

1.b.

- ① Why were you not trained in FHSIS? (Please check **all that apply**)
- Missed the training
 New in the service
 Others (Specify) _____
- ② How did you learn FHSIS? (Please check **all that apply**)
- Learn from colleagues (Specify if MHO/ PHN/ Midwife _____)
 Learn from daily work
 Learn from the manual (Specify) _____
 Others (Specify) _____

A. CARI

1. Who are the children with severe pneumonia? (Please check **all that apply**)
- Children with chest indrawing and fast breathing
 Children with no chest indrawing and fast breathing
 Children with no chest indrawing and no fast breathing
 Others (Specify) _____
2. Who are considered "Pneumonia cases seen (0-59 months)" as defined in the Modified-FHSIS? (Please check **all that apply**)
- Children (0-59 months) with chest indrawing and fast breathing
 Children (0-59 months) with no chest indrawing and fast breathing
 Children (0-59 months) with no chest indrawing and no fast breathing
 Others (Specify) _____

B. Tuberculosis

1. Who are considered "Pulmonary TB cases"? (Please check **all that apply**)
- With 2 or 3 sputum positive examination
 1 sputum positive with (+) CXR for TB
 1 sputum positive plus 1(+) culture examination
 Negative sputum with (+) CXR for Pulmonary TB
 Others (Specify) _____

C. EPI

Given is the TCL for EPI of barangay Baringkokodong Korba.

(See attached TCL for EPI)

1. Please complete the table in column 7.

(If there are the cases that it is supposed to be blank, leave it blank)

2. What are the antigens to be given to a child to be considered as FIC?

(Please check **all that apply**)

___ BCG

___ DPT

___ OPV

___ Measles

___ Hepa-B

___ Others (Specify) _____

3. Who are considered “Fully Immunized Children” as defined in the Modified-FHSIS in the given TCL for EPI above? (Please check **all that apply**)

___ AAA

___ BBB

___ CCC

___ DDD

___ EEE

___ FFF

___ GGG

___ HHH

___ JJJ

___ KKK

___ LLL

___ MMM

___ NNN

___ OOO

___ PPP

4. In the TCL for EPI above, who are considered “Fully Immunized Children” as defined in the Modified-FHSIS that is/are supposed to be reported for **July** 2004?

(Please check **all that apply**)

___ AAA

___ BBB

___ CCC

___ DDD

___ EEE

___ FFF

___ GGG

___ HHH

___ JJJ

___ KKK

___ LLL

___ MMM

___ NNN

___ OOO

___ PPP

D. Family Planning

1. Given are the monthly reports for **July** and **August** of barangay Baringkokodong Korba. Please complete all blanks found under the “Current Users” column for the monthly report of August 2004 using the information given in the tables below.

HIS (FHSIS) Report for the MONTH July , YEAR: 2004

FAMILY PLANNING			
METHODS	New Acceptors	Drop Outs	Current Users
A.Condom	3	5	135
B.Injection	0	3	65
C.IUD	0	0	0
D.LAM	24	4	189
E.NFP	0	0	0
F.Pills	2	3	71
G.Male Ster.	0	0	0
H.Fem.Ster.	0	0	0

HIS (FHSIS) Report for the MONTH August , YEAR: 2004

FAMILY PLANNING			
METHODS	New Acceptors	Drop Outs	Current Users
A.Condom	10	4	
B.Injection	2	3	
C.IUD	0	0	0
D.LAM	11	8	
E.NFP	0	0	0
F.Pills	6	2	
G.Male Ster.	0	0	0
H.Fem.Ster.	0	0	0

Change method: 0

Change clinic: 0

Pregnant: 0

2. Given below are the monthly report for **July** 2004 and the clients' information for **August** of De Mabirukan Barangay.

HIS (FHSIS) Report for the MONTH July, YEAR: 2004

FAMILY PLANNING			
METHODS	New Acceptors	Drop Outs	Current Users
A. Condom	3	5	135
B. Injection	0	3	65
C. IUD	0	0	0
D. LAM	24	4	189
E. NFP	0	0	0
F. Pills	2	3	71
G. Male Ster.	0	0	0
H. Fem. Ster.	0	0	0

Clients' information for **August**

- There were 5 clients who started using condom.
- There were 4 clients who stopped using condom and never came back for other method.
- There were 6 clients who started using injection
- There were 3 clients who stopped using injection and never came back for other method.
- There were 25 clients who started using LAM.
- There were 7 clients who stopped using LAM and never came back for other method.
- There were 7 clients who started using Pills.
- There were 2 clients who stopped using Pills and never came back for other method.
- For other methods, there were no clients and no drop-outs.

Changing method:

- 2 persons quitted using condom and started using LAM
- 3 persons quitted using condom and started using Pills
- 1 person quitted using LAM and started using Pills

Changing clinic:

- 2 clients came from another clinic and continue to use condom
- 2 clients came from another clinic and continue to use pills

Pregnant:

- 3 clients of condom became pregnant

Please complete all blanks in the August report below based on the given information in **page 5**.

HIS (FHSIS) Report for the MONTH August , YEAR: 2004

FAMILY PLANNING			
METHODS	New Acceptors	Drop Outs	Current Users
A. Condom			
B. Injection			
C. IUD	0	0	0
D. LAM			
E. NFP	0	0	0
F. Pills			
G. Male Ster.	0	0	0
H. Fem. Ster.	0	0	0

E. Rabies

1. Which of the following are considered as “Animal bites seen” as defined in the Modified-FHSIS?

(Please check **all that apply**)

- Dog bites
 Cat bites
 Human bites
 Others (Specify) _____

2. What is/ are “post exposure immunization”? (Please check **all that apply**)

- Given vaccines before bitten by a rabid dog
 Given vaccines after bitten by a dog
 Given vaccines after bitten by a rabid dog

F. Prenatal Care

Given is the TCL for Prenatal Care of barangay Baringkokodong Korba.

Client List for Pre-Natal Care

Date of Registration (1)	Family Serial Number (2)	Name (3)	Address (4)	Age (5)	LMP/G-P (6)	EDC (7)	Pre-Natal visits (Date) (8)			Risk Code /Date Detected
							First Trimester	Second Trimester	Third Trimester	
7-14-03	x x x	AAA AAAA	x x x	22	6-7-03/G1-P0		8-14-03	11-7-03	2-14-04 3-6-04	
7-18-03	x x x	BBB BBBB	x x x	19	6-13-03/G1-P0	3-20-04		12-20-03	1-14-04 2-20-04	
10-21-03	x x x	CCC CCCC	x x x	29	9-20-03/G2-P1	6-27-04	10-21-03	1-7-04	6-28-04	
10-29-03	x x x	DDD DDDD	x x x	36	10-4-03/G1-P0	7-11-04	10-24-03	3-12-04	7-7-04	
10-29-03	x x x	EEE EEEE	x x x	20	10-01-03/G1-P0	7-8-04	11-5-03		7-6-04	
11-5-03	x x x	FFF FFFF	x x x	21	7-20-03/G1-P0	4-27-04		12-7-03	3-27-04 4-15-04	
11-15-03	x x x	GGG GGGG	x x x	24	9-15-03/G3-P2	6-22-04	11-15-03			
2-15-04	x x x	HHH HHHH	x x x	21	1-12-04/G2-P1	10-19-04	2-15-04	7-10-04		
6-23-04	x x x	JJJ JJJJ	x x x	26	5-20-04/G3-P2	2-27-05	6-23-04 7-23-04			

1. Please **compute** for the EDC of the name "AAA AAAA" in the given TCL for Pre-natal.
2. Who are the "Pregnant women having 3 or more prenatal visits" as defined in the **Modified-FHSIS**? (Please check **all that apply**)
 AAA AAAA BBB BBBB CCC CCCC DDD DDDD
 EEE EEEE FFF FFFF GGG GGGG HHH HHHH
 JJJ JJJJ
3. In the given TCL for Pre-natal, how many "Pregnant women had 3 or more Prenatal Visits" as defined in the **Modified-FHSIS** that are supposed to be reported for **July** 2004? (Please write the **number**)
 _____ Pregnant woman/ women
4. Who is/ are counted as "Pregnant given complete iron dosage" as defined in the **Modified-FHSIS**? (Please check **all that apply**)
 Pregnant who are given advice to buy iron dosage
 Pregnant who are given prescription of iron dosage
 Pregnant who are given iron dosage for free
 Pregnant who are given advice for food
 Others (Specify) _____

G. Nutrition

1. In the Modified FHSIS report, who is/ are given Vitamin A supplementation? (Please check **all that apply**)

Pregnant
 Lactating mothers
 6 to 11 months old
 9 to 11 months old
 12 to 59 months old
 12 to 71 months old
 Others (Specify) _____

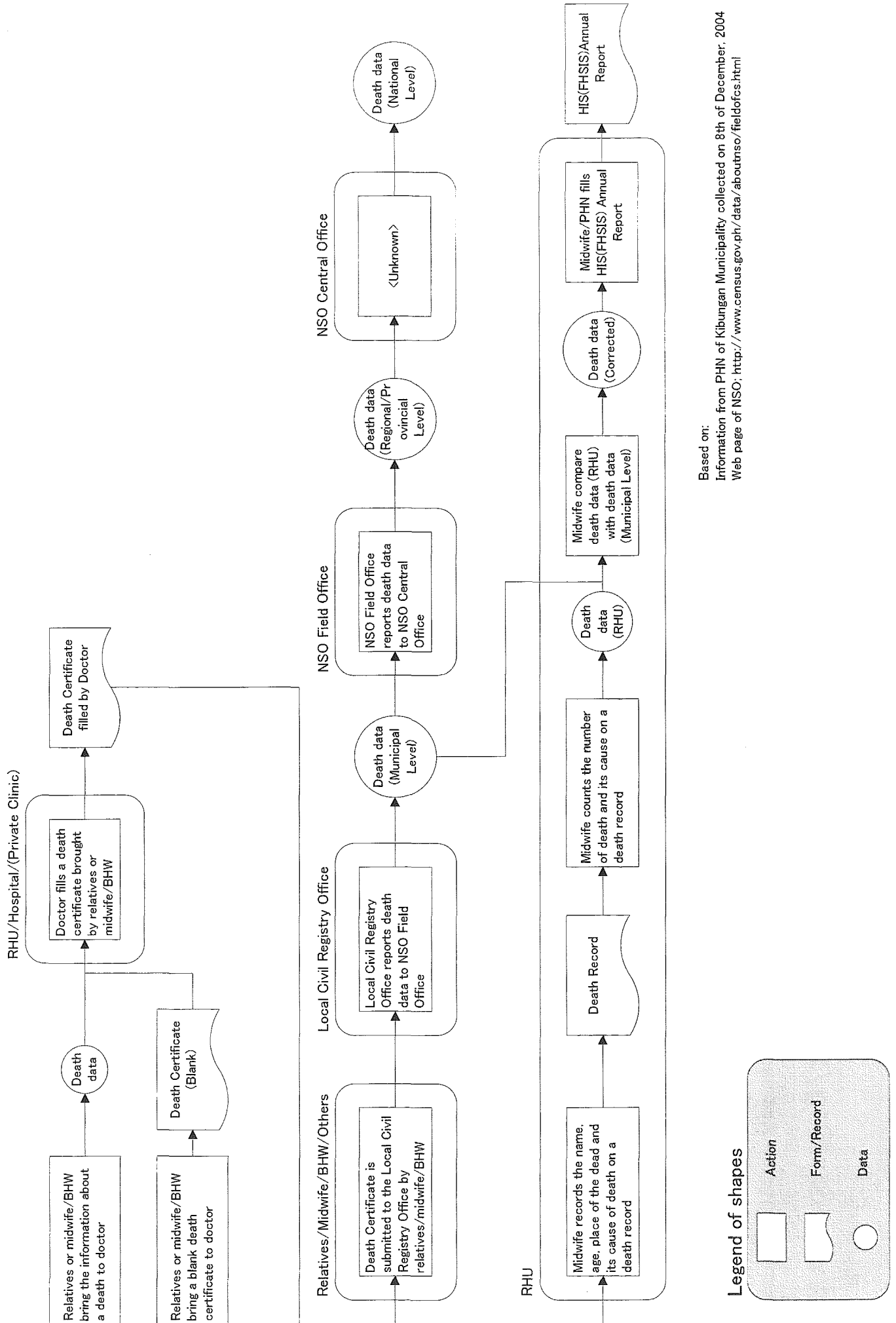
2. What is/ are your sources of data on Vitamin A supplementation for Modified-FHSIS report? (Please check **all that apply**)

Routine only
 GP (Garantisadong Pambata) only
 Others (Specify)

H. CDD

1. Who is/ are counted as “Diarrhea cases given ORS (0-59 months)” as defined in the Modified-FHSIS? (Please check **all that apply**)

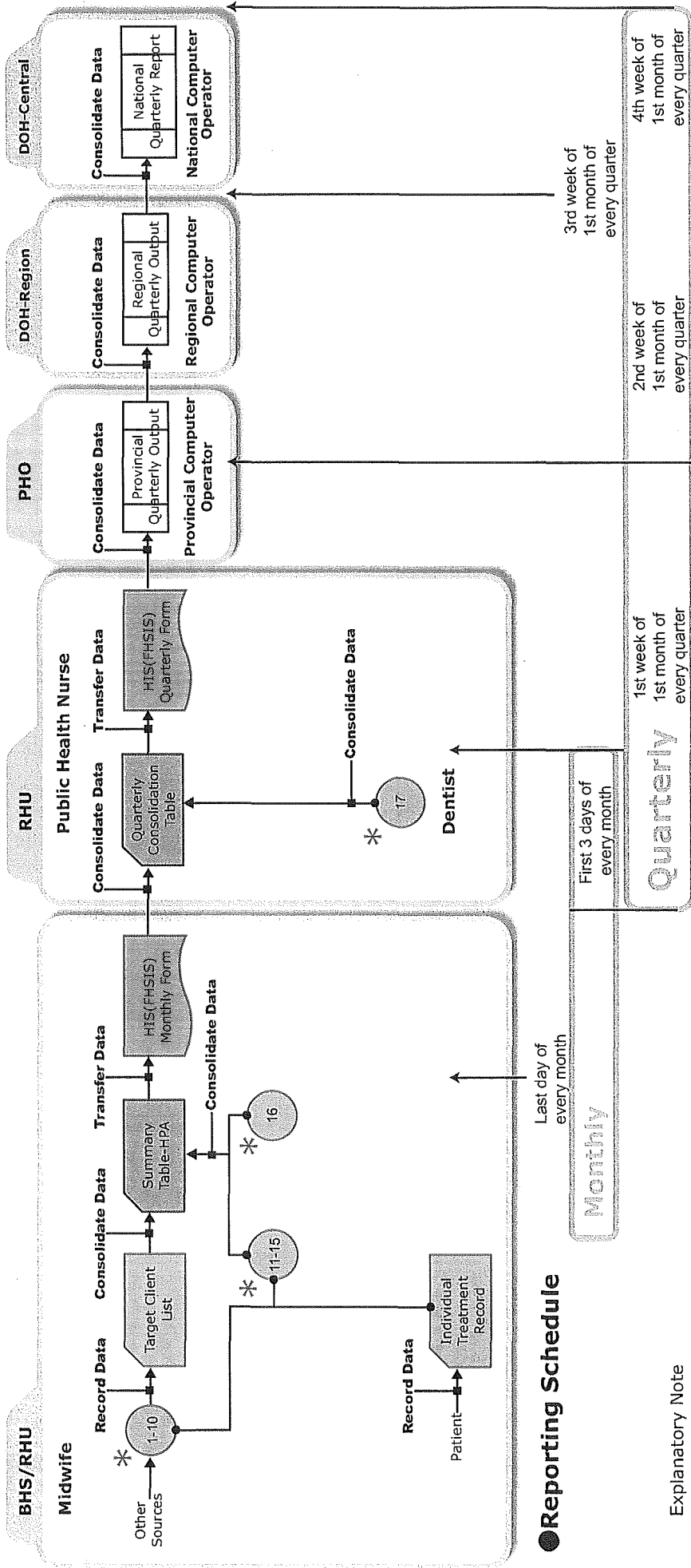
Children (0-59 months) given Oresol
 Mother/ Father of Children (0-59 months) given advice to buy Oresol
 Children (0-59 months) given Home made Oresol
 Mother/ Father of Children (0-59 months) given advice to make Home made Oresol
 Others (Specify) _____



Based on:
 Information from PHN of Kibungan Municipality collected on 8th of December, 2004
 Web page of NSO: <http://www.census.gov.ph/data/aboutnso/fieldofcs.html>

Data Recording/Reporting system of Modified-FHSIS source: Modified-FHSIS 1996 1/2

1. Health Program Accomplishment; HIS (FHSIS) Quarterly Report



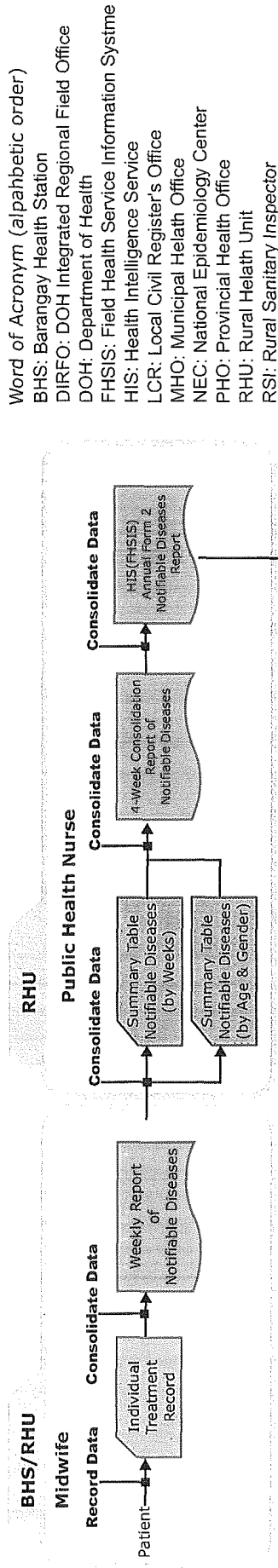
Word of Acronym (alphabetic order)

BHS: Barangay Health Station
 CDD: Control Diarrheal Disease
 DOH: Department of Health
 EPI: Expanded Program on Immunization
 FHSIS: Field Health Service Information System
 HIS: Health Intelligence Service
 HPA: Health Program Accomplishment
 PHO: Provincial Health Office
 RHU: Rural Health Unit
 STD: Sexually Transmitted Diseases
 TB: Tuberculosis

- * Name of Data
- 1: EPI Data
 - 2: Weighing Data
 - 3: Nutrition Data
 - 4: Pre-Natal Data
 - 5: Post-Partum Data
 - 6: Family Planning (Non-Surgical) Data
 - 7: TB Test Data
 - 8: TB Cases under SCC
 - 9: Leprosy Data
 - 10: ARI Data
 - 11: CDD Data
 - 12: Malaria Data
 - 13: Schistosomiasis Data
 - 14: Filariasis Data
 - 15: Rabies Data
 - 16: STD Data
 - 17: Dental Data

Data Recording/Reporting system of Modified-FHSIS source: Modified-FHSIS 1996 2/2

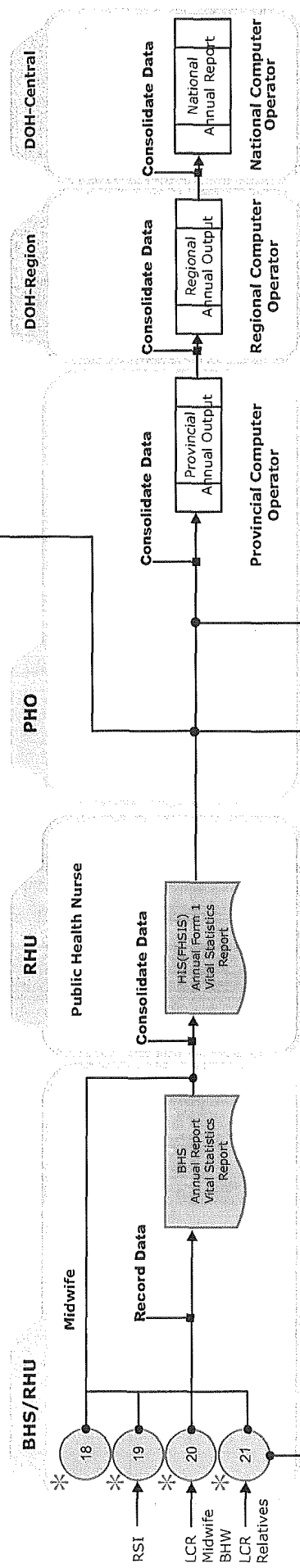
2. Notifiable Diseases Data Reporting



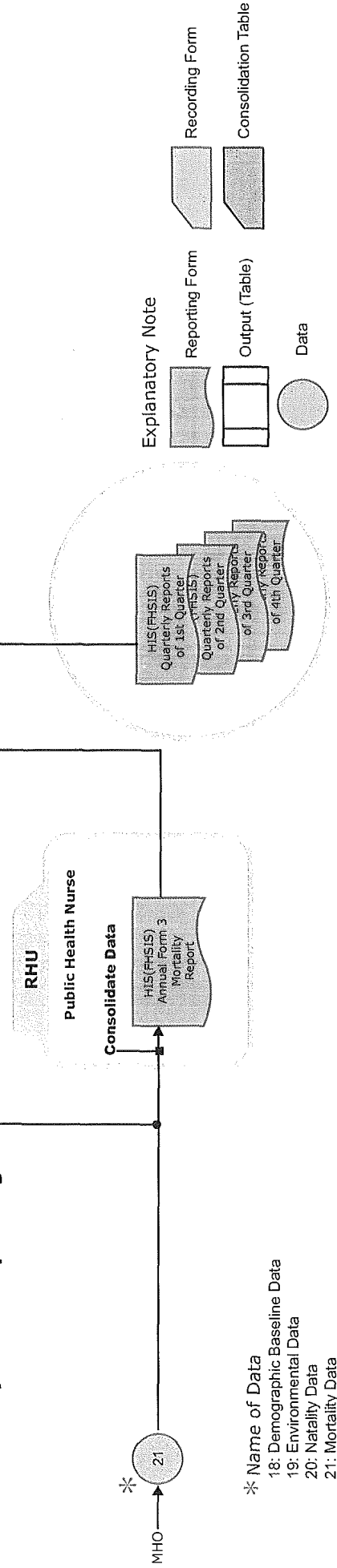
Word of Acronym (alphabetic order)

- BHS: Barangay Health Station
- DIRFO: DOH Integrated Regional Field Office
- DOH: Department of Health
- FHSIS: Field Health Service Information System
- HIS: Health Intelligence Service
- LCR: Local Civil Registrar's Office
- MHO: Municipal Health Office
- NEC: National Epidemiology Center
- PHO: Provincial Health Office
- RHU: Rural Health Unit
- RSI: Rural Sanitary Inspector

3. Vital Statistics Data Reporting



4. Mortality Data Reporting



- * Name of Data
- 18: Demographic Baseline Data
- 19: Environmental Data
- 20: Natality Data
- 21: Mortality Data

History of activities of FHSIS team 2004

Month	Date	Name of activities	Contents
	???	Workshop with midwives	Made Fishbone
Jan.		EPQI Workshop	Made Flow chart of modified-FHSIS
			Made indicator list
			Discussed about the result of Fishbone
			Made Survey plan
Jun.	10	EPQI Workshop	Discussed about the result of Fishbone
	11		Discussed about the flow chart of FHSIS
			Conducted quick validation survey at RHU and BHS
Sep.	17	Meeting of FHSIS team	Made an outline of survey questionnaire
	21	Meeting of FHSIS team	To share the information about current situation of fact surveys
			To make plan for FGD, Knowledge Survey, Timeliness Survey and Validation Survey
			To make draft of questions for Knowledge Survey
	22	Meeting of FHSIS team	To make draft of guide questions for FGD
			To pre-test questions for Knowledge Survey
	23	Meeting of FHSIS team	To prepare for inviting participants of Knowledge Survey & FGD
			To pre-test questions for Knowledge Survey
			To modify questions for Knowledge Survey
24	Knowledge Survey & Explanation of answers	For midwives and PHNs in Benguet province	
	Focus Group Discussion		
25	Meeting of FHSIS team	To wrap up the results of Knowledge Survey and FGD	
26	Meeting of FHSIS team		
Oct.	13	Meeting of FHSIS team	To prepare for logistics works
			To share the results of Knowledge Survey and FGD
Oct.	23	Meeting of FHSIS team	To make a plan for Validation Survey
			To set objectives for the research
Nov.	24		To set objectives on Validation Survey
			25
Dec.	1	Validation Survey	To set schedule for conducting Validation Survey
			To make draft idea of check list for Validation Survey
	2		Tuba RHU and Taloy-sur BHS
			Atok RHU
	7	Meeting of FHSIS team	Tublay Central BHS
			To share current situation of Validation Survey
	8	Validation Survey	Tublay RHU
			Kapangan RHU and Paykek BHS
Kibungan RHU and Sagpat BHS			
9		Sablan RHU and (Sablan BHS)	
10	Data encoding		

2005

Month	Date	Name of activities	Contents
Jan.		Validation Survey	???

ENSURING QUALITY OF HEALTH CARE IN THE PHILIPPINES: GAINS AND GAPS

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I. INTRODUCTION

Quality in health care has been studied in the past few decades and experts have struggled to define the quality in health care in a concise, generalizable and interpretable manner. Different perspectives were considered, from the providers of care, to health care plans and insurance organizations, both private and public, to purchasers of health care like employers and labor unions and to the patients themselves (1). Definitions and dimensions of quality of health care were also developed for individual patient (2,3) and to the quality of care provided by the health care system (4) for the entire population.

Although quality in health care was historically viewed as an implicit judgment at the level of patient-physician contact, quality of care efforts must focus at both population and individual level (5). Examining the quality of care at the systems level serves two purposes. Firstly, this exercise will demonstrate how well the health system is achieving the desired national health goals. Secondly, examining the quality of care provided by the health system will provide the information to policy makers on how to plan, finance and regulate the health system (6).

Often, the performance of the health system of the country is measured based on how much it has achieved the national health goals and objectives they have set out to do. The World Health Report 2000 published by the World Health Organization ranked the performance of the health system of 191 countries by looking at the three intrinsic goals of the health system: improving health outcomes, responsiveness of the health system and fair financing (7).

However, the discussion in this paper will follow the framework proposed by Evans et al (4) in that quality at the health system level will be viewed by looking at the health outcomes and responsiveness and not the financing goal of the health system.

Rationale. In the Philippines ensuring quality of health care was lodged in several offices/ institutions. In 1999, the government embarked on health sector reform agenda, which catalyzed the re-engineering and restructuring of the Department of Health (DOH). One of the five areas of reform was health regulation, which was viewed as a way to ensure that health products, facilities and services are of quality, safe, accessible and affordable to general population (8). The present structure of the DOH features 4 regulatory bureaus (Bureau of Food and Drugs, Bureau of Health Facilities and Services, Bureau of Health Devices and Technology and Bureau of Quarantine and International Health Services) but other offices like the National Center for Health Facility Development and the Bureau of Local Health Development (BLHD) also have quality improvement programs for hospital and local health systems, respectively. (9) In addition, the Philippines Health Insurance Corporation (PHIC), the primary institution mandated to manage the social health insurance in the country, has its own Quality Assurance and Research Policy Development Group (QARPDG). This office is responsible for the development and enhancement of quality assurance programs and at the same mandates to continuously review health care standards, performance monitoring and evaluation systems. (10)

Given that several offices are mandated to ensure that quality health care is provided to Filipinos, it is important to examine how far has Philippine health care system has gone in providing quality care, what have been done to achieve quality care and what are the evidences that quality have indeed been achieved. However, there is paucity of published researches that measure quality of health care in the country. In addition, surveys to examine patient's perception of quality of health care are few and patchy. There is therefore a need to assess how far the Philippine health care has gone in ensuring that quality of care has been delivered to Filipinos.

Objectives. Thus, this essay aims to examine how the Philippine health care system ensures the quality of health in the country. Specifically, this paper

will (1) describe the mechanism to ensure quality of care; (2) review the studies that provide evidences of quality of care are in Philippine s health system; (3) identify the problems that hinder the system to provide quality of care; and, (4) propose strategies to address the problems identified The output of this descriptive research can provide information to the policy makers as the government proceeds with its reform initiatives. As the implementation of Health Sector Reform Agenda is still underway, establishing a unified framework for quality improvement is critical. Linking or integrating quality assurance program in the over-all Monitoring and Evaluation system of the health sector is of utmost importance.

Scope and Limitations. This study will analyze the measures that will ensure quality delivery of health care services in the Philippines in terms of structure; process and outcomes. These will be discussed in the context by which they contribute to the attainment of the two out of three health care system goals: improving health status and responsiveness of the health system to the clients.

The analysis of this research will be limited by the availability of information. This research will rely mainly on secondary data. Policy documents, published studies in the Philippines and performance reports of several agencies mandated to ensure quality of services will be the main sources of information.

II. REVIEW OF LITERATURE

Quality of care has generated intense interests from various stakeholders in the health system for the last three decades. The government has to ensure that the health services provided to the population are not only safe but will result to improvement in health outcomes. Various purchasers of health services (e.g. health insurers, unions, employers) want assurance that the services they are paying for are accessible, effective, appropriate and provided by competent health professionals. Health providers emphasize technical excellence by which health care is delivered. Clients want a health care system that does not only care for them in a timely, effective and competent manner but one that also provides them adequate information so they can participate in decision making process while undergoing

treatment. All these characteristics of quality of health care has been identified as various domains of quality of care (4)

In recent years, the definition of quality of care has evolved to consider the interests of different players in the health care sector. The definition of quality of care has changed from Donabedian's definition in 1980 of high quality of care as that kind of care expected to maximize an inclusive measure of health care after considering the balance of gains and losses attendant to the process of care, to the Institute of Medicine's definition of quality in 1990 as that which consists of the degree to which health services or individuals and population increase the likelihood of desired outcomes and are consistent with current professional knowledge. (1) In 2000, Campbell et al differentiated the definition of quality of care for individual patients and for population. They argued that defining quality of care is most meaningful when applied to for individual patients as user of health care. They defined quality of care for individual patients as to "whether individuals can access the health structures and processes of care which they need and whether the care is effective". They further expounded the effectiveness of care in terms of effectiveness of clinical care and effectiveness of interpersonal care. For population, they defined quality of care as "the ability to access effective care on an efficient and equitable basis for the optimization of health benefit/ well-being for the whole population". (2) Furthermore, Evans et al proposed that defining quality in terms of outcomes at the population level will focus the attention of policy makers on whether health systems are achieving the desired national goals. (4)

Despite the debates and different perspectives in defining quality, the ability of researchers to measure quality of care has advanced considerably. Measuring quality of care does not only means reviewing the performance of health providers and to establish accountability but it also lay down the groundwork of improving the health delivery system. Quality of care can be evaluated on the basis of structure, process and outcome, as first proposed by Donabedian in 1980. Structural measures include characteristics of health providers and health facilities; process measures come from the components of the encounter between the health providers with the patient and/or with another health provider; and outcome measures focus on the patient's subsequent health status. However, there were few studies that looked at structural measures to assess quality of care. Meyer and Massagli in 2001 looked at 3 structural measures: use of computerized physician order entry, the selective referral of patients to high-volume providers for certain procedures and the availability of board-certified critical care specialists in intensive care units.

Although structural measures, like process and outcomes measures, face the same challenges of standardization, reliability, validity and portability, the authors propose that structural measures have the potential to fill important gaps in assessing quality (11).

Much of the efforts in measuring quality of care, however, have focused on process and outcome measures. Brooke et al in 1996 identified five methods to assess quality on the basis of process data, outcome data or both. (12) The first 3 methods are implicit, having no prior standards about what reflects quality care. In each of these three methods, the health provider reviews the data source and asks: was the process of care adequate? (First method), could better care have improved the outcome? (Second method) and considering both the process and outcome of care, was the over-all quality of care acceptable? (Third method) The fourth method evaluates the provision of care with the use of explicit process criteria. For example, how many private practitioners follow the WHO standard Directly Observed Treatment Short Course (DOTS) in managing TB patients? (13) The fifth method uses explicit a priori criteria to determine whether the observed results of care are consistent with the outcome predicted by the model. This however requires that the outcomes have been validated in the basis of scientific evidence and clinical judgment.

There was much debate on what better measure to assess quality of care: process or outcome. (7,14,15) Proponents of process measure argue process indicators can provide immediate feedback as they have the potential to identify exactly which step in the process has been followed or not which affect the patient's outcome. This advantage of process measure makes the providers more accountable to the care they provide to their clients. (7,14) Secondly, process measures are less costly when used to compare different providers or different health facilities because they require less risk adjustment for patient illness, as long as the population for which a procedure must be given should be defined. Thirdly, collecting process data is easier because care delivery occurs in a short period of time when the eligible patient can receive the specific process of care that is being evaluated. (7) Fourthly, process measures are easy to interpret. As example, use of aspirin in acute myocardial infarction is a direct measure of quality compared to hospital-specific mortality from myocardial infarction, a measure that can result from other factors outside the quality of care provided. (15)

On the other hand, outcome measures have also its advantages. These measures have intrinsic value as these provide information to policy makers,

purchasers of health care and patients, e.g. mortality rate from myocardial infarction in different hospitals. Secondly, outcome measure reflect the over all care provided and not only those that can be measured. Thirdly, outcome indicators are often used because the data to construct simple rates are collected in routine health information systems. (15)

Although these measures of health care have advantages, each of them has also several disadvantages, in terms providing direct link to desired health outcomes, ease of data collection, and reliability in interpreting these data. Indeed, selecting the performance indicator to measure quality needs to be put in the context of the assessment's purpose and audience (e.g. inform policy maker, identify poor performers to protect public safety or inform clients to facilitate their choice of provider).

Considering the different methods and data that can be used to measure quality, assessing the performance of a health system in terms of quality of care is likewise difficult and complicated. Evans et al proposed a framework that will describe and measure the quality of health systems by using a set of desirable outcomes. The authors picked up the three intrinsic goals of a health care system identified by the World Health Organization, (i.e. improvement of health status, responsiveness of health care and fair financing) and mapped the different domains of quality only in health status improvement and responsiveness. Fair financing responds to equity rather than quality of care. (4) Although the authors recognized that using outcome measures has its weaknesses, one important advantage of this measure is that it focuses that attention of policy makers on whether the health system is achieving the desired health goals. This difficulty in measuring health system quality is illustrated by the process of designing the National Quality Measurement and Reporting System of the United States and developing its measures of quality and system performance. (6,16,17,18) Measures of quality must not only provide the policymakers how the different systems are contributing to the national goals but the indicators must also provide clinical logic.

Logical Framework. In this essay, the assessment of Philippine health system will follow the framework proposed by Evans et al. The health status of Filipinos and the responsiveness of the health system will be examined using the different domains of quality. Optimal health for all (improved health status of population) will be achieved if the following are present: a) technical quality/ competence of the providers; b) appropriateness, effectiveness, safety, availability and timeliness of

health care; and, c) presence of preventive/ screening health services. Responsiveness of health system will be attained if patients have adequate information and they experience timely health services in a manner that is acceptable to them. Figure 1 illustrates the relation of these domains of quality in achieving these two health system goals within the structure and process of delivering health care.

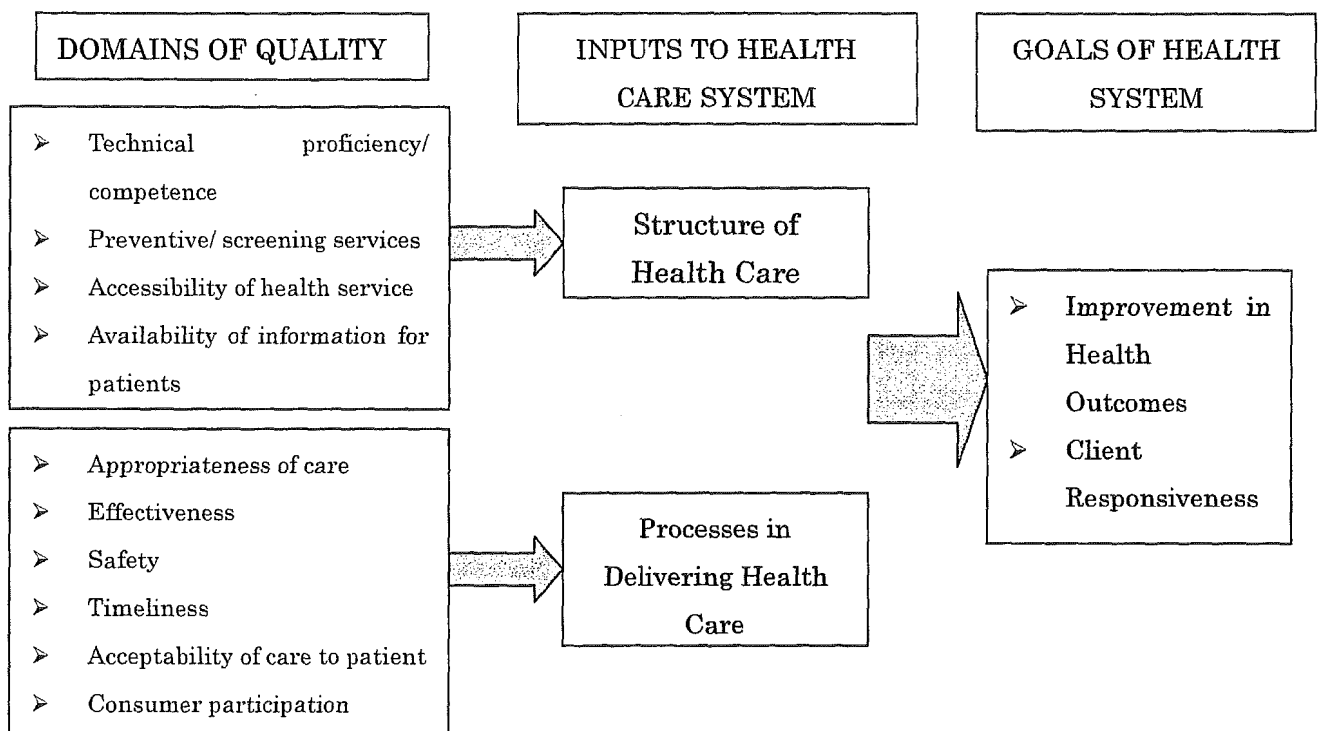


Figure 1. Domains of quality of care that are critical in achieving health system goals.

III. METHODOLOGY

This paper is a descriptive, conceptual study that analyzes how far the Philippine health care has gone in ensuring that quality health care is provided to Filipino people.

Data Sources. Health statistics, DOH and PHIC policies, agency performance reports, compendium of researches funded by the DOH, and the results of other studies done on quality of care in the Philippines are the main source of information. Some of these data are obtained from the appropriate offices while others are accessed from the Internet.

Data Analysis and Discussion. The Philippine health situation and the general condition of its health sector will be presented first. Structural and procedural inputs to the health care system will then be analyzed using the domains of quality identified in the logical framework. Studies that linked these inputs to health system goals will be reviewed while in the areas where no published study is available, the inputs will be measured against known standards. Gaps in the available information and studies done will be identified.

Figure 2 illustrates the framework for the discussion.

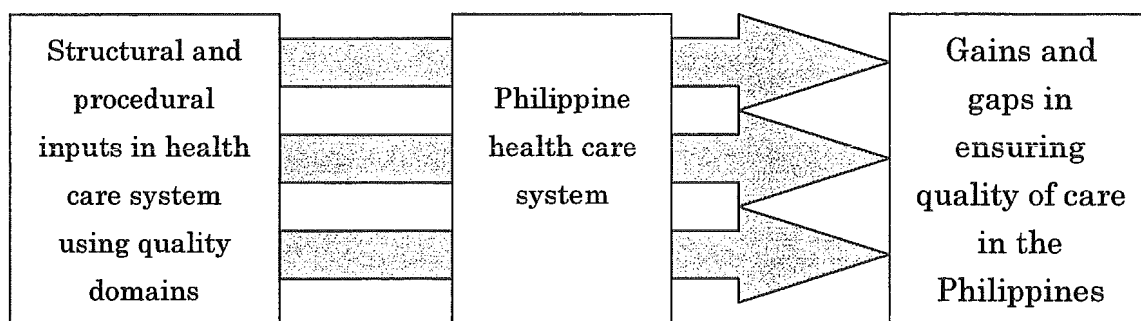


Figure 2. Framework for Discussion

IV. RESULTS AND DISCUSSION

Health Situation in the Philippines. The gains in the health status of the Filipinos for the last 50 years has leveled off as evidenced by decelerating improvement in the critical health indicators. Although the population growth rate of 2.36 is still considered high, Filipinos are living longer now with slight improvement in their life expectancy in the last 5 years from 66.3 years for male and 71.6 for female in year 2000 to 67.8 years for males and 73.1 for females in 2005. The decrease in the Infant Mortality Rate (IMR), a general indicator of the over-all quality and effectiveness of health care system, during the 80's was considered low but estimates in Table 1 showed IMR declined significantly in the last decade decreasing from 56 per 1,000 live births in 1990 to 29 per 1000 live births in 2003. (19)

Similarly, the reduction in maternal mortality rate was also slow, showing a slight improvement from 209 per 100,000 live births in 1990 to 172 per 100,000 live births in 1998. Despite this seemingly encouraging picture of

maternal health, this level is considered bleak if compared with other Asian neighbors like Malaysia, Thailand and Singapore. (20)

Table 1. Infant and Maternal Mortality Rates, Philippines, 1990-2003

	1990	1991	1992	1993	1994	1995	1998	2003
Infant Mortality Rate (Per 1000 Live Births)	57	55	54	52	50	49	35	29
Maternal Mortality Rate (Per 100,000 Live Births)	209	203	197	191	186	180	172	No data

Source: NSCB

The Department of Health reports the that top leading causes of death and diseases continue to show double burden of disease as both chronic and infectious diseases contribute to morbidity and mortality of Filipinos. (21) Ten leading causes of morbidity shows predominantly infectious diseases (Table 2) while the leading causes of mortality are generally non-communicable and chronic diseases (Table 3).

Table 2. Leading Causes of Morbidity Number and Rate/100,000 Population 2000

Causes	Number	Rate*
1. Diarrheas	866,411	1134.8
2. Bronchitis/Bronchiolitis	700,105	917.0
3. Pneumonias	632,930	829.0
4. Influenza	502,718	658.5
5. Hypertension	279,992	366.7
6. TB Respiratory	126,521	165.7
7. Diseases of the Heart	52,957	69.4
8. Malaria	50,869	66.6
9. Chickenpox	35,306	46.2
10. Measles	23,287	30.5

Source: DOH Health Statistics