ADMINISTRATIVE ORDER
No. 2006-0023

SUBJECT: Strategic and Operational Framework for Establishing Integrated Helminth Control Program (IHCP)

I. BACKGROUND/RATIONALE

Soil-transmitted Helminthiases (STH) or worm infections caused by *Ascaris lumbricoides*, *Trichuris trichiura* and hookworms are among the most widespread of all chronic human infections. They remain a public health problem having the widest distribution and the highest prevalence rate throughout the world (1998 WHO). The burden of disease associated with helminth infections and to a lesser extent, schistosomiasis is significant with at least two billion people affected worldwide. These diseases are estimated to account for the loss of 17 to 18 million disability adjusted life years (DALYs) worldwide (Professor Paul F. Basch, Stanford University). The 2004 UNICEF funded extensive survey to determine the extent of STH in the Philippines showed a cumulative prevalence of 66.0% among 12-71 months old children (de Leon and Lumampao, UP-CPH/DOH, 2005).

These parasites have been reported from tropical to subtropical countries like the Philippines, where poverty, inadequate sanitary facilities, inadequate safe potable water supply, inadequate knowledge on desired health behaviors, indiscriminate defecation and poor eating habits prevail. Persons living in an environment characterized by overcrowding, with inadequate water supply, facilities for human excreta disposal and poor housing are at a very high risk of contracting STH. The parasitic conditions are also traceable to poor human behavior hygienic practices, customs and traditions. The 2004 STH survey showed that only less than a third (30.0%) of households in the study areas have piped-in water while the other 69.7 percent depend on deep wells, open dug wells, springs, and a few on rainwater. The same study showed that a significant percentage (28.0%) of households still use unsanitary toilets.

Studies undertaken to assess the prevalence of worm infestation in the Philippines show that Filipinos continue to suffer from STH infection. STH prevalence has not been significantly reduced over time and that large disparities still exist among different regions and specific target population groups. Little improvement has been noted in reducing STH among the school children, while the rate of infection remains high among those 1-5 years old. Several factors were identified that account for the slow and low containment of the infection: (i) failure to comply with the recommended standards or technology; (ii) poor coverage of targeted population; (iii) weak promotion and advocacy; (iv) lack of enabling environment that supports STH prevention and control; and (v) increased cost of intervention and ineffective implementation.

Intestinal helminthes affect the most vulnerable sector of society - the children aged 1 to 12 years old causing decreased physical activity and poor performance in school. Adolescent females who lose about 35 ml of blood and 15.5 mg of iron during menstruation and the pregnant women requiring additional iron for a successful pregnancy and lactation are likewise at-risk to
the infection. Worm-infestation among these groups causes additional blood loss that usually leads to anemia.

Given these concerns, there is a need to integrate all related efforts and strengthen coordination of those involved to ensure better complementation of resources and obtain higher coverage and health outcomes. Within the DOH, several programs exist which are viable mechanisms to operationalize an integrated approach in preventing and controlling STH infections more effectively and efficiently. This needs to be expanded to other national and local agencies and organizations engaged in the same endeavor. This order provides the strategies and operational framework for implementing IHCP at the national, subnational and local levels.

II. OBJECTIVES

This Administrative Order aims to:

(i) provide strategic directions for establishing an integrated Helminth Control Program in the Philippines in line with the thrusts of the health sector reform agenda, particularly the Formula One Strategy;

(ii) provide policy guidance for DOH offices, its attached agencies, LGUs and other partners in the prioritization of related programs and activities pertinent to STH prevention and control nationwide; and

(iii) establish guidelines and procedures for an effective and efficient management and implementation of sustainable STH prevention and control services

III. COVERAGE AND SCOPE OF APPLICATION

This Order covers the central and regional offices of the Department of Health, hospitals and other attached agencies that could provide the enabling environment for the effective and efficient prevention and control of STH infections in the Philippines. It also applies to other partners in the health sector, both public and private, other national agencies, Local Government Units, NGOs, academe and other partners involved in the prevention and control of STH in so far as their operations are governed by technical guidelines and standards mandated by the DOH.

IV. DEFINITION OF TERMS

A. Soil-Transmitted Helminthiasis: Refer to worm infections caused by Ascaris lumbricoides, Trichuris trichiura and hookworms, known to be the most chronic of all human infections

B. Mass Treatment: refers to giving drugs to an entire group of people without prior diagnosis of current infection

C. Targeted Mass Treatment: refers to giving drugs to specific group in the community defined by age, or other social characteristics, irrespective of the infection status, e.g., children aged 1 – 12 years old

D. Selective Treatment: refers to giving of anthelminthic drug to an individual based on the diagnosis of current Infection
VI. THE INTEGRATED HELMINTH CONTROL PROGRAM (IHCP)

A. IHCP

1. Vision
   Healthy and Productive Filipinos in the 21st century

2. Goal
   To reduce mortality and morbidity due to STH infections

3. General Objective
   To reduce the prevalence of STH to below 50% among 1-12 year old by 2010
   and lower STH infection among adolescent females, pregnant women and other special
   population groups.

4. Specific Objectives
   1. To increase the coverage of deworming of target population groups at risk to STH
      infection.
      
      Indicators-
      • treatment of at least 85.0% of all 1-12 year old children through regular mass
        deworming campaign for preschoolers and school age groups; and
      • treatment of adolescent females, pregnant women, farmers, food handlers, soldiers
        and indigenous peoples consulting the health facility.

   2. To expand coverage of water, sanitation and hygiene
      
      Indicators-
      • increased access of households to safe water from 87.0% in 1998 (NDHS) to
        94.0% in 2010; and
      • increased sanitary toilet coverage from 75.0% in 2003 (NDHS) to 80.0% in 2010.

   3. To increase the proportion of targeted population observing healthy practices
      
      Indicators-
      • improved the practice of appropriate personal and food hygiene of at least 75%
        of mothers/caregivers with 1-12 year old children by the end of 2010

B. Guiding Principles

(1) Focal Targeting. Helminthes have adverse effects on preschoolers, schoolchildren,
   adolescent females, pregnant women and special groups like indigenous peoples,
   soldiers, farmers and food handlers. Interventions must be focused to them.

(2) Appropriate and Sound Technology. Regular and periodic chemotherapy for
   high-risk groups is continuously needed for at least 3 years. Access to quality
   deworming drugs must be assured. Safe water supplies, environmental sanitation and
   personal hygiene must be an integral component in STH services. Health education
   efforts must be geared towards the identified behaviours that promote healthy practices
   and to change or modify those that deter healthy practices.

(3) Evidenced-Based. Continuous update of STH-related policies and guidelines must
   be done in accordance to recommended international standards proven effective and
   applicable to the country. Efforts will be exerted to generate information to guide the
planning and implementation of STH programs and activities. Research findings will be used to focus interventions and approaches most responsive to the affected groups.

(4) Multi-Sectoral Collaboration. STH has long been recognized as a multi-sectoral concern. A comprehensive response is needed to address this concern. In this regard, networking with stakeholders must be proactively pursued and sustained. The government agencies, non-government organizations, private volunteer groups, religious and civic organizations and educational institutions can contribute to STH control through their respective capabilities, expertise, resources and networks.

(5) Involvement of the Community and Families. The prevention and control of STH infections depends largely on the commitment and participation of the communities and the families. Personal hygiene, safe water, sanitary toilets, proper waste disposals and other environmental sanitation measures are integral to the day-to-day life of the community and the families. Their involvement in planning, implementation and monitoring of STHCP prevention and control measures must take prime consideration.

C. Program Components

1. Chemotherapy

   Chemotherapy is a safe and efficient intervention with immediate results visible to affected clients as it reduces worm burden, worm transmission and chance of reinfection. As the major intervention for helminthes infection control, two approaches are applied: (a) mass targeted deworming and (b) selective deworming. Mass targeted deworming is applied to preschool children and school children while selective deworming is recommended for adolescent females, pregnant women, and the special population groups of food handlers, soldiers, farmers and indigenous peoples. Different dosages of deworming drugs are prescribed per target population group with corresponding frequencies and schedules.

   a. Deworming Targets

      a.1 For Mass Targeted Deworming

      • Children 1-5 years old suffer the greatest morbidity when infected. Deworming is intended as a curative care to ensure survival especially children below 3 years old.

      • Children 6-12 years old harbor the greatest load of infection and are the significant sources of transmission.

      a.2 For Selective Deworming Treatment

      • Adolescent females must be provided with anthelminthic drugs because they lose about 35 ml of blood containing approximately 15.5 mg of iron during menstruation;

      • Pregnant women must be provided with anthelminthic drugs because maternal anemia is at 44.0 percent (2005 FNRI Study). Blood loss and worm infection can aggravate maternal anemia and impact on birth and delivery outcomes.

      • Special groups like soldiers, farmers, food handlers and operators, and indigenous people are at risk to worm infestation because of their exposure to different intestinal parasites relative to their occupation or cultural practices;
b. Frequency and Duration of Deworming

For children 1-12 years, it is recommended to do mass deworming twice a year or every 6 months since re-infection rate in this group is almost 100.0 percent at 6 months after treatment (Cabrera et al., 1977-78). As infective eggs remain viable in the soil and are able to infect people for a maximum of two (2) years, mass chemotherapy should be done consecutively for three (3) years. It is expected that after the continuous 3 year mass chemotherapy given at twice a year, the worm prevalence would be below 50 percent, after which mass deworming is recommended to be done only once a year.

Selective deworming of special population groups (adolescent females, pregnant women, soldiers, food handlers/operators and indigenous peoples) must be done once a year anytime they consult the health facility.

c. Drug Dosage and Frequency by Target Groups

<table>
<thead>
<tr>
<th>Target Groups</th>
<th>Drug Dosage</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mass Targeted Deworming</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(1) 12-24 months children</td>
<td>albendazole, 200 mg, single dose or mebendazole, 500 mg, single dose</td>
<td>every 6 months</td>
</tr>
<tr>
<td>(2) more than 24 months old children</td>
<td>albendazole, 400 mg, single dose or mebendazole 500 mg, single dose</td>
<td>every 6 months</td>
</tr>
<tr>
<td>Selective Deworming</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(1) adolescent females</td>
<td>albendazole, 400 mg, single dose or mebendazole, 500 mg, single dose</td>
<td>once a year any time they consult the health facility</td>
</tr>
<tr>
<td>(2) pregnant women</td>
<td>albendazole, 400 mg, single dose or mebendazole, 500 mg, single dose</td>
<td>Once a year during the 2nd trimester once they consult the health facility</td>
</tr>
<tr>
<td>(3) Special Population Groups e.g. food handlers and operators, soldiers, farmers and indigenous people</td>
<td>albendazole, 400 mg, single dose or mebendazole, 500 mg, single dose</td>
<td>once a year any time they consult the health facility</td>
</tr>
</tbody>
</table>

d. Schedule of Deworming

Deworming will be administered to specific population groups according to the following schedule.

Table 1: Schedule of Deworming

<table>
<thead>
<tr>
<th>Target Groups</th>
<th>Schedule</th>
<th>Responsible Agency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Preschoolers, 1-5 years old</td>
<td>First Dose: GP Round 1 (April)</td>
<td>DOH, NGOs</td>
</tr>
<tr>
<td></td>
<td>Second Dose: GP Round 2 (October)</td>
<td></td>
</tr>
<tr>
<td>Schoolers, 6-12 years old</td>
<td>First Dose: July</td>
<td>DepEd</td>
</tr>
<tr>
<td></td>
<td>Second Dose: January</td>
<td></td>
</tr>
<tr>
<td>Filiariasis-endemic areas (2-year olds and above)</td>
<td>First Dose: June</td>
<td>DOH - FEP and ICHP</td>
</tr>
<tr>
<td></td>
<td>Second Dose: November</td>
<td></td>
</tr>
</tbody>
</table>

e. Drug Requirements and Preparations

The drugs recommended by WHO and DOH for the treatment of intestinal parasitism in children 12 months and above are albendazole or mebendazole. The same drugs are also recommended for female adolescents, pregnant women and the special
population groups but differ only in the dosage to be administered. Albendazole and Mebendazole are listed in the Philippine National Drug Formulary, Volume I, 5th Edition 2000, p 19.

2. Water, Sanitation and Hygiene (WASH)

The water, sanitation and hygiene component of the IHCP, patterned after the UNICEF WASH strategies from 2006-2010 serves as the cornerstone in reducing diseases especially those related to intestinal parasitism.

a. Ensuring the Provision of Safe, Adequate and Sustainable Water Supply.

The adequacy of water is as important as its accessibility. It has been stressed that basic hygiene measures especially handwashing should not be compromised by lack of water or lack of access to water as it has been shown to be the single most important factor in the prevention of infectious diseases. Sufficient water should be made available at all times for drinking, personal hygiene, food preparation, cleaning and laundry.

b. Promotion and Installation of Low Cost Technology and Culturally-Acceptable Sanitation Facilities

Promotion of sanitary toilets construction must be continued. Low cost sanitation technology should be encouraged and if possible, must be culturally acceptable to the community. The maintenance, repair and eventual replacement of water and sanitation facilities must be simple enough that can be done without requiring special skills. Coordination with concerned agencies with regard to other environmental sanitation measures (e.g. sewerage, proper waste disposal, etc.) must be pursued.

3. Behavioral Approaches

Behavioral change is central to the control of intestinal parasitism. It has been stated that the greatest culprit in the transmission of worms are the human beings, for worms are transmitted through poor personal hygiene such as neglecting to wash raw fruits and vegetables properly, eating with dirty hands or not wearing slippers. Because transmission is brought about by human behavior, the solution lies in changing the social, economic and cultural environment. Behavior change must be promoted among the claimholders (e.g. children, mothers/caretakers, family and community members) regarding their right to access basic health services that will help them exhibit healthy practices that prevent STH infection. Supportive behaviors towards STH prevention and control need to be advocated as well among duty bearers which include the national and local government officials, agency heads of different sectors, civil society, NGOs, etc. Their support is vital in scaling up coverage and sustaining the delivery of services.

a. Identification of Behaviours That Promote Health or Ill-Health. To achieve the desired behavioral change, it is necessary that behaviours, which have adverse effects on health, be first identified. Those behaviors that reduce the risk of infections should be reinforced and encouraged to enhance compliance. On the other hand, behaviors that impede good health outcomes must be modified or changed. The following table summarizes the promotive and deterrent behaviours to health.
Table 2: Behaviors That Promote Health or Ill-Health

<table>
<thead>
<tr>
<th>Desired Behaviour That Promotes Health</th>
<th>Behaviour That Contributes to Ill-health</th>
<th>How to Address the Problem</th>
</tr>
</thead>
<tbody>
<tr>
<td>Good personal hygiene like washing hands before eating and after using the toilet</td>
<td>Indiscriminate defecation, Improper use of latrines</td>
<td>Toilet construction, Installation of water and washing facilities, Information, Hygiene Education and Communication</td>
</tr>
<tr>
<td>Habitable use of footwear</td>
<td>Not wearing footwear</td>
<td>Information, Hygiene Education and Communication</td>
</tr>
<tr>
<td>Clean and safe preparation of food (Avoid undercooked meat products, unwashed fresh fruits/vegetables)</td>
<td>Use of untreated human feces as night soil</td>
<td>Information, Hygiene Education and Communication, Local Ordinance, Monitoring</td>
</tr>
</tbody>
</table>

b. Development and Implementation of Advocacy and Communication Plan. An overall advocacy and communication plan to support adoption of STH preventive measures among the target audiences will be developed as the basis in designing and conducting promotional activities appropriate to different audiences. An inventory of existing IEC materials on STH prevention and control will be done and each material will be assessed as to their effectiveness in generating the desired behaviors.

- **Promotion of Hygiene as a Family Competency Through the Six Key Habits.** It is imperative that community and family members are properly taught the proper way of personal hygiene as the first step to creating an enabling environment. Hygiene education aims to clarify the myths and beliefs of individuals regarding the presence of helminthes, increase their understanding of the epidemiology of helminthes infection, patterns of distribution of the parasite within the human population and modes of transmission, and improve their appreciation of the benefits of personal hygiene in the prevention and control of the STH infection. Hygiene education must center on: (1) latrine/toilet utilization, (2) washing of hands before eating and after using the toilet, (3) wearing of slippers or shoes, (4) hygienic preparation of food, (5) drinking potable water; and (6) clipping of finger nails.

- **Strengthen Face-to-Face Communication.** Service providers in health facilities, schools and daycare centers must be able to effectively communicate the above key messages to target audiences. Personal communication skills of these staff need to be enhanced.

- **Provision of IEC Materials.** Appropriate promotion materials in the form of posters, leaflets, CDs, flyers, games, radio spots, etc. will be developed based on the results of the assessment documents. Other mass media initiatives will be pursued if necessary.

c. Involvement of Families and Communities for Behavioral Change. The relationship of the mother with the child is of utmost importance in STH prevention because the former is the primary caregiver. Other family members (e.g. fathers, siblings and helpers) who also play an active part in rearing the child when the mother is away must be taught the same significant factors affecting the prevention and control of worms. Community-based IHCP management is considered for children aged 1-5 years old and children below 12 years old who are out of school. For this to be successful and sustainable, communities must be involved in planning, implementation, monitoring and evaluation of STH-related programs and activities in their area.

d. Advocacy and Social Mobilization. Advocacy and social mobilization efforts must be pursued among various groups of national and local stakeholders. These efforts must redound to their active participation in implementing the STH program, increased budget
allocation, issuances of supportive policies and political will to act on issues and concerns that prevent people from accessing the services.

D. Key Strategies

The IHCP, as a public health program must be mainstreamed into the on-going health sector reforms being pursued by the DOH in partnership with the LGUs. The IHCP implementation must take into account reforms in governance, service delivery, financing, regulations and development of management support systems. It is believed that mainstreaming IHCP initiatives into the overall health sector reform agenda, particularly through the Formula One Strategy will most likely succeed and result to better health outcomes in the long run.

1. Improve Governance

The successful control of STH infection lies on the commitment and support of the leaders and officials responsible in implementing the STH prevention and control. Governance over IHCP management and implementation must be improved to reduce STH infection as a threat to public health. In particular, national and local officials have to become accountable to their mandates through: (i) the issuance of policies and guidelines that will set the overall direction of the program, (ii) allocating adequate funds to support the implementation of STH preventive measures, and (iii) mobilizing all concerned sectors to perform their expected roles in STH prevention and control.

2. Improve Quality and Scale-up Service Delivery

Reforms in service delivery must aim towards the improvement in the quality of deworming services and increased access of the targeted population, especially the poor to affordable yet effective deworming services. Improving the quality of services require: (i) reforms in the competencies of service providers, (ii) setting standards and protocols, and (iii) provision of necessary logistics, supplies and facilities to enable them deliver the service. Improving access on the other hand requires deworming drugs at affordable prices and the availability of services in the different health service facilities or outlets. Continuing quality control program/activities on IHCP have to be undertaken.

a. Capacity Building. Stakeholders must have the necessary competence to perform their expected tasks. They must be provided with appropriate knowledge, attitudes and skills in line with their work, and these must be done on a continuing basis.

b. Development and Issuance of Protocols and Guidelines. Standards and guidelines serve as the roadmap in the implementation of the IHCP and provide direction to health planners and workers in the communities. Policy directions and guides will be disseminated through series of orientations/meetings with CHD and LGU personnel involved in maintaining the health of the community. Service delivery protocols for each service level (home, BHS, RHU, hospital, private practitioner) will also be developed.

c. Expansion of Service Delivery Points. IHCP services must be made available and accessible to target population. It is therefore necessary to establish additional service outlets and tap other existing programs to deliver IHCP interventions.

d. Availability and Affordability of Deworming Drugs. Deworming drugs of high quality but of cheaper price must be made available in the health facilities, schools and day care centers. Logistics requirements during mass deworming must also be provided.

3. Financing Reforms

Significant amount of resources are needed to realize the goals and objectives of the IHCP. Given the limitations of the existing budget of the national and local governments, not
all areas can be covered and the targeted population in those areas may not be completely reached. The implementation of the IHCP requires a concerted effort in reforming the financing of STH prevention and control in order to sustain the continued provision of deworming services. There are basically three tracks to be pursued to improve the financing of the IHCP.

(1) Efficiency in program implementation needs to be improved in order to maximize the utilization of limited resources. More efficient procurement and distribution of the deworming drugs, better-focused installation of water and sanitation facilities and equitable distribution of the limited resources must be done. The Php 3.0 million deworming drugs procured by DOH need to be distributed rationally according to needs by LGUs and their own capacities to buy their own requirements. It is believed that the limited resources of the government must be focused to the poorest of the targeted population, and those who are able and willing to pay must be encouraged to pay for their own drug requirements.

(2) Additional funds must be mobilized to finance the procurement of deworming drugs, install the necessary water and sanitation facilities and to establish management systems to support the prevention and control of STH. This requires mobilization of resources outside the government sector - private sector, NGOs, donor community and other international organizations.

(3) Financing schemes established by the LGUs for health in general must be supported in order to sustain the delivery of deworming and other related services. These include the continued enrollment of indigents to PhilHealth, compliance to PhilHealth accreditation requirements for different benefit packages it offers. The capitation fund for example received by RHUs may be tapped to finance the procurement of deworming drugs or to support other STH prevention and control activities. Introduction of users' fees to those who are able to pay must be explored while the inclusion of deworming drugs into the Revolving Drug Project of the LGUs must also be looked into.

4. Regulatory Reforms

Effective implementation of the IHCP also requires reforms in regulations related to STH prevention and control. Reforms in regulations must ensure that those concerned comply with laws, policies and guidelines. Promotion of STH-related laws and policies must be intensified, more frequent and thorough monitoring of compliance must be done and the political will of local officials to act on those that do not comply need to be strengthened. Issuance of sanitation permits to food handlers or establishments must follow the required process and criteria.

5. Management Systems Support

Management support systems must be put in place to ensure that reforms in governance, financing, service delivery and regulations will take place. These include: (i) the development of deworming drug procurement and logistics management system, (ii) management information system, (iii) research; and (iv) surveillance system.

a. Drug Procurement and Logistics Management. The procurement of deworming drug is more cost effective if done by bulk at the central level and not by individual LGUs/agencies. The DOH will establish a procurement and distribution mechanism to ensure easier access by the targeted groups to quality and affordable deworming drugs. The assistance of UNICEF and WHO in procurement will be tapped. LGUs who have the capacity to procure their own deworming drugs can obtain these from the Botika ng Barangay or other pharmacy or drug outlets in the area. They are encouraged though to follow the recommended drugs and ensure strict assessment of the quality of drugs.

b. Information Management System. Masterlisting of target clients must be done before the deworming activity is carried out. The lists must be updated regularly on an annual basis at
the least. BHWs must be mobilized to complete the master lists of the pregnant women, female adolescents and young children not yet in school. Schoolteachers will be asked to complete the lists of their school children and Day Care Workers to complete the list of enrolled 3-5 year old preschoolers. Review and validation of the master lists especially of children must be done to avoid double listing. Under the GP activity, standard forms (see attached) will be used to record and report the coverage. Dewormed pregnant women and adolescent females will be recorded by the health facilities they consulted. Routine reports by each health facility must incorporate the coverage of deworming of these population groups. Reports from the schools, day care centers and health facilities must be submitted to the PHO-IHCP Coordinator.

c. Research. Local partners, stakeholders and the academe are encouraged to undertake their own researches applicable to their areas. Follow-up survey (prevalence and KAP) to evaluate impact of mass treatment after the 4th dose of deworming or after 2 years of mass treatment must be done.

d. Surveillance. Sentinel sites in different areas patterned after the LF should be set-up in strategic areas to track the yearly progress of mass deworming. This would guide implementers in prioritizing strategic actions to improve coverage of mass deworming and WASH package.

VII. IMPLEMENTATION MECHANISMS

The following clarifies the roles and functions of the different stakeholders in STH prevention and control. Organizational structures proposed to manage and implement the program at various levels of operations are also presented.

A. Establishment of Organizational Structure

Organizational structure shall be established at various levels of operations to ensure the effective and efficient implementation of the IHCP. At present, the IHCP at the national level is placed directly under the Infectious Disease Office of the National Center for Disease Prevention and Control (NCDPC) and under the Health Operations Cluster at the regional level. An overall IHCP Coordinator must be designated at the national level and similarly in the regions and provinces.

In view of the multi-faceted issues concerning STH prevention and control, a Technical Working Group (TWG) will be established at all levels to include representatives from concerned DOH offices and other national government agencies, international donor community and civil society.

Functions of the TWG shall include: (i) to review and recommend STH prevention and control policies, (ii) ensure technical soundness of IHCP intervention measures, (iii) coordinate the allocation of resources to avoid overlap and redundancy of inputs, and (iv) advocate and promote IHCP initiatives. Each representative to the TWG shall be responsible in endorsing program policies and directions within their organization and implement the program based on said directives and issuances.

The proposed organizational structure to be established at each level of operations is shown in Annex 1.

B. Roles and Responsibilities

1. Department of Health

a. The Policy and Standards Development and Technical Assistance Teams for Service Delivery, specifically the National Center for Disease Prevention and Control through the Infectious Disease Office shall be responsible for:
• Update policies and guidelines on the implementation of the mass treatment program;
• Orient regional/provincial IHCP coordinators on program, policies and guidelines;
• Provide proficiency training to medical technologists/microscopists on laboratory diagnosis of helminthes and other parasites;
• Assists in the procurement of deworming drugs for mass treatment through UNICEF/WHO or PTIC;
• Advocate among LGUs to allocate funds to augment supply of deworming drugs for mass treatment;
• Develop prototype IEC materials on STH; and
• Monitor and evaluate the mass treatment program.

b. The Field Implementation and Coordination Teams headed by the USEC/ASEC shall provide overall coordination and technical support on the implementation of this program at the regional level.

c. The Center for Health Development/Hospital shall be responsible for the following:

• Provision of budgetary allocation for the procurement of deworming drugs for mass treatment;
• Conduct orientation of provincial/municipal health workers on mass treatment implementation guidelines;
• Coordination with the LGUs/RHUs on mass treatment implementation;
• Advocate among LGUs to allocate funds to augment supply of deworming drugs for mass treatment;
• Reproduce prototype IEC materials for distribution to LGUs; and
• Monitor implementation of mass treatment programs and submit accomplishment reports to Central Office.

2. Local Government Units (LGUS)

a. Local Officials
• Allocate budget for the procurement of deworming drugs for mass treatment;
• Coordinate with other concerned institutions (e.g. schools, NGOs, church, academe, etc.) to support implementation of mass deworming; and
• Provide support for advocacy, orientation of health workers on mass treatment implementation, transport and other logistics support.

b. Provincial/City Health Office

• Coordinate with the LGUs and RHUs/health centers on mass treatment implementation;
• Advocate among LGUs to allocate funds to augment supply of deworming drugs for mass treatment; and
• Record and submit accomplishment reports to the CHDs.

c. Rural Health Units/Health Centers

• Complete master lists of targeted population for mass deworming;
• Implement the mass deworming program; and
• Record and submit the accomplishment reports using the attached forms (Annex 3 – IHCP Recording and Reporting Forms) to the PHO.

The role and responsibility of other stakeholders is shown in Annex 2.
VIII. REPEALING CLAUSE


IX. EFFECTIVITY

This Order takes effect immediately upon approval.

FRANCISCO T. DUQUE III, MD, MSc.
Secretary of Health
Annex 1

Figure 1: Composition of TWG At the National Level

Chair
Director of NCDPC - DOH

Co-Chair
Division Chief of MCH - DOH

DOH

IDO, MCH, EOHQ, NCHP

Other National Agencies

Civil Society

CWC, FNRI, RITM, DepEd, DSWD,

UP-CPH, UP-NIH, Save the Children, Plan International

WHO, FTCI, UNICEF

Figure 2: Regional IHCP Organizational Structure

Technical Working Group
(DepEd, DILG, DSWD, NGOs, private organizations, other concerned agencies)

CHD Regional Director

Regional IHCP Coordinator

DOH Reps

Province 1

Provincial IHCP Coordinators

Province 2

Province 3

Province 4

Figure 3: Local IHCP Organizational Structure

Technical Working Group
(PHO, schools, NGOs, private organizations, etc.)

Provincial Governor

Municipal Mayor

RHU MSWD

DOH Reps

Family Community
## Annex 2
### Roles and Responsibilities of Stakeholders on STH Prevention and Control

<table>
<thead>
<tr>
<th>Stakeholders (e.g. Civil Society, TWG, Phil Health, DOH)</th>
<th>Governance</th>
<th>Service Delivery</th>
<th>Financing</th>
<th>Regulation</th>
</tr>
</thead>
</table>
| **DOH**  
- overall program policy and direction  
- training program development and conduct of TOT  
- local legislation/ordinances  
- securing budget for IHCP  
- designation of staff and personnel to carry out the program  
- procurement and distribution of deworming drugs  
- coordination with other sectors  
- installation of the surveillance system  |  
- provide technical assistance  
- monitoring and evaluation  
- development of health education/promo materials  
- conduct research  |  
- subsidize logistic for indigent and population at risk (rationalized augmentation)  
- resource mobilization  
- explore health financing schemes in support to STH prevention and control  
- efficient implementation of IHCP  |  
- review of laws, standards and policies  
- issuances of implementing rules and guidelines  
- monitor compliance to national laws and policies relative to STH prevention and control  |
| **Government National Agencies (e.g. DOH, DSWD, DSWD, DSWD, etc.)**  
- participation in TWG  
- dissemination of program policies and guidelines  |  
- health education and promotion  
- participation in research and surveillance  |  
- logistic support for target population  
- resource mobilization  |  
- monitoring and evaluation  |
| **International Organizations (e.g. WHO, UNICEF, CI, SHN, PI, etc.)**  
- participation in TWG  
- international standards and guidelines  |  
- technical assistance  
- conduct of mass deworming  
- installation of WASH facilities  
- behavior changing activities  |  
- logistics support (deworming drugs, mobilizing cheaper quality materials)  
- assist in procuring cheaper quality materials  |  
- monitoring and evaluation  |
| **NGO Partners**  
- participation in TWG  |  
- conduct of mass deworming  
- installation of WASH facilities  
- behavior changing activities  |  
- logistics support  
- reproduction of IEC materials  |  
- monitoring and evaluation  |
| **Academic Institutions (e.g. UPCPH, UP, etc.)**  
- participation in TWG  |  
- research and surveillance  
- capacity building  |  
- logistic support  
- resource mobilization  
- implement users' fees or enhance drug revolving fund  
- encourage market segmentation  
- enrolment of indigents to PhilHealth  
- meet/comply PhilHealth accreditation requirements  |  
- monitoring and evaluation  |
| **Local Government**  
- local legislation/resolutions  
- secure budget allocation for deworming and WASH  
- multi-sectoral collaboration  
- deployment of staff for IHCP implementation  |  
- procurement and distribution of deworming drugs  
- undertake deworming  
- information giving and counseling  
- building staff capability  
- implement/maintain surveillance system  
- recording and reporting  
- installation of WASH facilities (e.g. toilet, water, etc.)  |  
- logistic support  
- resource mobilization  
- implement users' fees or enhance drug revolving fund  
- encourage market segmentation  
- enrolment of indigents to PhilHealth  
- meet/comply PhilHealth accreditation requirements  |  
- monitoring compliance to WASH and deworming policies and guidelines  
- mobilizing concerned units of the local government to implement sanctions, warning, etc  |
**Annex 3: IHCP Recording and Reporting Forms**

**FORM 1: MASS TARGETED DEWORMING ACCOMPLISHMENT REPORT**

**INTEGRATED HELMINTH CONTROL PROGRAM**

For the Period: ________

**Instruction:** To be filled in by the Midwife/Barangay Health Worker, School Teacher or Day Care Worker every 6 hs.

<table>
<thead>
<tr>
<th>Service Outlet:</th>
<th>RHU/Health Center:</th>
<th>School:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Province: _______</td>
<td>Municipality: _______</td>
<td></td>
</tr>
<tr>
<td>of Deworming: _______</td>
<td>Prepared by: _______</td>
<td></td>
</tr>
</tbody>
</table>

For Children Dewormed in the BHS, RHUs, Health Centers or Private/NGO Clinics (to be filled in by the MW/BHW or other health staff)

<table>
<thead>
<tr>
<th>Children</th>
<th>Total No. of Targeted Children</th>
<th>Total Number of Children Dewormed</th>
<th>% of Targeted Children Dewormed</th>
</tr>
</thead>
<tbody>
<tr>
<td>1-5 years old</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>6-12 years old</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
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<td></td>
</tr>
</tbody>
</table>

For Children Dewormed in the Day Care Centers (To be filled in by the Day Care Workers)

<table>
<thead>
<tr>
<th>Children</th>
<th>Total No. of Targeted Children</th>
<th>Total Number of Children Dewormed</th>
<th>% of Targeted Children Dewormed</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tbody>
</table>

For Children Dewormed in Schools (To be filled in by the School Teachers)

<table>
<thead>
<tr>
<th>School Grade</th>
<th>Total No. of Targeted Children</th>
<th>Total No. of Children Dewormed</th>
<th>% of Targeted Children Dewormed</th>
</tr>
</thead>
<tbody>
<tr>
<td>e 1</td>
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<td>e 2</td>
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<td>e 5</td>
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<tr>
<td>e 6</td>
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</tbody>
</table>
INTEGRATED HELMINTH CONTROL PROGRAM
FORM 2: ADVERSE EFFECTS REPORTING FORM

For the Period: ____________________

Instructions: To be filled in by the Physician/Midwife/Barangay Health Worker, School Nurse every 6 months

<table>
<thead>
<tr>
<th>Province:</th>
<th>Municipality:</th>
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</table>

<table>
<thead>
<tr>
<th>Service outlet:</th>
<th>RHU/Health Center:</th>
</tr>
</thead>
<tbody>
<tr>
<td>School:</td>
<td></td>
</tr>
<tr>
<td>Of Deworming:</td>
<td>Prepared by:</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Name of Patient</th>
<th>Age</th>
<th>Complete Address</th>
<th>Chief Complaint and Date of Onset</th>
<th>Action Taken</th>
</tr>
</thead>
<tbody>
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</table>
INTEGRATED HELMINTH CONTROL PROGRAM
FORM 3: ANNUAL SELECTIVE DEWORMING ACCOMPLISHMENT REPORT

For the Period: ____________________

Instructions: To be filled in by the midwife/nurse in the BHS/RHU/health center/NGO or private clinic

Province: ________________  Municipality: ________________

Service Outlet: ________________  RHU/Health Center: ________________

<table>
<thead>
<tr>
<th>Population Group</th>
<th>Total No. of Targeted Population</th>
<th>No. Dewormed</th>
<th>% Dewormed of Total Targets</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pregnant Women</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Adolescent Females</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Food handlers</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Soldiers</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Indigenous People</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>settlers (specify)</td>
<td></td>
<td></td>
<td></td>
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</tbody>
</table>