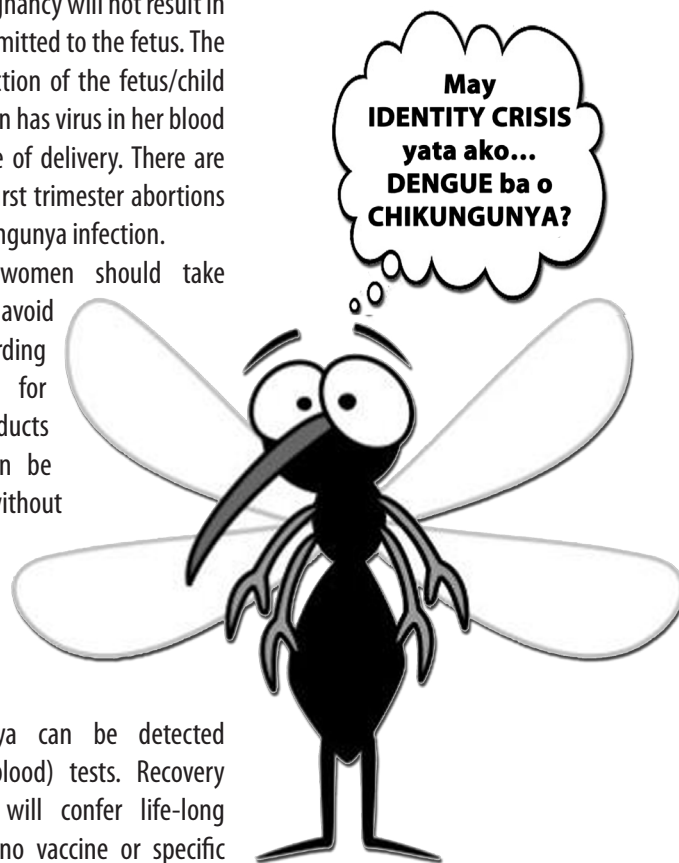
Pregnant women should take precautions to avoid mosquito bites. According to the US Centers for Disease Control, products containing DEET can be used in pregnancy without adverse effects, and there is no evidence that the virus is transmitted through breastmilk.

Chikungunya can be detected using serological (blood) tests. Recovery from an infection will confer life-long immunity. There is no vaccine or specific antiviral treatment currently available for chikungunya. Treatment is symptomatic and can include rest, fluids, and medicines to relieve symptoms of fever and aching such as ibuprofen, naproxen, acetaminophen, or paracetamol. Aspirin should be avoided.

Infected persons should be protected from further mosquito exposure (staying indoors in areas with screens and/or under a mosquito net) during the first few days of the illness so they cannot contribute to the transmission cycle.

## Outbreaks

The World Health Organization said chikungunya was first identified in Tanzania in the early 1952 and has caused



periodic outbreaks in Asia and Africa since the 1960s. In Europe and the Americas, only minor incidence rates occur and these are caused by imported cases from travellers. Italy is the only European country which has had an outbreak. The Americas have not had any major outbreaks so far. Outbreaks are often separated by periods of more than 10 years.

In the Philippines, according to Health Assistant Secretary Enrique "Eric" A. Tayag, the last significant number of chikungunya cases happened in the 1960s until Tropical Storm Sendong hit in 2011 when outbreaks hit Cagayan de Oro and Davao. Last year, there were cases in 12 areas of the country.



In the first half of 2013, the Department of Health had registered a total of 2,594 suspected chikungunya cases, but only 157 of them had been confirmed. No deaths were recorded. Outbreaks were confirmed in Kiamba and Maitum in Sarangani; Villareal and Daram in Western Samar; Ma. Aurora in Aurora; Sindangan in Zamboanga del Norte; Sta. Rita in Samar; Concepcion in Romblon; Santiago in Agusan del Norte; and Patnongon in Antique.

### Prevention and Control

Prevention and control of chikungunya can be combined with dengue control efforts. Typically, these mosquitoes do not fly far. The majority remain within 100 meters of where they emerged, feeding almost entirely on humans mainly during daylight hours both indoors and outdoors.

Control of these mosquitoes is mainly achieved by eliminating habitat and breeding sites by frequently emptying and

cleaning containers and by interrupting the aquatic stages of development through the use of insecticides either by biological control agents, killing adult mosquitoes using insecticides, or by combinations of these methods.

The DOH reiterates the practice of the 4 o'clock habit using the STOP, LOOK and LISTEN approach. STOP means "dropping" everything and shifting current task for mosquito control. LOOK means that around 4 o'clock and until next hour, assigned teams in the community, school or workplace to carry out systematic "search and destroy" activities that will identify and eliminate mosquito-breeding sites. LISTEN entails heeding the instructions from authorities for synchronous implementation of the 4 o'clock habit. This can be done on a daily basis, or at least on a weekly basis.

For individual and household protection, clothing that minimizes skin exposure during daylight hours when mosquitoes are most active affords some

protection from the bites of dengue and chikungunya vectors and is encouraged particularly during outbreaks.

Repellents may be applied to exposed skin or to clothing. The use of repellents must be in strict accordance with label instructions. Insecticide-treated mosquito nets afford good protection for those who sleep during the day (e.g. infants, the bedridden and night-shift workers).

Where indoor biting occurs, household insecticide aerosol products, mosquito coils or other insecticide vaporizers may also reduce biting activity. Household fixtures such as window and door screens and air-conditioning can also reduce biting.

For those who use pesticides, it is important to remember that all pesticides are toxic to some degree. Safety precautions for their use – including care in the handling of pesticides, safe work practices for those who apply them, and appropriate field application – should be followed.

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## KALAbeat

### Sa Dako Pa Roon...

*Isang gabi isang estudyante ang nakasakay sa jeepney at siya nalang ang natitirang pasahero. Napansin niyang iniba ng drayber ang rota at nagtanong siya...*

**ESTUDYANTE:** Manong, hindi po ito ang daan papunta sa dorm ko. Matapos ang limang minutong paglalakbay, ibinalik ng drayber sa tamang daan. At pagdating sa harap ng dorm, bago bumaba ang estudyante ay pinagbilinan siya ng drayber...

**DRAYBER:** Iha, pagpasok mo, hubarin mo agad ang damit mo at kung pwede ay sunugin mo. Iniba ko ang rota ko kasi pagtingin ko sa salamin kanina, wala kang ulo.



**H A P P Y H A L L O W E E N !**

# Fasting and Peptic Ulcer Disease

by

**TATO M. USMAN, MD, MPAIM**

DOH Center for Health Development -  
Autonomous Region in Muslim Mindanao

## Fasting

Muslims all over the earth had just concluded 'eid'l fit'r or Muslim feast day to mark the end the month-long fasting on August 9, 2013.

In the noble Qur'an, Allah Almighty says, "O you who believe, fasting is prescribed for you as it was prescribed for those who were before you, in order that you may learn piety" (Qur'an 2:183). In other words, fasting is prescribed to those people even before the time of Prophet Muhammad (*peace be upon him or PBUH*). Even in the Holy Bible, fasting was prescribed by Jesus (*PBUH*) when his disciples asked him how to cast the evil spirits away and answered, "But this kind never comes out except by prayer and fasting" (Matthew 17:21).

Fasting is called *sawm* in the Qur'an. The word *sawm* literally means "to abstain". In Chapter Maryam, Allah almighty tells us about Mary, the mother of Jesus (*PBUH*), who said, "I have vowed a fast for the sake of the Merciful, so today I shall not speak to anyone". (Qur'an 19:26) The meaning of this verse is "I have vowed to abstain from speaking to anyone today". According

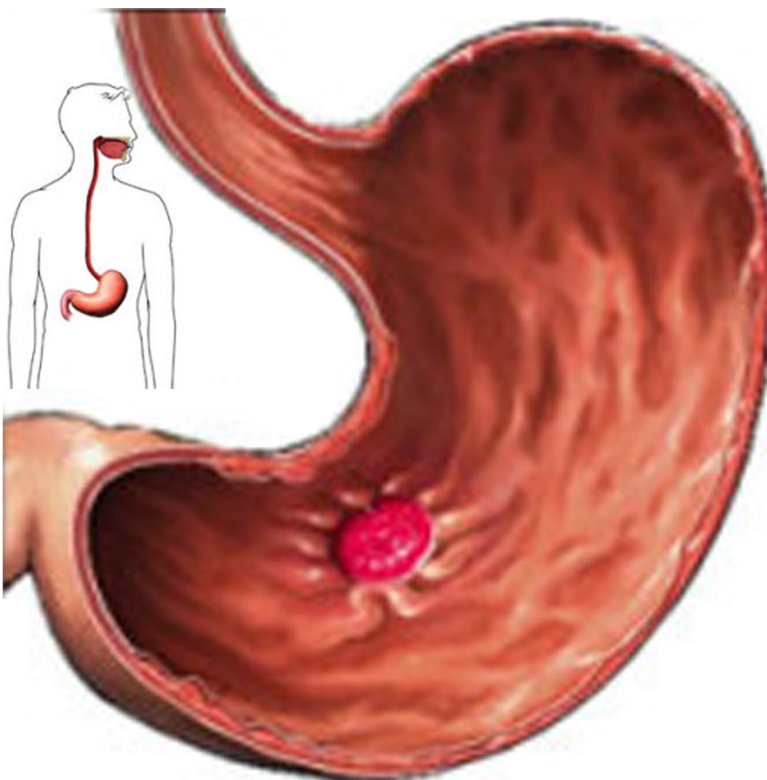
to Shari'ah (Islamic Law), the word *sawm* means to abstain from all those things that are forbidden during fasting from dawn to sunset, and to do this with the intention of fasting.

Conversely, you can eat and drink starting sunset up to dawn only. Allah Almighty says, "Eat and drink until the white thread of dawn becomes distinct from the black thread (of night)" (Qur'an 2:187). In the authentic Hadith, the Prophet (*PBUH*) said, "Eat and drink until Ibn Umm Maktum (the caller to prayer during his time) gives the call to prayer at dawn." Ibn Umm Maktum was a blind man, and he used to give call to

a prayer after people tell him that the dawn has appeared. It is good to eat until the last minute until dawn starts as the Prophet (*PBUH*) said, "My community will remain following the balanced way as long as they make iftar (Arabic term for meal to break the fast) early and delay their sahur (Arabic term for meal just before dawn)."

Fasting in the month of Ramadan is obligatory upon every Muslim, male or female, who is adult (i.e. has reached puberty) and sane and who is not sick or on a journey.

Sickness could be a temporary sickness from which a person expects to be cured soon. Such a person is allowed not to fast during the days of his/her sickness, but he/she must fast later after Ramadan to complete the missed days. Those who are sick with incurable illness and expect no recuperation, such people are also allowed not to fast but they must pay by giving a day's meals for each missed fast to a needy person. One can also give instead of the money for meals to a needy person. Likewise, women in their menses and post-natal bleeding are not allowed to fast, but they must make up later after Ramadan. Pregnant women and



*The stomach and peptic ulcer disease. (Illustration grabbed from the Internet)*



mothers who are nursing babies, if they find it difficult to fast they can also postpone their fasting to a later time when they are in a better condition.

Journey according to the Shari'ah is any journey that takes you away from your city of residence, a minimum of 48 miles or 80 kilometers. However, the journey must be for a good cause because it is a sin to travel during fasting month (Ramadan) in order to avoid fasting. A Muslim should try to change his/her plans during Ramadan to be able to fast and should not travel unless it is necessary. The traveler who misses fasts of Ramadan must make up those missed days later after Ramadan as soon as possible.

### Peptic Ulcer Disease (PUD)

Peptic ulcer (also called peptic ulcer disease or PUD) is a sore in the lining of the stomach or duodenum. The duodenum is the first part of the small intestine. A peptic ulcer in the stomach is called a gastric ulcer. One that is in the duodenum is called a duodenal ulcer. A peptic ulcer also may develop just above your stomach in the esophagus, the tube that connects the mouth to the stomach. But most peptic ulcers develop in the stomach or duodenum.

The most common cause of PUD is infection with bacterium called *Helicobacter (H.) Pylori*. This bacterium lives in acidic environment of the stomach that weakens the protective coating and allows damaging digestive juices to eat away at the sensitive lining below.

Another cause is the long-term use of nonsteroidal anti-inflammatory medicines (NSAIDs) such as aspirin and ibuprofen. These NSAIDs inhibit the protective properties of prostaglandin in the lining of gastrointestinal tract.

Two major risks factors favor the development of PUD – smoking and drinking

alcohol. Smoking may increase the risk of peptic ulcers in people who are infected with *H. pylori* while alcohol can irritate and erode the mucous lining of your stomach, and it increases the amount of stomach acid that is produced.

In the World Health Organization (2011) list, the top 20 countries with highest death rates on PUD are: Cambodia, Philippines, New Guinea, Kiribati, India, North Korea, Myanmar, Malawi, Nepal, Bangladesh, Cote d'Ivoire, Guinea, Timor-Leste, Namibia, Mozambique, Guinea-Bissau, Ethiopia, Uganda and Swaziland.

These countries are non-Muslims and therefore it cannot be attributed to month-long fasting. Notably, Philippines with a Muslim minority, ranked second with the highest death rates due to PUD. Is it because of the Muslim populace in its Southern part? In the Autonomous Region in Muslim Mindanao (ARMM), PUD is not included among the 10 leading causes of deaths. Even at the provincial level, PUD is still not among the leading causes of death except in Lanao del Sur which ranked 8th. However, PUD cannot be ascribed to fasting but rather on the high prevalence of tobacco use in the said province.

### Fasting and PUD

From 2009 to 2011, a total of 321 patients were evaluated to determine the effect of fasting on people with existing PUD based on the upper gastrointestinal endoscopy (UGE) as a diagnostic work-up. The patients were divided into three groups: Patients who have been evaluated by UGE, in the month just before Ramadan (group I, n=69), in Ramadan month (group II, n=132) and in the month just after Ramadan (group III, n=120). In conclusion, this study revealed that duodenal ulcers and duodenitis were found more during Ramadan month. This

research was conducted by the Cumhuriyet University, School of Medicine, Department of General Surgery in Sivas, Turkey.

In the study, fasting is done in people diagnosed with PUD. However, based on the Shari'ah, it was mentioned earlier that people suffering from diseases are exempted to perform fasting. Understandably, people with PUD are exempted to perform month-long fasting unless with clearance preferably from the Muslim physicians so that appropriate medications will be taken.

On the other hand, people who are healthy have demonstrated that fasting is beneficial to health if it is done correctly. Meaning, people who are not smokers or alcohol drinkers did not develop PUD. In fact, people with elevated cholesterol were reduced when they performed month-long fasting provided they ate healthy foods and physically active during the evening. In fact, the Prophet (PBUH) said: "Fast for better health".

Logically, divine guidance outweighs medical science because the latter is changeable depending on the latest discovery. Moreover, God Almighty will not prescribe things that will ruin their creations and He will not prohibit things that are beneficial to their creations. In gist, it is no way that the creation is above his creator.

Allah Almighty says, "And if all the trees on earth were pens and the sea (were ink wherewith to write), with seven seas behind it to add to its (supply), yet the Words of Allah would not be exhausted. (Qur'an 31:27)

Furthermore, Allah Almighty says, "The month of Ramadan is that in which was revealed the Qur'an, wherein is guidance for mankind and the clear signs of guidance and distinction. Thus whosoever among you witness the month must fast..." (Qur'an 2: 185).

Allah Almighty knows best.

*Sino ang umutot?*

# Intestinal Gas

*Eksena sa jeep...*

DRAYBER: Woooh. Grabe! Sino ang umutot sa inyo? Ambaho naman!

*Walang umamin at mas lalo lang sumakit ang ulo ng drayber...*

DRAYBER: Kung sino 'yung umutot, hindi pa nagbabayad!

MICHAEL: Hoy, Manong Drayber! Bayad na kaya ako!

## Sino ang Umutot?

*Sino ang umutot?* Well, we all do. Passing gas occurs naturally and you do it around 20 times a day. But its presence can be socially embarrassing or even painful.

Gas is always present air in the digestive tract – the large, muscular tube that extends from the mouth to the anus. You notice intestinal gas only if it is excessive or causing pain.

Excess intestinal gas in the stomach or upper intestine may result in excess burping or belching. It may result from swallowing more than a usual amount of air while eating, drinking or chewing gum.

Excess intestinal gas in your lower intestine may result in increased gas being passed from your anus (flatulence, a.k.a. farting or *utot*). It is the normal byproduct of bacterial action on food that is not broken down until reaching the colon. Intestinal gas related to bacterial action is made up of hydrogen, carbon dioxide and sometimes methane.

Excess gas from either location can cause cramping or pain, often without an obvious pattern. Bloating or a feeling of fullness and swelling in the abdomen, the area between the chest and hips, is another symptom of gas. Gas pains are usually intense, but brief. Once the gas is gone, your pain often disappears. In some cases, however, the pain may be constant or so intense that it feels like something is seriously wrong. Gas can sometimes be mistaken for heart disease, gallstones, or appendicitis.

By itself, intestinal gas is usually just a sign of a normally functioning digestive system. But if you burp, belch or fart more than 20 times a day, it may already indicate a digestive disorder which includes: celiac disease or an immune reaction to eating gluten – a protein found in wheat, barley and rye; food allergy; GERD or gastroesophageal reflux disease which is

a chronic digestive disease that occurs when stomach acid or, occasionally, bile flows back (refluxes) into your food pipe (esophagus); lactose intolerance or the inability to fully digest the milk sugar (lactose) in dairy products; peptic ulcer; irritable bowel syndrome, among others.

Consult your doctor if your gas is accompanied by: severe, prolonged or recurrent abdominal pain; nausea or vomiting; bloody stools; weight loss; fever; and chest pain. In addition, talk to your doctor if your gas or gas pains are so persistent or severe that they interfere with your ability to live a normal life. In most cases, treatment can help reduce or alleviate the problem.

## What Makes Us Fart

Many foods naturally give you gas, but foods that produce gas in one person may not cause gas in someone else. It depends on how well individuals digest food and the type of bacteria present in the intestines.

Foods that contain carbohydrates can cause gas. All carbohydrates are eventually broken down into simple sugar by the body. The biggest gas-generating ingredients are sugars, especially the following:

- **Fructose** – a natural ingredient in plants like onions, corn, wheat and even pears. It is often concentrated into a sugary syrup for soft drinks and fruit drinks.
- **Lactose** – the milk's sweet natural ingredient, also added to foods like



Photo grabbed from the internet.



bread and cereal. Some people are born with low levels of lactase, the enzyme that breaks down lactose, a fact that inflates their gassy susceptibility.

- **Raffinose** - the secret gassy ingredient in beans, which is also found in broccoli, cauliflower, cabbage, asparagus and other vegetables.

- **Sorbitol** - the indigestible sugar found in almost all fruits. It is also used as an artificial sweetener in "diet" and "sugar-free" foods. Anything that is deceptively sweet like sugar-free gum, candy and soda can cause gas.

People who eat high-fiber products, especially insoluble fiber, are at an increased risk for developing flatulence. Fiber passes through your system in an undigested form until it reaches your large intestine. This can create excess gas in the digestive tract, especially for those who have difficulty digesting fiber. To avoid excess gas, increase your intake of fiber at a slower pace to give your body time to adjust.

And yes, *kamote* (sweet potato), the food that is the culprit in most fart jokes in the Philippines, causes gas. On the other hand, rice, the staple that we routinely eat, may be the only food that does not produce gas.

### Other Causes of Excess Gas

*Tatlong bata ang nagpasikatan...*

ED: Ang tatay ko lumalabas ang usok ng sigarilyo sa ilong.

ANGEL: Wala iyan, ang tatay ko... pinapalabas ang usok sa tenga!

RAUL: Wala palang binatbat ang mga tatay n'yo sa tatay ko. Kapag nanigarilyo ang tatay ko, lumalabas ang usok sa puwet!



ED: Maniwala ka d'yan!

ANGEL: At paano mo nalaman 'yon? Mapapatunayan mo ba 'yun?

RAUL: Tingnan n'yo pa ang brief ng tatay ko... May nicotine pa!

Smoking tobacco is a common cause of farting. For some people, this is due to swallowing air while smoking or chewing tobacco. For others, the ingredients in tobacco products can cause irritation of the stomach lining, resulting in dyspepsia, gastritis and flatulence. To eliminate gas that is caused by smoking or chewing tobacco, limit your use of tobacco products. Quitting is obviously the best solution and a good choice for your health.

Swallowed air is another cause of intestinal gas. You swallow air every time you eat or drink. You may also swallow air when you are nervous, eat too fast, chew gum, suck on candies or drink through a straw. Some of that air finds its way into your lower digestive tract.

In some cases of excess gas, antibiotic use may be a factor because antibiotics disrupt the normal bacterial flora in your bowel. Excessive use of laxatives also may contribute to problems with excess gas.

Constipation, on the other hand,

may make it difficult to pass gas, leading to bloating and discomfort.

### Smells Bad, Sounds Funny

Most of the time intestinal gas smells bad and sounds funny,

Fermented foods produce different types of fumes, some of which smell. Flatulence contains odorless gases, such as nitrogen, carbon dioxide, oxygen, and methane, but it also contains the nasty hydrogen sulfide which causes the smell.

If you have noticed, some of these fumes are flammable, like methane and oxygen, and that means you can set farts aflame. **HEALTHbeat** searched the Internet and found that some people who allegedly tried to set their farts ablaze got burned doing it. But of course, not everything in the Internet is true, but we warn you NOT to try proving it to yourself either. Hahaha.

How much odor is produced also depends on the food you eat. Vegetarians might fart as often as meat-eaters, but their flatulence does not smell as much because vegetables produce less hydrogen sulfide. The more sulfur-rich the foods you eat, the more your farts will stink because bacteria will generate sulfides and mercaptans as they break down the nutrients.

Now, about the funny sounds. Farting is brought to the rectum by specialized contractions of the muscles in the intestines and colon. The noises commonly associated with flatulence are caused by the vibration of the anal sphincter, and occasionally by the closed buttocks.

*Eksena sa silid-aralan...*

TITSER: Ambaho. Kung sino man ang umutot sa inyo, umamin lang, bibigyan ko ng grade na 99!

ERIC: Ma'am, gawin na po ninyong 100, kasi natae na po ako eh!

# My Husband

## Happy Anniversary

AILEEN: Happy Anniversary, babe...  
 BOY: Happy Anniversary too, baby ko! Nakikita mo ba yung naka-park na bagong kotse sa labas?  
 AILEEN: Oh my gosh! Babe, yes... nakikita ko!  
 BOY: Binillhan kita ng tsinelas, ganyan ang kulay!

## Ginabi

*Ginabi ng uwi si Mister at inip na inip na nag-iintay si Misis.*

ELLEN: (Mataas ang boses) Bakit ngayon ka lang ha? BAKIT NGAYON KA LANG?!?  
 EMAN: (Nag-isip ng isasagot at mas tinaasan ang boses) Eh ikaw, bakit kanina ka pa ha? BAKIT KANINA KA PA?!?

## Nasa Dugo

WILSON: Nasa dugo talaga namin ang pagiging gwapo.  
 EMY: Pambihira naman. Bakit sa dugo pa? Hindi na lang sa mukha!

## Suntok

NELSON: Tigilan mo nga ako ang kulit mo naman.  
 WENG: Ang arte mo naman.  
 NELSON: Nanununtok ako ng maganda.  
 WENG: Oh sige, suntok nga, oh?  
 NELSON: Bakit maganda ka ba?

## Patay na Bird

JOEL: Love, may patay na bird, oh...  
 EVELYN: (Tumingin sa langit) Nasaan sweetheart?!?  
 JOEL: So you mean babe, may patay na bird na lumilipad?!? Konting gamit naman ng utak, babe. Please.

## Long Weekend

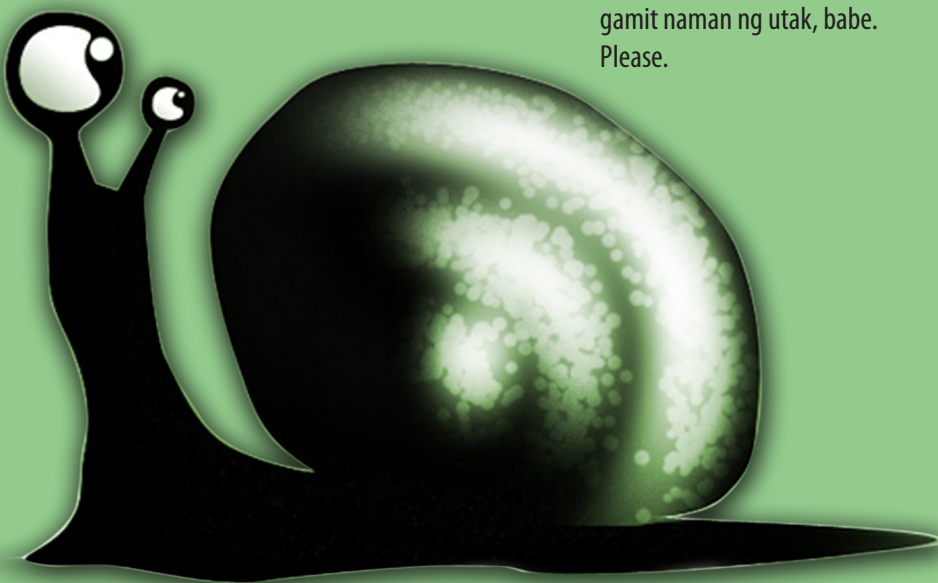
NEIL: Simula na bukas ang long weekend holiday. Gusto ko masaya ako kaya heto ang tatlong plane tickets sa Boracay.  
 MACON: Bakit tatlo?  
 NEIL: Para sa iyo at sa mga magulang mo.

## Bagong Celfone

DELIA: Love, ang ganda ng bagong celfone mo ah.  
 OSCAR: Oo, hon. Bagong issue ng opisina sa akin.  
 DELIA: Mukhang bagong model yan. Anong mga FEATURES?  
 OSCAR: Madami! Nandito ang FEATURE ko, FEATURE mo at ng mga anak natin... At FEANITURAN ko din ang motor ko, tingnan mo.

## Pera o Asawa

EDGAR: Pare, ano ang mas mahalaga, pera o asawa?  
 BRIAN: Syempre, pera! Kasi, ang pera, habang tumatagal, lumalaki ang interes. Ang asawa, habang tumatagal, nawawalan ka ng interes, tapos, inuubos pa ang pera mo.







*DOH understands that proper education can translate to better health. Thus DOH, regularly holds community health teachings and health promotion activities to equip Filipinos with the right information to safeguard their health.*





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