

# **FHSIS**

## **EXECUTIVE SUMMARY**

# **2004-2008**



**Public Health Surveillance and Informatics Division**  
**National Epidemiology Center**  
**Department of Health**  
Manila, Philippines

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## **Message from the Director**

The Field Health Services Information System (FHSIS) provides the Department of Health (DOH) with management information on several public health programs.

It is the official system of the DOH, designated as national health statistics as per Executive Order 352.

Operational since 1989, it provides health services data to monitor activities in each of these programs on routine basis (monthly, quarterly or annually) from the Barangay Health Stations, municipality, province, cities and regions.

This Executive Summary of FHSIS data from 2004-2008 is the first ever attempt in the documentation of data utilization for policy directions and systems improvement. This was possible through the efforts and collaboration of the National Epidemiology Center, National Center for Disease Prevention and Control and the National Statistics Office.

I am proud to present this innovative approach in enhancing the quality of the Field Health Services Information System.

A handwritten signature in dark ink, appearing to read 'E. Tayag', written over the printed name.

**ENRIQUE A. TAYAG, MD, FPSMID, PHSAE, CESO III**  
**Director IV**

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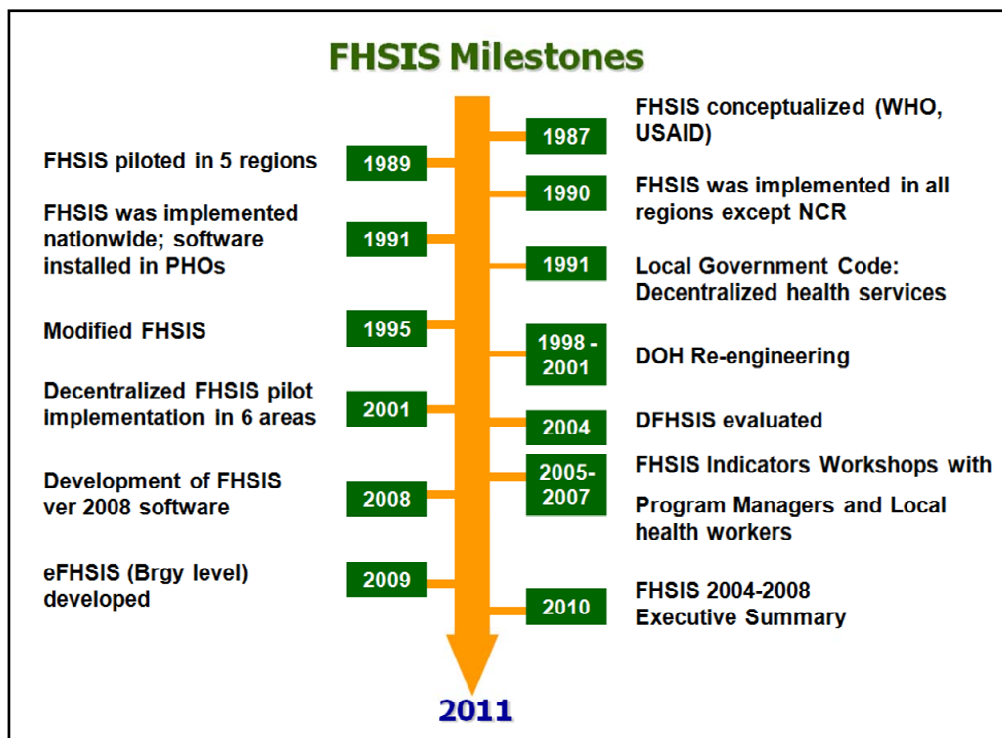
All the FHSIS Regional Coordinators, for their continued hard labor in giving us quality reports from their respective areas.

And also, Mr. Francis Raize Nicholas Bautista and Ms. Diana Colleen Sims for their assistance in making this document.

# Background

The Field Health Services Information System (FHSIS) is a major component of information networks developed by the Department of Health (DOH). This has been designed to assess the performance of the health programs. Other information relevant to these programs are obtained from other sources such as Hospital Services Information System, Physical Resources Information System and Human Resources Information System.

The **Executive Order 352** provides FHSIS the mandate as the official information system of the Department of Health. The FHSIS is also included by the National Statistical Coordination Board (NSCB) in a system of designated statistics. Currently, FHSIS is the only information system in the whole government machinery that operates down the barangay level. It remains viable because of the dedication of field health personnel who believe that information can be a powerful tool in improving the effectiveness of health services delivery and ultimately the health of the Filipino people.



## Objectives of FHSIS

1. To provide summary data on health service delivery and selected program accomplishment indicators at the barangay, municipality, district, provincial, regional, and national levels
2. To provide data which, when combined with data from other sources, can be used for program monitoring and evaluating purposes
3. To provide a standardized, facility-level database which can be accessed for more in-depth studies
4. To ensure that data reported are useful and accurate and are disseminated in a timely and easy fashion
5. To minimize the burden of recording and reporting at the service delivery level in order to allow more time for patient care and promotive activities



## Acronyms

BEMOC	Basic Emergency Obstetric Care
CARI	Care for Acute Respiratory Infections
CBMIS	Community-based Monitoring and Information System
CDD	Control of Diarrheal Diseases
CPAB	Child Protected at Birth
CSR	Contraceptive Self-Reliance
CU	Current Acceptors
DMPA	Depot Medroxyprogesterone Acetate
DOH	Department of Health
DPT	Diphtheria, Pertussis, Tetanus (vaccine)
DPWH	Department of Public Works and Highways
FHSIS	Field Health Services Information System
FIC	Fully Immunized Children
FP	Family Planning
GP	Garantisadong Pambata
HepB	Hepatitis B (vaccine)
HIV	Human Immuno-deficiency Virus
IDD	Iodine-deficiency Disorder
IMCI	Integrated Management of Childhood Illness
IMR	Infant Mortality Rate
LBW	Low Birth Weight
LGU	Local Government Units
LWUA	Local Water Utilities Administration
MDA	Mass Drug Administration
MMR	Maternal Mortality Ratio
MDG	Millennium Development Goals
MNCHN	Maternal Neonatal Child Health and Nutrition
MV	Measles Vaccine
MWSS	Metropolitan Waterworks and Sewerage System
NA	New Acceptors
NFP	Natural Family Planning
NTMR	Neonatal Tetanus Mortality Rate
ORS	Oral Rehydration Solution
PhilMIS	Philippine Malaria Information System
PIDSR	Philippine Integrated Disease Surveillance and Response
PIPH	Province-wide Investment Plan for Health
RCA	Rapid Coverage Assessment
RHU	Rural Health Units
SI	Sanitary Engineers
TB	Tuberculosis
TCL	Target Client Lists
TEVs	Travel Expenses Voucher

## 1. Leading Causes of Morbidity

### Leading Causes of Morbidity Philippines, 2004-2008

Table 1A.1

	Disease	Rate per 100,000 population				
		2004	2005	2006	2007	2008
	ALRI and Pneumonia	971.6	828.0	828.8	718.0	1840.6
	Bronchitis/Bronchiolitis	900.8	738.7	689.9	577.8	871.6
	Acute Watery Diarrhea	722.0	723.4	707.7	640.0	580.8
	Influenza	475.5	487.1	435.0	414.6	557.8
	Hypertension	428.2	458.8	522.8	472.6	485.4
	TB Respiratory	129.1	137.1	169.9	136.0	404.8
	Chickenpox	58.5	36.0	-	27.4	107.8
	Diseases of the Heart	46.4	52.6	49.3	37.2	39.5
	Malaria	24.9	36.0	27.6	27.5	36.4
	Dengue Fever	19.8	24.1	19.6	28.2	28.7
	Acute Febrile Illness	-	-	32.5	-	-

### Remarks

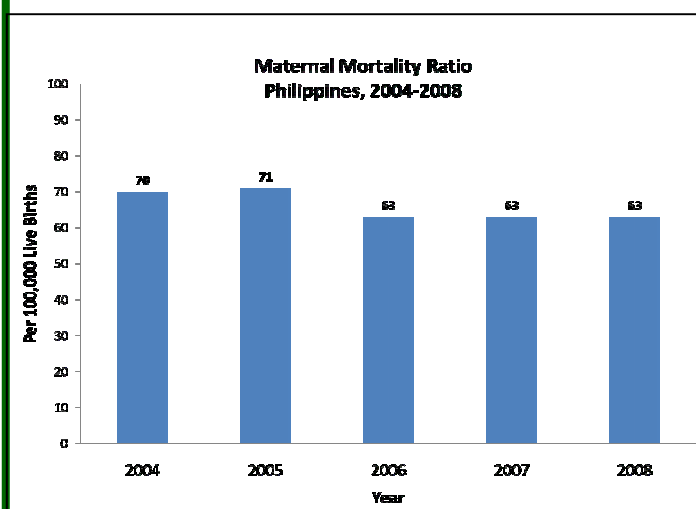
- Ten leading cause of morbidity remains the same in recent years.
- Eight out of ten are infectious and only two diseases (hypertension and diseases of the heart) are non-infectious.
- Among the infectious causes, pneumonia and diarrhea continues to be the most common causes of morbidity for the past five years in Rural Health Centers.
- In 2008, all the pneumonia and diarrhea cases comprises 48% of the total cases belonging in the top ten leading causes of morbidity.
- Hypertension and diseases of the heart comprises 10% of the total number of cases belonging in the top ten leading cause of morbidity.

### Recommendations

- Reduction of pneumonia and diarrhea cases will still greatly decrease disease morbidity in the community.
- Establishment/Improvement of non-communicable disease registries from hospitals may give better prevalence rates on diseases of the heart and hypertension which continues to be in the top leading causes of morbidity in the Rural Health Units.
- The use of ICD coding of diseases in the Rural Health level would be helpful in targeting diseases for prevention and control.

## B. Mortality and Natality

Fig. 1B.1 Maternal Mortality Ratio



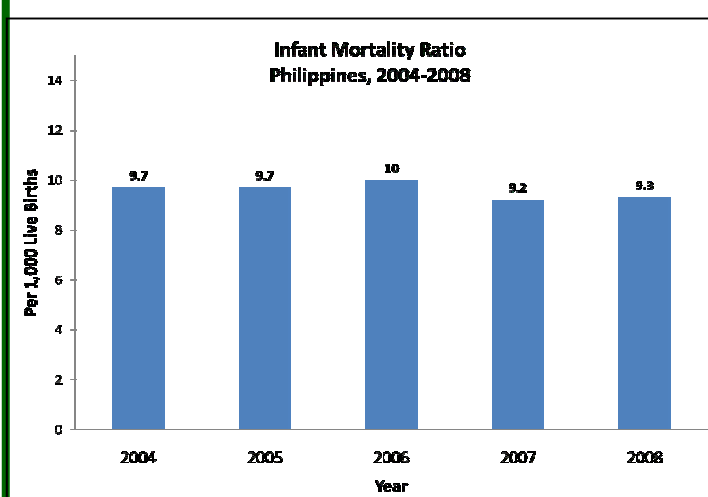
### Remarks

- There is a slow decline in MMR trend for the past five years with an average of 66 Maternal Deaths per 100,000 live births.
- The low MMR may be due to limitations of data source which is strictly from Rural Health Units' maternal deaths reports.

### Recommendations

- Maternal death reviews should be strengthened in the Rural Health Units.
- Policies on improvement maternal death reporting should be in place in RHUs.
- Advocacies on birth and death registrations should be strengthened.
- Awareness, advocacy, implementation and sustainability of MNCHN strategies particularly on facility-based deliveries and skilled-birth attendants.
- Consider deleting this indicator in the FHSIS due to its limitation on source of information.

Fig. 1B.2 Infant Mortality Ratio



### Remarks

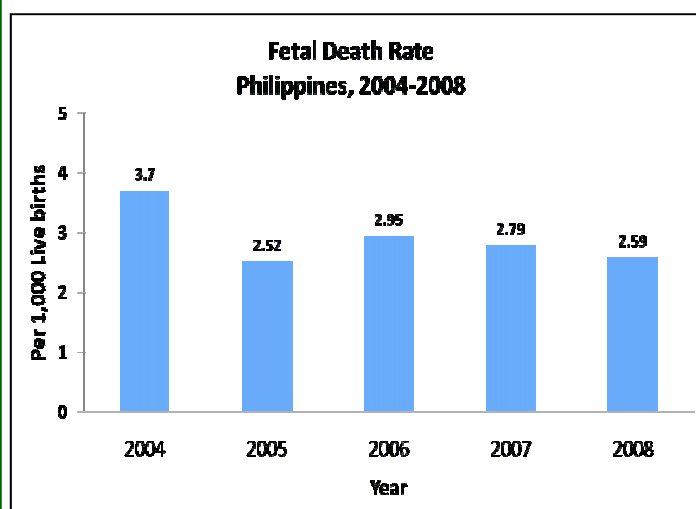
- There is a steady trend of Infant Mortality Ratio for the past years with an average of 9.6 per 1,000 live births.
- Low IMR may be due to limitations of FHSIS source which are registered deaths reported in the RHUs.

### Recommendations

- Data on Neonatal Mortality is also important in the MDGs and MNCHN goals.
- Awareness, advocacy and implementation of MNCHN Strategy (including implementation of essential newborn care in all health facilities)
- Policies on improvement of reporting of mortalities such as strengthening birth registrations, advocacy, and free registrations should be established.
- Consider deleting this indicator in the FHSIS due to its limitation on source of information.

## B. Mortality and Natality

Fig. 1B.3 Fetal Death Rate



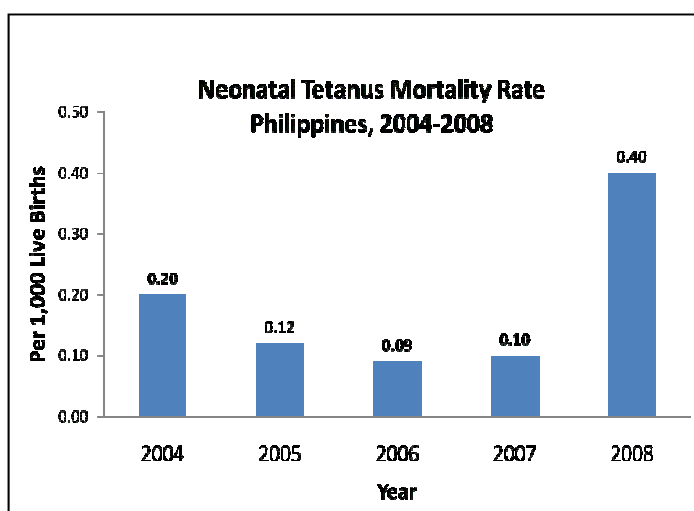
### Remarks

- There is a decreasing trend from 2004 baseline for the past five years with an average of 2.9 per 1,000 live births.
- The low FDR may be due to limitations of data source which is strictly from Rural Health Units' fetal death reports.

### Recommendations

- Studies on causes and circumstances of these fetal deaths for a better health outcome should be done.
- The seemingly low Fetal Death Rates might be due to underreporting (like abortion cases).
- Accurate determination of Age of Gestation should be done to get real Fetal Death Rates.

Fig. 1B.4 Neonatal Tetanus Mortality Rate



### Remarks

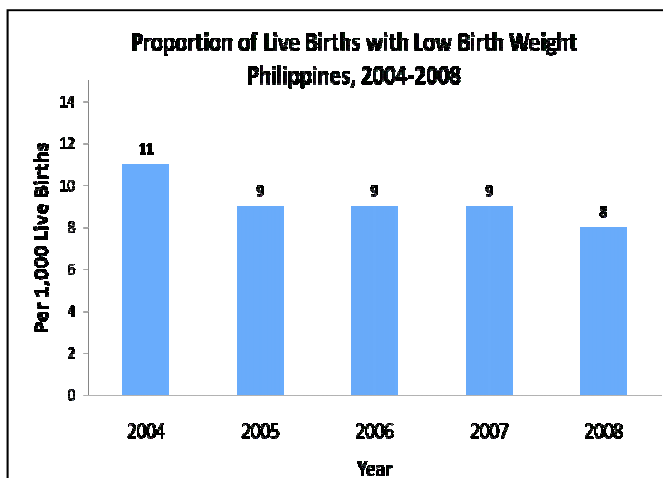
- The trend is increasing in the past five years.
- It has remained low (< 1 per 1,000 Live Births).
- An increase in 2008 may be due to enhance neonatal tetanus deaths surveillance for neonatal tetanus elimination.
- For further analysis NTMR by province should be done to identify priority areas

### Recommendations

- Strengthening of tetanus vaccination of women of reproductive age should be done.
- Chart reviews of all neonatal deaths (for possible tetanus cases in NBs)
- Advocacy for facility-based deliveries by skilled birth personnels

## B. Mortality and Natality

Fig. 1B.5 Live Births with Low Birth Weight



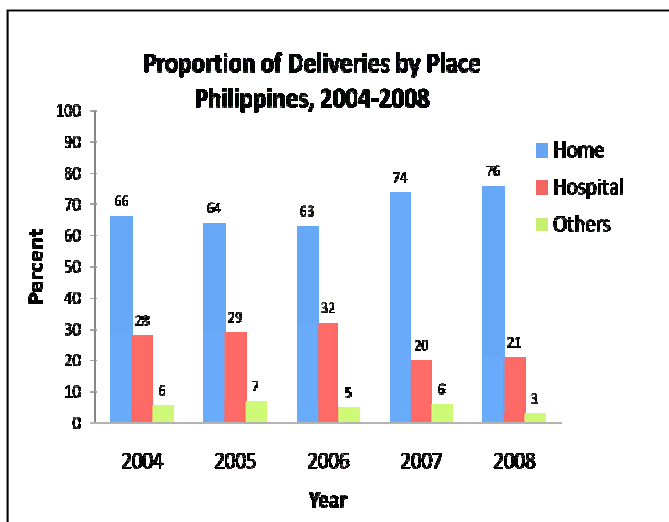
### Remarks

- There is a decreasing trend of Live Births with Low Birth Weight for the past five years.
- Causes for LBW are undetermined in this result.
- Possible cause may be not readily available micro supplementation goods or/ and poor access to prenatal case services.

### Recommendations

- Strengthen quality prenatal care for women (like schedule on prenatal visits) should be revisited.
- Advocacy on Iron and Folic Acid supplementation for pregnant women
- Advocacy for Facility-Based deliveries
- Further studies which focuses on the causes for LBW may determine more specific prevention strategies.

Fig. 1B.6 Deliveries by Place



### Remarks

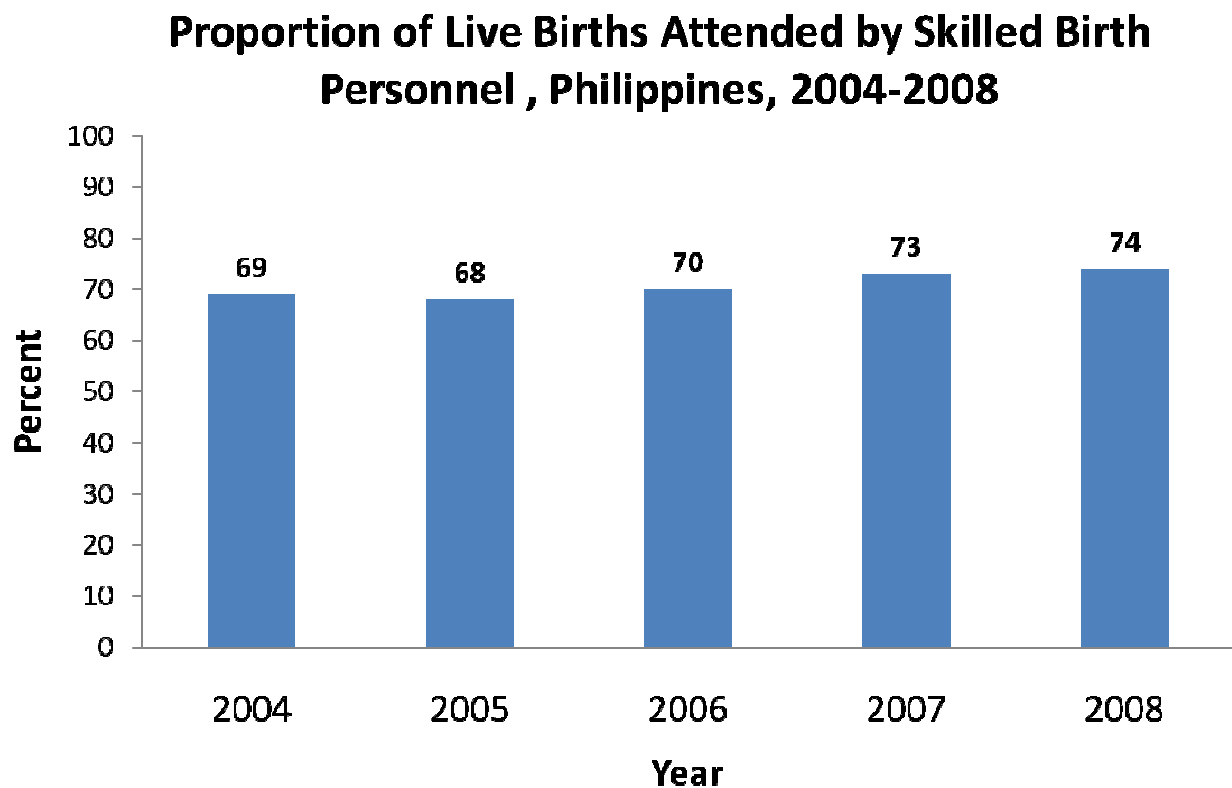
- There is an increasing trend on deliveries in the home while deliveries done in the hospital (including health facilities and private clinics) is increasing for the past five years.
- Home deliveries may include midwives and *hilot* (traditional) attendants.

### Recommendation

- Strengthen advocacy for health facilities deliveries

## B. Mortality and Natality

Fig. 1B.7



### Remarks

- The trend for deliveries attended by skilled health personnel (doctors, nurses and midwives) is decreasing while deliveries by traditional birth attendant is increasing for the past 5 years.
- These live births are reported by the RHUs

### Recommendations

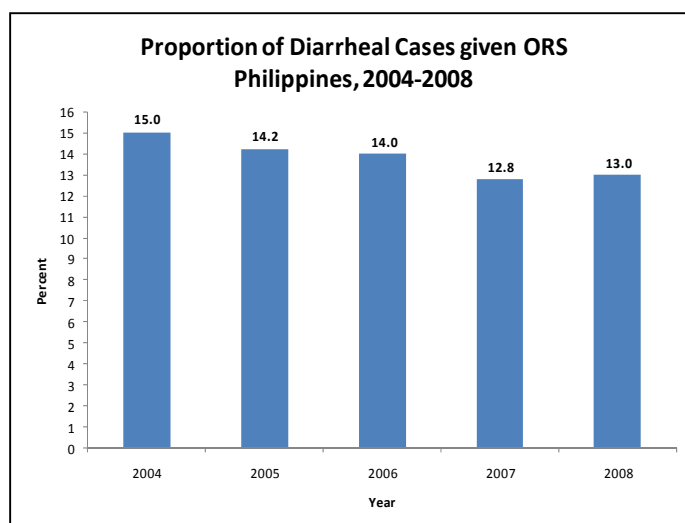
- Implementation of Basic Emergency Obstetric Care or BEMOC strategy in coordination with DOH
- Institutionalization of essential health care package for women
- More awareness on package of delivery and incentives for health personnel

## 2.A Child Care and Nutrition Program

### Remarks

- The trend for the past 5 years is stable (from 13 to 15%).
- 13-15% is a low coverage
- All diarrheal cases must be given ORS as per policy.
- This data does not count ORS being prescribed.
- Home remedies for which ORS were given may not have also been counted.

Fig. 2A.1 Diarrheal Cases given ORS



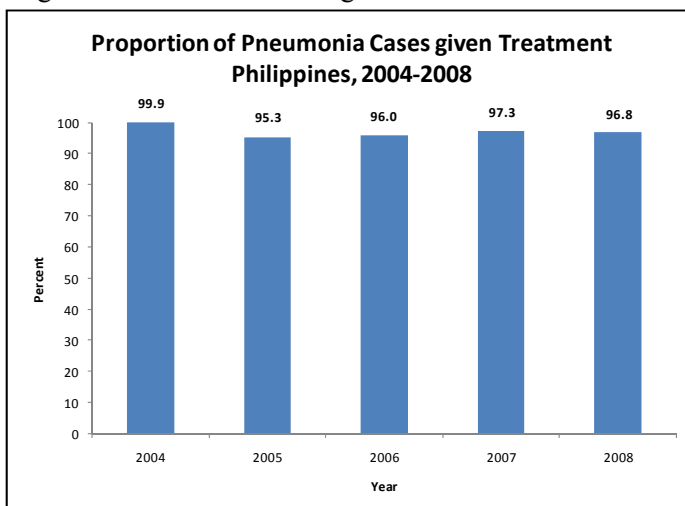
### Recommendations

- Comparison with data on supplies of ORS might be needed for further interpretation of data.
- CDD policy should be reiterated in the LGUs.

### Remarks

- The trend is almost stable (range 95.3 – 99.9%) and with high coverage (target is 100%).
- Available antibiotics maybe attributed to the high coverage

Fig. 2A.2 Pneumonia cases given treatment



### Recommendations

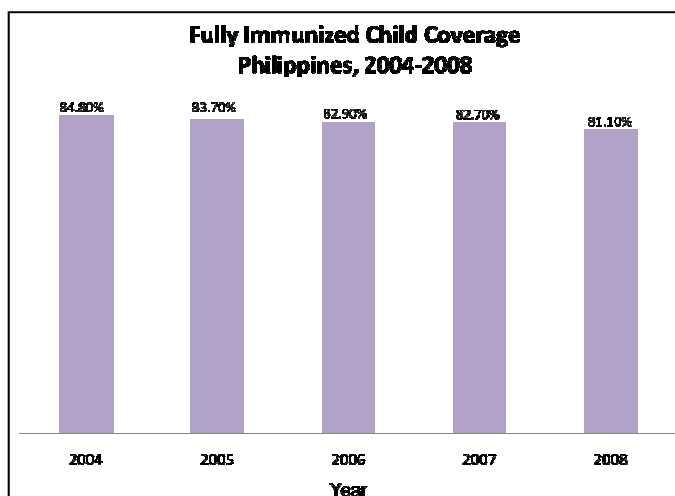
- Comparison to the pneumonia case fatality rates should be done to really determine proper case management of pneumonia.
- Institutionalize Integrated Management of Childhood Illnesses on-the-job training at the RHU level for sustainability
- CARI Policy should be emphasized.

## 2.A Child Care and Nutrition Program

### Remarks

- There is a decreasing trend of FIC for the past 5 years.
- FIC Coverage is still low when compared to national target of 95%.
- 3% under 1 y.o. population and projected population for each year were used.
- Probable underreporting which may be due to lack of data reconciliation at all levels of the health system (regional, provincial and RHUs).

Fig. 2A.3 Fully Immunized Children (FIC) Coverage



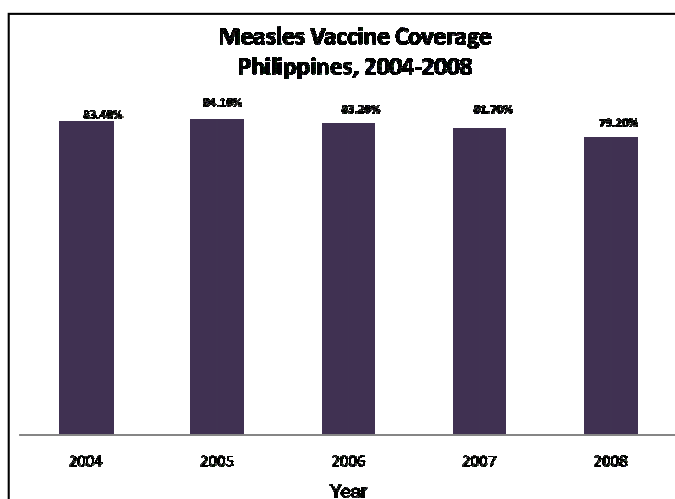
### Recommendations

- 2.7% of the total population under 1 year old should be used (based on latest Population Survey).
- Delayed and incomplete reports should be considered in the specific quarter.
- Rapid Coverage Assessment (RCA) data may be used to further validate the result.
- Regular tracking of defaulters may increase coverage.
- Consider including immunization data from the hospitals (e.g. OPD) in the over-all municipal/provincial/city/regional reports.

### Remarks

- There is a decreasing trend for the measles coverage.
- There is no significant difference of FIC and measles coverage.
- Low coverage for measles may be attributed to underreporting.

Fig. 2A.4 Measles Vaccine Coverage



### Recommendations

- Consider regular analysis on the following indicators: FIC, DPT1 & DPT3, OPV3, AMV, HepaB3, HepaB birth dose.
- Data reconciliation in all health system levels should be done to validate results.
- Consider including immunization data from the hospitals (e.g. OPD) in the over-all municipal/provincial/city/regional reports.

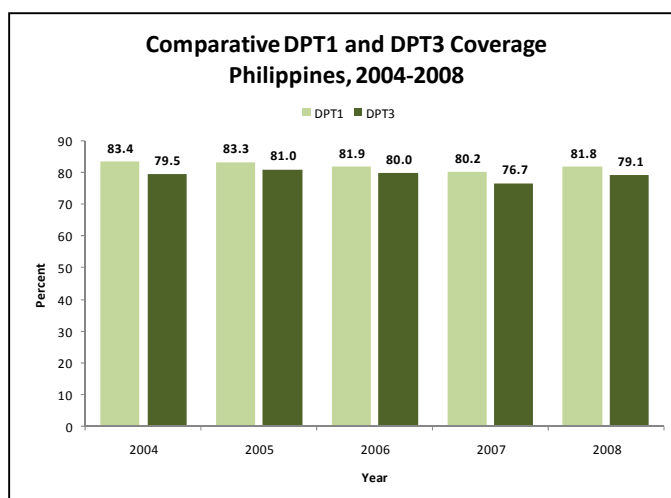


## 2.A Child Care and Nutrition Program

### Remarks

- DPT1 is used as an indicator to determine the access of the client to immunization in the health center. A 95% DPT1 coverage is required to have a good access to immunization.
- DPT3 is used to determine the utilization (follow-up) of the immunization services in the health center.
- For the past 5 years, 95% coverage for both the DPT1 and DPT3 has never been achieved although a slight increase in coverage was observed in 2008.

Fig. 2A.5 DPT1 and DPT3 Vaccine Coverage



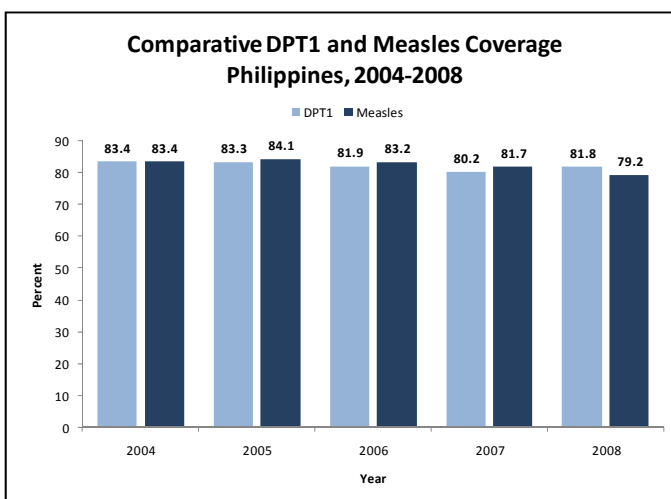
### Recommendations

- Mobilization of health workers to track defaulters
- Ensure availability of vaccination logistics

### Remarks

- Generally, there is a slight decrease of the measles coverage for the past 5 years. A 95% measles coverage was not achieved. This is critical in the maintenance of the measles elimination targeted in 2012.
- DPT1 coverage in 2008 is higher than measles vaccination which is given at 9 months old.
- In 2008, measles coverage is lower than DPT1 which means there was good access but with poor utilization.
- Poor follow-up of the defaulters/missed children for measles in 2008 as compared in years 2005, 2006 and 2007 (DPT1 vs. MV).

Fig. 2A.6 DPT 1 and Measles Coverage

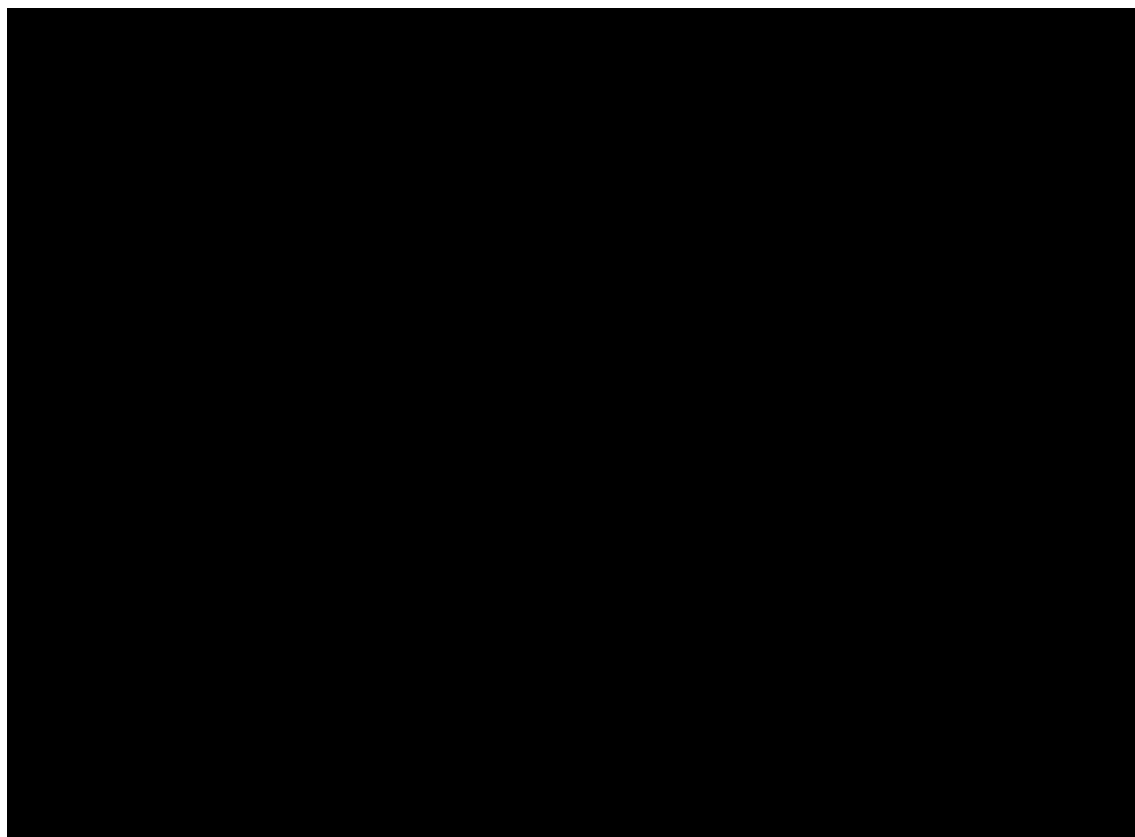


### Recommendations

- Follow-up of defaulters should be strengthened.
- Identification of priority areas with poor measles coverage to support measles elimination program

## 2.A Child Care and Nutrition Program

Fig. 2A. 7 DPT, OPV1 and HepB1 Vaccine Coverage



### Remarks

- In 2004 and 2005, HepB1 coverage was very low. This was attributed to the 40-60% procurement of HepB vaccines only. However in 2006 until 2008, a significant increase in the coverage was noted. DOH started to procure the 100% HepB vaccine for the eligible population.
- Data revealed that such schedule was followed from 2006 to 2008.
- Low coverage may be attributed to the following:
  - Poor follow-up of the defaulters and missed children
  - Inadequate TEVs for outreach immunization services
  - Inadequate BHWs to conduct follow-up visits
  - Lack of validation of the submitted LGU FHSIS report (monthly & Summary reports) and compare with in the Target Client List (TCL)
  - Excluded immunizations administered in the hospitals (e.g. out patient departments)
  - Lack of supervisory visits and monitoring visits

### Recommendations

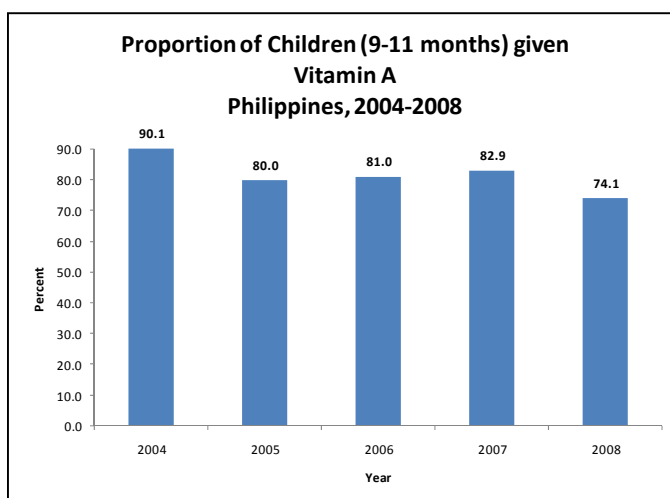
- As per guidelines, DPT1, OPV1 and HepB1 should be given together on the same immunization schedule of the child and should be strictly implemented.
- Data reconciliation at all health system levels should be done to verify results.

## 2.A Child Care and Nutrition Program

### Remarks

- Since 2004, the proportion of children given vitamin A is decreasing.
- In 2004, there was a catch-up campaign nationwide. In this campaign, measles vaccine and vitamin A were given to all 9-11 month old children using a door-to-door approach.
- *Garantisadong Pambata (GP)* campaign is conducted twice a year (April & October) since 1998.
- GP result in 2008 was 86%.
- Since 2005-2007, supply of vitamin A was not stable. In 2008, there was delay in the procurement and distribution of vitamin A at the local level.

Fig. 2A.8 Children (9-11 mos) given Vitamin A



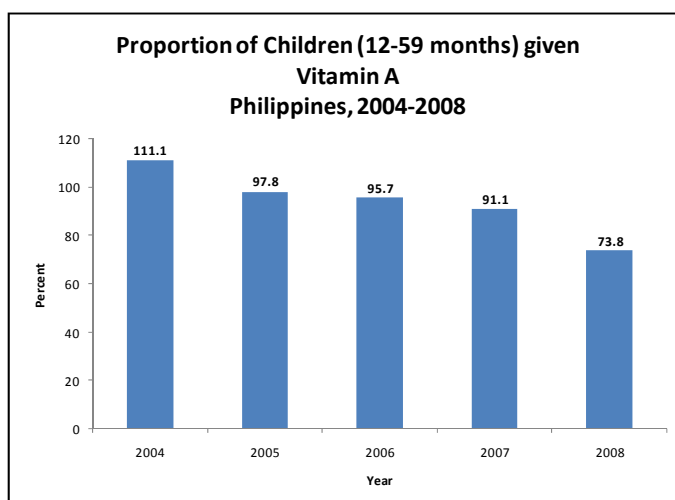
### Recommendations

- GP campaign should be continued.
- Strategies should be done to encourage health-seeking behavior for malnourished children.
- A clear guideline should be developed for cost sharing between DOH and LGU for the procurement of vitamin A.

### Remarks

- There was a decreasing trend in the coverage of vitamin A distribution for children 12-59 month old.
- The remarks in the above are applicable.
- GP result in 2008 was 87%, however this data reflect only the performance during the GP period. The FHSIS data reflects the whole year data in the RHUs.

Fig. 2A.9 Children (12-59 mos) given Vitamin A



### Recommendations

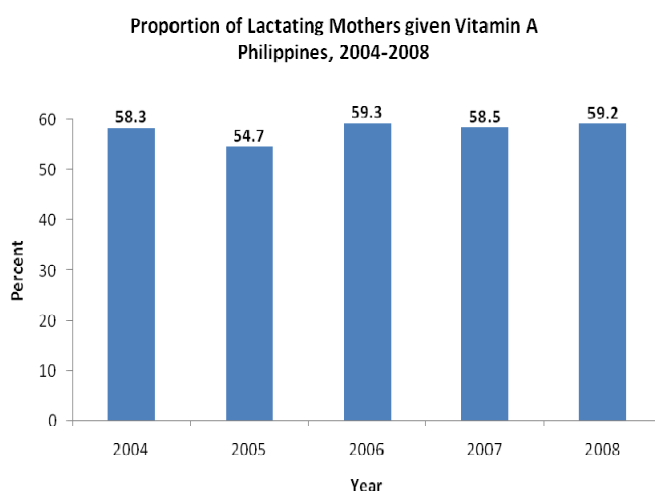
- GP campaign should be continued.
- Strategies should be done to encourage health-seeking behavior for malnourished children.
- Develop a clear guideline in terms of cost sharing between DOH and LGU for the procurement of vitamin A

## 2.A Child Care and Nutrition Program

### Remarks

- The coverage remains low (below 80%) in the past 5 years.
- Most post-partum women were not seen during the four-week period post-partum (probably home deliveries).
- The DOH does not have vitamin A allocation for post-partum women so in some instances surplus of vitamin A allocated for children were used for them instead. There are health facility deliveries with which post-partum women were not provided vitamin A.
- Giving vitamin A to post-partum women should be part of the PhilHealth package.
- Inconsistently high post partum population estimate but decrease in estimation may also be due to improved family planning practices.

Fig. 2A.10 Lactating Mothers given Vitamin A



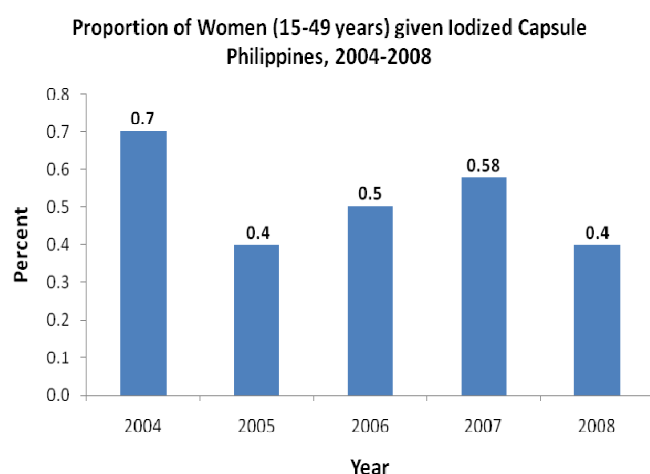
### Recommendations

- Allocation for vitamin A for post-partum women should be part of the Province-wide Investment Plan for Health (PIPH).
- Develop a clear guideline in terms of cost sharing between DOH and LGU for the procurement of vitamin A.

### Remarks

- The data shows program is a failure.
- There was change in policy that DOH would only give iodized capsule in Iodine Deficiency Disorder (IDD) endemic areas.

Fig. 2A.11 Women (15-49 yo) given Iodized salt

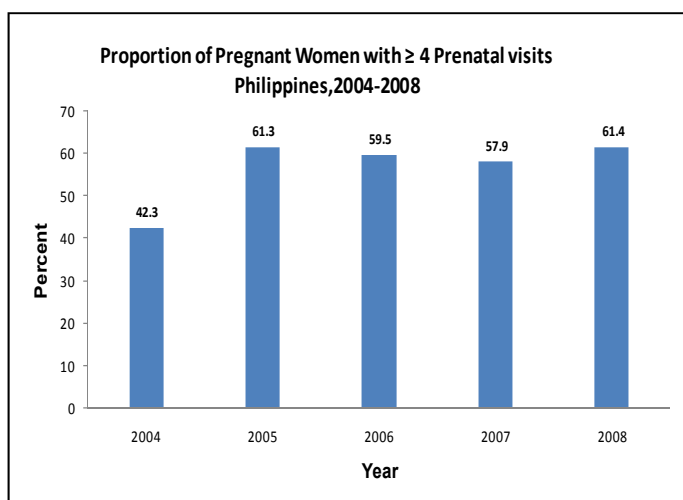


### Recommendations

- The salt iodization program should be enhanced as the primary approach in the prevention of IDD.
- This indicator should be replaced with Households tested on iodized salt utilization.

## 2.B Maternal Care Program

Fig. 2B.1 Pregnant women with 4 prenatal visits



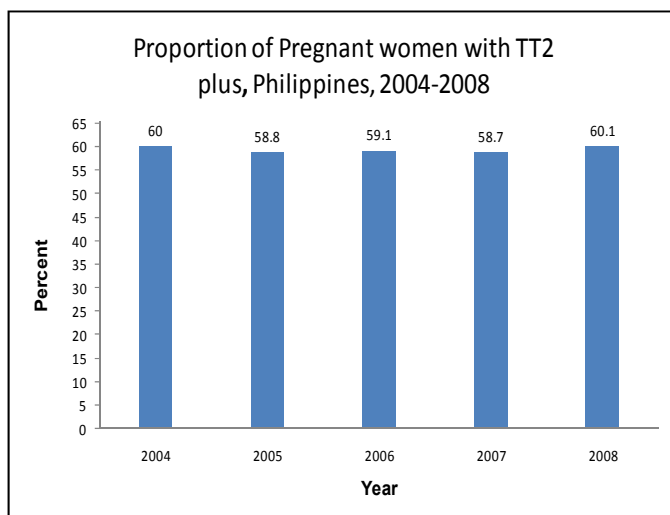
### Remarks

- Trend for the past 5 years is stable but the coverage is still low.
- The advocacy on 4 prenatal visits was started in 2005 and established in 2008.
- Poor prenatal visits services may be due to geographical limits, fast-turn over of trained personnel and logistics problems.

### Recommendations

- As a strategic thrust for NOH 2005-2010, the indicator should be continually collected to improve the quality of maternal health care.
- There should be a training for health workers on proper recording of the indicator.
- There should be consideration for per diems of the health workers reaching far-flung areas.

Fig. 2B.2 Pregnant women with TT2 plus



### Remarks

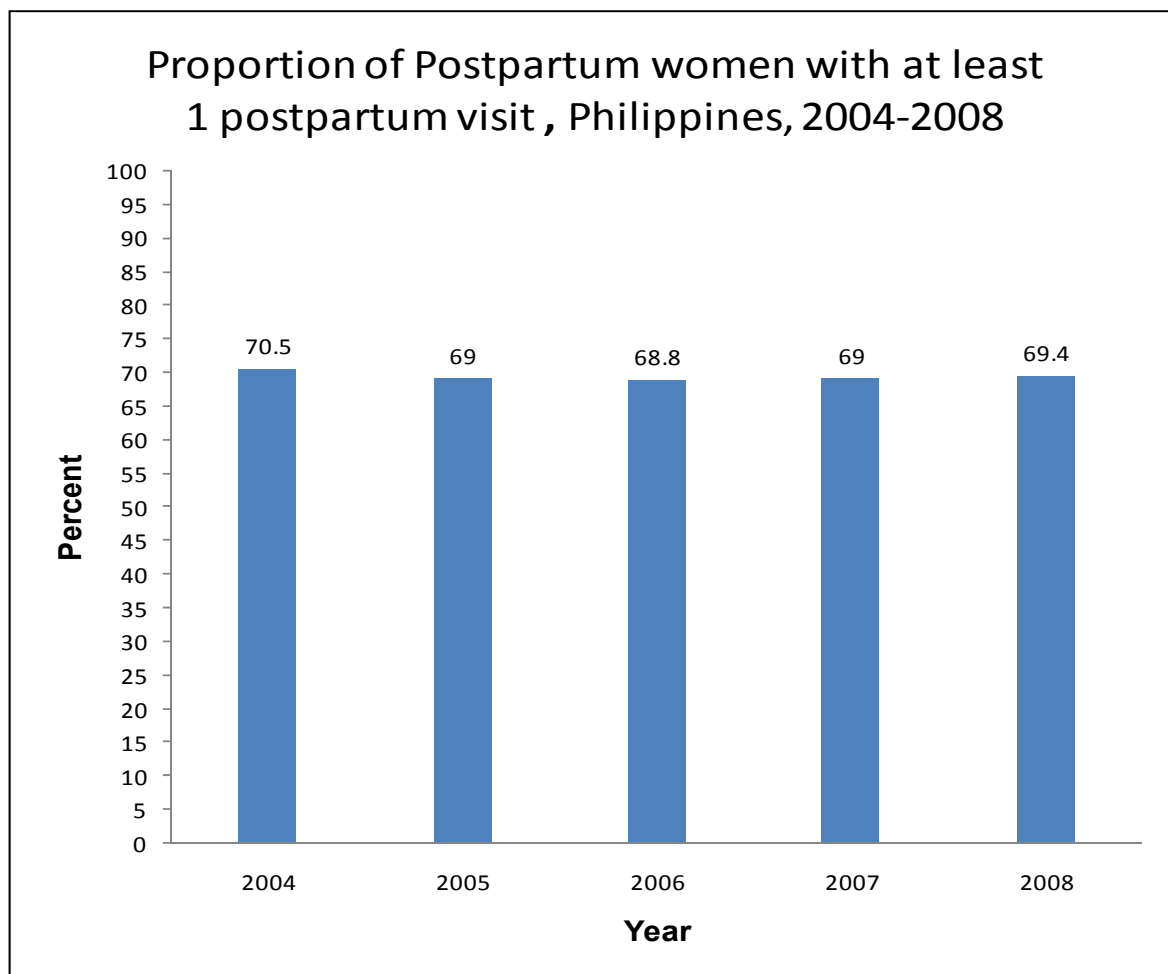
- The trend of the past 5 years is stable but the coverage is low.
- The low coverage (from the target of 80%) may be due to confusion of health personnel on the guidelines for the administration of TT vaccine for women.
- The low coverage may also due to underreporting and poor recording of pregnant women given TT2plus.
- There may be inadequate supply or support of supplies (e.g. syringes and needles) by the LGUs.

### Recommendations

- Child Protected At Birth (CPAB) may also be used for proxy indicator while in transition.
- Advocacy for prenatal quality care which includes completion of tetanus toxoid for women reproductive age should be enhanced.
- Advocacy for Maternal Newborn Child Health and Nutrition (MNCHN) should be strengthened.

## 2.B Maternal Care Program

Fig. 2B.3 Postpartum women with at least 1 postpartum visit



### Remarks

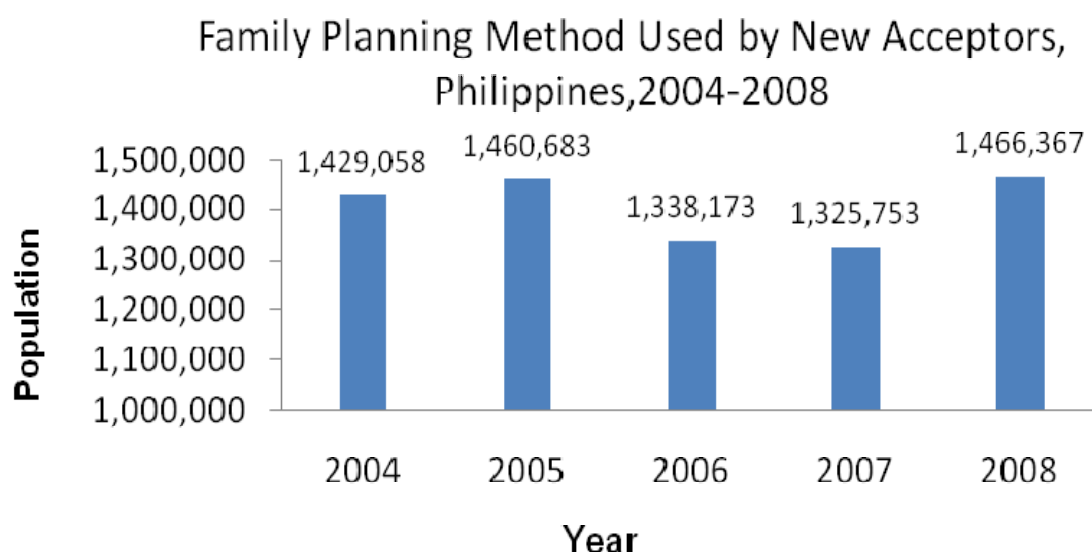
- The trend is stable but still below the target of 80%.
- Low coverage maybe due to that most deliveries are still done at home and *hilot* attending the delivery do not report the postpartum deliveries to the midwives.

### Recommendations

- There should be an advocacy for health facility delivery.
- Postpartum care should be extended to more women after childbirth, after miscarriage and after unsafe abortion.

## 2.C Family Planning Program

Fig. 2C.1



### Remarks

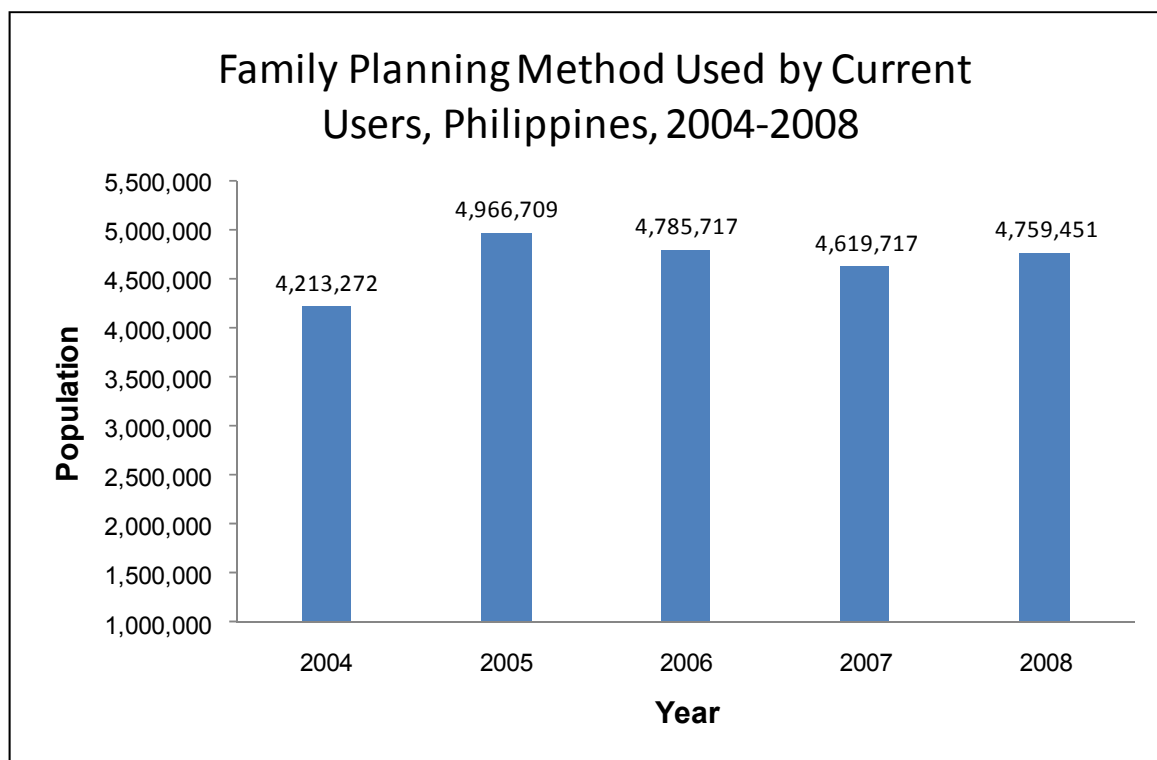
- The decreasing trend from 2005 to 2007 is due to the gradual phasing out of FP commodities supplied by the DOH (e.g. condom, pills, DMPA).
- The number of New Acceptors increased in 2008 as some LGUs positively responded to Contraceptive Self Reliance (CSR) strategy.
- Modern Natural Family Planning (NFP) did not have a significant contribution to FP acceptors.
- The slight increase in 2005 is due to the *Ligtas Buntis* awareness campaign while in 2008, Performance-based grants which were used to purchase FP commodities were provided by DOH.

### Recommendations

- Advocacy to LGU policy makers on the impact of FP as a health and development intervention (decrease maternal and child mortality, decrease basic needs services- health, education, housing, etc)
- Advocate for formulation of CSR policy and plan at the LGU level
- Conduct assessment and monitoring of CSR implementation status at the LGU level
- Identification/master listing through Community-based Monitoring and Information System (CBMIS) of men and women of reproductive age with unmet needs for FP services (for forecasting of commodity requirements and service provision by method)
- Consider reviving *Ligtas Buntis* campaign during FP month (August)
- There is a need to regularly validate data at all levels (drop outs/defaulters per method, definition of NA & CU).
- There should be timely submission of complete and accurate data to the next higher level.
- MNCHN policies is a venue for integration of maternal, child and family planning services.
- Encourage public/private partnership in service provision, data recording and reporting
- Intensify mainstreaming of NFP and permanent FP methods at the local level for those who have achieved their desired family size

## 2.C Family Planning Program

Fig. 2C.2



### Remarks

- There was a slight increase from 2004 to 2005 and plateau from 2005 to 2008.
- The slight increase was due to *Ligtas Buntis* campaign.
- In 2005-2007, there was no implementation of Contraceptive Self-reliance of LGUs.

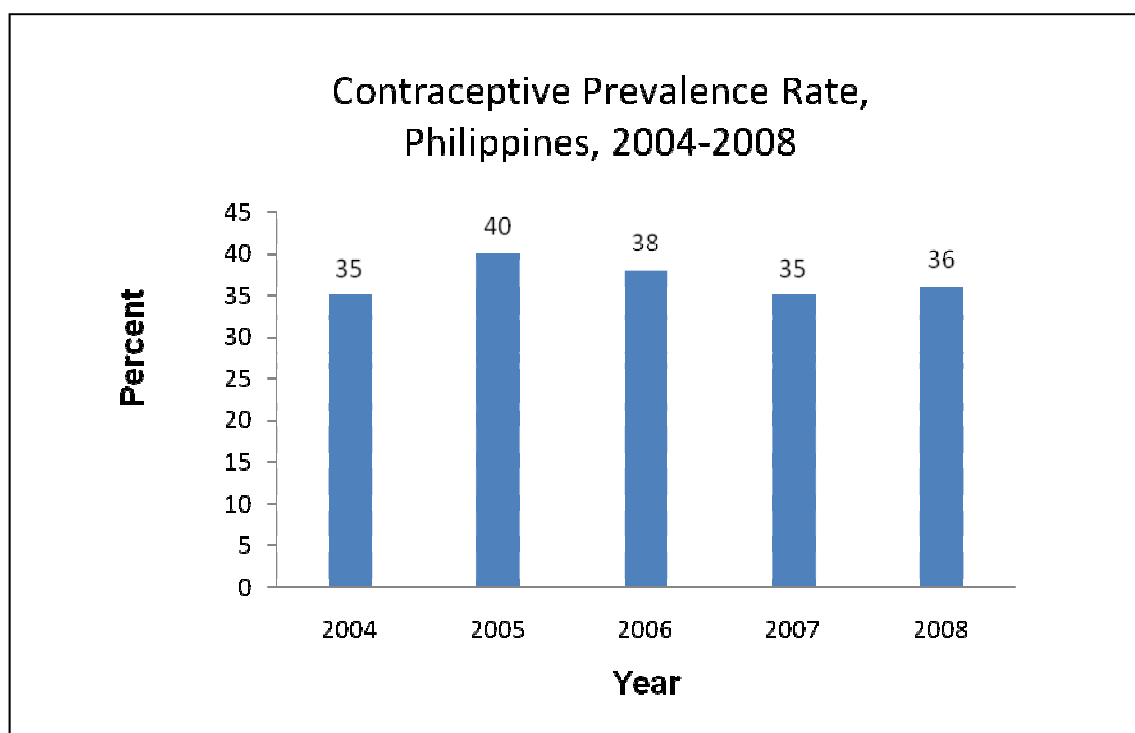
### Recommendations

- Advocacy to LGUs on the impact of FP as a health and development intervention (decrease maternal and child mortality, decrease basic needs services- health, education, housing, etc)
- Advocate for formulation of CSR policy and plan at the LGU level
- Conduct assessment and monitoring of CSR implementation status at the LGU level
- Identification/master listing through CBMIS of men and women of reproductive age with unmet needs for FP services (for forecasting of commodity requirements and service provision by method)
- Consider reviving *Ligtas Buntis* campaign during FP month (August)
- There is a need to regularly validate data at all levels (drop outs/defaulters per method, definition of NA & CU).
- Timely submission of complete and accurate data to the next higher level.
- MNCHN policies is a venue for integration of maternal, child and family planning services.
- Encourage public/private partnership in service provision, data recording and reporting
- Intensify mainstreaming of NFP and permanent FP methods at the local level for those who have achieved their desired family size



## 2.C Family Planning Program

Fig. 2C.3



### Remarks

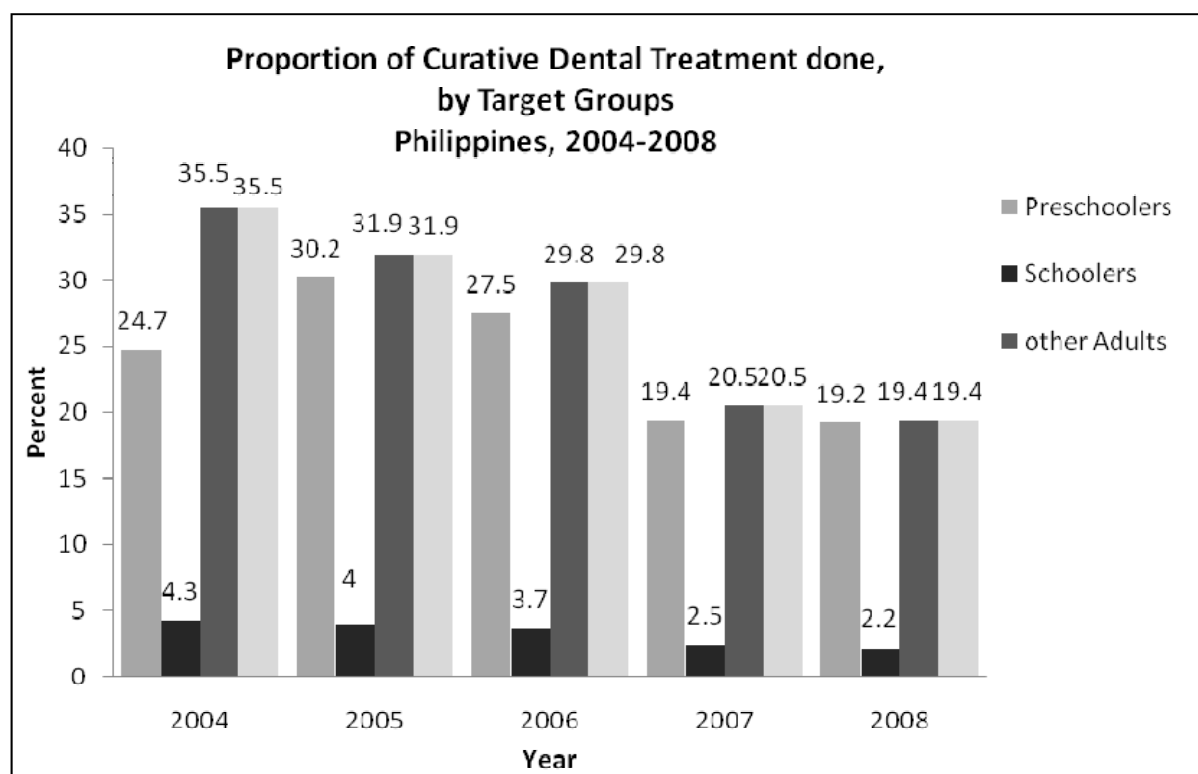
- There was a slight increase of 5% from 2004 to 2005.
- The result of FHSIS CPR which is 36% in 2008 is comparable to the result of National Demographic Health Survey (NDHS) which is 34%.

### Recommendations

- Advocacy to Local Chief Executives on the impact of FP as a health and development intervention (decrease maternal and child mortality, decrease basic needs services- health, education, housing, etc)
- Advocate for formulation of CSR policy and plan at the LGU level
- Conduct assessment and monitoring of CSR implementation status at the LGU level
- Identification/master listing through CBMIS of men and women of reproductive age with unmet needs for FP services (for forecasting of commodity requirements and service provision by method)
- Consider reviving *Ligtas Buntis* campaign during FP month (August)
- There is a need to regularly validate data at all levels (drop outs/defaulters per method, definition of NA & CU).
- Timely submission of complete and accurate data to the next higher level
- MNCHN policies is a venue for integration of maternal, child and family planning services.
- Encourage public/private partnership in service provision, data recording and reporting
- Intensify mainstreaming of NFP and permanent FP methods at the local level for those who have achieved their desired family size

## 2.D Dental Care Program

Fig. 2D.1



### Remarks

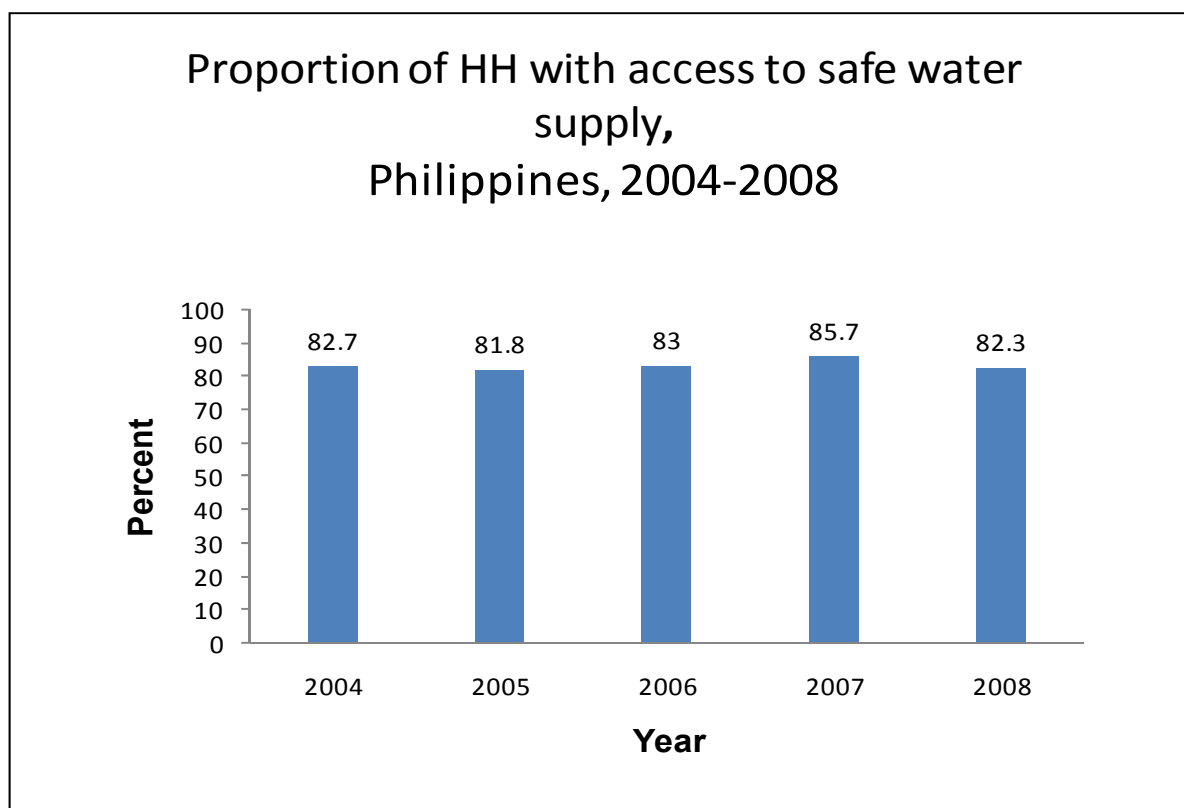
- There is a continuous decline in the curative dental treatment among the 4 targeted groups.
- Low accomplishments may be due to the lack of Public Health Dentists (PHDs) to perform curative treatment because not all health centers/ municipalities have PHDs (with a ration of 1,975 PHD : 2,756 Municipalities).
- Lack of functional dental units may also be attributed to the low coverage
- Confusion on who has the responsibility for school children (whether DOH or DepED) may attribute to decline in coverage.

### Recommendations

- Development of Basic Oral Health Care (BOHC) package should be done for pre-school children. This is more comprehensive rather than "curative alone".
- Change the indicator to "Preschoolers provided with BOHC"
- Integration of the BOHC in other child health activities e.g. GP and other preschool activities.
- Day Care Centers should focus on pre-school children where they can develop healthy habits such as proper and regular toothbrushing with the help of Day Care teachers. The Department of Education advocacy for this age group may prove essential.
- A national mandate for RHUs to fill items for dentists in the RHUs should be supported by the PIPH.
- Follow-up charts on pregnant women
- Curative Dental Treatment should not be included anymore as a service accomplishment indicator.

## 2.E Environmental Program

Fig. 2E.1



### Remarks

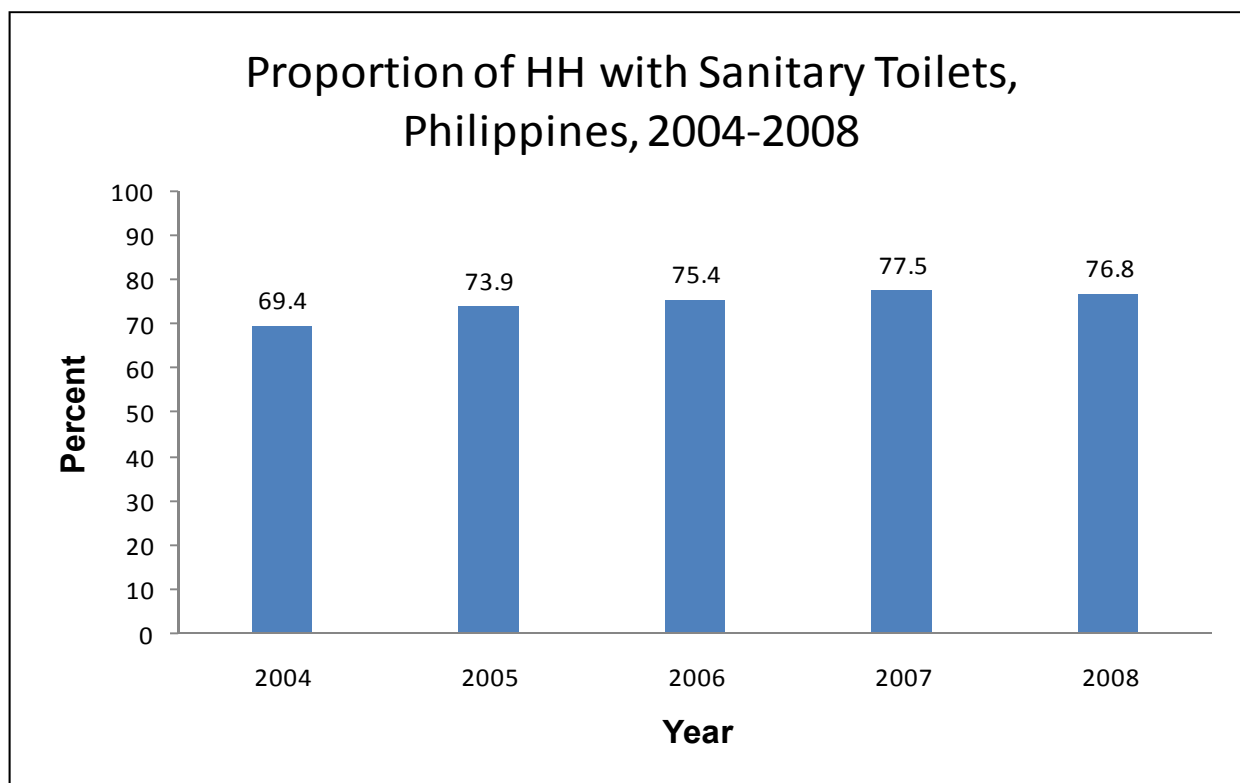
- The trend for the past 5 years is stable but the coverage is low.
- Low coverage may be due to lack of facilities for monitoring water quality and no major developments in infrastructure.
- At 2% increase per year, the Philippines is on track of the MDG target (87%) on HH with access to safe water supply.
- This data may show water sources which were tested for water quality.
- Increase may be due to water supply program of the government managed by DPWH, LWUA and MWSS.

### Recommendations

- Regular monitoring of water quality
- Harmonize the FHSIS data in the Unicef/WHO Joint Monitoring System
- DOH to actively involve in the provision of potable water program
- Data validation system should be established.
- Training of newly hired Sanitary Inspectors (SI) on data recording and reporting
- Water quality laboratories in the districts should be established/upgraded to ensure conformance to safe drinking water standards.

## 2.E Environmental Program

Fig. 2E.2



### Remarks

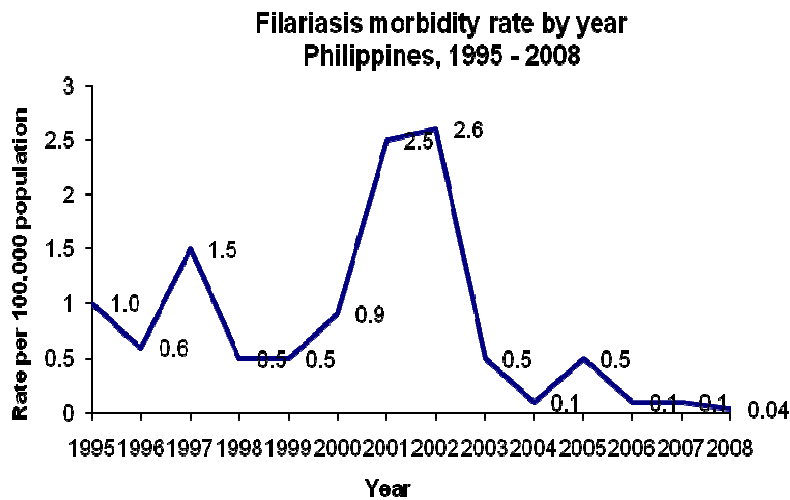
- There is an increasing trend.
- The slight drop in 2008 is due to the recent calamities and maybe to incomplete reports.
- Provincial disparity is noted.
- Poor provinces have less improvements or remain the same.
- If the current trend will continue, the MDG target on sanitation is certain or achievable (83%).
- 20M Filipinos still defecates in unsanitary manner
- Current initiatives are focused on basic sanitation even in urban or urbanizing communities where septage management and sewerage system are more appropriate systems.

### Recommendations

- Increase in coverage is mainly covered by government housing projects.
- Sanitation facilities are less given priority by households particularly in the poor communities both in the urban and rural areas.
- Governments at all levels, including the DOH, have no concrete program on sanitation due to the unavailability of funds.
- Recent calamities have a great impact on sanitation facilities wherein a lot of them were destroyed and unserviceable.
- Existing sanitary facilities are poorly operated and managed.
- Data validation system should be established.
- Unsanitary practices may result to contamination of our water bodies including our water sources.
- There should be training of newly hired SIs on data recording and reporting.
- The DOH is to develop program packages on sanitation for LGUs with budget too include under the PIPH.

### 3. Disease Control Program

Fig. 3A.1 Filariasis Morbidity Rate



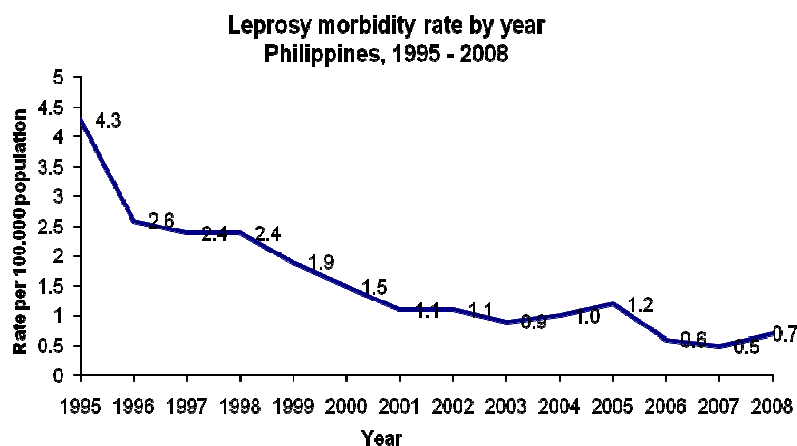
#### Remarks

- There is a sudden decrease of Filariasis Morbidity Rate in the past five years with a significant peak in 2001 and 2002.

#### Recommendations

- Filariasis elimination in endemic areas can be achieved through intensified health information and advocacy campaigns.
- Commitment for funding of mass treatment for complete coverage for all endemic areas should be secured by the government (national and local).

Fig. 3B.1 Leprosy Morbidity Rate



#### Remarks

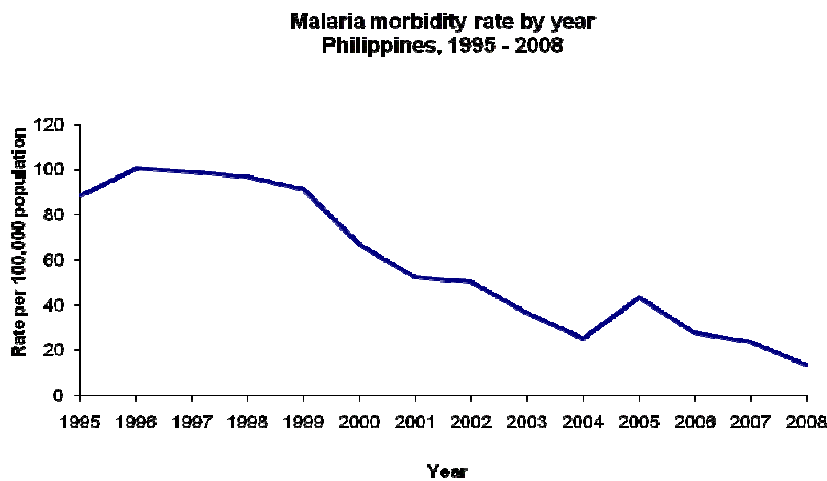
- The trend of Leprosy Morbidity Rate is gradually decreasing with slight peak in 2005 and 2008.

#### Recommendations

- Leprosy Morbidity Rates by province should be analyzed to determine priority areas for mass drug administration.
- Additional indicators as recommended by WHO should be routinely collected:
  - New cases detected ages children below 15 years old
  - New cases detected with disability grade 2
  - New cases detected by sex

### 3. Disease Control Program

Fig. 3C.1 Malaria Morbidity Rate



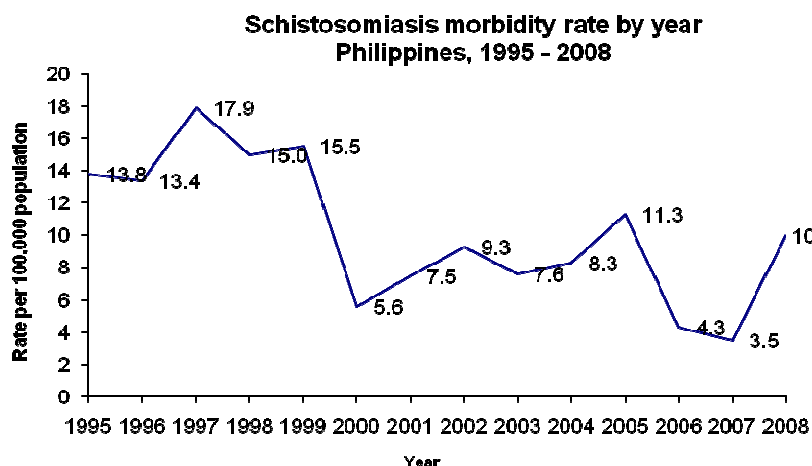
#### Remarks

- There is a decreasing trend from 1995 to 2008.
- Decrease may be due to the following:
  1. Increasing funds from 2003 onwards
  2. Capability building in terms of diagnosis, case management and vector control
  3. Improved health seeking behaviors of people living in endemic areas
  4. Increasing number of malaria-free areas

#### Recommendations

- Intensify surveillance (Disease, Entomological and Laboratory) in endemic areas and sustain malaria-free areas
- Sustain and improve the skills and capability of personnel in the diagnosis, treatment and control of malaria
- Intensify IEC both for endemic and malaria free areas
- Sustain the timely reporting and improve the quality of reporting
- Reconcile the data from program and FHSIS
- Harmonize Philippine Malaria Information System (PhilMIS) and PIDSR

Fig. 3D.1 Schistosomiasis Morbidity Rate



#### Remarks

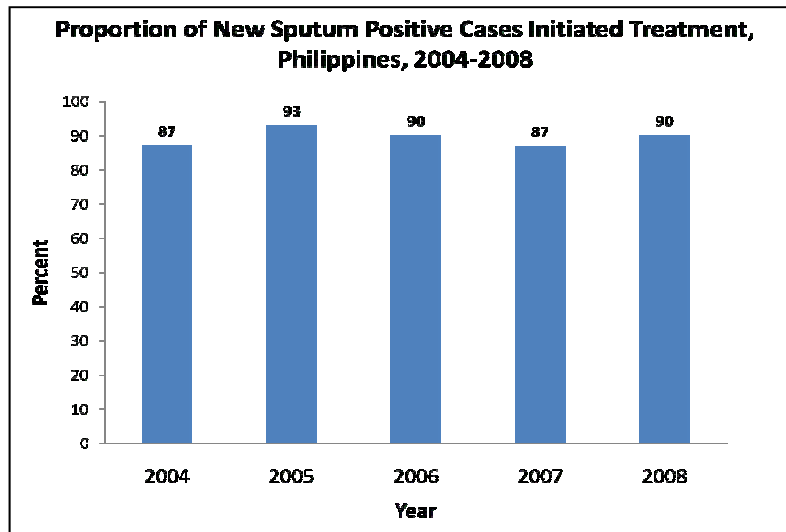
- This graph represents the passive case finding data.
- Spike in the trend may be due to the following:
  1. Irregular supply of Praziquantel that cannot sustain the Mass Drug Administration (MDA)
  2. Improved health seeking behaviour
  3. Decreased environmental sanitation

#### Recommendations

- More active case finding and sentinel data (i.e. among pre-school age children who are not included in the mass treatment)
- LGU should procure Praziquantel specifically for Schistosomiasis.
- Harmonize FHSIS data with Schistosomiasis Information System at all health system levels

### 3. Disease Control Program

Fig. 3E.1 New Sputum Positive Cases Initiated Treatment



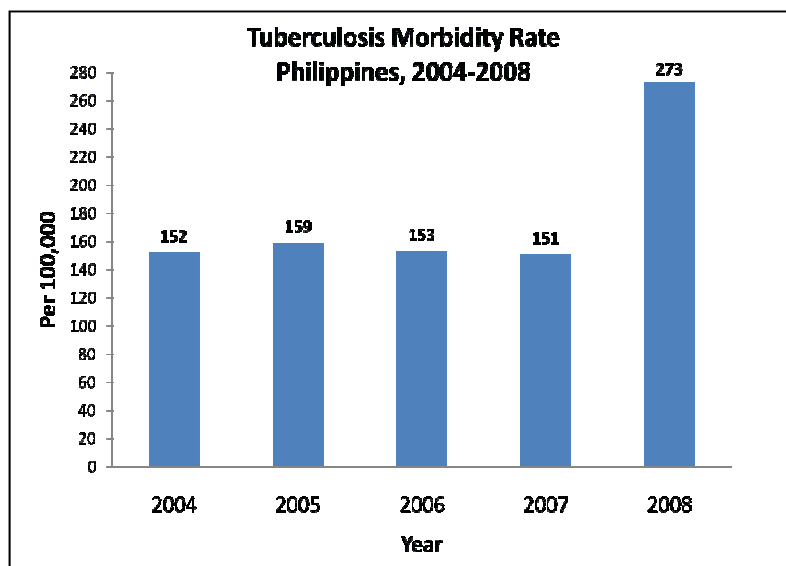
#### Remarks

- About 90% sputum positive cases are being treated in the past five years.
- Lack of immediate treatment may be due to difficulty in tracing sputum positive cases and lack of drugs.

#### Recommendations

- Policy formulation with signed Administrative Orders for Programmatic Management of Drug Resistant TB, Childhood TB, TB in Prisons/Jails, TB/HIV Collaboration services are already being provided in selected sites. Reports of all these initiatives should be considered for inclusion in the FHSIS.
- Tuberculosis (TB) Information System integrated with national M&E and the FHSIS

Fig. 3E.2 Tuberculosis Morbidity Rate



#### Remarks

- There is a steady trend of TB Morbidity Rate from 2004-2007 but with a sudden increase in 2008.
- In 2008, The TB Morbidity Rate of the program is 156 per 100,000 population with a 42% discrepancy from FHSIS.

#### Recommendations

- There should be data reviews between TB Program data and FHSIS data from the levels of the RHUs, Provinces, Center for Health Developments and the national.
- Consider cases from sources other than Rural Health Units like Hospitals and private clinics