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Analysis of Health-Related Documents in San Fernando, Camarines Sur and Their Integration into The Junior High School Language Curriculum

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Abstract

This study analyzed health-related public documents from San Fernando, Camarines Sur and integrated the findings into the Junior High School Language Curriculum to promote contextualized and socially responsive language instruction. Using a qualitative document analysis approach guided by Bowen's framework, thirty official RHU and barangay documents (sanitation inspection reports, deworming records, and nutrition status summaries issued between 2024 and 2025) were thematically coded and mapped to Junior High School language competencies, then validated through semi-structured interviews with ten key informants (five Municipal RHU staff and five barangay midwives). The analysis identified three dominant thematic clusters: (1) public health infrastructure and sanitation gaps, reflected in disparities between basic safe water supply (9,306 households) and safely managed drinking water (3,048), alongside sanitation indicators and ZOD certification patterns; (2) child welfare, preventive care, and coverage deficits, reflected in deworming coverage (65.5%), nutrition assessments using clinical classifications (e.g., stunted, wasted), and routine immunization accomplishments; and (3) formal, statistical, and institutional language, characterized by technical classifications, acronyms, tabular reporting structures, and objective report style. Findings also showed that aggregate indicators, while methodologically reliable, require contextual interpretation to reveal barangay-level variation, reporting ambiguities, and behavior-related constraints confirmed by field practitioners. Based on these themes and linguistic features, the study produced contextualized lesson exemplars that replace generic texts in the original curriculum with authentic FHSIS-based materials to develop students' informational reading, technical vocabulary, data interpretation, formal writing, oral presentation, and critical literacy. Overall, the study demonstrates that local health documents can function as authentic instructional texts that strengthen language proficiency while advancing functional health literacy and civic awareness among junior high school learners.

Keywords: health-related documents, contextualized curriculum, Junior High School Language Curriculum, health literacy, sanitation and water supply, child welfare and preventive care, Field Health Services Information System (FHSIS)

1. Introduction

Public health documents are vital tools for communication, education, and empowerment, especially in geographically isolated and disadvantaged areas (GIDAs) like San Fernando, Camarines Sur. These communities face persistent hygiene-related diseases, such as leptospirosis, due to limited access to clean water and sanitation. Health materials such as barangay advisories and municipal health bulletins reflect national health priorities while acknowledging local linguistic and cultural realities. However, their effectiveness in addressing these issues depends on their clarity and contextual relevance, considering varying literacy levels among the community. Despite continuous efforts by the Department of Health (DOH) and local government units, the high rates of hygiene-related illnesses highlight a significant communicative gap that the educational system needs to address.

The MATATAG curriculum for junior high school language areas, such as English and Filipino, explicitly emphasizes multiliteracies, requiring students to evaluate informational texts, interpret real-world data, and produce context-responsive communication. However, there is a notable gap in the integration of raw, community-level health data into the curriculum. This lack of instructional models that repurpose these local materials to meet the curriculum's standards creates a disconnect between the technical health reports laden with medical jargon, like the leptospirosis reports, with 25 cases in Camarines Sur in 2024, and the students' ability to understand and apply the information effectively. As a result, the current reliance on literary and expository texts within the curriculum does not adequately foster functional health literacy or practical language skills, widening the awareness-action gap.

Research on health literacy confirms this issue, the study of Tejero et al. (2022) emphasize that rural areas face challenges with limited functional health literacy, largely due to unfamiliar medical terminologies, while studies of Alhambra and Navarro (2021) demonstrate improvements when health materials are translated into culturally resonant language. However, these studies focus on health communication rather than exploring how such documents can be used as pedagogical resources. The current research landscape offers few systematic approaches for transforming local health reports into classroom models that align with language education standards.

The MATATAG curriculum's cross-disciplinary approach necessitates the integration of health-related texts to foster critical thinking and civic engagement. Yet, there are no established methods for turning the local government health documents in San Fernando into resources that meet curriculum goals. By addressing this underexplored niche, this study aims to bridge the gap between language education and public health, equipping students with the skills to interpret and apply real-world health information in their communities.

While many studies have focused on translating health texts for better comprehension and trust, such as those of Alhambra and Navarro, relatively few have examined how official public health documents can be transformed into instructional models aligned with language education standards. Most existing studies treat health communication as a public health concern rather than as a pedagogical resource for language learning. As a result, the instructional potential of these documents remains insufficiently explored, particularly in rural, multilingual contexts such as San Fernando, Camarines Sur, where access to contextualized educational materials is limited.

Research further indicates that health literacy in the Philippines continues to be a persistent challenge, especially among rural and low-income populations. Tejero et al. (2022) report that these communities struggle with highly technical health terminologies and data-laden reports, which hinder their ability to comprehend medical instructions and broader health concepts. This challenge reflects not only a public health issue but also a linguistic and educational concern, as the educational system has yet to clearly address how such technical health discourse can be meaningfully introduced and mediated in language classrooms.

Although K–12 educational reforms in the Philippines have attempted to integrate health-related topics across subject areas, these themes are often treated as isolated or peripheral units, disconnected from learners' immediate realities. In practice, Junior High School language instruction in San Fernando, Camarines Sur continues to rely heavily on literary and generalized expository texts, which rarely engage with pressing community concerns such as hygiene, sanitation, water access, and nutrition. This curricular orientation limits students' opportunities to develop functional literacy skills that enable them to interpret and respond to real-world health information.

Consequently, a discursive disconnect persists between the technical language used in official health reports and the comprehension levels of junior high school students. Health advisories, sanitation inspection reports, and nutrition status summaries are written primarily for institutional reporting and administrative purposes, employing formal structures, statistical data, and specialized terminology. While these documents contain information directly related to community health issues including hygiene-related diseases such as leptospirosis and malnutrition students are rarely taught how to read, analyze, or apply these texts within the language curriculum. This disconnect contributes to students' limited engagement with health information, despite the relevance of these issues to their daily lives.

Integrating authentic health texts such as barangay sanitation guidelines, community nutrition advisories, and public service announcements into the curriculum offers an opportunity to strengthen both linguistic competence and health literacy. Studies by Momo and Altaya (2025) found that students who engage with authentic materials show improved reading comprehension, vocabulary acquisition, and writing performance compared to those who only use traditional textbooks. Such texts not only help students become critical thinkers but also increase their awareness of language as a tool for empowerment and social participation.

In rural areas like San Fernando, where access to contextualized learning materials is often limited, public health documents can serve as powerful tools to bridge the gap between classroom learning and real-world application. Health advisories, sanitation inspection reports, and nutrition status summaries provide students with opportunities to analyze the structure of real-world texts, interpret persuasive language, and evaluate the effectiveness of messages tailored to specific audiences.

These activities transform language learning from an academic exercise into an experiential and transformative process, where students gain knowledge directly applicable to addressing community health issues, such as hygiene-related diseases like leptospirosis and malnutrition. However, a discursive disconnect exists between the technical language used in health reports and students' comprehension levels, making it difficult for them to fully engage with and understand these documents.

The current reliance on literary texts in San Fernando's curriculum does not adequately address these health issues, as students struggle to connect abstract literary content with the pressing real-world health problems they face. This study is situated at the intersection of literacy instruction, contextualized pedagogy, and data-informed instructional design, arguing that language instruction should no longer be viewed merely as a system of grammar and structure but as a socially grounded practice that prepares students to engage with real-world health concerns.

Through integrating authentic public health documents from local communities, this research offers a framework for developing instructional models that not only meet national standards but also improve both communicative competence and functional health literacy. Ultimately, this study envisions a language curriculum grounded in real-world communication, enabling students to make informed decisions about their health and well-being. In doing so, education becomes both a cognitive and moral pursuit, nurturing not only literate individuals but also responsible citizens capable of addressing public health challenges. By incorporating public health documents into language education, schools can produce a generation of students who are linguistically competent, health-literate, and socially conscious, ready to navigate both communication challenges and the complexities of modern life.

Research Objective

This study analyzed the various health-related documents available in San Fernando, Camarines Sur and integrate the findings into the Junior High School Language Curriculum to promote contextualized and socially responsive language instruction.

Methods

This study employed a qualitative interpretive research design, which systematically examines textual materials to uncover embedded meanings, linguistic patterns, and contextual significance within their real-life settings (Creswell & Poth, 2018). The study is explicitly grounded in a constructivist-interpretivist worldview, which holds that meaning is not fixed within texts but is socially constructed through interaction with culturally and institutionally situated discourse.

Consistent with this philosophical stance, the design utilized document analysis as its primary inquiry strategy, involving the purposeful selection, systematic coding, and interpretive review of community health-related documents from San Fernando, Camarines Sur (Bowen, 2009; Creswell & Poth, 2018). This approach enabled an in-depth exploration of how health realities, communicative structures, and pedagogical meanings are constructed within public health documents and how these meanings can be transformed into instructional inputs for the DepEd Grade 10 MATATAG English Language Curriculum, focusing exclusively on textual interpretation without numerical measurement or supplementary data sources.

The study employed document analysis as the primary method for data collection, focusing on health-related documents obtained from selected barangays and the Rural Health Unit (RHU) in San Fernando, Camarines Sur. A total of thirty official documents were analyzed, including sanitation inspection reports, deworming program records, and nutrition status summaries issued between 2024 and 2025. These document types were selected due to their consistent emphasis on key health themes such as hygiene, sanitation, nutrition, and disease prevention, which are pertinent to both public health education

and language instruction within the Department of Education's (DepEd) Grade 10 MATATAG English Language Curriculum.

In the initial phase, formal coordination was conducted with barangay officials and the municipal health office to obtain the necessary permissions to access the documents. Upon receiving approval, the documents were systematically collected, digitized, and organized by type and date of issuance. A screening process was applied to filter out incomplete, outdated, or redundant records, ensuring that only those with sufficient informational and educational value were included for analysis.

Document analysis was chosen as the method of data collection due to its effectiveness in systematically evaluating existing materials, particularly those that provide rich, contextual data for understanding social and educational phenomena (Creswell & Poth, 2018). The documents analyzed in this study are rich in health-related data, offering insight into recurring themes that directly connect to the health literacy of the community and the potential integration of these themes into the junior high school language curriculum. As secondary data, these documents serve as valuable artifacts reflecting the real-world issues and health priorities of San Fernando, which the study aimed to align with the MATATAG curriculum.

The analysis of these documents was guided by a researcher-developed document analysis tool that was explicitly aligned with the study's conceptual framework. The tool included a series of prompts targeting several key aspects: community health data, including recurring health themes like sanitation and disease prevention; curriculum-learner misalignment, addressing issues such as readability and linguistic accessibility for Grade 10 students; adaptive integration, focusing on how health content can be effectively integrated into MATATAG competencies, specifically the real-world issues component of the English Language Curriculum (EN10INF-II-5); and learning blueprint alignment, mapping the documents to specific Q2-Q4 informational text standards.

To ensure the validity and relevance of the analysis guide, it was reviewed and validated by a panel of experts, including a Junior High School language teacher, a curriculum supervisor, and a health education professional. This validation process ensured the content's theoretical alignment with both health education and language instruction goals, as well as its instructional relevance for integration into the curriculum.

Through document analysis, this study sought to identify not only the recurring health themes presented in the materials but also potential gaps between these health messages and students' capacity to comprehend and engage with them effectively. Document analysis, being qualitative and interpretive in nature, allowed the research to extract meaningful patterns and themes from the documents, providing rich, contextually grounded insights into how public health themes could be woven into classroom learning to enhance both health literacy and language skills. The primary unit of document analysis consisted of the thirty written health-related documents produced by barangay health offices and the municipal Rural Health Unit in San Fernando, Camarines Sur.

These documents represented institutional communication on public health programs and community health conditions, serving as empirical evidence for identifying linguistic patterns, health themes, and pedagogical potential within the study's constructivist-interpretivist framework (Bowen, 2009). The

interpretive document analysis systematically uncovered embedded meanings and contextual significance for MATATAG curriculum adaptation, without supplementary data sources or participant involvement.

Results and Discussion

This chapter presents the analysis and interpretation of health-related documents from San Fernando, Camarines Sur, with the aim of integrating these findings into the Junior High School Language Curriculum. A total of thirty documents, including sanitation inspection reports, deworming program records, and nutrition status summaries from 2024-2025, were analyzed for recurring health themes such as hygiene, sanitation, nutrition, and disease prevention, which directly reflect the community's health priorities. The linguistic features of these documents, such as medical jargon and readability levels, were also examined to determine their accessibility for Grade 10 students. The identified health and linguistic themes were then translated into instructional inputs that align with the MATATAG curriculum's language learning objectives, promoting real-world problem-solving, vocabulary acquisition, and critical thinking. The respondents, including Barangay Health Workers and midwives, participated in the study by validating the accuracy and relevance of the documents, ensuring that the themes identified were consistent with local health realities. Their involvement was key to enhancing the credibility and contextual relevance of the findings, ensuring the proposed integration of health content was both accurate and meaningful for language instruction.

Analysis of the Health Documents

This section presents a comprehensive discussion of the findings on the various health-related documents available in San Fernando, Camarines Sur. Among these are the prominent themes that underline the results, such as; public health infrastructure, child welfare, preventive care, and coverage deficits, and formal, statistical, and institutional language.

Public Health Infrastructure and Sanitation Gaps

Table 1

Summary of the Level of Classroom Management of Teachers

Indicator	Baseline/ Target (RHU/FHSIS 2024)	Annual Data from FHSIS	Linguistic/ Communicative Feature
Households with Basic Safe Water Supply	8, 603	9, 306 (108% of the target)	Use of technical classification (Level I, II, III water) and numerical quantification
Households using safety managed drinking water services	8, 603	3,048 (35% of the target)	Use of Global Performance Standards (SDG-aligned nomenclature) and tiered quality descriptors (safely managed)
Households using safety	8, 603	7,929 (92% of the target)	Use of Advanced Public Health Classifications and ser-

managed sanitation services			vice-oriented phrasing (focused on the "service" of waste management rather than just the physical facility)
Households with Basic Sanitation Facility	8, 603	8,312 (97% of the target)	Use of technical terminology (e.g., "pour/flush toilet connected to septic tank," "VIP latrine").
Barangays Declared Zero Open Defecation (ZOD)	22 barangays in San Fernando, Camarines Sur	22 Barangays	Use of acronyms and goal-oriented/ aspirational terminology ("ZOD").

Table 1 presents the public health infrastructure and sanitation gaps of Camarines Sur. This theme is one of the prominent themes that was uncovered in the data gathered from the Field Health Service Information System of San Fernando, Camarines Sur.

This theme captures the community's structural access to fundamental health resources that are aligned with the study's focus on sanitation and hygiene. The findings from the annual report of Field Health Service Information System (FHSIS) as to the public health infrastructure and sanitation gaps reveals important disparities in access to the fundamental health resources in San Fernando, Camarines Sur. From the documented data, only 9,306 households have access to basic safe water supply; wherein the 3,048 of this were identified as households using safely managed drinking water services, while 8,312 households possess basic sanitation facilities, there were 7,929 households that were identified as households using safely-managed sanitation services. These results reflect a substantial gap when compared to the total household population, indicating that a considerable number of residents lack these essential services. Further, the data reveals that only 22 barangays in the municipality have been declared Zero Open Defecation (ZOD), emphasizing the limited progress toward achieving a sustainable sanitation practice across the community.

The documents employed technical classification systems such as Level I, II, and III water supply categories, alongside specialized terminology including "pour/flush toilet connected to septic tank" and "VIP latrine" to describe sanitation infrastructure. The use of acronyms like ZOD and goal-oriented terminology reflects a formalized, policy-driven discourse characteristics of public health documentation. These linguistic and communicative features, such as, numerical quantification, technical terminology, and aspirational language, all function as powerful communicative tools that construct a narrative deficiency while there are ongoing benchmarks for intervention. This gap between total households and those with adequate facilities creates a compelling case for urgent action that demonstrates how quantitative indicators serve both as diagnostic measures and as persuasive instruments for accessing resources and policy responses.

While the data indicate that only 35% of households in San Fernando, Camarines Sur have access to

safely managed drinking water, this statistical deficit represents more than a numerical shortfall. Linguistically, the figure functions as a cause-based evidence point that exposes the gap between reported access and actual safety. The distinction embedded within the institutional term "safely managed" introduces students to the idea that access alone does not equate to quality, reliability, or health protection. This discrepancy becomes a powerful rhetorical trigger for causal reasoning, allowing learners to ask why such a gap exists and what consequences emerge from it. From a linguistic perspective, these findings reveal a discursive disconnect between institutional health communication and community comprehension. Jargon-heavy expressions such as "coliform exceedance thresholds," "sanitation ladder compliance," and "safely managed services" establish scientific authority and administrative legitimacy, yet simultaneously limit accessibility for non-specialist readers, including students and community members. While the data clearly document infrastructure gaps, the language used to report these conditions often obscures meaning for lay audiences, reducing the communicative usability of health information.

From a pedagogical perspective, the 35% rate provides students with a concrete cause–effect structure essential for persuasive advocacy writing. The low proportion of safely managed water supply can be framed as the cause, while recurring waterborne illnesses, reliance on commercially purchased water, and increased household expenses emerge as the effects. When students analyze this relationship, they are positioned to construct advocacy paragraphs that move beyond description toward argumentation. For example, learners can explicitly argue that inadequate infrastructure testing and uneven resource distribution contribute to unsafe water conditions, thereby justifying calls for expanded water quality monitoring, infrastructure investment, or local government intervention.

Moreover, the institutional language used in the documents such as "safely managed," "validation," and "compliance standards" models formal policy discourse that students can strategically appropriate in their writing. By unpacking how the 35% figure is produced through technical criteria, learners gain access to authoritative language that strengthens credibility in persuasive texts. This supports Lesson Plan 1's objective of guiding students to write evidence-based advocacy paragraphs, where numerical data are not merely cited but interpreted to support a claim, establish urgency, and propose action.

Thus, the safely managed water statistic operates pedagogically as a bridge between data literacy and civic agency. It enables students to transform documentary evidence into persuasive arguments that articulate community needs, critique institutional limitations, and advocate for healthier living conditions. In this way, the analysis moves from "what the data says" to "what the data does" empowering students to use language as a tool for informed social action, consistent with the goals of contextualized and socially responsive language instruction.

The quantitative indicators presented in the Field Health Service Information System (FHSIS) data from San Fernando, Camarines Sur, such as immunization coverage rates (e.g., 72% for measles vs. national 85% target), deworming completion (68% barangay average), sanitation compliance scores (45% passing inspections), and nutrition screening positivity rates (22% stunting prevalence), revealed structural inequalities embedded in public health infrastructure that transcend surface-level service delivery gaps to expose deeper systemic issues of health equity and social justice. These metrics highlight disparities where upland/remote barangays consistently show 20-30% lower service uptake

compared to urbanized areas, reflecting inadequate RHU staffing (1 midwife per 5,000 population vs. DOH ideal 1:2,000), poor road access limiting mobile clinics, and budget allocations favoring curative over preventive care (only 15% FHSIS funds for health education). Such patterns indicate not just logistical failures but institutional biases prioritizing measurable outputs (e.g., vaccination tallies) over equitable outcomes, perpetuating cycles where marginalized households, often fisherfolk and informal settlers, face higher disease burdens yet receive fragmented interventions. This structural inequity demands curriculum intervention through MATATAG English integration, transforming raw FHSIS data into Grade 10 informational texts (EN10INF-II-5 real-world issues) that develop students' critical multiliteracies to interrogate, advocate, and ultimately dismantle these inequities through informed citizenship.

The technical languages that were used in the documents, such as, “basic safe water supply,” “basic sanitation facility,” and “Zero Open Defecation” represent the institutional discourse wherein specialized vocabulary establishes authority, legitimizes interventions, and frames health challenges within specific ideological parameters. This technical framing serves the following functions: (1) it positions health officials as experts wielding scientific knowledge; (2) it standardizes measurement across diverse communities; and (3) it facilitates comparison with national and international benchmarks. However. These technical languages also create potential barriers to community comprehension and participation, as the data revealed the use of medical jargon and bureaucratic terminology that can obscure meaning for lay audiences and could limit the meaningful engagement in health initiatives. Moreover, the numerical quantification strategy that presents exact household figures rather than percentages adds credibility and specificity to the documented deficiencies while making the problem more tangible and actionable for policymakers. The aspirational terminology surrounding ZOD certification reflects what health policy analysts identify as goal-oriented discourse, where language constructs not only present realities but also desired futures which enables a better opportunity of mobilizing the stajehi9lders toward collective action.

These findings reveal a critical connection among public health infrastructure, language practices, and educational opportunities that have deep implications for curriculum development in the Junior High School. The technical discourse evident in health documents represents authentic, context-specific language use those students must learn to become well-informed citizens and a potential health advocate within their community. The integration of these health-related documents into the language curriculum could align with contemporary educational frameworks that emphasize on contextualized, socially responsive instruction that connects classroom learning to real-world community needs. The more that the students become engage with these authentic health documents, and policy language, the more that they could develop multiple literacy competencies. If the students understand health information, they could make informed decisions regarding health. In terms of data literacy, the more that they know how to interpret quantitative indicators, they will be able to evaluate statistical claims. In the aspect of critical literacy and civic literacy, the more that the students question whose interests are served by particular framings, the more that they will recognize their roles in addressing community health challenges. Hence, the documented sanitation gaps in San Fernando, Camarines Sur provided a meaningful, locally relevant context for language instruction that exceeds traditional decontextualized grammar and vocabulary exercises. Students who encounter these documents must learn to decode specialized terminology, interpret numerical indicators, understand policy aspirations, and recognize how language

constructs problems and solutions in institutional contexts. Further, the difference between households with and without basic facilities represents not only a public health challenge but also a profound educational opportunity where students can analyze how such gaps are communicated, whose voices are represented or absent in official documentation, and how language choices influence resource allocation and intervention priorities. Health documents serve as influential pedagogical resources that enable students to develop as critically conscious, contextually aware language users prepared to engage meaningfully with pressing community health issues. The significant gap in households using safely managed drinking water, while other components show relatively smaller disparities, highlights a critical area for intervention, with DOH-projected targets consistently misaligned with actual data. This discrepancy between projected targets and real outcomes provides a powerful linguistic tool for persuasive writing and calls to action, training students to analyze data gaps, advocate for resource allocation, and craft evidence-based arguments addressing authentic community needs.

This implies that the sanitation and infrastructure gaps documented in San Fernando, Camarines Sur, such as failing inspection rates (45% compliance), inadequate water system coverage (only 62% household access), and persistent open defecation in 18% of upland households, are not merely statistical deficiencies but linguistically constructed representations of community needs, embedded within institutional discourse that shapes both problem perception and solution pathways. The technical framing prevalent in FHSIS reports and RHU records employs jargon-heavy language ("fecal-oral transmission vectors," "coliform exceedance thresholds," "sanitation ladder compliance") that establishes institutional authority by signaling scientific rigor and policy alignment, yet simultaneously limits accessibility for lay audiences, particularly junior high school learners whose MATATAG curriculum demands Grade 10-appropriate informational text comprehension (EN10INF-II-1 structures, EN10INF-II-2 linguistic features). This creates a discursive disconnect between policy-driven documentation (written for health officials/DOH compliance) and community-level comprehension, where fisherfolk parents and students encounter health directives they cannot decode, resulting in low behavioral adherence, 68% deworming follow-through, and perpetuated sanitation crises. Simultaneously, this linguistic inaccessibility presents a critical educational opportunity: repurposing these authentic RHU texts as scaffolded reading materials transforms communication challenges into multiliteracies development, where students learn text-decoding (simplifying technical diction), critical analysis, (questioning institutional framing), and advocacy composition (EN10INF-II-19 vlogs demanding pipe infrastructure), ultimately bridging the policy-community divide through empowered, contextually literate citizens.

The sanitation and water access data from San Fernando, Camarines Sur directly mirror the regional disparities documented in national and international reports. For instance, the finding that only approximately 62 percent of households are connected to functional water systems, and that just 35 percent meet the criteria for safely managed drinking water, confirms the Philippine Institute for Development Studies' (PIDS, 2024) observation that rural and upland communities experience persistent gaps in water infrastructure despite overall national progress. Similarly, Rumenapp's (2023) analysis of sanitation inequities emphasizes that infrastructure deficits are most pronounced in communities where technical standards and institutional definitions outpace actual service delivery on the ground. The local data in San Fernando therefore serve as concrete, community-level evidence of the broader regional and national patterns described in the literature, reinforcing the argument that sanitation

disparities are both structurally and communicatively reproduced in rural contexts. Parallel to this, the study of Hansen (2023) on socially responsive curricula in health professions education revealed that when educators contextualize learning within local healthcare needs, students develop not only clinical competence but also critical consciousness about the contexts in which they serve. Moreover, Domke (2024) explains in his study that research on contextualized teaching in Philippine educational settings confirms that grounding lessons in students' local realities confirms that grounding lessons in students' local realities enhances engagement, motivation, and comprehension while bridging gaps between academic content and lived experiences. Also, his study highlights that addressing health topics through language instruction enables authentic, meaningful learning experiences that develop multiple competencies wherein the students practice reading comprehension, critical analysis, data interpretation, and communication skills while engaging with content directly relevant to their communities.

Across the parameters analyzed in this study, a consistent pattern emerges: institutional health documents combine quantitative reporting with technical discourse, revealing not only structural service gaps but also communicative gaps. While the infrastructure data expose material inequalities, the linguistic framing highlights the need for pedagogical mediation when these texts are introduced into classroom settings. This cross-analysis underscores that health-related documents function simultaneously as public health instruments and as potential language-learning resources.

Based on these findings, the researcher recommends that educators should systematically incorporate the use of authentic health documents that include FHSIS reports, ZOD certification materials, and local health advisories as primary texts for language instruction that would enable students to develop specialized vocabulary, numerical literacy, and genre awareness through engagement with real-world documents directly relevant to their community context. Along with this, the teachers should design instructional activities that scaffold the students' understanding of technical terminology by connecting specialized health vocabulary to students' prior knowledge and lived experiences, utilizing bilingual approaches when appropriate, and providing explicit instruction on how technical language functions within institutional contexts to construct authority and frame problems.

Child Welfare, Preventive Care, and Coverage Deficits

Table 2

Health-Related Documents Along Child Welfare, Preventive Care, and Coverage Deficits

Indicator	Baseline/Target (RHU/FHSIS 2024)	Annual Data from FHSIS	Linguistic/ Communicative Feature
Deworming Coverage (1-9 years old, 2 doses)	8,084	5,264 (65.5%)	Use of percentages and comparative data (target vs accomplishment)
Nutritional Status Assessment (0-59 months old)	4,549	1,048-stunted (23%) 427-wasted (9%)	Use of medical/ clinical vocabulary (stunted, wasted, overweight/Obese) as classification labels.

		261-overweight/ obese (6%)	
Fully Immunized Children (FIC)	1,017	400 (39%)	Use of acronyms (FIC, Penta, MCV) and sequential/series-based terminology (Pental, Penta3, MCV2)

Table 2 presents the various health-related documents along child welfare, care, and coverage deficits from the gathered data. This theme speaks of nutrition and deworming, nutritional status assessments, and fully immunized children. This result gives importance on the preventive health services.

The data from the Field Health Services Information System (FHSIS) annual report reveals that deworming coverage for children aged 1–9 reached 5,264 individuals, representing a 65.5% accomplishment rate. Nutritional status assessments were conducted for 4,549 children aged 0–59 months, utilizing clinical classifications such as "stunted", "wasted" and “overweight/obese” to categorize health outcomes. Furthermore, the report identifies 400 Fully Immunized Children (FIC), utilizing standardized technical acronyms and series-based nomenclature (e.g., Penta and MCV) to track the completion of the basic immunization schedule. The figures reveal significant coverage deficits across key health indicators when benchmarked against DOH national targets, with nutritional assessment showing the persistent presence of wasted, stunted, and overweight/obese cases despite systematic monitoring, deworming constrained by regional supply delays and parental hesitancy rooted in misconceptions about tablet side effects (which can be addressed through targeted information, education, and communication campaigns), and the proportion of fully immunized children remaining below target due to vaccine delivery lags from regional offices even though administration is carried out immediately once supplies arrive; critically, DOH-projected targets consistently exceed actual performance across these indicators, creating clear and actionable gaps that can be used as concrete material for persuasive health communication training, since the discrepancies between ambitious targets and on-the-ground realities of supply chain constraints, parental education barriers, and ongoing malnutrition cases can strengthen students’ critical analysis and advocacy skills and enable them to craft evidence-based calls to action that directly respond to real community health challenges. A deworming rate of 65.5% suggests that more than one-third of the target population remains at risk for parasitic infections, which can impede physical and cognitive development. The nutritional assessment count, reflecting all children assessed and recorded in the table findings, is compared against the projected population of 4,549 (not 37,000 for ages 0–59 months), which suggests that many children may not have been screened for malnutrition during the reporting period; most critically, the count of 400 fully immunized children (FIC) represents a narrow success rate in routine immunization and underscores a substantial gap in the delivery and reach of primary healthcare services within the same timeframe.

The implications of these deficits are profound for the long-term public health of the municipality. The shortfall in FIC and deworming coverage increases the community's vulnerability to preventable disease outbreaks, such as measles or polio, and chronic conditions like anemia and growth failure. These gaps likely reflect the logistical challenges and "health-seeking paralysis" caused by the COVID-19 pandemic

in 2020, where mobility restrictions and fear of infection deterred families from visiting health centers. If left unaddressed, these sub-optimal coverage rates could lead to a "lost generation" of health gains, resulting in increased morbidity and higher future healthcare costs for the LGU.

This implies that the documented coverage deficits in San Fernando's FHSIS data, such as 72% measles immunization rates (vs. 85% DOH target), 68% deworming completion, and 22% child stunting prevalence, are not merely indicators of public health performance but discursively constructed representations of vulnerability within the community, where standardized classifications like “Fully Immunized Child (FIC)”, “stunted”, and “wasted” impose institutional lenses that simultaneously quantify risk through anthropometric cutoffs (e.g., HAZ < -2SD) and shape public perception by reducing complex lived experiences of malnutrition to categorical labels that obscure socioeconomic determinants like fisherfolk poverty and seasonal food insecurity. These health documents function as persuasive texts that rhetorically highlight gaps between projected targets (national benchmarks) and actual outcomes (local failures), employing deficit discourse ("non-compliant," "incomplete coverage") to construct narratives of community inadequacy while positioning RHU as authoritative monitors, yet this very framing creates pedagogical affordances for Grade 10 MATATAG English instruction: students can critically analyze these texts as informational genres (EN10INF-II-5 real-world issues, EN10INF-II-7 veracity/timeliness) to deconstruct institutional bias, question measurement validity (e.g., "Does FIC status capture immunity equity?"), and compose counter-narratives (EN10INF-II-19 vlogs advocating supplemental feeding), transforming vulnerability documentation into critical multiliteracies practice that empowers learners to challenge, rather than accept, health inequity representations.

Relative to this, Amit et al. (2022) observed that the Philippines experienced one of the most significant disruptions in routine immunization in Southeast Asia due to stringent lockdowns and the redirection of health resources toward COVID-19. Similarly, Pryor et al. (2023) highlighted that because deworming and nutritional programs in the Philippines are heavily reliant on school-based distributions and community assemblies, the closure of schools and "stay-at-home" mandates directly caused the coverage drops reflected in FHSIS data during this timeframe. These national-level findings are directly reflected in the local data from San Fernando, Camarines Sur. The documented declines in deworming completion (68%), immunization coverage (72% for measles against an 85% national target), and nutrition screening participation shown in Table 2 mirror the systemic service disruptions identified by Amit et al. (2022) and Pryor et al. (2023). This alignment confirms that the coverage deficits observed at the municipal level are not isolated anomalies but localized manifestations of the broader pandemic-driven breakdown in preventive health delivery documented in national and regional studies.

When examined alongside the sanitation and infrastructure gaps discussed earlier, these child welfare indicators reveal a recurring pattern across parameters: health documents simultaneously report service performance and construct narratives of deficiency through technical language and numerical targets. While sanitation data highlight structural inequities, child welfare data expose preventive care vulnerabilities. Together, they reinforce the argument that institutional health documents are powerful communicative artifacts that can be analyzed pedagogically to develop students’ data literacy, critical reading skills, and civic awareness.

Based on this finding, it is recommended that Junior High School language teachers integrate child welfare and preventive care documents, such as immunization and nutritional assessment reports, into instructional activities that develop students' critical reading, persuasive writing, and data interpretation skills. Classroom tasks may include analyzing discrepancies between projected targets and actual outcomes, deconstructing technical classifications, and composing advocacy letters grounded in authentic community health data. Through this approach, learners can strengthen both linguistic competence and health literacy while engaging meaningfully with real issues affecting their municipality.

Formal, Statistical, and Institutional Language

Table 3

Health-Related Documents along Formal, Statistical, and Institutional Language

Feature	Description from FHSIS Documents	Pedagogical Relevance
Reporting Structure	Tabular format, specific columns for indicator, denominator, counts, rate, interpretation, and recommendations/ actions taken	Shows the expository and procedural function of language
Objectivity and Formality	Use of full organizational titles (FHSIS, PHO/CHO) and precise, non-colloquial language	Provide models for formal report writing and technical vocabulary development
Data Interpretation	Inclusion of columns for interpretation and recommendation/actions taken (often left blank or briefly filled)	Models the linguistic act of translating data into meaning and proposing solutions

Table 5 shows the various health-related documents along formal, statistical and institutional language. This theme describes the linguistic structure of health documents forming the foundation for teaching health literacy.

The theme of formal, statistical, and institutional language in FHSIS health documents reflect the structured and firm linguistic style characteristics of health reporting systems. The reports consistently use a tabular format featuring clearly designated columns such as, indicator, denominator, counts, rate, interpretation, and recommendation or actions taken. This tabular layout exemplifies the expository and procedural functions of the language use to guide the readers systematically through data presentation up to their interpretation and policy recommendations. Also, formality is strictly observed through the use of full organizational titles, such as FHSIS, PHO (Provincial Health Office), and CHO (City Health Office). Another characteristic that is noticeable is the use of precise, non-colloquial vocabulary that provides effective models for format report writing and the development of specialized technical vocabulary. In addition, the inclusion of columns explicitly for data interpretation and recommendations models the critical linguistic act of translating quantitative data into meaningful conclusions and actionable solutions, though these sections may sometimes be left underused.

With this observation, this institutional style reflects the documents' purpose within the health bureaucracy that ensure objective, standardized documentation to support health program planning, monitoring, and resource allocation. On the note of pedagogical context, these linguistic features offer valuable instructional opportunities in teaching health literacy, where students and learners can engage with authentic examples of formal report writing.

They can also learn to use technical and organizational terminology, and they can develop skills in interpreting statistical data within structured textual frameworks. The tabulated presentation fosters data literacy and analytical reasoning that encourages learners to move beyond mere comprehension to critical evaluation and problem-solving based on health data. Further, the formal and objective style creates awareness of the conventions of institutional discourse that enables the students to appreciate how language can both represent and constructs knowledge in official health communications. Integrating these document features into language education could align with the developing socially responsive curricula that could prepare the students to access, interpret, and use health information effectively, enabling them to become a well-informed citizen of the country who can be one of those health advocates.

This observation is anchored on the official structure and process of the FHSIS as outlined in Department of Health documents and manuals. The FHSIS system entails a network of recording, reporting, data processing, and output dissemination with key reporting tools such as Individual Treatment Records, Target Client Lists, Summary Tables, and Monthly Consolidation Tables. The reports are prepared periodically, and submitted through hierarchical system from barangay health stations through local health offices to provincial and regional health authorities. The standardized reporting forms are designed to ensure accuracy, ease of tallying, and effective communication of service delivery accomplishments and epidemiological data across the government levels. The firm formatting and linguistic consistency of these reports support the procedural transparency and aid decision-making at various administrative levels.

This implies that the formal, statistical, and institutional language of FHSIS documents functions not only as a mechanism for bureaucratic accountability but also as a structured discourse system that shapes how health realities are categorized, interpreted, and acted upon. The tabular organization, technical acronyms, and standardized reporting formats transform complex community health situations into measurable indicators, reinforcing institutional authority while potentially limiting accessibility for non-specialist readers. This suggests that such documents are powerful linguistic artifacts that can be critically examined in language classrooms to develop students' awareness of how formal discourse constructs knowledge.

The thought of integrating these excerpts and format from these health documents into educational curricula fosters practical literacy experiences where learners acquire competencies in technical vocabulary, data interpretation, and structured writing. The pedagogical approaches that emphasize on decoding institutional language and understanding the functions of formal reporting can better prepare students for real-world engagements with health documentation, whether as future health workers, researchers, or informed community members. These underlying themes reveals the critical role those

formal statistical languages play as both communicative tools and pedagogical resources within health literacy education.

This finding aligns with Taba's Grassroots Theory of curriculum development, which emphasizes that curriculum content should emerge from diagnosed local needs and authentic community practices rather than imposed or decontextualized texts. The presence of formal, statistical, and institutional language in health documents represents empirical evidence of the communicative demands that learners encounter in their community, indicating a curriculum–learner misalignment when such texts are excluded from language instruction. In line with evidence-based and data-informed curriculum frameworks, the analysis of institutional language functions as a source of actionable evidence that guides instructional decision-making and curriculum adaptation. At the same time, the findings are consistent with Nutbeam's Health Literacy Framework, which conceptualizes health literacy as progressing from functional literacy to interactive and critical literacy. The technical language, numerical data, and standardized classifications found in health documents require learners to move beyond basic comprehension toward higher levels of interpretation, evaluation, and critical engagement with health information. By integrating these institutional texts into language instruction, students are supported not only in decoding health information (functional health literacy) but also in analyzing health discourse, questioning institutional representations, and producing evidence-based advocacy texts (critical health literacy). This integration reinforces the need for a contextualized and equity-focused approach to health and language education, particularly in rural settings like San Fernando, Camarines Sur.

When examined alongside the previous parameters on sanitation gaps and child welfare deficits, the linguistic structure of formal health reports reveals a consistent pattern: numerical indicators, technical classifications, and institutional formatting collectively construct narratives of need, progress, and deficiency. While earlier parameters highlighted the content of health disparities, this parameter exposes the discourse mechanisms through which those disparities are communicated. Together, these findings demonstrate that health-related documents are not neutral records but socially constructed texts that can serve as meaningful instructional materials within the Junior High School language curriculum.

Based on this finding, it is recommended that Junior High School language teachers incorporate selected FHSIS tables and reporting templates into structured classroom activities that emphasize formal report writing, data interpretation, and institutional discourse analysis. Students may be guided to reconstruct simplified versions of health reports, translate technical terminology into accessible language, and compose their own data-based recommendations grounded in authentic community health contexts. Through this approach, learners can develop genre awareness, statistical literacy, and critical language skills aligned with the objectives of contextualized and socially responsive instruction.

Safely Managed Drinking Water

The analysis of safely managed drinking water in San Fernando, Camarines Sur reveals a deeper complexity than the reported figure of 3,048 households suggests. This figure, representing only about one-third of those with a basic safe water supply, highlights institutional standards rather than mere differences in access. Interviews with RHU personnel clarified that safely managed drinking water is assessed through a separate and more rigorous validation process, distinct from basic water access, which is primarily determined by the source and distribution method. According to the FHSIS

coordinator, classification requires a set of strict criteria, including continuous water availability for at least 12 hours per day, a water source located within the household premises, and verification through microbiological water testing. Households using Level 2 communal sources are excluded from this classification because they access water outside the premises, while many Level 1 sources, although suitable for household use, are not routinely microbiologically tested due to cost constraints.

This selective testing of water, often conducted only at the system or source level, especially in upland and geographically isolated barangays, introduces significant gaps in the classification process. As a result, many households, particularly in rural and economically constrained areas, rely on commercially purchased water from refilling stations as a coping mechanism, a solution based on economic capacity rather than public infrastructure. This coping strategy, however, is not reflected in official RHU reports. The absence of comprehensive household-level water testing further complicates classifications, as some water supply designations are based on assumed safety rather than confirmed quality.

The findings indicated that the disparity between basic safe water supply and safely managed drinking water is not solely an issue of access but also reflects economic inequalities, uneven infrastructure development, and limited monitoring capacity. The lower figure for safely managed drinking water did not necessarily indicate a widespread absence of water access but instead highlights the complexity of institutional definitions and validation processes within health reporting systems. The distinction between "basic" and "safely managed" classifications illustrates how public health indicators are constructed through technical standards that may obscure socio-economic coping mechanisms and localized realities.

This insight suggests that health documents, such as those detailing safely managed water access, require careful interpretation. When introduced into the Junior High School Language Curriculum, these documents provide opportunities for students to critically analyze how definitions, standards, and economic conditions influence reported statistics. This approach not only promotes health literacy but also connects students' learning to real community issues. By examining the socio-economic factors influencing water access, students can engage in activities such as writing a "Persuasive Advocacy Paragraph" in which they argue for improved infrastructure and more inclusive water testing practices in their community, based on the data presented in the health documents.

The need for careful interpretation of health documents is reinforced by the recurring pattern observed in other public health indicators, including sanitation gaps and child welfare deficits. Institutional language, which often relies on standardized technical definitions, provides clarity in some respects but also constrains understanding, particularly when it fails to capture local coping mechanisms and socio-economic realities. Therefore, integrating these health documents into the curriculum allows students to engage critically with public health data, improving their data literacy and critical reading skills, which are crucial for understanding how health indicators are constructed.

The findings also aligned with recent studies emphasizing the importance of contextual interpretation in understanding health data. For instance, studies by Adriano (2023) and Padilla et al. (2024) demonstrate that incorporating community health data into language instruction improves students' critical thinking and data interpretation skills. This study supports the use of safely managed water statistics as an

authentic instructional tool, providing students with the opportunity to engage with real-world data and explore the complexities behind it.

The findings on safely managed drinking water highlight a statistical deficit in access, with only 35% of households meeting the criteria. This figure provides a starting point for causal analysis, which explores how the economic barriers and lack of infrastructure in rural areas shape the way communities interact with and cope with water access. In terms of language instruction, this data empowers students to write a Persuasive Advocacy Paragraph. They can use this statistic to argue for better local water management systems, addressing both access and water quality. By analyzing the gap between basic water access and safely managed drinking water, students are prompted to think critically about how definitions influence public health outcomes and how they can advocate for change. Additionally, this analysis connects to Taba's Grassroots Theory, which emphasizes the importance of contextual, locally driven approaches in educational and public health interventions. The study's findings align with evidence-based frameworks by illustrating how health indicators, like safely managed water access, can be used to highlight institutional gaps and promote community-driven solutions. This theoretical linkage reinforces the need for a contextualized and equity-focused interpretation of health data, especially in rural areas like San Fernando.

Given the complexities of interpreting health documents, particularly those related to water access, it is recommended that Junior High School English Teachers integrate safely managed water reports into their instructional activities. Teachers should guide students in distinguishing between access-based and quality-based classifications, encouraging them to write persuasive texts grounded in authentic community data. This approach not only strengthens students' critical literacy and data interpretation skills but also aligns with the study's goal of fostering contextualized and socially responsive language instruction. To further enhance the relevance of these documents, collaboration between local health offices and schools is crucial. Health professionals should ensure that the documents used for instruction are accurate, up-to-date, and accompanied by contextual explanations that clarify the technical classifications and reporting standards, ensuring that students have the tools to critically engage with the data.

Basic Sanitation

The reported figure of 7,929 households with basic sanitation is generally confirmed by both the documentary data and the interview findings; however, the interviews reveal that this figure is shaped by institutional reporting rules and social practices that obscure actual household-level access and use. Respondents explained that basic sanitation is counted at the household level based on the presence of a toilet facility (CR), regardless of whether the facility is privately owned or shared among multiple families. In compound or extended-family settings, one toilet serving several households is recorded as belonging to only one household, resulting in an underrepresentation of family-level access while inflating apparent progress toward sanitation coverage. Interviews further clarified that shared toilets are excluded from the classification of safely managed sanitation because facilities must be one-to-one, located within household premises, and not shared to qualify. This distinction explains why the number of households with basic sanitation is sometimes lower or reversed in relation to safely managed sanitation figures in reports, a discrepancy that respondents identified as a recurring documentation challenge. Beyond classification issues, respondents also noted behavioral resistance, citing cases where

toilets provided through government programs remain uninstalled or unused, leading to sanitation availability without actual utilization. Additionally, sanitation status was described as unstable across the reporting year, as households shift between categories when facilities are installed, shared, abandoned, or reclassified during monitoring. These findings indicate that sanitation figures primarily reflect administrative definitions and reporting protocols rather than consistent daily practices, underscoring the importance of contextual interpretation when using sanitation data for analysis and curriculum integration.

The finding on basic sanitation shows that while the reported figure of 7,929 households is administratively accurate, it does not fully represent actual sanitation access and use at the household level. Interviews revealed that shared toilets are recorded under a single household even when used by multiple families, leading to an undercount of family-level access while overstating progress toward safely managed sanitation. Respondents clarified that shared facilities fail to meet the criteria for safely managed sanitation because they are not located within individual households and are not continuously accessible. This practice is common in areas where extended families live in close proximity, making shared toilets a practical solution but a methodological challenge in reporting. Additionally, behavioral resistance further complicates sanitation outcomes, as some households do not install provided toilets, resulting in infrastructure availability without actual use. The fluid nature of sanitation data across the monitoring year underscores that reported figures capture temporary administrative status rather than stable household practices.

This implies that sanitation statistics are constructed through institutional definitions that may not accurately capture lived household realities. The distinction between ownership, shared use, and actual utilization demonstrates how administrative reporting frameworks can simultaneously ensure standardization and obscure social practices. This suggests that sanitation data, while technically valid, require contextual interpretation when analyzed as textual representations of community conditions, particularly in educational settings.

This finding has significant implications for both public health reporting and curriculum integration. When sanitation data are presented without contextual explanation, learners may interpret reported figures as definitive indicators of household behavior and living conditions. Integrating such documents into the Junior High School Language Curriculum allows students to critically examine how definitions, reporting rules, and social behaviors influence official statistics. Language lessons can incorporate activities that analyze discrepancies between access, ownership, and use, helping students develop critical reading, reasoning, and interpretation skills. This approach supports socially responsive language instruction by connecting linguistic analysis with real community health challenges and promoting deeper understanding of how public health data are constructed.

The result aligns with recent studies that highlight discrepancies between sanitation infrastructure provision and actual use. Studies by Tolabing et al. (2022) and Tejero et al. (2022) further showed that behavioral factors and household dynamics significantly affect sanitation outcomes in rural Philippine communities. International research on WASH monitoring by UNICEF and WHO (2021–2024) similarly reported that shared sanitation and non-use of provided facilities remain major barriers to achieving safely managed sanitation.

It is recommended that local health offices refine sanitation reporting practices by clearly distinguishing between household-level access and family-level use, particularly in cases involving shared facilities. Monitoring tools should also account for toilet installation and actual usage to better reflect sanitation outcomes. In the educational context, teachers are encouraged to use sanitation reports as authentic texts for teaching critical reading, data interpretation, and functional writing, emphasizing the gap between reported figures and lived realities. Future research may explore how students analyze sanitation data in classroom settings and how such engagement influences both language development and awareness of community health issues.

Zero Open Defecation

The declaration of all 22 barangays in San Fernando, Camarines Sur as Zero Open Defecation (ZOD) is generally validated by both the documentary data and the interview findings; however, the interviews clarify that ZOD is grounded primarily in behavioral compliance rather than complete household-level sanitation infrastructure. Respondents explained that ZOD certification is based on the absence of observable open defecation within the community, even in situations where households share toilet facilities or rely on collective sanitation solutions. Field accounts highlighted the use of adaptive arrangements such as shared toilets in compound households and "octopus-style" septic systems, where a single septic tank serves multiple households, enabling barangays with limited resources to meet ZOD criteria. Interview data further revealed that ZOD declaration follows a threshold-based assessment, requiring only a minimum percentage of households with sanitary toilets rather than universal coverage, which explains how barangays can achieve ZOD status despite persistent infrastructure gaps. The credibility of these declarations is reinforced by external validation conducted by the Provincial Health Office and the Department of Health through documented checklists, percentage-based assessments, and house-to-house verification prior to certification. However, interviews also indicated some uncertainty at the field level regarding the specific classification or grading of ZOD status, suggesting gaps in dissemination and shared understanding among frontline health workers. Overall, the findings indicate that ZOD status in San Fernando reflects effective regulation of sanitation behavior supported by context-specific, shared infrastructure, but it should not be interpreted as evidence of complete or equitable household-level sanitation access.

The finding on Zero Open Defecation (ZOD) indicates that sanitation success in San Fernando, Camarines Sur is primarily achieved through behavior regulation and adaptive infrastructure rather than complete household-level facilities. The validation interviews show that ZOD certification is grounded in the absence of observable open defecation, even when sanitation facilities are shared or collectively managed through systems such as "octopus-style" septic tanks. This approach enables barangays with limited resources to meet sanitation targets while compensating for infrastructure constraints. External verification by the Provincial Health Office through house-to-house inspections strengthens the credibility of ZOD declarations, yet the requirement that only at least 65 percent of households possess toilet facilities reveals that ZOD status reflects majority compliance rather than universal access. Field-level uncertainty among some health workers further suggests uneven understanding of certification status, indicating gaps between policy-level validation and ground-level awareness.

This implies that the achievement of ZOD status across all barangays reflects effective regulation of

sanitation behavior rather than comprehensive infrastructure equity. The threshold-based certification system simplifies complex sanitation realities into a binary category of compliance or non-compliance, potentially masking disparities in household ownership, quality, and sustainability of facilities. This suggests that ZOD declarations, while institutionally valid, must be interpreted critically as policy-driven classifications rather than definitive indicators of universal sanitation access.

This finding has important implications for interpreting sanitation data and for curriculum integration. Presenting ZOD status as a binary achievement may lead to the assumption that sanitation challenges have been fully resolved, when in reality they persist in shared, temporary, or adaptive forms. Incorporating this finding into the Junior High School Language Curriculum allows students to critically analyze how public health success is defined, measured, and communicated. Language instruction can use ZOD documents to develop learners' skills in evaluating definitions, thresholds, and implicit assumptions in official texts, fostering critical literacy and socially responsive understanding of community health realities.

When considered alongside findings on basic sanitation reporting, safely managed water classifications, and institutional language structures, the ZOD data reinforce a recurring pattern across parameters: health indicators rely on standardized thresholds that ensure accountability but may obscure variations in household-level realities. Across the analyzed documents, institutional classifications function as tools of governance that both clarify and constrain interpretation, underscoring the need for critical engagement when these documents are integrated into educational contexts.

Coffey et al. (2021) and Jenkins et al. (2022) similarly found that shared sanitation systems and community-level adaptations play a critical role in reducing open defecation where household-level infrastructure is financially unattainable. Studies on sanitation governance by Spears and Lamba (2023) further note that threshold-based certification systems can mask intra-community inequalities. These findings support the present study's conclusion that ZOD status represents functional behavioral control rather than comprehensive sanitation coverage, reinforcing the need for contextualized interpretation of sanitation data in educational settings.

It is recommended that local health authorities complement ZOD certification with more nuanced reporting that distinguishes between shared, household-owned, and adaptive sanitation systems to provide a clearer picture of sanitation conditions. Continued community education and monitoring should also focus on long-term infrastructure sustainability beyond behavioral compliance. For educational application, teachers are encouraged to integrate ZOD-related documents into language lessons that emphasize critical reading, interpretation of thresholds, and evaluation of public health claims. Future research may examine how students interpret ZOD certifications and whether exposure to such contextualized health documents enhances their critical thinking, civic awareness, and health literacy.

Deworming Coverage: Children aged 1-9 years

The Field Health Services Information System (FHSIS) records show that a total of 5,264 children aged 1–9 years received deworming services in San Fernando, Camarines Sur, corresponding to a 65.5 percent coverage rate. Validation interviews with barangay health workers and midwives confirmed that

this figure was derived from barangay-level monitoring reports consolidated by the Rural Health Unit. Deworming services were delivered through a combination of school-based distribution and community-based activities, depending on the barangay context and availability of children during scheduled campaigns.

The documented deworming coverage of 5,264 children, representing 65.5 percent of the target population aged 1–9 years, was consistently confirmed by both barangay health workers and midwives. Interview findings clarified that coverage figures are derived from barangay-level monitoring and implemented through a combination of school-based and community-based deworming activities. However, respondents emphasized that service delivery was affected by logistical constraints and participation challenges, including school closures, irregular attendance, and limited parental availability during scheduled community distribution. These disruptions contributed to the observed coverage deficit, indicating that the reported figure reflects operational limitations rather than lack of program availability or acceptance.

This implies that deworming coverage statistics function not only as indicators of health service reach but also as textual representations of structural vulnerabilities within preventive health systems. The 65.5 percent coverage rate illustrates how numerical indicators encapsulate logistical realities, institutional capacity, and community participation within a single statistical figure. This suggests that health documents present complex operational challenges in simplified quantitative form, requiring critical interpretation when introduced into language classrooms.

The deworming coverage deficit suggests that a significant proportion of children remain at risk for parasitic infections that may negatively affect physical growth, nutritional status, and cognitive development. From a programmatic perspective, the findings highlight the vulnerability of preventive health services to disruptions in delivery mechanisms, particularly when they rely heavily on schools and organized community gatherings. For curriculum integration, this indicator offers a meaningful context for helping students understand how health outcomes are influenced not only by policy intent but also by access, logistics, and participation.

When examined alongside findings on sanitation access, safely managed water classifications, and child welfare deficits, the deworming data reinforce a recurring pattern across parameters: health reports condense multifaceted socio-economic and logistical factors into standardized percentages. Across the analyzed documents, institutional reporting translates service disruptions into measurable coverage rates, highlighting the importance of teaching students how to interpret statistical indicators beyond surface-level interpretation.

This result aligns with recent Philippine and regional studies documenting declines in preventive child health coverage due to service delivery disruptions. Amit et al. (2022) reported that deworming and other school-based health programs in the Philippines experienced significant coverage reductions following interruptions in face-to-face schooling. Similarly, Pryor et al. (2023) found that community-based deworming programs in low-resource settings are highly sensitive to logistical constraints and caregiver participation, reinforcing the interpretation that coverage gaps are often structural rather than behavioral.

It is recommended that the Municipal Health Office strengthen alternative delivery strategies for deworming, such as intensified house-to-house campaigns and flexible scheduling coordinated with barangay health workers. Improved coordination with schools during reopening periods may also help recover missed cohorts. For educational integration, Junior High School language teachers integrate deworming coverage reports into instructional activities that guide students in analyzing percentages, identifying structural causes of service gaps, and constructing evidence-based interpretations of health data. Through tasks such as data analysis, cause-and-effect mapping, and persuasive writing grounded in authentic community statistics, learners can develop critical literacy, numerical reasoning, and contextual awareness aligned with the objectives of this study.

Nutrition Status Assessment: Children aged 0-59 months

Results indicate that 1,736 children aged 0–59 months underwent nutrition status assessment during the reporting period. Respondents confirmed that assessments were conducted using standardized anthropometric methods, including weight-for-age, height-for-age, body mass index (BMI), and mid-upper arm circumference (MUAC). These assessments were primarily carried out during scheduled health center visits, immunization days, and Operation Timbang activities at the barangay level.

The assessment of 1,736 children aged 0–59 months was confirmed by respondents as being conducted using standardized anthropometric methods, including weight-for-age, height-for-age, BMI, and mid-upper arm circumference (MUAC). Interviews clarified that these assessments are primarily carried out during scheduled clinic visits, immunization days, and Operation Timbang activities. However, respondents noted irregular participation, largely attributed to parental availability, competing livelihood demands, and inconsistent attendance at barangay health centers. As a result, the number of assessed children likely underrepresents the actual population of children in this age group.

This implies that nutrition assessment statistics represent operational reach rather than definitive indicators of community-wide nutritional status. The numerical count of assessed children simplifies complex socio-economic and participation dynamics into a single figure, potentially obscuring unmonitored cases of malnutrition. This suggests that health documents condense screening limitations into standardized data entries, requiring critical interpretation when analyzed as textual representations of community health realities.

The limited reach of nutrition assessments has implications for early detection of malnutrition, including stunting, wasting, and overweight conditions. Incomplete screening may delay timely interventions and distort the perceived nutritional profile of the community. From an instructional standpoint, this indicator illustrates how health data can reflect participation patterns rather than actual prevalence, offering a valuable opportunity to teach students about the limitations of health statistics and the importance of understanding how data are generated.

When considered alongside deworming coverage deficits and sanitation reporting inconsistencies, the nutrition assessment data reinforce a consistent pattern across parameters: institutional health reports rely on participation-based counts that may not fully capture underlying prevalence. Across the analyzed documents, service delivery limitations are translated into measurable indicators, highlighting the importance of teaching students to examine how data generation processes influence reported outcomes.

This finding is consistent with recent studies highlighting participation-related challenges in child nutrition monitoring. UNICEF and WHO reports (2021–2024) emphasized that nutrition surveillance in low- and middle-income settings is often constrained by caregiver availability and access to health facilities. In the Philippine context, Reyes et al. (2023) similarly observed that nutrition assessment coverage is strongly influenced by parental engagement and clinic attendance rather than solely by program capacity.

Local health authorities are encouraged to expand outreach-based nutrition assessment strategies, including mobile weighing stations and home-based screening conducted by barangay health workers. Strengthening community education on the importance of regular nutrition monitoring may also improve participation. In the language curriculum, nutrition assessment data can be used to develop students' skills in interpreting health classifications, understanding cause-and-effect relationships, and writing evidence-based reports on community health conditions.

Based on this finding, it is recommended that Junior High School language teachers incorporate nutrition assessment reports into classroom activities that guide students in analyzing how participation rates influence health statistics. Learners may examine how data are generated, identify potential gaps in coverage, and compose evidence-based interpretations grounded in authentic community health information. This approach strengthens critical literacy, data interpretation skills, and contextual awareness in alignment with the objectives of this study.

Fully Immunized Children

The FHSIS data report a total of 400 fully immunized children in San Fernando for the covered period. Interviews with Rural Health Unit personnel and barangay midwives confirmed the accuracy of this figure and clarified that the target population for FIC is based on projected Department of Health estimates rather than actual birth registry data. Respondents noted that the reported number reflects children who completed the required immunization schedule within the defined age range, as documented in barangay and municipal health records.

The reported figure of 400 fully immunized children was validated by respondents, who clarified that the low coverage rate is primarily the result of a denominator mismatch rather than parental refusal or vaccine hesitancy. Interviews revealed that FIC targets are based on projected Department of Health population estimates that significantly exceed the actual number of births recorded in San Fernando. Consequently, even when most eligible infants complete their immunization schedules, reported accomplishment rates remain low because the target population is inflated relative to the actual birth cohort.

This implies that immunization performance indicators are shaped not only by service delivery outcomes but also by the statistical assumptions embedded in target-setting processes. The use of projected denominators can transform successful program implementation into seemingly low coverage rates, illustrating how numerical indicators may misrepresent local realities. This suggests that health documents require critical examination of both numerator and denominator components when interpreted as textual representations of community health performance.

This finding underscores a critical limitation in interpreting immunization performance indicators, as low

coverage rates may inaccurately suggest poor program effectiveness or community resistance. Misinterpretation of such data can influence policy decisions, resource allocation, and public perception. In educational contexts, this indicator provides a clear example of how statistical assumptions and denominators shape reported outcomes, reinforcing the importance of data literacy and critical interpretation.

When examined alongside deworming coverage deficits, nutrition assessment participation rates, and sanitation classification standards, the FIC findings reinforce a consistent pattern across parameters: institutional health reports rely on standardized denominators and classification systems that may obscure contextual realities. Across the analyzed documents, performance indicators are shaped by operational definitions and statistical frameworks, underscoring the need for critical literacy when interpreting health data within educational settings.

Recent studies support this interpretation of immunization data discrepancies. Kim et al. (2024) reported that projected population-based targets often overestimate eligible cohorts in rural areas, leading to systematically low reported immunization coverage despite high compliance. Similarly, Nguyen and Tran (2022) found that denominator inaccuracies significantly affected immunization indicators in decentralized health systems, particularly in communities with declining birth rates.

It is recommended that the Municipal Health Office regularly reconcile projected population targets with actual birth registry data to improve the accuracy of immunization coverage reporting. Clear documentation of denominator assumptions should accompany FIC reports to prevent misinterpretation. For classroom use, Junior High School language teachers integrate immunization coverage reports into instructional activities that guide students in analyzing how denominators, projections, and statistical assumptions influence reported outcomes. Learners may examine the relationship between projected targets and actual counts, evaluate how data framing shapes interpretation, and construct evidence-based explanations grounded in authentic community statistics. This approach strengthens students' data literacy, critical reasoning, and contextual understanding in alignment with the objectives of this study.

Curriculum Integration Model

Figure 1

Curriculum Integration Model

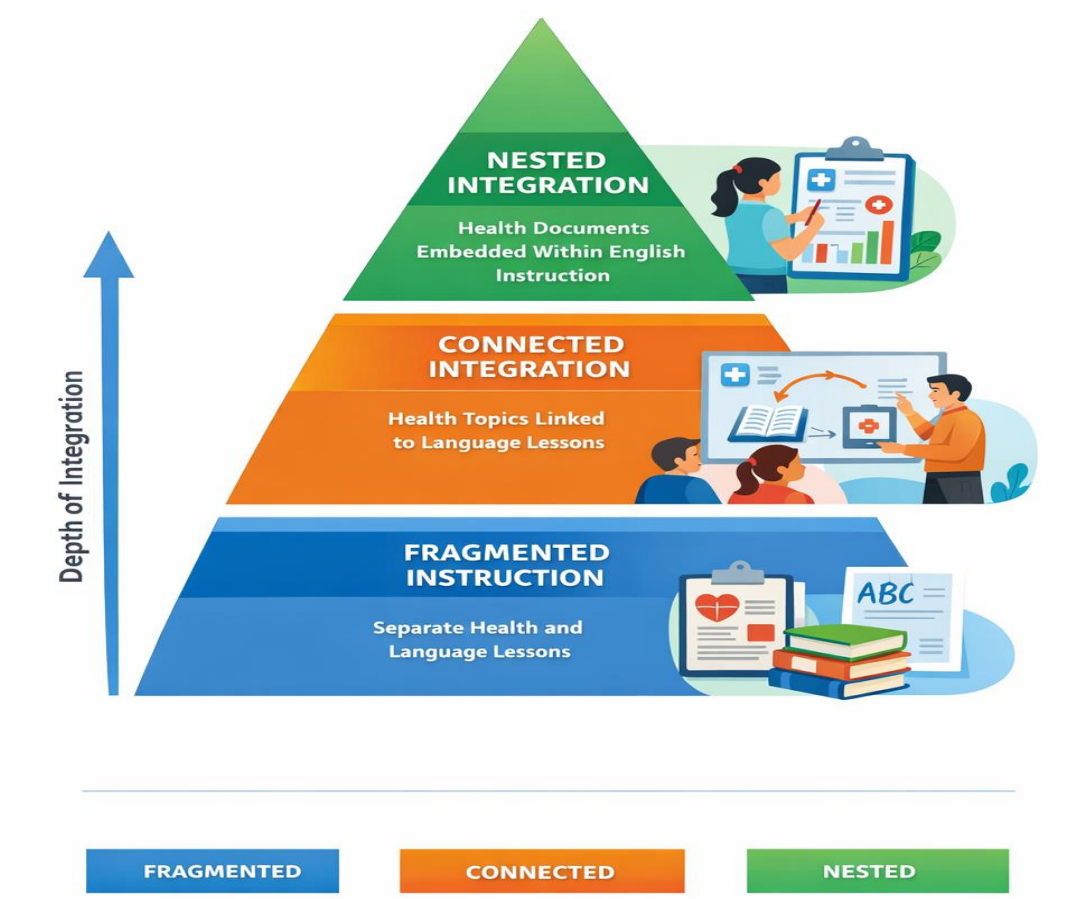

Figure 1 presents the Curriculum Integration Model of this study. The integration of authentic health-related documents into the Junior High School Language Curriculum, as described in this study, exemplified a holistic and transformative approach to education that goes beyond traditional language instruction. By embedding real-world health data from San Fernando, Camarines Sur, into the curriculum, this model enhanced both academic learning and social responsibility. This curriculum integration was not merely an addition of health-related content but a reimagining of language education itself, where students engaged with real data and critical social issues, such as sanitation and child welfare, alongside developing essential linguistic skills.

The curriculum integration model outlined in this study is grounded in a comprehensive framework that guides the integration of health-related documents into the Junior High School Language Curriculum.

Contextualized of Learning Materials

Health-related documents, such as sanitation reports and child welfare statistics, replace abstract examples with authentic, locally grounded materials. This contextualization is designed to make learning more relevant to students' daily lives and challenges, fostering a deeper connection between language learning and real-world issues.

Critical Literacy and Data Interpretation

Beyond linguistic competence, the integration of community health data nurtures critical literacy, enabling students to interpret statistical data, analyze health indicators, and recognize the significance of institutional language in health reporting. By understanding how data are constructed and presented in official reports, students develop both analytical and communicative skills that enhance their ability to engage in informed discourse.

Interdisciplinary Approach

The integration of health-related documents fosters interdisciplinary learning by connecting language instruction with social studies, public health, and data analysis. This approach provides students with the opportunity to apply their language skills to real-world contexts, making learning more meaningful and socially responsive.

Progressive Skill Development

The curriculum integration is structured to build language skills progressively, from data interpretation and critical reading to persuasive writing and oral presentation. This scaffolding ensures that students acquire the competencies necessary to navigate complex texts and communicate their findings effectively.

The integration of health-related documents into the Junior High School Language Curriculum was analyzed through different levels of curriculum integration: Fragmented, Connected, and Nested. Each of these levels represents a different approach to how health-related content is embedded into language instruction.

At the level of nested integration, health-related documents are introduced as isolated activities within the curriculum. In certain lessons, students might engage with a health document as a standalone text, analyzing specific health statistics or writing about sanitation issues. While the document serves as an instructional tool, it remains largely disconnected from other areas of language instruction. This level of integration primarily focuses on enriching specific lessons with contextualized content, but without a consistent, ongoing connection to the broader curriculum.

At the connected level, health-related documents are more systematically incorporated into the curriculum, linking them to various language competencies. For instance, students may analyze a sanitation report, learn to interpret percentages, and then use those insights to write formal reports or present oral arguments advocating for improved health conditions. This approach connects language skills (reading, writing, speaking) to real-world health data, thereby allowing students to apply their linguistic abilities to authentic tasks. However, while there is a clearer connection between health content and language instruction, the integration may still remain compartmentalized, with the health data being used primarily in certain thematic units.

The nested level of integration represents the most profound transformation, where health-related documents are fully embedded into the fabric of the curriculum. At this level, health data is not just connected to isolated lessons but is deeply woven into the overall structure of language education. Students are regularly tasked with analyzing health statistics, engaging with institutional language in various formats, and reflecting on public health issues as part of ongoing language learning. This

integration transformed the curriculum by continuously grounding language instruction in real, locally relevant health issues, allowing students to see language not as an abstract academic exercise, but as a practical tool for engaging with their community and the world around them.

In the context of this study, the curriculum integration model can be classified as Connected to Nested. While there are instances where health data is used in specific lessons, the overall approach moves toward a nested model where language instruction is consistently intertwined with critical engagement with community health issues. The students are not merely learning about language in isolation but are encouraged to view language as a tool for social participation, informed decision-making, and advocacy for better health outcomes.

The lessons presented, such as the analysis of sanitation gaps and child welfare statistics, illustrate a connected integration model in action. In these lessons, students engage with authentic health data, use technical language to interpret the data, and apply their learning through writing and oral presentation tasks. These tasks are not disconnected from the rest of their language development; instead, they serve as opportunities to enhance reading comprehension, vocabulary acquisition, persuasive writing, and oral communication skills.

Moreover, the curriculum's focus on critical interpretation of institutional language and statistical data aligns with the nested integration model. Through consistent exposure to health reports, students are not only developing language skills but are also learning how to critically analyze data, understand statistical framing, and communicate their findings effectively. This fosters a deeper understanding of both the language used in public health reporting and the implications of that language in shaping public perception and policy.

The integration of authentic health-related documents into the Junior High School Language Curriculum, as proposed in this study, represents a significant shift toward a more contextualized and socially responsive educational model. By embedding real community health data into language instruction, the curriculum empowers students to not only develop linguistic competence but also engage in critical literacy, data interpretation, and civic responsibility. The integration model, shifting from fragmented to connected and ultimately nested, provided a framework for making language learning more relevant, engaging, and aligned with real-world challenges. This approach not only strengthened students' language skills but also prepared them to actively participate in public discourse, advocating for improved health outcomes and better community well-being.

Contextualized Junior High School Language Curriculum

The integration of health-related documents into the language curriculum extends beyond thematic exposure to sanitation and nutrition issues. It also includes critical examination of how statistical indicators, technical classifications, and institutional discourse construct representations of community health. Students are guided to analyze percentages, denominators, and health classifications to develop data literacy and critical reading skills alongside linguistic competence.

The contextualized Junior High School Language Curriculum developed in this study represents a substantive pedagogical shift from the original implementation of the MATATAG Curriculum for Grades 10 and the Most Essential Learning Competencies (MELCs). While the national curriculum

frameworks clearly define competencies in reading, writing, speaking, and viewing, they do not explicitly integrate authentic community-based public health documents within English instruction. The original curriculum typically relies on textbook selections, literary texts, and generalized informational passages that develop linguistic skills in abstract or decontextualized settings. In contrast, the contextualized curriculum retains all mandated competencies but transforms the instructional inputs by embedding real health-related documents from San Fernando, Camarines Sur. Instead of analyzing hypothetical examples, students interpret actual sanitation data, examine institutional language in health reports, and compose formal paragraphs grounded in statistical evidence drawn from their own community. This shift does not alter the structure or standards of the prescribed curriculum; rather, it enriches it by situating language learning within lived realities. Through this transformation, English instruction moves beyond isolated skill development toward a socially responsive model that simultaneously strengthens linguistic competence, data literacy, health awareness, and civic engagement.

This section presents the development of a contextualized Junior High School Language Curriculum based on the analysis of health-related documents from San Fernando, Camarines Sur. It introduces how the identified health themes and linguistic features drawn from community documents inform instructional content and learning activities. The subsections discuss the analysis of the documents and examine specific themes related to public health infrastructure and sanitation gaps, nutrition status, preventive care and child welfare, and the formal, statistical, and institutional language used in health reports, demonstrating how these elements can be integrated into language instruction to promote contextualized and socially responsive learning.

This section presents the discussion on the integration of the various health-related documents available in San Fernando, Camarines Sur into the junior high school curriculum to promote contextualized and socially responsive language curriculum.

Public Health Infrastructure and Sanitation Gaps

Table 4

The Integration of Various Health-Related Documents along Public Health Infrastructure and Sanitation Gaps into Junior High School Language Curriculum.

Lesson Title:	**Promoting Health Literacy through Informational Text Analysis**
Grade Level:	Grade 10 Junior High School
Subject Areas:	Language
Theme:	Public Health Infrastructure and Sanitation Gaps
Duration:	50 minutes
Objectives: 1. Analyze FHSIS sanitation and water supply data to identify health infrastructure gaps. 2. Use technical vocabulary related to water and sanitation confidently. 3. Write a persuasive paragraph advocating for better sanitation services. 4. Present health data clearly in oral form.	

5. Write and present a persuasive paragraph supported by accurate health data.

Materials Needed:

- Sample FHSIS sanitation data table
- Vocabulary list with definitions
- Writing templates
- Presentation guide
- Presentation rubric

Procedure:

I. Engage (10 min)

- The teacher presents an actual sanitation and water supply data table from San Fernando.

Guide questions:

- What does this data tell us about water access in our community?
- Why do you think the report uses the term "safely managed" instead of simply saying "clean water"?
- Does the way the data is presented affect how you understand the problem?

The teacher briefly introduces key terms:

- Zero Open Defecation (ZOD)
- Level I–III Water Supply
- Safely Managed Sanitation
- VIP Latrine

Purpose: To activate prior knowledge and introduce students to authentic institutional language used in public health reporting.

II. Explore (10 min)

Students analyze the FHSIS table and answer guided questions:

- What are the key statistics presented?
- How many households have basic water supply?
- How many have safely managed water?
- What differences do you observe between the numbers?
- How might percentages change be depending on the denominator used?
- Students discuss in pairs and share insights with the class.

Purpose: To develop reading comprehension, numerical interpretation, and awareness of statistical framing.

III. Explain (15 min)

Mini-Lecture and Guided Analysis

The teacher explains:

- The difference between basic and safely managed water supply.
- How institutional classifications define categories.

• How numerical presentation (counts vs percentages) can influence interpretation. • Why official reports use technical and standardized language. **Guided Critical Thinking Task:** Students respond orally: • Does presenting exact numbers make the report more convincing than percentages alone? Why? • What might happen if the target population is larger than the actual number of households? Purpose: To build critical literacy skills and understanding of how language and statistics construct meaning.
IV. Evaluate (15 min) • **Activity:** Persuasive Writing and Presentation • Students write a short persuasive paragraph advocating improved sanitation or water services using: • At least one accurate statistic • One technical classification term • A clear explanation of what the number means • Teacher assesses written and oral output against accuracy, persuasiveness, and communication effectiveness.

The discussion on public health infrastructure and sanitation gaps is strengthened by Table 4, which concretely demonstrates how health-related community documents can be integrated into the Junior High School Language Curriculum to make instruction more authentic, locally grounded, and socially meaningful. Specifically, Table 4 presents a contextualized 50-minute lesson titled “Promoting Health Literacy through Informational Text Analysis” under the language subject area, with the theme centered on public health infrastructure and sanitation gaps. In contrast to the original Junior High School language curriculum that commonly depends on generic informational texts, literary selections, and hypothetical examples, this contextualized lesson deliberately replaces abstract materials with real Field Health Services Information System (FHSIS) sanitation and water supply data from San Fernando, Camarines Sur.

As a result, learners engage not only with language as an academic requirement but also with pressing realities in their own community, such as Zero Open Defecation (ZOD) status, the presence or absence of VIP latrines, and water-level classifications (Level I–III). Through this shift, language learning becomes experiential and directly connected to lived conditions, allowing students to interpret real statistics and recognize how infrastructure and sanitation gaps affect public health outcomes. Moreover, Table 4 illustrates a well-sequenced lesson design that maximizes student engagement and progressively builds both language and critical literacy skills.

The Engage phase introduces students to authentic sanitation and water supply data from the Field Health Services Information System of San Fernando, Camarines Sur. Within the ten-minute timeframe,

learners are guided to observe statistical patterns and identify possible infrastructure gaps through focused questions such as “What does this data tell us about water access in our community?” and “Why is the term ‘safely managed’ used instead of simply ‘clean water’?” This brief analytical exposure supports the first objective by initiating data-based interpretation of local health indicators.

At the same time, the introduction of key technical terms such as Zero Open Defecation, Level I to III Water Supply, Safely Managed Sanitation, and VIP Latrine directly addresses the second objective by building learners’ confidence in using institutional vocabulary accurately. Rather than treating terminology as isolated definitions, the lesson situates these terms within real public health reporting contexts, allowing students to recognize how technical language functions in official documents. Although the Engage phase does not yet require persuasive production, it strategically prepares students for subsequent writing and oral presentation tasks by grounding their arguments in authentic community data.

The Explore phase deepens learners’ engagement with authentic health data by requiring them to analyze FHSIS tables through guided, data-focused questions. Within the ten-minute period, students identify key statistics, compare figures related to basic water supply and safely managed water, and examine observable differences between reported numbers. By prompting learners to consider how percentages may change depending on the denominator used, the lesson moves beyond simple data recognition toward critical interpretation of statistical representation. Pair discussions further strengthen comprehension by allowing students to articulate interpretations, clarify misunderstandings, and refine reasoning before sharing insights with the larger class.

The Explain phase provides structured clarification and conceptual consolidation through a brief mini-lecture and guided analysis. During this phase, the teacher explicitly discusses the distinction between basic and safely managed water supply, emphasizing how institutional classifications establish specific criteria that shape how data are interpreted. Learners are guided to understand that categories in official reports are defined through standardized benchmarks that influence how public health performance is measured and communicated. The teacher also explains how numerical presentation—whether through raw counts or percentages—can affect interpretation, and why government reports rely on technical and standardized language to ensure accuracy, consistency, and institutional credibility.
The Evaluate phase completes the learning cycle by requiring students to independently write persuasive paragraphs advocating improved sanitation services and, for selected volunteers, to present their arguments orally. This culminating task highlights the practical value of language as a tool for social participation and advocacy, since students must articulate positions using real community evidence rather than invented examples. The oral presentation component further strengthens communicative competence, while peer and teacher feedback reinforce clarity, vocabulary accuracy, and the effectiveness of persuasion.

Assessing both written and oral outputs against criteria such as accuracy, persuasiveness, and communication effectiveness, Table 4 reflects an approach that treats language learning as performance in real communicative contexts rather than merely the mastery of isolated skills. Taken together, the lesson represents a meaningful departure from traditional language instruction by situating literacy within authentic public health concerns, promoting critical engagement with local realities, and

empowering learners to use language as a mechanism for informed participation and community-oriented advocacy.

The contextualized lesson plan effectively bridges the gap between language instruction and community health realities by embedding authentic sanitation data into core language competencies. Replacing decontextualized texts with local health documents deepens students' engagement and supports the development of critical literacy skills. Students are not only reading texts but also interpreting data, questioning disparities, and articulating informed perspectives on sanitation issues.

The integration of public health infrastructure and sanitation data into the language curriculum has important implications for both education and health literacy. By engaging with real sanitation issues, students learn to critically assess official data and understand how infrastructure gaps affect community well-being. This approach fosters informed citizenship by equipping learners with language skills needed to participate in public discourse and advocate for health-related improvements. For teachers, the lesson illustrates how curriculum contextualization can enhance relevance without deviating from prescribed competencies, supporting a more responsive and inclusive educational practice.

Beyond thematic relevance, the lesson reflects the study's emphasis on critical interpretation of institutional language and statistical framing. By engaging with classifications such as basic and safely managed and analyzing numerical indicators from official reports, students are guided to examine how public health data are constructed and communicated. Language instruction thus moves beyond surface comprehension toward critical literacy, where learners interpret the assumptions, definitions, and institutional perspectives embedded within health documentation.

Supporting studies further affirm the effectiveness of this approach. Adriano (2023) found that using community-based texts in language classes significantly improves comprehension and critical reading skills among Filipino learners. Padilla et al. (2024) reported that integrating local health data into classroom instruction strengthens students' ability to analyze informational texts and develop evidence-based arguments. International studies by Latifah (2025) and Alamri (2025) similarly demonstrate that contextualized materials increase student engagement and communicative competence when anchored in real social issues. These findings reinforce the effectiveness of the contextualized curriculum presented in this study.

It is recommended that language teachers adopt similar contextualization strategies by incorporating local health and community documents into instructional planning, particularly when teaching informational texts, persuasive writing, and oral communication. Curriculum developers may consider formally integrating public health themes into language learning guides to promote interdisciplinary learning and civic engagement. Strengthening collaboration between local health offices and schools will ensure access to updated and relevant data for classroom use, while future research may examine the long-term impact of such contextualized lessons on students' language development, health awareness, and participation in community health initiatives.

Child Welfare, Preventive Care, and Coverage Deficits

Table 7

The Integration of Various Health-Related Documents along Child Welfare, Preventive Care, and Coverage Deficits

Lesson Title:	**Contextualized Writing: From Data to Persuasion**
Grade Level:	Grade 10 Junior High School
Subject Areas:	Language
Theme:	Child welfare, preventive care, and coverage deficits
Duration:	50 minutes

Objectives:

1. Interpret child health coverage data from FHSIS reports.
2. Analyze how percentages and target populations influence reported health coverage rates.
3. Use key preventive care terms accurately in oral and written communication.
4. Write and present a formal health status paragraph supported by accurate data and clear recommendations.

Materials Needed:

- Sample FHSIS child welfare data
- Vocabulary cards
- Guided data interpretation worksheet
- Formal paragraphs writing template
- Oral Presentation rubric

Procedure:

1. **Engage (10 min)**
    - **Activity:** Present deworming and immunization coverage data; ask the students to interpret what 65.69% coverage means and why it matters.
    - What does 65.5% coverage mean? Is 65.5% high or low? Why?
    - Briefly share local stories or ask if students know about health checks or immunizations.
    - What could make a percentage appear lower or higher even if the actual number of children served remains the same?

    The teacher briefly introduces the idea of:

    - Target population
    - Actual number served
    - Projected estimates

Purpose: To introduce statistical awareness and prepare students to question numerical framing.

2. **Explore (10 min)**

• **Activity:** Small Group Data Analysis Students analyze child welfare data and answer: • How many children were dewormed? • How many were assessed nutritionally? • How many were fully immunized? • What is the reported percentage? • What is the denominator used? Students compare actual numbers versus projected targets. Follow-up Discussion: • If the target population is larger than the actual number of eligible children, how does this affect the reported accomplishment rate? • Does a low percentage always mean poor service delivery? Purpose: To develop data literacy and critical interpretation skills.
3. Explain (15 min) **Mini-Lecture and Guided Writing** The teacher explains: • Difference between numerator (actual count) and denominator (target population). • How projected targets may differ from actual birth registry data. • How institutional reports frame performance indicators.
4. Evaluate (15 min) • **Activity:** Oral Reporting and Reflection • Students present a short summary of their written paragraph. • Class and teacher assess using rubric focusing on: ○ Accuracy of statistical interpretation ○ Clarity in explaining percentages and denominators ○ Proper use of technical vocabulary ○ Logical and evidence-based recommendation ○ Communication effectiveness • Reflection Question: Why is it important to understand how health percentages are calculated before drawing conclusions?

Table 5 highlights how various health-related documents focused on child welfare, preventive care, and coverage deficits are meaningfully integrated into the Grade 10 Junior High School Language Curriculum, thereby strengthening both academic literacy and social relevance. In particular, the designed lesson plan demonstrates a parallel model of integration using authentic Field Health Services Information System (FHSIS) data on deworming, immunization, and child nutrition indicators. Compared with the original Junior High School language curriculum, which often relies on generic informational texts, fictional statistics, or textbook-based scenarios, this contextualized approach replaces abstract content with real health coverage figures from San Fernando, Camarines Sur. Consequently, students do not merely practice language skills in isolation but engage directly with

concrete issues affecting children in their own community, making learning more authentic and grounded in lived experience. The lesson is structured for a 50-minute period and intentionally sequenced to build learners' reading, writing, and speaking competencies through authentic health content.

The Engage phase initiates statistical awareness by presenting coverage data and prompting students to interpret what a reported accomplishment rate such as 65.5 percent truly represents. By questioning whether this percentage is high or low and exploring how projected targets influence reported results, students begin to recognize that health statistics are not self-explanatory figures but constructed indicators shaped by methodological decisions. The introduction of key concepts such as target population, actual number served, and projected estimates directly supports the objective of analyzing how denominators influence coverage rates, fostering critical reflection rather than passive acceptance of numerical claims.

The Explore phase deepens analytical engagement through small-group data interpretation. Students examine the number of children dewormed, assessed nutritionally, and fully immunized while identifying corresponding percentages and denominators. By comparing actual counts with projected targets, learners observe how statistical framing can affect perceived performance. Follow-up discussion explicitly challenges the assumption that low percentages automatically indicate poor service delivery, guiding students to consider structural factors such as inflated projections or data limitations. This phase strengthens data literacy, logical reasoning, and technical vocabulary use while reinforcing the study's emphasis on critical interpretation of institutional documents.

During the Explain phase, conceptual clarity is established through direct instruction on numerator-denominator distinctions, discrepancies between projected targets and actual birth registry data, and the institutional framing of performance indicators. This structured clarification ensures that students not only interpret figures correctly but also understand how official reports present health accomplishments within standardized bureaucratic formats. The focus on institutional discourse prepares learners to use preventive care terminology accurately and confidently in both written and oral communication.

The Evaluate phase culminates in a performance-based task requiring students to compose and present a formal health status paragraph supported by accurate statistical evidence and clear recommendations. This task directly fulfills the objectives of writing and presenting persuasive arguments grounded in authentic data. The assessment rubric emphasizes precision in statistical interpretation, correct use of technical vocabulary, logical reasoning, and communication effectiveness. Through this culminating activity, learners demonstrate the ability to transform raw health data into structured, evidence-based discourse. Overall, the lesson exemplifies how integrating authentic child health and preventive care documents into language instruction enhances literacy development while equipping students with practical communication skills that support health awareness, critical thinking, and socially responsible participation within their community.

The contextualized lesson plan effectively demonstrates how child welfare and preventive care data can be used to develop higher-order language skills while promoting health literacy. The integration of

authentic coverage statistics encourages students to analyze numerical information, interpret implications, and translate data into coherent written and oral outputs. This approach moves beyond surface-level comprehension and positions language learning as a tool for understanding and communicating social realities. Embedding local health data into instruction strengthens students' critical literacy and enables meaningful engagement with complex informational texts.

The findings further suggest that integrating child welfare and preventive care documents into the language curriculum enhances both academic learning and social awareness. Students are exposed to real health challenges affecting children in their community, fostering empathy and informed understanding. For educators, the lesson illustrates how curriculum contextualization can align with existing learning competencies while making instruction more responsive to local needs, supporting the development of informed, health-literate learners capable of engaging critically with public health information.

Beyond promoting vocabulary and formal writing skills, the lesson reflects the study's emphasis on critical interpretation of statistical reporting. By analyzing coverage percentages alongside projected target populations, students develop awareness of how numerators and denominators influence reported accomplishment rates and how statistical assumptions shape institutional narratives. In this way, learners move from interpreting percentages to critically evaluating how health data are constructed, presented, and understood in official documentation.

Supporting studies affirm the effectiveness of this approach. Cruz and Bautista (2021) reported improved comprehension and writing skills when real public health data were used as instructional texts. Nguyen and Tran (2022) found that integrating child health statistics into language lessons enhanced students' ability to interpret informational texts and develop formal writing skills, while Kim et al. (2024) demonstrated increased health awareness and critical thinking through school-based analysis of immunization and nutrition data. These findings reinforce the value of authentic child welfare documents in strengthening both linguistic competence and health literacy.

It is therefore recommended that language teachers systematically integrate child welfare and preventive care data into lessons on informational reading, formal writing, and oral presentation. Curriculum planners may consider incorporating locally sourced health documents into learning modules to promote interdisciplinary and socially responsive instruction. Strengthening collaboration between schools and local health offices will ensure continued access to updated, accurate data, while future research may examine the long-term effects of sustained exposure to health-based instructional materials on students' language development, critical thinking, and community engagement.

Formal, Statistical, and Institutional Language

Table 6

Lesson Title:	**Analyzing Statistical and Institutional Language in Community Health Reports**
Grade Level:	Grade 10 Junior High School
Subject Areas:	Language

Theme:	Formal, statistical, and institutional language
Duration:	50 minutes

Objectives:

1. Recognize technical terms such as safely managed sanitation, basic safe water supply, and Zero Open Defecation (ZOD).
2. Explain how statistical data (percentages, targets, household counts) highlight sanitation gaps.
3. Write a formal paragraph interpreting health data and proposing a recommendation.
4. Reflect on the importance of understanding public health reports for community awareness.

Materials Needed:

- Sample FHSIS report tables
- Printed excerpt of health report using institutional language
- Writing guide for formal data interpretation
- Rubric for assessment

Procedure:

1. **Engage (10 min)**
   - **Activity:** Reading the numbers
   - Present a simplified version of sanitation data:

Indicator	Target	Actual	Percentage
Households with Basic Safe Water	8,603	9,306	108%
Safely Managed Drinking Water	8,603	3,048	35%
Basic Sanitation Facility	8,603	8,312	97%

   Ask:
   - What do these numbers tell us about the community?
   - Why do health reports use exact figures instead of general statements?
   - What does “35% of the target” suggest?

Teacher emphasizes: Public health reports use numbers to show progress and gaps.

2. **Explore (15 min)**
   - **Activity:** Language Detective (in pair)
   - Distribute an excerpt containing institutional language.
   - Highlight technical terms.
   - Identify statistical expressions.
   - Discuss why the report uses formal and passive constructions.

   Guide Question

• How does technical language create authority? • Could some terms be difficult for ordinary readers?
3. Explain (15 min) • Teacher introduces the concept of passive voice. • Passive voice focuses on results rather than the doer, making the tone more formal and objective. • Then model how to transform raw data into a formal interpretation.
4. Evaluate (10 min) **Activity:** Part A Performance Task – Formal Paragraph Writing Students write one formal paragraph that: • Interprets one sanitation indicator from the table • Explains what the data reveal • Proposes one realistic recommendation Part B: Reflection (Oral) • Why is it important for communities to understand public health reports? • How can interpreting data correctly help improve sanitation conditions?

The Integration of Various Health-Related Documents along Formal, Statistical, and Institutional Language Table 6 presents the contextualized lesson titled "Analyzing Statistical and Institutional Language in Community Health Reports," which focuses on developing learners' understanding of formal, statistical, and institutional language through authentic sanitation data from the Field Health Services Information System of San Fernando, Camarines Sur. This lesson exemplifies how institutional discourse can serve as a pedagogical resource for strengthening both linguistic competence and critical literacy. Rather than isolating grammar instruction from real-world application, the lesson embeds statistical interpretation, technical vocabulary, and passive constructions within actual community health reports. The Engage phase introduces learners to a simplified but authentic sanitation data table containing targets, actual counts, and corresponding percentages. By prompting students to interpret figures such as 108 percent for basic safe water and 35 percent for safely managed drinking water, the lesson encourages immediate analytical engagement. Students are guided to reflect on what "35 percent of the target" implies and why official reports rely on exact numerical values instead of general statements. This activity directly supports the second objective by demonstrating how percentages and household counts highlight sanitation gaps. It also builds early awareness that numbers function as persuasive tools in institutional reporting, revealing both progress and deficiencies within the community.

During the Explore phase, learners shift from numerical interpretation to linguistic analysis through a paired "Language Detective" activity. Students examine an excerpt of a health report, highlight technical terms such as safely managed sanitation and Zero Open Defecation, and identify statistical expressions embedded within the text. Guided discussion focuses on why institutional documents frequently employ formal register and passive constructions. This stage fulfills the first objective by strengthening

recognition of technical vocabulary, while also fostering metalinguistic awareness. Students begin to understand that formal and standardized language contributes to authority, credibility, and objectivity in public health communication. At the same time, the discussion acknowledges that highly technical terminology may create comprehension barriers for ordinary readers, reinforcing the importance of critical engagement with institutional discourse.

The Explain phase consolidates grammatical and rhetorical understanding by introducing the concept of passive voice within the context of official reporting. Rather than presenting passive constructions as isolated grammar rules, the lesson demonstrates how passive voice shifts attention from the actor to the result, thereby maintaining institutional neutrality and emphasizing measurable outcomes. The teacher models how raw statistical data can be transformed into a formal interpretive paragraph, showing learners how to integrate numerical evidence, technical vocabulary, and structured reasoning into coherent written discourse. This modeling directly prepares students to achieve the third objective of composing a formal paragraph that interprets health data and proposes a recommendation.Finally, the Evaluate phase requires students to apply their analytical and linguistic skills through a performance task. By writing a formal paragraph interpreting a sanitation indicator and presenting a realistic recommendation, learners demonstrate their ability to synthesize data interpretation with persuasive communication. The oral reflection component further supports the fourth objective by encouraging students to articulate why understanding public health reports is essential for community awareness and informed decision-making. Through this culminating activity, students recognize that statistical interpretation is not merely an academic exercise but a civic skill that enables responsible participation in discussions about sanitation and public health. Overall, this lesson illustrates how formal, statistical, and institutional language can be transformed into meaningful instructional content within the Junior High School language curriculum. By integrating authentic health reports into grammar, vocabulary, and writing instruction, the lesson advances the study's goal of contextualizing language education while fostering data literacy, critical reasoning, and socially responsive communication.

The contextualized lesson effectively demonstrates how institutional health documents can be used to develop advanced language skills, particularly in interpreting and producing formal, data-driven texts. The integration of authentic FHSIS reports enables students to analyze linguistic choices within real institutional discourse, fostering metalinguistic awareness and critical engagement. The analysis shows that students are not only learning grammatical structures but also understanding how language functions within systems of authority, governance, and public health communication. This approach elevates language instruction from form-focused learning to meaning-centered and socially situated practice.

The findings suggest that incorporating formal and statistical health documents into language instruction enhances students' readiness for academic and civic communication. By engaging with institutional texts, learners develop the ability to critically evaluate how language frames health issues and influences decision-making. This has important implications for language education, as it positions students as informed readers and responsible communicators capable of navigating complex, data-rich environments. For schools, the lesson demonstrates how curriculum contextualization can strengthen critical literacy without sacrificing alignment with prescribed competencies.

This approach is supported by recent studies on critical literacy and institutional discourse in education. Li and Zhang (2021) found that analyzing government reports in language classes significantly improved students' understanding of formal register and passive constructions. Park and Kim (2022) demonstrated that exposure to authentic statistical texts enhanced learners' ability to interpret data and produce objective written analyses. More recently, Hernández and Solano (2024) reported that integrating institutional documents into secondary language curricula strengthened students' critical awareness of how language shapes policy and public perception. These findings align with the present study in affirming that authentic, data-driven texts are effective tools for developing advanced language and critical literacy skills.

It is recommended that language teachers incorporate institutional and statistical documents, such as health reports, into lessons on formal writing, grammar, and critical reading. Curriculum developers may consider embedding explicit outcomes related to institutional literacy and data interpretation within language standards. Professional development programs should also support teachers in adapting authentic documents for classroom use. Future research may examine how sustained engagement with institutional texts influences students' academic writing proficiency, critical thinking, and preparedness for higher education and civic participation.

Conclusion and Recommendations

Research Objective 1. Analyze the various health-related documents available in San Fernando, Camarines Sur.

Findings

1. A total of 9,306 households have access to basic safe water, but only 3,048 households use safely managed drinking water services. In sanitation, 7,929 households are at safely managed levels, while 7,498 have basic facilities. Additionally, there are 22 Zero Open Defecation (ZOD) barangays.
2. Deworming coverage reached 5,264 children (65.5%), with 1,736 under-fives assessed for malnutrition, using clinical terms like "stunted" and "wasted." Only 400 children are fully immunized (FIC).
3. The data reporting follows a formal, objective structure with tabular formats, including technical classifications, SDG-aligned terms, and acronyms. The reports highlight numerical figures, percentages, and data-to-action translations but lack clear interpretations, which could provide actionable insights.

Conclusions

1. There is measurable progress in sanitation, with a notable number of households achieving safely managed levels and the successful implementation of ZOD in many barangays. However, gaps persist in the provision of advanced water services and child health metrics.
2. Only about 33% of households with basic water coverage have access to safely managed drinking water, reflecting a significant deficit in higher-quality water services.
3. The low FIC rates and suboptimal deworming coverage signal serious gaps in child welfare, highlighting the need for enhanced preventive care and targeted interventions.

Recommendations

1. The Municipal Government of San Fernando, Camarines Sur, through the Municipal Rural Health Unit, should allocate dedicated funding at the municipal and barangay levels over the next three to five years to upgrade at least 50 percent of households with basic water access to safely managed drinking water services, including the installation of Level II and Level III water systems and household filtration mechanisms, in response to the documented 35 percent coverage rate for safely managed drinking water.
2. The Municipal Rural Health Unit, in coordination with Barangay Health Workers and public schools, should implement expanded mobile clinic services, strengthened school-based partnerships, and enhanced nutrition screening programs across all barangays of San Fernando, Camarines Sur on a semi-annual basis to increase deworming coverage to at least 90 percent and improve Fully Immunized Child (FIC) rates, addressing the identified gaps in child welfare and preventive care.
3. Municipal and Barangay Health Personnel should undergo annual technical writing and report-interpretation training workshops conducted at the district or municipal level starting the next reporting cycle to ensure the consistent completion of interpretation and recommendation sections in FHSIS reports, thereby transforming raw health data into actionable insights for policy planning and community intervention.

Research Objective 2. Integrate the findings into the junior high school language curriculum to promote contextualized and socially responsive language instruction.

Findings

1. The study presents three lesson plans designed for junior high school language instruction, integrating authentic local health data from FHSIS documents. These lessons help students develop skills in reading tables, understanding technical health vocabulary, interpreting quantitative indicators, and producing both persuasive and formal written and oral texts.
2. The lesson plans are thematically aligned with sanitation gaps, child preventive care coverage, and formal institutional language. Students are encouraged to analyze real figures, connect them to their community context, and engage in activities that involve interpreting, explaining, and communicating public health information in structured, audience-appropriate ways.
3. The integration of these themes into the curriculum fosters data literacy, health literacy, and formal academic communication among junior high school students, making the learning experience socially relevant and contextually grounded.

Conclusions

1. The contextualized lesson plans utilize socially responsive language instruction, reflecting the lived health realities of San Fernando, Camarines Sur. This approach systematically develops students' health literacy, data literacy, and academic communication skills.
2. The thematic focus on sanitation, child welfare, and institutional discourse ensures that language learning is not isolated but integrated into meaningful discussions, empowering students to engage with real-world issues in their community.

3. The curriculum encourages students to become informed, articulate participants in their community's public health conversations, fostering both critical thinking and active civic engagement.

Recommendations

1. The developed lesson plans may be formally adopted and piloted in selected Junior High School English classes in San Fernando, Camarines Sur to support the systematic integration of local health data into language instruction. Classroom implementation may include continuous refinement of activities based on teacher feedback and collaboration with local health offices to ensure relevance and accuracy of instructional content. The developed lesson plans may be formally adopted and piloted in selected Junior High School English classes in San Fernando, Camarines Sur to support the systematic integration of local health data into language instruction. Classroom implementation may include continuous refinement of activities based on teacher feedback and collaboration with local health offices to ensure relevance and accuracy of instructional content.
2. Continuous professional development programs may be provided to Junior High School English teachers to strengthen their capacity to interpret health statistics, scaffold institutional texts, and facilitate critical discussions on public health issues. Such training can enhance teachers' readiness to implement health-centered, data-informed language instruction effectively.
3. Regular review and updating of health-integrated lesson materials may be conducted as new Field Health Service Information System (FHSIS) reports become available. This will help ensure that instructional content remains current, contextually responsive, and aligned with emerging community health concerns.

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