

Reference Materials on Maternal and Child Health Related Policy Issues for Inter-Local Health Zones(ILHZ)

Province of Leyte
(Version 1)



August 2013

DOH/JICA/ IC Net Limited/HANDS

TABLE OF CONTENTS

I. Status, policy and activities on Maternal and Child Health(MCH).....	5
1. General Status of Maternal and Child Health in Leyte province	5
2. Status of Maternal and Child Health by Rural Health Unit (RHU) in Leyte province	7
3. Department of Health Main Health Thrusts (2005-present).....	8
4. Maternal and Child Health related activities and program in Leyte Province	9
II. Roles and responsibilities of LGU on Maternal and Child Health.....	11
1. General LGUs' roles and responsibilities in Maternal and Child Health.....	12
2. Expected LGU's support: Sustaining SMACHS EV initiatives.....	16
III. Maternal and Child Health (MCH) related Ordinances.....	19
1. Inter relationship of the three ordinances.....	19
2. Facility Based Delivery (FBD)	20
3. User's Fee (UF).....	20
4. Incentive for Volunteers (IV).....	21
IV. Practices on enactment/implementation of Maternal and Child Health (MCH) related ordinances in Leyte Province	22
1. Status of enactment of Maternal and Child Health (MCH) related ordinances.....	22
2. Steps on enactment of ordinances.....	23
3. Practices on Facility Based Delivery (FBD).....	25
4. Practices on Users Fee (UF)	33
5. Practices on Incentives for Volunteers (IV)	38

LIST OF ACRONYMS AND ABBREVIATIONS

ANC	Antenatal Care (Prenatal check up during pregnancy)
BEmONC	Basic Emergency Obstetric and Neonatal Care
BHS	Barangay Health Station
BHWs	Barangay Health Workers
CEmONC	Comprehensive Emergency Obstetric and Neonatal Care
CHD 8	Center for Health Development Eastern Visayas Office
CHT	Community Health Team
CHW	Community Health Workers
C/P	Counterpart
DH	District Hospital
DOH	Department of Health (in Manila)
DOH-CHD EV	Center for Health Development Eastern Visayas Office
FBD	Facility Based Delivery
ILHZ	Inter-local Health Zone
ILHZ-TMC	Inter-local Health Zone Technical Management Committee
IMR	Infant Mortality Rate
IV	Incentives for Volunteers
JICA	Japan International Cooperation Agency
KP	Kalusugan Pangkalahatan (Universal Health Care)
LGU	Local Government Unit
LHSD	Local Health Support Division
MC Book	Mother and Child Book
MCH	Maternal and Child Health
MCP	Maternity Care Package
MD	Maternal Death
MDGs	Millennium Development Goals
MDR	Maternal Death Review
MNDR	Maternal and Neonatal Death Review
MHO	Municipal Health Office (Officer)
MMR	Maternal Mortality Ratio
MNCHN	Maternal, Newborn and Child Health and Nutrition (Health Policy)
ND	Neonatal Death
NDR	Neonatal Death Review
NDHS	National Demographic Health Survey
NMR	Neonatal Mortality Rate
PH	Provincial Hospital
PHO	Provincial Health Office
PNC	Postnatal Care (Check up after delivery)
RHU	Rural Health Unit
SHP	Skilled Health Professional
SMACHS-EV	Project for Strengthening Maternal and Child Health Services in Eastern Visayas
SSV	Supportive Supervision
TBA	Traditional Birth Attendant
UF	User's fee

FOREWORD

In the Philippines, more than half of the pregnancies are reportedly at risk due to such causes as women experiencing more than four pregnancies or closely spaced pregnancies, i.e., less than three years' interval between pregnancies. The Maternal Mortality Ratio (MMR) was 162 per 100,000 live births in 2006, but increased to 221 in 2011. It is still far from the national Millennium Development Goals (MDG) of 52 per 100,000 live births by 2015. Therefore, the Government of the Republic of the Philippines (GRP) needs to reduce the MMR at a faster rate to achieve the national MDGs. However, the outlook for achieving them in five years is not promising. Meanwhile, the under-five mortality rate and the Infant Mortality Rate (IMR) have constantly decreased over the last 15 years. Thus, the Department of Health (DOH) predicts that it will achieve the national MDG 4 (reduction of child mortality) of 27 neonatal deaths per 1,000 live births in five years. Moreover, the DOH gives priority to maternal and child health program and has issued the Maternal, Neonatal and Child Health and Nutrition (MNCHN) policy that focus on improving the quality of services and delivery care.

From July 2010 to July 2014, the Japan International Cooperation Agency (JICA) conducts a Maternal and Child Health (MCH) project named Strengthening Maternal and Child Health Services in Eastern Visayas (SMACHS EV, or the "Project") in Leyte Province and Ormoc City. The Project aims to introduce the Basic Emergency Obstetric and Neonatal Care (BEmONC) system and improve the quality of MCH services according to the MNCHN policy. One of the project activities is to advocate LGUs on the support of MCH services by strengthening ILHZ function, which includes MCH related ordinances.

All Inter-Local Health Zone (ILHZ) in Leyte Province are now functional and conduct many activities, such as regular ILHZ TMC meeting, Maternal and Neonatal Death Review (MNDR) and referral system etc. Most of the community interventions, including implementation of ordinances, are roles and responsibilities of LGUs. In Leyte Province, enactment of MCH related ordinances progressed significantly. However, direct intervention and support to health centers and the communities are not yet enough. DOH and LGUs interventions to communities and to the improvement of the quality of health services need to be harmonized to obtain maximum results.

The Project, Department of Health-Center for Health Development in Eastern Visayas (DOH-CHD EV), and Provincial Health Office (PHO) agreed on the urgency to develop "Reference Materials on Maternal and Child Health Related Policy Issues for Inter-Local Health Zones(ILHZ)" to help them get and share ideas of main health interventions such as enactment and implementation of ordinances which is one of the most powerful interventions in the community by LGU. However, sometimes it gives a negative impact to the communities due to the inadequate infrastructures, financial resources and support to health workers. Ordinances should be culture sensitive to avoid giving unnecessary burden to the people. This material presents the status and examples of implementation of ordinances in Leyte Province to provide ideas and serve as reference for ILHZ.

We hope this material will help LGUs support communities to improve maternal and child health status and to prevent maternal and child deaths.

Director Jaime Bernadas

*Department of Health-Center for Health Development Eastern Visayas
(DOH-CHD EV)*

INTRODUCTION

Many interventions are done by the Department of Health (DOH) to achieve the national Millennium Development Goal (MDG) 4, reduction of child mortality, and MDG 5, reduction of maternal mortality, by 2015. A lot of effort was made on quality health services such as to improve the quality of health facilities and to strengthen the capacity of health workers. However, the progress of interventions to communities by LGUs, such as advocacy, improvement of physical access and support to community health volunteers, are varied.

Inter-Local Health Zone (ILHZ)¹ started since 2002 to build a strong partnership between DOH and LGUs for effective intervention especially in the communities. ILHZ is a district health system to improve cooperation /coordination among LGUs in health operations in the catchment community to assure access of individuals to a range of services necessary to meet their health care needs, and to manage more efficiently and equitably the cooperating LGUs' resources for health.² Yet the functions of ILHZ are not well understood by some LGUs and sometimes their support to ILHZ are not regular. Also, some LGUs in the same ILHZ do not have common/ collaborative strategies to tackle the health problem.

The Department of Health-Center for Health Development Eastern Visayas (DOH-CHD EV), Provincial Health Office (PHO) and the JICA SMACHS EV project decided to develop a reference material to promote and support better collaboration of LGUs within the ILHZ. The material is to help ILHZ board members for their better understanding of the following issues.

- Current status of Maternal and Child Health (MCH)
- LGUs role and responsibilities in Maternal and Child Health (MCH)
- Enactment and implementation of Maternal and Child Health(MCH) related ordinances such as Facility Based Delivery(FBD), User's Fee(UF) and Incentives for Volunteers(IV)

In this material, the status, obstacles, challenges, suggestions and recommendations on the above-mentioned issues are presented.

Core Team Members:

Dr. Paula Paz Sydiongco: Local Health Support Division, Chief, DOH-CHD EV

Dr. Corazon Sabulao: Maternal and Child Health Coordinator, DOH-CHD EV

Dr. Verna Fernandez : MS, ILHZ Coordinator, DOH-CHD EV

Dr. Ofelia Absin, Acting PHO 2, Provincial Health Office, Leyte

Dr. Edgardo Daya: PHO 1, Provincial Health Office, Leyte

Dr. Ma.Teresa Caidic, Chief Technical, Provincial Health Office, Leyte

Ms. Marina Alvaran: Maternal and Child Health Coordinator, Provincial Health Office, Leyte

ILHZ Technical Management Committee chairpersons in Leyte Province

Municipal Health Officers of Leyte Province

Ms. Satoko Ishiga: Chief Advisor, Project "Strengthening Maternal and Child Health Services in Eastern Visayas(SMACHS EV)", Japan International Cooperation Agency(JICA)

Mr.Minjel Naparate: Field Program Officer, SMACHS EV, JICA

¹ An **ILHZ** is a clustering of contiguous local government units (municipalities, component cities of a province/s) with a core referral hospital (district or provincial hospital) wherein preventive primary public health care is integrated with hospital care. (DOH: <http://www.doh.gov.ph/content/what-ilhz.html>)

² Quoted from <http://www.doh.gov.ph/content/what-ilhz.html>

I. Status, policy and activities on Maternal and Child Health(MCH)

1. General Status of Maternal and Child Health in Leyte Province

The fifth Millennium Development Goal (MDG 5) is to reduce the maternal mortality ratio worldwide by 75% between 1990 and 2015.³ An essential strategy for achieving MDG 5 is to ensure that all births are managed by skilled health professionals. This strategy requires high population coverage and an enabling environment, including 24-hour access to effective emergency obstetric care.⁴

In the Philippines, the Maternal Mortality Ratio (MMR), which was 162 per 100,000 live births in 2006, increased to 221 in 2011. It is still far from the national Millennium Development Goal (MDG) No. 5, MMR, at 52 per 100,000 live births by 2015. However, the outlook for achieving them in five years is not promising. Meanwhile, the mortality rate for children under the age of five and the Infant Mortality Rate (IMR) have consistently decreased over the last 15 years. Thus the Department of Health (DOH) predicts that it will be able to achieve the national MDG No.4 (reduction of child mortality) of 27 per 1,000 live births in five years by reducing neonatal deaths.

The following data of Leyte Province is based on the Field Health Service Information System (FHSIS) by Department of Health and the report to Provincial Health Office. Some data in 2012 are yet to be finalized.

1) Status of main Maternal and Child Health indicators in Leyte Province

Definition of indicators:

➤ Maternal Mortality Ratio:

Maternal death is defined as “The death of a woman while pregnant or within 42 days of termination of pregnancy, irrespective of the duration and site of the pregnancy, from any cause related to or aggravated by the pregnancy or its management but not from accidental or incidental causes.”⁵ It is expressed as the number of maternal death per 100,000 live births. The national target by 2016⁶ is 50 per 100,000 live births.

Maternal Mortality Ratio (MMR)	2009	2010	2011	2012
MMR in Leyte Province	39.64	74.49	67.02	70.37
MMR in Eastern Visayas	84.31	91.57	79	93

➤ Neonatal Mortality Rate:

Neonatal death is defined as “Deaths during the first 28 completed days of life.

³ Sachs JD, McArthur JW. The Millennium Project: a plan for meeting the Millennium Development Goals. *Lancet* 2005; 365: 347-53 pmid:

⁴ Graham W, Bell J, Bullough C. Can skilled attendance at delivery reduce maternal mortality in developing countries? In: DeBrouwere V, Van Lerberghe W, eds. *Safe motherhood strategies: a review of the evidence* (Studies in Health Services Organization and Policy). ITG Press; 2001. pp. 91-131. & Campbell OMR, Graham WJ. on behalf of The Lancet Maternal Survival Series steering group. Strategies for reducing maternal mortality: getting on with what works. *Lancet* 2006; 368: 1284-99 doi: [10.1016/S0140-6736\(06\)69381-1](https://doi.org/10.1016/S0140-6736(06)69381-1) pmid: [17027735](https://pubmed.ncbi.nlm.nih.gov/17027735/).

⁵ <http://www.who.int/healthinfo/statistics/inmaternalmortality/en/>

⁶ National objectives for Health Philippines 2011-2016, DOH.

Neonatal deaths may subdivide into early neonatal deaths, occurring during the first seven days of life, and late neonatal deaths, occurring after the seventh day but before the 28th completed day of life.” It is expressed as the number of neonatal death per 1,000 live births. National target by 2016⁷ is **10** per 1,000 live births.

Neonatal Mortality Rate (NMR)	2009	2010	2011	2012
NMR in Leyte Province	NA	NA	4.19	2.71
NMR in Eastern Visayas	NA	NA	NA	NA

➤ **Infant Mortality Rate:**

Infant mortality is defined as the death between birth and exactly one year of age expressed as the number of infant death per 1,000 live births. The national target by 2016⁸ is **17** per 1,000 live births.

Infant Mortality Rate (IMR)	2009	2010	2011	2012
IMR in Leyte Province	7.56	6.02	7.41	6.17
IMR in Eastern Visayas	8.98	7.76	9.39	6.95

2) Status of delivery

Status of delivery is classified as delivery attended by Skilled Birth Attendant (SBA) and delivery unattended by skilled birth attendants. Skilled Birth Attendant (SBA) delivery includes; a) Facility Based Delivery (FBD: delivery in health facilities with skilled health workers such as midwives, doctors, and nurses) and b) home delivery with skilled birth attendants.

Facility based delivery is most recommended one because of the availability of appropriate equipment. However, home delivery with skilled birth attendants is still acceptable, to cases with problems of accessibility to health facilities. **Home delivery with hilots (unskilled birth attendants) should be avoided due to high risk.** The national target by 2016⁹ is **90%** for both.

Delivery with Skilled Birth Attendant(SBA)	2009	2010	2011	2012
SBA in Leyte Province	79.5%	81.5%	84.0%	85.0%
SBA in Eastern Visayas	71.5 %	78.8 %	75.0%	79.3 %

Facility Based Delivery (FBD)	2009	2010	2011	2012
FBD in Leyte Province	42.3%	55.5%	73.1%	83.0%
FBD in Eastern Visayas	54.6%	50.3%	57.6%	66.3 %

3) Status of Antenatal Check-up/Postnatal Check-up(ANC/PNC)

- **Antenatal care (ANC**, also known as prenatal care) refers to the regular medical and nursing care recommended for women during pregnancy. In the Philippines, it is recommended to go at least 4 ANCs. The first visit should be done in the first trimester, another during the second trimester and completing two more visits in the last trimester until delivery. The national target by 2016¹⁰ is **90** %.

⁷ National objectives for Health Philippines 2011-2016.

⁸ National objectives for Health Philippines 2011-2016.

⁹ National objectives for Health Philippines 2011-2016.

¹⁰ National objectives for Health Philippines 2011-2016.

Antenatal Care (ANC) 4 times and more	2009	2010	2011	2012
ANC in Leyte Province*	37.7%	22.3%	28.0%	32.7%
ANC in Eastern Visayas**	54.4%	57.1%	51.4%	48.8%

*Cleaned data.

** Data is not cleaned.

- **Postnatal care (PNC, Postpartum** in reference to the mother) is the care given to the baby and mother immediately after the birth /delivery until the first six weeks.

Postpartum Visits (PNC) 2 times and more	2009	2010	2011	2012
PNC in Leyte Province	59.8%	63.8%	61.1%	62.3%
PNC in Eastern Visayas	60.8%	55.4%	66.2%	54.3%

2. Status of Maternal and Child Health by Rural Health Unit (RHU) in Leyte Province

Table 1: Status of Maternal and Child Health by RHU in Leyte Province

Rural Health Unit of Municipality	Reported No. of Maternal Death		Reported No. of Neonatal Death		Facility Based Delivery	ANC (Prenatal Care)	PNC (Postnatal Care)
	2011	2012	2011	2012			
Abuyog I	0	0	1	1	95.7%	52.8%	68.4%
Abuyog II					93.1%	33.6%	47.9%
Alang-alang	2	0	0	2	90.7%	26.7%	68.4%
Albuera	1	0	13	7	90.5%	29.0%	72.8%
Babatngon	0	0	0	0	98.1%	40.1%	87.6%
Barugo	0	0	1	3	69.2%	24.5%	39.8%
Bato	0	1	4	6	88.0%	16.5%	54.4%
Baybay I	2	4	6	12	67.8%	25.1%	59.4%
Baybay II					78.5%	31.0%	58.4%
Burauen	0	1	3	4	82.9%	27.1%	33.5%
Calubian	2	0	5	1	55.4%	53.9%	65.1%
Capoocan	0	0	0	1	88.7%	36.8%	66.3%
Carigara	1	0	2	0	95.8%	29.1%	55.8%
Dagami	0	1	0	1	91.6%	25.3%	69.6%
Dulag	0	0	2	0	81.1%	29.9%	64.9%
Hilongos I	0	0	8	8	86.2%	10.8%	53.6%
Hilongos II					87.5%	22.6%	50.8%
Hindang	0	1	6	1	78.7%	13.8%	48.9%
Inopacan	0	0	5	0	82.2%	30.7%	60.9%
Isabel	1	0	4	3	91.5%	52.2%	60.2%
Jaro	0	0	0	1	92.4%	14.3%	50.3%
Javier	1	0	1	0	98.1%	55.1%	40.9%
Julita	0	0	0	1	81.5%	42.8%	67.5%
Kananga	0	2	6	7	44.9%	17.4%	69.1%
Lapaz	0	0	0	2	60.9%	16.6%	68.4%
Leyte-leyte	0	3	3	4	84.3%	35.1%	64.7%
MacArthur	0	1	1	0	84.8%	26.2%	78.7%

Mahaplag	0	0	3	3	66.9%	21.8%	56.4%
Matag-ob	0	0	14	9	81.4%	35.4%	56.3%
Matalom	0	1	2	1	93.9%	69.2%	90.1%
Mayorga	0	0	0	1	83.7%	23.7%	60.5%
Merida	2	2	6	8	96.7%	13.8%	55.9%
Palo	0	0	5	1	80.7%	25.4%	71.1%
Palompon I	2	0	11	4	78.8%	30.4%	57.8%
Palompon II							
Pastrana	0	0	0	1	92.1%	37.9%	62.9%
San Isidro	1	3	2	5	77.3%	27.0%	48.4%
San Miguel	0	0	2	0	77.9%	36.3%	54.2%
Sta. Fe	0	0	0	0	100.0%	60.2%	100.0%
Tabango	2	1	2	4	33.9%	36.5%	100.0%
Tabon-tabon	1	1	1	0	97.0%	34.3%	70.7%
Tanauan	0	0	2	1	89.8%	15.0%	50.7%
Tolosa	0	0	0	0	98.2%	63.4%	59.7%
Tunga	1	0	0	0	96.7%	53.3%	59.7%
Villaba	1	0	5	4	65.5%	35.7%	62.2%
Unknown*	0	0	6*	1*			
TOTAL	20	21	132	108	83.0%**	32.7%**	62.3%**

*The location of death is unknown

**Average of all LGUs.

3. Department of Health Main Health Thrusts (2005-present)

The following are the three main national health policies.

FourMula One

In 2005, the Department of Health adapted FourMula One for Health as the implementation framework for the Health Sector Reform Agenda (HSRA). FourMula ONE for Health is directed at achieving goals of better health outcomes, more *responsive health system and equitable health care financing*. Province-wide investment plans for health and LGU scorecards were developed, and ILHZs were strengthened.

Maternal, Newborn and Child Health and Nutrition (MNCHN) Policy

In 2008, the DOH issued the Maternal, Neonatal and Child Health and Nutrition (MNCHN) policy implementing health reforms for rapid reduction of maternal and neonatal mortality. It focuses on improving the *quality of services and care for mothers and children*. MNCHN grants were provided to the provinces to improve indicators like Antenatal Care, Facility Based Delivery, Fully Immunized Child, and Contraceptive Prevalence Rate.

Universal Health Care

In 2010, the Aquino administration issued AO no.2010-0036, the Aquino Health Agenda: Achieving Universal Health Care for All Filipinos also referred to as *Kalusugan Pangkalahatan (KP)*, to improve, streamline and scale-up reform strategies in FourMula One in order to address inequity in health outcome by ensuring *equitable access to quality health care, especially for the poorest of the poor*. This involves financial risk protection, health facility enhancement and achieving Millennium Development Goals.

4. Maternal and Child Health related activities and program in Leyte Province


1) Department of Health –Center for Health Development Eastern Visayas

The following are the main programs related to Maternal and Child Health, which DOH-CHD EV is currently implementing in Leyte Province.

No	Title of activities	
1	Health Facility Enhancement Program(HFEP)	Upgrading/Renovations of Health Facilities – Hospital/RHU/BHS (Infrastructure and Equipment packages)
2	MNCHN Program	Training of doctors, nurses and midwives Upgrading hospitals/RHUs/BHSs Provision of drugs, medicines Vaccine, Vitamin A, Oxytocin, Zinc, Micronutrient powder Provision of Family Planning commodities Provision of Mother and Child book Provision of vaccine refrigerator Provision of supplies e.g. needles, syringes for vaccination, safety collector’s box, newborn screening kits Monitoring and supportive supervision on programs
3	Strengthening ILHZ and referral	Give technical support to ILHZ TMC Give technical support to Regional Health Referral System Memorandum of Understanding Monitoring of implementation of Health Referral System Give technical assistance in crafting in the ordinances/policies related to maternal and child health

2) Development Partners

The following are the main projects organized and supported by international development partners in Leyte Province. USAID targets Family Planning (FP) and approaches private sectors, which are not included in the JICA project.

Name of the Project	Name of Donor	Main activities
<p>SMACHS EV (Strengthening maternal and Child Health Service in Eastern Visayas)</p> 	<p>JICA (2010-2014)</p>	<ul style="list-style-type: none"> • Provision of equipment ¹¹ for the 18 JICA target RHUs • Capacity building of doctors, nurses and midwives of RHUs/BHS on Basic Emergency Obstetric Newborn Care.(BEmONC)¹² • Strengthening monitoring system on maternal and child health services in Rural Health Units • Strengthening referral system • Technical inputs on maternal and neonatal death review. • Supporting community health team activities • Advocacy of LGUs through strengthening function of ILHZ
<p>Integrated Health for Visayas</p>	<p>USAID (2013-2018)</p>	<ul style="list-style-type: none"> • Scaling up Family Planning(FP) Service Delivery, strengthening the supply of MNCHN/FP Service of public sector • Removal of Local Policy and Health Systems Barrier • Strengthening DOH CHD EV's capability to support on local operations in the content of the MNCHN strategy
<p>Private Sector Mobilization for Family Health (PRISM) -Phase 2</p>	<p>USAID (2010-2014)</p>	<ul style="list-style-type: none"> • Increasing private sector contribution on family planning • Maximizing the contribution of professional practice of midwives on Family Planning and Maternal and Child Health • Develop alternative distribution points of Family Planning and MNCHN commodities • Strengthening referral network (Service Delivery Network) • Collaboration with private health facilities

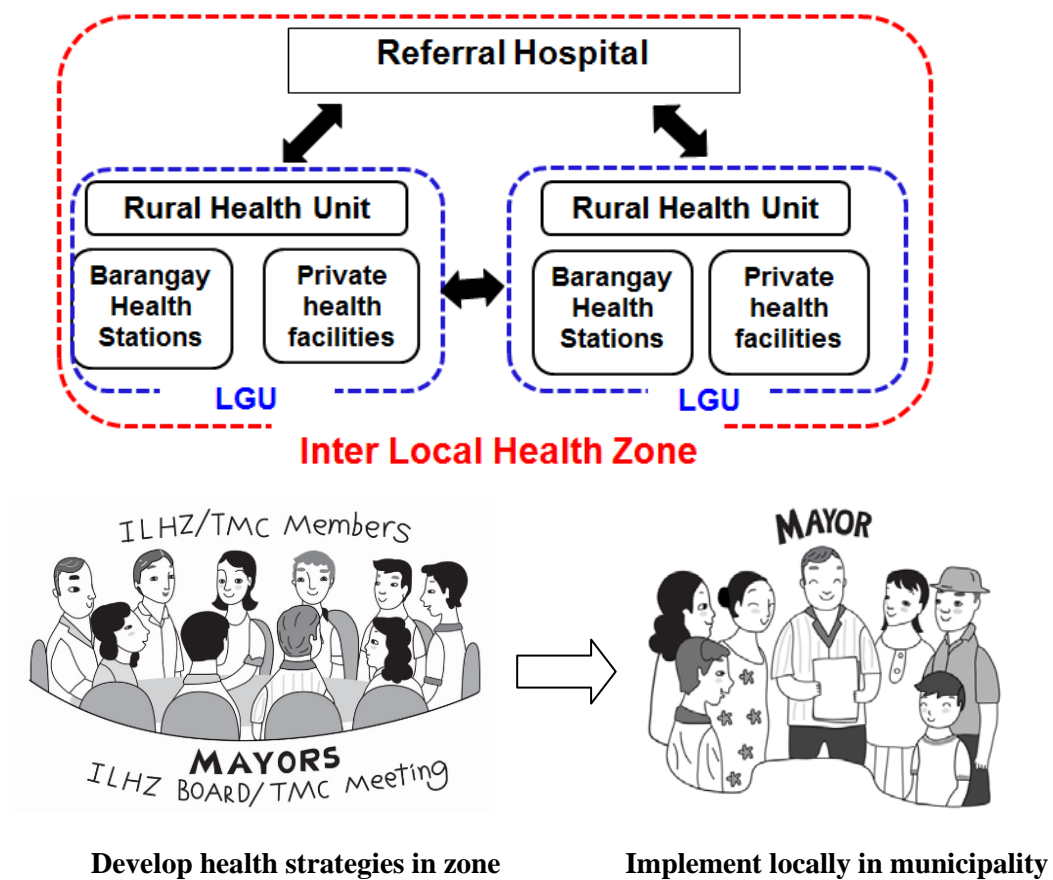
¹¹ JICA provided medical equipment which are related to maternal and neonatal care to 18 selected RHUs in Leyte Provinces. But other activities includes 41 LGUs .

¹² Of MCH care, BEmONC is considered very important as many maternal and child deaths occur during delivery and neonatal period.

II. Roles and responsibilities of LGU on Maternal and Child Health

Inter-Local Health Zone (ILHZ) is the ideal governance structure for the local health system development. It is a zone comprising of a cluster geographically contiguous municipalities with a defined population base served by a core referral hospital and a number of primary level facilities such as Rural Health Units and Barangay Health Stations. The importance of establishing ILHZ is to re-integrate hospital and public health services for a holistic delivery of health services.

Figure 1: Concept of Inter-Local health Zone



Aim for Inter-Local Health Zone

- Universal coverage of health insurance
- Quality services of hospital and RHU services
- Effective referral system
- Integrated health planning
- Appropriate health information sharing
- Integration of public health and curative hospital care
- Human Resources sharing
- Strong cooperation between LGUs and the health sector

1. General LGUs' roles and responsibilities in Maternal and Child Health

LGUs have certain roles and responsibilities to ensure the health and well-being of the people in the community. Listed below are the ways by which LGUs can support for the improvement of Maternal and Child Health.

Though good health facilities and assignment of sufficient number of quality health personnel are essential, prioritization of implementation varies according to the status and need of the RHU.

1) Enactment and implementation of Maternal and Child Health related ordinance

Refer to “III: Maternal and Child Health related ordinances”

- Smooth and culture friendly implementation of health related ordinance



2) Support national campaign & health events (e.g. Vaccination)

- Support procurement of essential consumables and drugs for vaccination campaign (needles, syringes, Paracetamol, Anti-allergy, etc.)
- Shoulder transportation of health personnel and community health volunteers
- Provision of collaterals such as T-shirts, umbrella, fan etc.
- Advocacy support (posters, tarpaulin, tri-media campaign etc.)
- Provision of meals for health volunteers who join the events.



3) Support national health program

- Reproduction of Mother and Child book and all MNCHN forms (BEmONC clinical form, Supportive supervision form, referral forms, etc.)
- Support improvement of monitoring (e.g. support transportation, participate in regular supportive supervision¹³)
- Support program/ project implementation of all development partners
- Coordinate with stakeholders in the municipality (meeting etc.)
- Support bloodletting activities quarterly (e.g. communication, provision of food, transport for donors to go to RHU/ hospital)
- Local implementation of the National Health Insurance Program (Shoulder the cost for indigent, reimbursement of fee to health facilities)
- Enactment and implementation of MCH related ordinances and inclusion of budget for the implementation of ordinances.



4) Support maintenance of health facilities and supply of consumables

- Construction of burial pits for sharps and biological waste (placenta)
- Ensure back up power in case of power interruption (generator)
- Ensure adequate and safe water supply
- Ensure repair and renovation of facilities, when necessary
- Ensure cleanliness of surroundings of health facility
- Share PhilHealth reimbursement and user's fee with health facilities
- Provide communication facilities (landline, internet)
- Provide basic and emergency medicine (IV fluid, oxytocin, anti-biotic).
- Provide medical supplies and laboratory reagent
- Conduct rational procurement of drugs according to "DOH drug formulary".
- Ensure proper storage and dispensing of drugs in the health facilities.



¹³ Explain what are supervision. BEmONC supervision, (DH-RHU), (PHN-BHS)

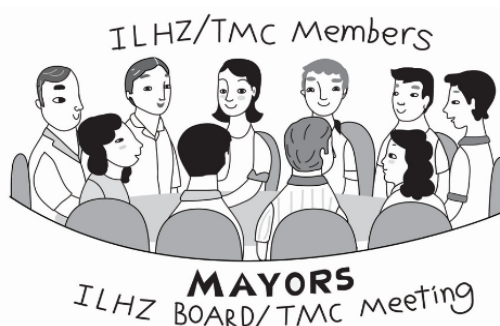
5) Ensure adequate health manpower and capacity building

- Recruitment of sufficient number of needed health manpower, adapt required ratio of health personnel
Minimum requirement: 1Municipal Health Officer /20,000 population,
1 midwife/5,000 population
- Ensure security of tenure of health workers according to the required standard qualification.
- Update salary and benefits(incentives) for health manpower
- Ensure to send personnel to the trainings.
- Shoulder the training cost of health personnel(fee, transportation, accommodation, per diem)
- Support staff development (e.g. Conduct technical exchange, inception workshop, team building, values orientation)
- Give recognition to good and performing health personnel.



6) Ensure functionality of Inter-Local Health Zone (ILHZ)

- Regular attendance to Inter-Local Health Zone (ILHZ) board meeting quarterly and ILHZ Technical Management Committee (TMC) meeting monthly.
- Approve ILHZ work and financial plan timely (by November of the previous year)
- Conduct regular municipal local health board meeting monthly
- Contribute Common Health Trust Fund (CHTF) annually in annual municipal budget
- Attend orientation/update of ILHZ by Department of Health-Center for Health Development in Eastern Visayas & Provincial Health Office.
- Deliberate and approve resolutions passed by ILHZ TMC and follow up implementation
- Integrate municipal health plan into ILHZ health plan



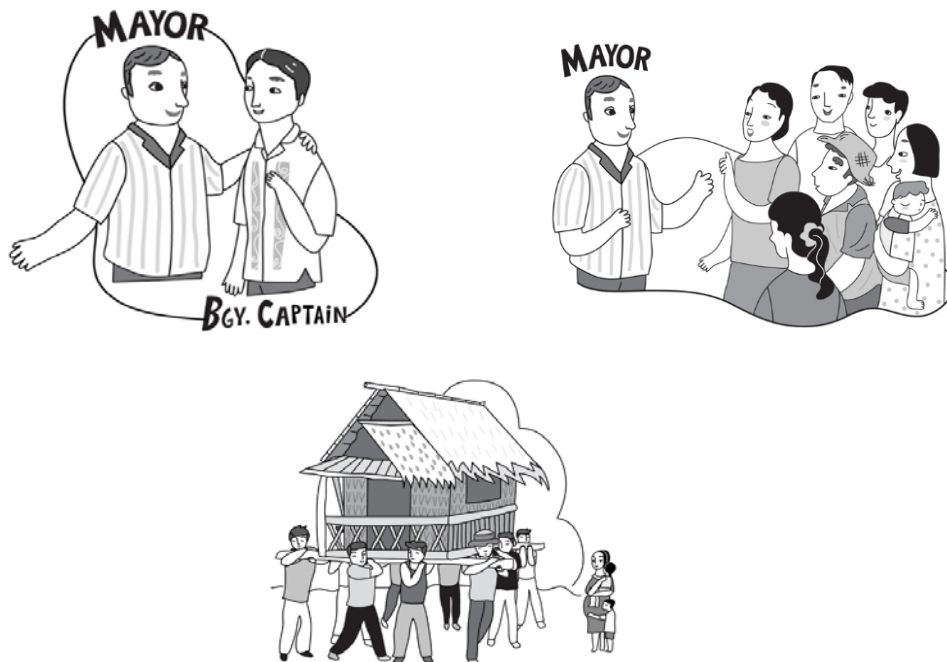
7) Support functional referral system

- Harmonize and collaborate with other LGUs within the ILHZ to support the core referral hospitals(District Hospitals, Province Hospital)
- Provide emergency transport car to Rural Health Unit (maintenance, reimbursement of fuel cost)
- Provide communication facility (provision of mobile, ensure communication line from referring facilities to referral facility)
- Improve access to health facilities (e.g. construction of road or bridge, coordination)
- Establish birthing clinics for poor access area. Construction of waiting home for pregnant women (especially for Facility Based Delivery)
- Reproduction of referral log books and forms



8) Empower communities

- Support community health volunteers in the process of recruitment, selection, and tenure (e.g. certificate).
- Provide transport allowance and incentives
- Involvement of barangay captain in health related activities and counterpart budget
- Advocacy to communities (community assemblies, meetings)



2. Expected LGU's support: Sustaining Strengthening Maternal and Child Health Services in Eastern Visayas (SMACHS EV) initiatives

Based on the identified roles and responsibilities of LGUs, the SMACHS EV presents the concrete examples on supports by LGUs, which are expected to ensure efficacy and sustainability of the whole activities after the closure of the project in 2014.



The project duration is from June 2010 to July 2014. The activities, which were conducted by SMACHS EV together with expected roles of LGUs, are presented below.

1) Provision of equipment

- JICA provided necessary BEmONC equipment to 18 RHUs (AlangAlang, Albuera, Bato, Dulag, Hindang, Inopacan, Isabel, Jaro, Javier, MacArthur, Leyte, Mahaplag, Merida, Pastrana, San Miguel, TabonTabon, Tanauan, Tolosa) and Kananga Municipal Hospital and Tabango Community Hospital.¹⁴
- PHO will provide equipment to non JICA targeted facilities through Health Facility Enhancement Program (HFEP)

To use equipment effectively and in good condition, maintenance and supply of consumables are required for an effective use of equipment. However, Municipal Health Officer (MHO) should check the situation and make a timely request to LGUs.

- Budget consumables and repair cost annually. MHO will calculate the approximate amount.
- Pay maintenance expenses of equipment according to the request (e.g. for repair, exchange of spare parts)
- Supply of consumables (e.g. battery for Doppler, Oxygen for tank, etc.)

2) Capacity building of medical doctors, nurses, midwives of RHUs/BHSs

- JICA trained 22 teams composed of 1 doctor, 1 nurse, and 1 midwife from the 18 RHUs, Kananga Municipal Hospital and Tabango Community Hospital on Basic Emergency Obstetric and Newborn Care.(BEmONC)
- JICA trained 105 Midwives of BHSs under 18 RHUs on BEmONC.
- PHO will train the rest of the non-JICA targeted RHUs and BHSs in 2013 and 2014 on BEmONC in Eastern Visayas Regional Medical Center.
- JICA trained District/Provincial hospital teams to conduct supportive supervision to monitor the health services of RHUs and BHSs.

One key factor in ensuring quality health services is to continually build health personnel capacity. On that account, LGU can support such endeavor by allocating funds for the activities. In addition, the local government can provide transport for the District/Provincial hospital teams in visiting and monitoring RHUs.

- Budget at least one training for doctors, nurses and midwives.
- Shoulder the training/meeting cost (e.g. transport, accommodation, training fee, per

¹⁴ These 20 health facilities (18RHU,1 municipal hospital and 1 community hospital) are JICA targeted facilities on provision of equipment and training.

- diem etc.)
- Offer transport (car, bus) to district/province hospital team to conduct supportive supervision. Team will communicate with the LGUs, if they need support.

3) The conduct of effective Maternal and Neonatal Death Review(MNDR)

- The first Maternal and Neonatal Death Review (MNDR) in the Philippines was conducted in Leyte Province.
- Each ILHZ conducts quarterly MNDR
- Bi annual provincial MNDR is conducted regularly.

LGUs should recognize at least the number of maternal death. Maternal and Neonatal Death Review is an important meeting to learn from the death and prevent the similar incidents.

- Receive/ask the report from MHO if maternal death occurs.
- Organize municipal level meeting if maternal death occurs often.
- Contribute annual ILHZ fee to support budget to hold ILHZ based MNDR.
- Offer the venue of ILHZ based MNDR, if necessary.
- Support cost of information collection in the community (e.g. for interview of families)

4) Strengthening referral system

- ILHZ based Health Referral System protocol is confirmed by LGUs and implemented.
- Trained about 70 hospital workers and 340 public health workers on referral system
- Support regular conduct of referral meeting.

Referral is strongly an access-related issue. As a key stakeholder, the LGU can improve referral by improving physical access and communication network. Also, LGUs can support in the improvement of quality of referral facilities.

- Allocate budget to conduct regular referral meeting at least once a year.
- Support improvement of emergency communication network
- Print and distribution of telephone directory of emergency contacts to the community and health workers
- Ensure emergency communication line (landline, radio etc.) between hospitals and health facilities
- Ensure emergency transport
 - Provide ambulance to RHUs/ hospitals for emergency
 - Establish system to shoulder transport fee for indigent people
 - Organize Barangay Captains to establish local emergency transport
- Improve service quality of referral hospital through ILHZ
- Support employment of health personnel, upgrade of facilities, equipment and supply of consumables.

5) Strengthening function of Community Health Team (CHT)

- About 250 health workers were trained as facilitators of CHT training.
- About 2,200 Community Health Teams (CHT) from JICA target municipalities were trained on community activities. The Project developed and distributed CHT guidebook.
- The Project provided stationary, bag, T-shirts etc. as incentives to volunteers.
- 3 CHT conventions were held. Outstanding CHT members who contributed to the improvement of Maternal and Child Health status were awarded.

Community Health Team (CHT) members are the main players in the community to reach to households. Their roles are becoming obligatory and tough. LGUs should be the main supporter of CHT members as they are the only players who can directly approach the community.

- Support essential logistics for CHT members to conduct their activities
 - Provision of essential forms such as MC book and stationaries
 - Support transportation fees
- Budget to conduct regular CHT meeting/ CHT convention
 - Support meals, transport fee for monthly CHT meeting
 - Include CHT recognition/awarding into existing events such as municipal Christmas ceremony.
- Advocate barangay captain on the support of CHT activities
 - Support monthly meeting
 - Supply incentives for volunteers
- Provide incentives or regular honorarium for CHT volunteers through enactment of ordinances
- Advocacy of barangay captain on CHT activities
- Support orientation or re-orientation of CHT volunteers
 - Transportation cost, per diem, accommodation

6) Strengthening Inter-Local Health Zone (ILHZ) function

- Support conduct of Joint Inter-Local Health Zone Technical Member Committee (ILHZ TMC) meeting. (At least twice per year)
- Support conducts of Joint ILHZ board meeting
- Advocate LGUs on the participation in the ILHZ activities and the support on MCH activities

ILHZ is a system to improve the health status of the areas in collaboration with neighboring municipalities to share burden and costs.

- Participation in the ILHZ related activities at each ILHZ (e.g. meeting etc.)
- Collaboration with other municipalities in the same ILHZ on health related activities (e.g. Joint health campaign etc.)
- Participation in the joint ILHZ board meeting
- Annual contribution of ILHZ fund
- Support management of ILHZ fund
- People friendly implementation of Maternal and Child Health (MCH) related ordinance

III. Maternal and Child Health (MCH) related Ordinances

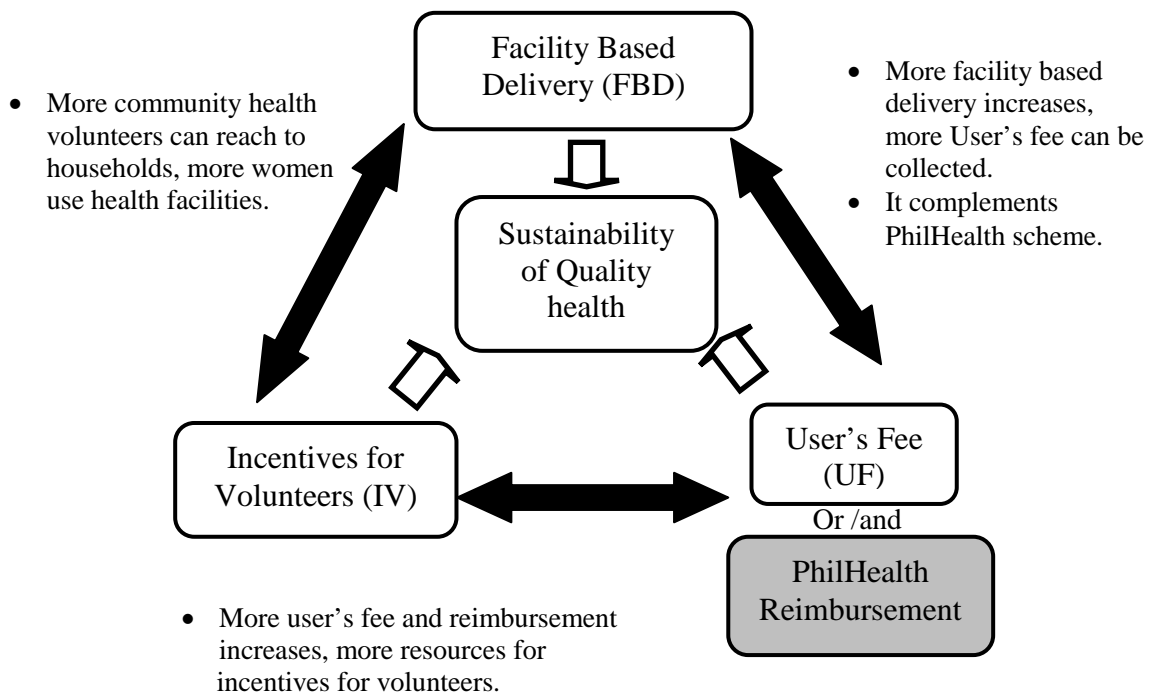
Three ordinances are considered vital in the improvement of the status of Maternal and Child Health (MCH) in the LGUs. This chapter will explain what are these ordinances and the status of its implementation. The experiences of some municipalities tell us that ordinances should be culture sensitive and supportive to the communities.



1. Inter relationship of the three ordinances

Facility Based Delivery, User's Fee and Incentives for Volunteers are interrelated. Therefore, to save time and effort in the deliberation, community hearing and approval, some municipalities have combined the three ordinances into one ordinance. The following chart presents how three ordinances are interrelated.

Figure 2: Inter relationship of three ordinances



- More mothers deliver at health facilities
 - More fund to ensure quality services at health facilities through PhilHealth reimbursement and/or user's fee.
 - More resources to give incentives for health workers and CHT
- More incentives to CHT
 - Better performance of CHT, better access to households to advocate community
 - More mothers deliver at health facilities

2. Facility Based Delivery (FBD)

The ordinance on Facility Based Delivery (FBD) promotes quality antenatal care (ANC), Delivery, and Postnatal care (PNC) at health facilities. It promotes pregnant women to deliver at health facilities to prevent death, which may occur before/during/after delivery due to the lack of skilled birth attendants, equipment, and delay of referral.



Contents of FBD ordinance

- Ensure quality antenatal care (ANC), delivery and postnatal care (PNC) at health facilities.
- Regulation of delivery by unskilled birth attendant (Hilots/ Traditional Birth Attendants)
- Fines, sanction and offences for offenders
- Special assistance to mothers

Benefits of implementing FBD ordinance

- Increase demand for better access to quality health facilities
- Increase demand for quality health services on ANC/delivery/PNC
- Increase number of clients and the amount of income (e.g. PhilHealth reimbursement, user's fee)
- Reduce maternal and neonatal deaths due to the complications in home deliveries and by unskilled birth attendants

3. User's Fee (UF)

The User's fee ordinance is intended to establish fees to be collected for certain health services. It applies to those non-PhilHealth clients availing services from PhilHealth accredited facilities or those clients availing the same benefits from non-PhilHealth accredited facilities.

In general, there are four main sources of financing: (1) national and local government, (2) Insurance (government and private), (3) user fees/out of pocket, and (4) donors. User's fee is a direct income that comes from the payment of services provided by the health facilities (Birthing facilities/RHU/hospitals). When the facilities are not accredited by PhilHealth scheme, users are not covered by insurance scheme and treatment are not covered by insurance scheme, LGU can still charge fee by ordinance to get funds to ensure the quality services at health facilities.

Contents of User's fee ordinance

- List of services and laboratory exam and corresponding rate/fees
- Flow of payment
- Financial flow and income sharing scheme
- Exceptions and support to indigent people



Benefits of implementing User's Fee ordinance

- Enable to get the funds to ensure quality of services of health facilities independently (complementary with PhilHealth reimbursement)
 - Even if user's and their treatment are not covered by insurance scheme package.
- Enable to ensure source of incentives for health workers.

4. Incentive for Volunteers (IV)

The ordinance on Incentives for Volunteers (IV) aims to encourage and motivate community health workers in implementing their tasks.

“Volunteers” are persons who serve specific functions on their own accord and without compulsion or promise of re-numeration. However, community health volunteers are now expected to perform multiple tasks in the Universal Health Care (Kalusugan Pangkalahatan) as main players to reach households members, which make their tasks almost compulsory. They sometimes pay for necessary expenses such as transport. Many community-based works cannot be done without community health volunteers. Therefore, a system to provide stable supports for them should be established to ensure continuity of their activities.

Contents of Incentives for Volunteers (IV) ordinance

- Criteria on who are entitled to receive incentives
- Rate and frequency of payment
- Source of incentives
- Requirements and process on how to avail incentives



Benefits of implementing Incentives for Volunteers ordinance

- Increase motivation of volunteers to perform their task
- Improvement in quality/quantity of services provided by community health volunteers (e.g. pregnancy tracking, antenatal Care ,prenatal care, postpartum care, newborn care etc.)
- Increase utilization of health facilities by clients
- Improve health promotion in households

An illustration of a woman wearing a dark uniform with 'MUNICIPALITY XXX' on it, holding a sign that says 'CHT' and an umbrella with 'MUNICIPALITY XXX' on it. She is standing next to a large scroll containing text.

Please recognize us as
“Community Health Workers.”
and please support us to
continue our work.

Current tasks of Community Health workers

- Households profiling
- General health education
- Pregnancy tracking
- Identification of Tuberculosis
- Education on Family Planning
- Promotion of pre and post-delivery check up
- Promotion of facility based delivery
- Participation in Monthly meeting and reporting

**Are they Community Health Volunteers ??
Or Community Health Workers?**

IV. Practices on enactment/implementation of Maternal and Child Health (MCH) related ordinances in Leyte Province

1. Status of enactment of Maternal and Child Health (MCH) related ordinances

The status is based on the database, which the Project updates regularly. There are **10 Inter-Local Health Zones** composed of 41 municipalities in the Province of Leyte. The current status of enactment of three ordinances¹⁵ is presented in the following table. 26 (63.4%) have Facility Based Delivery ordinance, 27 (65.9%) of 41 municipalities have User's Fee ordinance, and 23(56.1%) have Incentives for Volunteer ordinance.



Table 2: Status of enactment of ordinances

Name of ILHZ	Name of Municipality	FBD	UF	IV	Name of ILHZ	Name of Municipality	FBD	UF	IV
Calesan	Calubian	1	1	1	Leyte Plains	Burauen	1	1	1
	Leyte	1	1	1		Dagami	1	1	1
	San Isidro	1	1	1		Julita	1	1	1
Golden Harvest	AlangAlang	1	1	1		Lapaz	1	1	1
	Babatngon	0	0	0		TabonTabon	1	1	1
	Pastrana	0	0	0		Leyte West Coast	Isabel	1	1
	Sta. Fe	1	1	1	Palompon		1	1	1
Goodwill	Barugo	1	1	1	Tabango		0	0	0
	Jaro	0	0	0	Villaba		0	0	0
	SanMiguel	1	1	1	Mabahinhil	Bato	0	1	0
	Tunga	0	0	0		Hilongos	0	0	0
	Capoocan	0	0	0		Hindang	1	1	0
	Carigara	0	0	0		Matalom	0	0	0
Kammao	Albuera	1	1	1	Maharlika	Abuyog	1	1	1
	Kananga	1	0	0		Javier	1	1	1
	Mata-gob	0	1	0		MacArthur	1	1	1
	Merida	1	1	1		Mayorga	1	0	0
Leyte Gulf	Dulag	1	1	1	Mainbay	Baybay	0	1	0
	Palo	0	0	0		Inopacan	1	1	1
	Tanuan	1	1	1		Mahaplag	0	0	0
	Tolosa	1	1	1		Total	26/41	27/41	23/41

0: RHU which have no ordinance.

1: RHU which enacted municipal ordinance

¹⁵ This number includes 3 in 1 ordinances as enactment of ordinance.

2. Steps on enactment of ordinances

To get a clear picture on the implementation of ordinances, the Project conducted an in depth interview with Municipal Health Officers (MHOs) in municipalities that have ordinances from October 2012 to March 2013.

1) Steps of the enactment of ordinances

A) Steps to enact and implement ordinances

Very similar processes are taken by municipalities. The following are the usual steps in enacting ordinances.

- Drafting of ordinance
- 1st reading, deliberation
- 2nd reading, deliberation
- Public hearing
- 3rd reading
- Publication
- Approval by Sangguniang Bayan (SB), Mayor, and Vice Mayor
- Validity from Sangguniang Panlalawigan (SP) of Leyte Province
- Dissemination: Barangay Captains, community, Community Health Teams, RHUs, Hilots
- Public announcement (Newspaper, Radio, Bulletin board, etc.)

However, in terms of process, target group and grade, there is a difference in relation to ordinance drafting public hearing and disseminating the information. For example, draft is made by copying from other municipalities or having a collaborative drafting as ILHZ. Then with regards to public hearing, the difference lies in the mass or the population or the target group. Furthermore, there is a variation in the type of media used in the dissemination – bulletin board, poster, brochures, radio and TV are some of the commonly utilized form.

2) Suggestions on enactment of ordinances in the process



Suggestions on the processes:

The following four steps in the process of enactment/implementation of ordinance influence a lot.

	Process	Suggestions
1	Drafting ordinance	<p>It is a time consuming process if draft to be made from scratch. Learn from municipalities with existing ordinances or to use ILHZ network to draft an ILHZ resolution, which will later be adapted as municipal ordinance.</p> <ul style="list-style-type: none"> • Use prototype ordinances (e.g. Get a template from Provincial Health Office) • Pattern from existing ordinance and localize. (e.g. Consult with other municipalities in the same ILHZ) • Collaborate with other municipalities in drafting ordinance.
2	Popularization Advocacy	<p>Involvement and participation of the constituents is important, especially in clarifying issues and concerns. Be strategic and systematic in order to cover the entire concerned populace in the area or municipality.</p> <ul style="list-style-type: none"> • Conduct hearing strategically. (e.g. Invite focus group who might be affected by ordinances) • Conduct hearing systematically (e.g. community assembly, barangay sessions) • Good preparation of hearing (e.g. pre information, better arrangement) • Presence of technical people (e.g. Municipal Health Officer)
3	Dissemination	<p>Continuous dissemination is essential.</p> <ul style="list-style-type: none"> • Use the most effective media for mass dissemination. (e.g local newspaper) • Use media that is suitable for the target group. • Use existing opportunities (e.g. during flag ceremony, ABC meeting, community assembly meeting etc.) • Use health facilities for dissemination (e.g. during consultation, poster/ bulletin board of RHU, BHS, Birthing clinic, pre-marriage counseling, local announcement “Bandillo”) • Plan both short and long-term dissemination. (e.g. intensive dissemination by special measures, during regular community assembly)
4	Implementation	<ul style="list-style-type: none"> • Clarify the commitments of LGUs before starting the implementation, particularly, in support groups that might be affected by the implementation. • Set a rule to allow exceptions for deferment of implementation of ordinance/penalty by register. (e.g. the communities which have difficulties in access and indigent households etc.) • Allow reprimanding for first offenses and give a chance to discuss the case with the offenders.

3. Practices on Facility Based Delivery (FBD)

It is still a big question if LGUs or Department of Health (DOH) can force people to deliver in a health facility as people have their own right to choose where and how they deliver their baby.



However, it is universally recommended that professional care such as delivery by skilled birth attendant and facility-based delivery be practiced in order to ensure the health of both mother and newborn.

Ordinance is a measure to encourage people for safe delivery to improve maternal and child health. However, when LGUs start implementing the FBD ordinance, people who have poor access to health facilities must not be disregarded and overlooked. Therefore, LGUs need to have a strong support and commitment in ensuring better access to the health facilities/health professionals and provision of quality services.

1) Reaction of people in the communities

Some people positively accepted ordinance as it ensures safe delivery, others accepted as negative. The main opponents and reasons are presented below. LGUs need to prepare how to convince them and the most important, support them.

Main group which are affected by implementation of Facility Based Delivery ordinance

- Hilots: they lose their means of livelihood
- Women who are not entitled by PhilHealth : they have to pay extra cost
- Women who have poor geographic access to facilities: it will give them heavy burden to go to facilities.
- Women who have children/family: they cannot care for their children/family during delivery if they go to health facilities.

2) Penalty and actual implementation of penalty

Of the interviewed municipalities, only two have experiences in implementing penalties. Most of municipalities do not experience penalty payment yet. The reasons most municipalities do not implement penalty payment are:

- a) No violation of ordinance
- b) No strict implementation of ordinance
- c) The case stays at reprimand level
- d) Humanitarian reasons
- e) Penalty is not fixed yet.

It seems that LGUs try to neutralize or loose implementation to avoid heavy burden on people that might be caused by the strict implementation of penalty. The following are samples of penalties.

Table 3: Existing penalties on Facility Based Delivery ordinance by municipality

LGUs	Contents of penalty
Inopacan	<ul style="list-style-type: none"> • For pregnant women and hilots: <ul style="list-style-type: none"> - 1st offense: Mother and hilots are reprimanded by the RHU for counseling - 2nd offense: Fine of P 2500 for mother, P 500 for Hilots

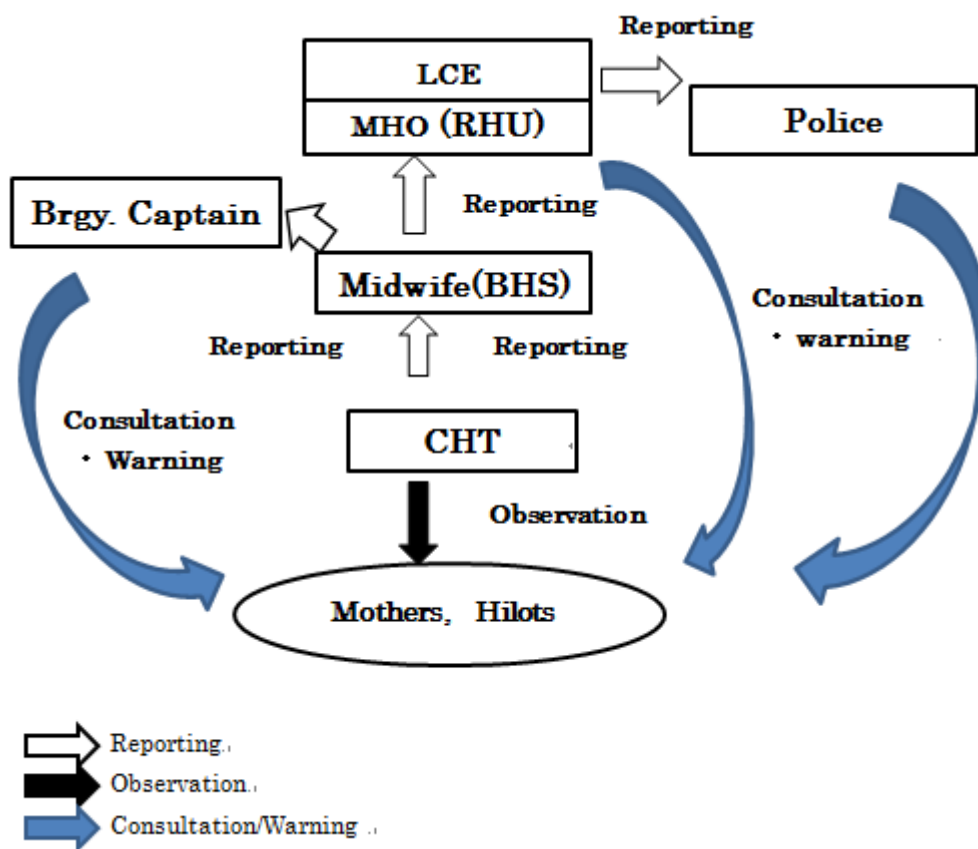
Hindang	<ul style="list-style-type: none"> • For hilots: Fine of P 1,000 • For pregnant women: Fine of P 1,000 or 5 days community work
Tolosa	<ul style="list-style-type: none"> • For pregnant women <ul style="list-style-type: none"> - who failed to undergo 4 prenatal check-ups shall be charge P 500 - 1st offense: Summoned by the RHU for counseling. - 2nd offense: Fine of P 200 and/or community service of 2 hours for 3 days. - 3rd offense: fine of P 500 and/or community service of 2 hours for 3 days.
Mayorga	<ul style="list-style-type: none"> • For pregnant women and hilots: Fine of P 2,500 for both
Kananga	<ul style="list-style-type: none"> • For hilots <ul style="list-style-type: none"> - 1st offense: Fine of P 1,000. or imprisonment of 1month or both (depending upon the discretion of the court.) - 2nd & subsequent offenses: Fine of P 2,500 or imprisonment of 6 months or both. • In case of maternal and/or neonatal death: hilots may be filed for violation of existing laws for higher penalty..
Palompon	<ul style="list-style-type: none"> • For hilots <ul style="list-style-type: none"> - 1st offense : Reprimand - 2nd offense: Fine of P 500 or rendition of community work for 8hrs a day for 2 days at court's discretion - 3rd offense : Fine of P 1,500 or imprisonment for 3 days at court's discretion
Calubian	<ul style="list-style-type: none"> • For hilots <ul style="list-style-type: none"> - 1st offense: Reprimand and counseling MHO or his representative - 2nd offense: Fine of P 750 or a community service of 8hrs x 2 days - 3rd offense: Fine of P 1,000 and imprisonment of one week upon discretion of the court. • For pregnant women : Fine of P 500
Santa Fe	<ul style="list-style-type: none"> • For hilots <ul style="list-style-type: none"> - 1st offense: Reprimand - 2nd offense: P 1,000 or rendition of community work for 8 hrs for 2 days - 3rd offense: P 2,500 or imprisonment for 3 days • For pregnant women: 1st offense , Fine of P 1,000, 2nd offense, fine of P1,500
Tanauan	<ul style="list-style-type: none"> • For hilots <ul style="list-style-type: none"> - 1st offense : Fine of P200 - 2nd offense :Fine of P500 - 3rd offense: Fine of P1,000 or an imprisonment of 3days at the discretion of the court. • For pregnant women <ul style="list-style-type: none"> - Lacking pre natal visit are charge additional P500. - 1st delivery: Fine of P 600 - 2nd :Fine of P700 or rendition of community work for 8 hours/day for 2 days, - 3rd: Fine of P1,000 or rendition of community work for 8 hours/ day for 3 days • Member of the family or household who consent or conspire with the pregnant woman for the delivery at home or outside any health facility/clinic etc. shall after conviction by a proper court be penalized in like manner as the pregnant woman.
Leyte	<ul style="list-style-type: none"> • For hilots <ul style="list-style-type: none"> - 1st offense: Reprimand - 2nd offense : Fine of P 1,000 or 3 days community work - 3rd offense: Fine of P 1,500 or 5 days community work
La Paz	<ul style="list-style-type: none"> • For hilots <ul style="list-style-type: none"> - 1st Offense: Find of P200 - 2nd Offense: Fine of P500 - 3rd Offense: Fine of P1000 • For pregnant women: Fine of P1000 shall be collected for the deliveries made outside the birthing facility or rendition of community work of the immediate family member for 8 hours per day for 3 days
Albuera	<ul style="list-style-type: none"> • For hilits <ul style="list-style-type: none"> - 1st offense: Reprimand - 2nd offense: Fine of P1,500 or rendition of community work for 8 hours/day for 2 days at the discretion of the court - 3rd offense: fine of P 2,000 or an imprisonment for 3 days at court's discretion • For pregnant Women e: 1st delivery, fine of P1,500s, Subsequent deliveries: Fine of P 2,000

Julita	<ul style="list-style-type: none"> • For hilots <ul style="list-style-type: none"> - 1st offense: Reprimand - 2nd offense: Fine of P1,000 or rendition of community work for 8 hours a day for 2 days at the discretion of the court - 3rd offense: Fine of P2,000 or an imprisonment of 3 days ay court's discretion • For pregnant women <ul style="list-style-type: none"> - 1st delivery: Fine of P1,000, Subsequent delivery: Fine of P2,000
Javier	<ul style="list-style-type: none"> • For hilots: <ul style="list-style-type: none"> - 1st offense: Fine of P1,000 - Subsequent Offenses: Fine of P2,500
Abuyog	<ul style="list-style-type: none"> • For hilots <ul style="list-style-type: none"> - 1st offense: Reprimand - 2nd and 3rd offense: Fine of P2,500 • For pregnant women c: Fine of P 2,500
San Isidro	<ul style="list-style-type: none"> • For hilots <ul style="list-style-type: none"> - 1st offense: Reprimand by the executive department or by legislative department of the Municipality - 2nd offense : Fine of P1,000 or imprisonment for one month at court's discretion • For pregnant women <ul style="list-style-type: none"> - 1st delivery: Summoned by the RHU for MCH counseling. - 2nd offense: Penalized in accordance with the penal provision
San Miguel	<ul style="list-style-type: none"> • For hilots <ul style="list-style-type: none"> - 1st offense: Reprimand - 2nd : Fine of P500or rendition of community work for 8 hours a day for 2 days at the discretion of the court - 3rd offense and Onwards: Fine of P1,000 or imprisonment for3 days at discretion of the court • For pregnant women <ul style="list-style-type: none"> - 1st delivery made outside the maternity clinic: Fine of P1,200 - Subsequent deliveries: Fine of P 700
Isabel	<ul style="list-style-type: none"> • For hilots <ul style="list-style-type: none"> - 1st offense: Reprimand - 2nd offense: Fine of P500or rendition of community work for 8 hours a day for 2 days at the discretion of the court - 3rd offense and Onwards: Fine of P1,000 or imprisonment for3 days at discretion of the court • For pregnant women <ul style="list-style-type: none"> - 1st delivery made outside the maternity clinic: Fine of P1,200 - Subsequent deliveries: Fine of P 700
Dulag	<ul style="list-style-type: none"> • For hilots <ul style="list-style-type: none"> - 1st offence :Fine of P 200 - 2nd offence : Fine of P 500 - 3rd offence : Fine of P1,000 or imprisonment of 3-days or both • For pregnant women <ul style="list-style-type: none"> - 1st delivery, fine of P 600 - 2nd offense: P 700 or rendition of community work for 8 hours a day for 2days. - 3rd offence: subsequent offences , P 1000 or rendition of community work for 8 hours a day for 3 days
Merida	<ul style="list-style-type: none"> • For hilots <ul style="list-style-type: none"> - 1st offense: Fine of P1,000 or rendition of community works for 8 hours a day for 3 days - 2nd offense: Fine of P2,500 or imprisonment of 6 months or both fine and imprisonment upon the discretion of the court , • For pregnant women: Fine of d P1,200
MacArthur	<p>There are still considerable number of hilots/deliveries at home yet not penalized for humanitarian reasons.</p> <ul style="list-style-type: none"> - 1st offense: Reprimand by RHU, - Subsequent Offenses : fine of P2,500

A) Process of implementing reprimand

- Community Health Team (CHT) may be the prime informant about home delivery. The CHT then reports to Barangay Health Station (BHS) midwife.
- Midwives of BHS reports to MHO/barangay captain.
- MHO/ barangay captain will report to Local Chief Executive (LCE).
- LCE will give a letter to the police which in turn will hand over a letter to the offenders (hilots/ mother).
- MHO with the police and/or Barangay Captain or LCE will confer with the summoned offender to give a warning and discuss and explain the case.

Figure 3: Sample flow of reporting and reprimanding.



B) Process of paying fine

- Offenders (hilots and mothers) are invited to the Police Dept. for conference and then they are given payment order to pay corresponding penalty at the Municipal Treasurer's Office with Official Receipt.
- RHU will be sending letters regarding the penalties of the offenders (hilots and mother). Home delivery penalties are collected from the family member through the Municipal Treasurer's Office

3) Supports experienced by LGU in Leyte Province for fair implementation of Facility Based Delivery (FBD) ordinances



Some municipalities have good practices and experiences in the implementation of their FBD ordinance. Each must learn from others in terms of the commitments/supports from LGUs for smooth implementation.

	Target	LGU's support and commitment
1	Support for Health facilities	<ul style="list-style-type: none"> • LGU maintains the facility, shoulders water and electric bills, provides supplies and equipment. • LGU supports the enhancement of water system, lighting facilities as well as finances. • LGU donates the lot or allocates fund for the birthing facility building • LGU incorporates the fund for birthing facilities in the regular budget.
2	Support for Health workers	<ul style="list-style-type: none"> • LGU hired 2 job order midwives and 1 job order nurse to manned the birthing facility in addition to the regular staff of the Municipal Health Office who goes on duty. • LGU hired additional manpower midwife, RN Heals (8), Rural Health Midwife (2) • LGU employed additional physician, midwives, and midwife aide. • LGU gave some incentives to health workers as stipulated in the ordinance. • LGU gave incentives for support staff
3	Support for CHT	<ul style="list-style-type: none"> • LGU gave additional incentives to Community Health Team(CHT) in addition to the barangay incentives they receive • If pregnant women go to health facilities for delivery, P400 is given as incentive for CHT partners who had Antenatal/postnatal tracking. • When CHT members bring patients to RHUs for deliveries, incentives are given.
4	Support for TBA	<ul style="list-style-type: none"> • Included and recruited TBAs in the CHT training are now active in pregnancy tracking. • Graduation/exit ceremony for hilots was conducted. • This is an idea of MHO to formally recognize the efforts of hilots. There were no cash incentives given, rather a certificate of appreciation was given for their valuable contribution as partners in health.

5	Support for Mothers	<ul style="list-style-type: none"> • Those living in far-flung barangays are advised to come to the most accessible birthing facility when expected date of confinement (EDC) is near. • If pregnant women go to health facilities, they receive Mother and Child Book, Birth Plan, Tetanus Immunization, complete iron supplementation and are followed up by Community Health Team. • P 1,000 is given as incentive for pregnant mother who delivered at the facility with PhilHealth.
6	Good practices on Transport	<ul style="list-style-type: none"> • LGU provides ambulance • Supports the transportation cost (fuel, driver), through an ambulance. In addition, the ambulance is always ready to pick up patients. • The ambulance fetches pregnant women who have no means of transport. • LGU provides transportation for those from far-flung barangays by using the LGU service to cater or to bring the patients to the birthing clinics. • LGU provides ease in access of ambulance use to transport women in labor from the barangay to the birthing clinic and /or RHU as well as transporting postpartum women and her newborn back home once discharged.
7	Good practices on Fee	<ul style="list-style-type: none"> • For the first year of implementation, user's fee of Php 2,500 has not been collected yet in order to encourage mothers to deliver at the Rural Health Unit (RHU). • To encourage them to deliver at the health facility, all targeted indigents were enrolled in the LGU Sponsored PhilHealth Program to cover for the delivery expenses. • Newborn Screening for those who delivered in the facility is shouldered by the LGU. • LGU sponsors the enrollment of all pregnant women and indigents in PhilHealth. LGU implements the ordinance. • LGU provides incentive to Health Personnel and Health Partners and pregnant women who delivered in the facility. • LGU sponsors the membership of constituents in the PhilHealth but there is still a problem on providing supplies to the RHUs. What the RHUs is doing is collecting payments from clients and use the collection in purchasing another supplies in preparation for the coming patients.
8	Good practices on Dissemination	<ul style="list-style-type: none"> • The Sanggunian Bayan (SB) disseminated the ordinance to each and every barangay. They likewise provided a copy to each barangay to be posted at the barangay hall. • There is continued advocacy on the ordinance by midwives during antenatal care. • CHT disseminate through massive campaign with the help of their barangay officials. Also campaign was done from midwives to community. • Direct advocacy from LGUs to communities was done. • Dissemination of information has also been implemented by the ABC- Association of Barangay Captain as well as the Police. • LGU spearheads the advocacy on ordinance. All hilots are summoned by LGU in the municipality and informed about the existing ordinance.. • Dissemination of information is regularly conducted.

A good practice of Alangalang

An impressive increase from 68% in 2011 to 91% in 2012 in its facility-based deliveries has been noted in the municipality of Alangalang since its implementation of the ordinance last year. This is attributable to the collaborative efforts of the LGU and the RHU Staff on their strict implementation of the ordinance in all its 54 barangays.

The Municipal Health Officer considers the unyielding pursuit of the LGU, particularly in the barangay level, as a key contributing factor in the enforcement of the ordinance by calling up traditional birth attendants who still deliver babies at home. On the other hand, the Rural Health Unit, which expects around 80-100 deliveries per month, takes part in the advocacy by having 3-5 midwives on duty every day.

Aside from passing and implementing the ordinance, the LGU also hired two Job Order midwives. The increase in personnel made it more possible for the facility to meet the increasing demand for its services. Moreover, the health workers recognize and put stress on the importance of the public hearing for the ordinance, which served as an avenue for the people to be informed thus traditional birth attendants started to refrain from handling home deliveries. The execution of the ordinance strengthened and significantly increased the facility based delivery.

4) Summary and suggestions



One of the most important things to remember in implementation of Facility Based Delivery ordinance is for LGUs to take special consideration of the people who will be affected.

For example, LGUs should provide additional assistance for indigent mothers and recruit hilots as members of Community Health Teams.

LGUs should have the commitment to improve access to health facilities. The main objective of the ordinance is to provide a good environment for safe delivery and to make the community understand the importance of facility based delivery.

*Suggestion for LGUs on implementation
of Facility Based Delivery ordinance*

- For health facilities: Provide budget for health facilities to ensure quality service
 - Sufficient number of community health workers
 - Good environment (facilities, equipment)
 - Sufficient consumables (supplies)
- For hilots: As stipulated in the ordinance, Hilots are not allowed to handle deliveries. Involve the hilots in the Community Health Team, and give incentives when they bring pregnant women to health facilities
- For indigent people: Support fee to entitle PhilHealth scheme, exemption of user's fee of health facilities, incentive for facility delivery, intensive advocacy to the group etc.
- Communities that have difficulties on access to health facilities: Deferment of implementation of penalty for the community until conditions becomes satisfactory.
- Improve physical access to health facilities.
 - Repair or construction of road for the prioritized communities
 - Organize emergency transport system
(e.g. municipal ambulance/ car advocate community to have their own emergency transport system)
 - Organize emergency communication network
(e.g. Provision of telephone directly on emergency transport for communities, stamping on Mother and Child book for mothers)
 - Give financial support for emergency transport
(e.g. shoulder fuel and driver's cost)
- Establish more birthing facilities for better access
- Establish waiting home for women who are from poor access community.
- Establish a system of mobile Antenatal care/Postnatal care.
- Establish a system of home visits on Antenatal care/Postnatal care for mothers who have poor access to health facilities.

4. Practices on Users Fee (UF)

User's fee is a resource put up to stabilize the management of health facilities when other resources such as fund from the national and local government, private and government insurance, donor support are sometimes not available or delayed in distribution.

However, in some municipalities, user's fee is not implemented as some Mayors want to give free care, which is ideal if there are certain resources to provide the needs and essentials of health facilities. On the other hand, if no stable resources are found, introduction of user's fee might be imperative **to guarantee quality of health services**. Also, **introduction of user's fee increases enrollees of PhilHealth**.

User's Fee is usually charged to non-PhilHealth clients or for treatments that are not covered by the PhilHealth scheme. With this, two critical issues regarding user's fee are apparent: a) only a little amount of the collected fee is used for the RHUs and b) indigent people cannot afford to pay user's fee.

According to the report from RHUs, user's fee is well implemented without major problems. However, RHUs cannot get collateral resources from the fee. LGUs need at least to share the fee with health facilities and staff to ensure the quality of their services. Also, LGUs ought to exempt or find a way to support indigent people such as shouldering the entitlement of PhilHealth scheme.

In most municipalities, user's fee is imposed on some services such as issuance of medical certificate, newborn screening, minor surgery, dental care, delivery and laboratory examination.

1) Contents and range of user's fee

Main categories of the maternal and child health (MCH) related user's fee include delivery, laboratory exam and sometimes antenatal and postnatal care (ANC/PNC). The fees vary among and depend on LGUs.

How to set the fee?

The fees are usually set as per meeting of SB on Health and MHO according to:

- Policy of sustainability such as affordability and acceptability in community
- Actual cost of materials (e.g. film, medicines, consumables, kit etc.)
- Consultation with other municipalities in the same ILHZ
- Difficulties of the skills (e.g. different fee for the 1st and 2nd delivery)
- The following table is the range of fees set by LGUs.

Findings:

- Some User's fee ordinances were developed by adapting/ referring to the existing ordinance of other LGUs without adjusting the fee with local situation.
- Some fees are based on the standard rate of the provincial ordinance and modified according the economic classification of municipalities.
- Laboratory is used not only by clients of RHUs/BHSs but also by clients from private clinics that do not have laboratory facilities. Thus, fee of laboratory examination as well as delivery fee can be regular resources of income



Table 4: Range of user's fee

Contents of fee	Amount (range) in Php
Medical certificate	30-50
Minor Surgery	100-110/per care
Dental care	50/per care
Delivery	Fee is varied. In most cases, fee for the 1 st delivery is higher than the succeeding deliveries
	1 st : 200,600, 1000,1200, 1500, 2500
	2 nd : 400,500,800,1300,2000
ANC or PNC	Some charge ANC/PNC, some offer free check up 200/package
Newborn screening	600
Laboratory examination	Blood hematology: 25-50/per exam
	Blood chemistry: 80-200/per exam depends on the kind of exam
	Urinary exam: 25-50/per exam
	Radiography: 150-300/per exam depends on the kind of exam

2) Reaction of people on User's Fee ordinance

Initially, people were negative about the fees but later realized that it is a responsibility or obligation for them. Eventually, the reaction of people on UF became quite positive and User's Fee became well accepted. This is reflected on the patient's satisfaction on the services rendered and the equipment and facility maintenance.

However, there are still some people who are against the User's Fee, particularly those who cannot afford to pay. Thus, LGUs should have strategies on how to support them financially and set criteria as to whom and how they will be given such support.

Affected group:

- Indigent people/clients
- Non-PhilHealth members

Major reaction:

Most Municipal Health Officers mentioned the positive changes after the implementation of ordinance such as:

- LGU is able to generate from the user's fee enough fund to defray the cost of consumable items like alcohol, cotton, reagents, etc.
- Sustainable flow of maintenance of facility, good flow of medical supplies, medicines, and equipment
- Increase of enrollees in PhilHealth Insurance sponsored by LGU
- Good flow of supply of laboratory kits and consumables
- Continuous provision of incentive for health professionals
- LCE permits Rural Health Unit to make decisions in relation to the facility's operations
- Incentives motivate health volunteers/RHU staff more.
- Increase in municipal income
- Improvement of quality of service on maternal and child health care, and increase of Facility Based Delivery.
- Payment procedures require extra burden to go to municipal treasury.

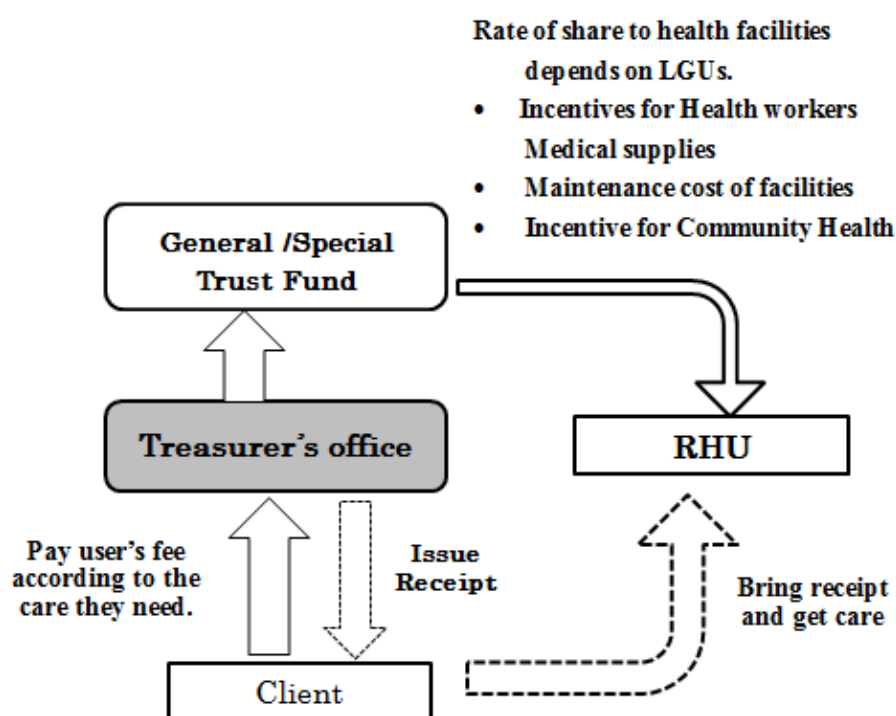
3) Flow of collection and usage of fee

Fee collection is through the Municipal Treasurer's Office, to which clients give the payment for the health services they need. The collected User's fee are pooled in the LGU's general trust fund and certain portions are allocated for various expenses such as fees for the health professionals who handled the delivery and for the CHT who looked after the mother from pregnancy to postpartum, supplies and medicines, and utilities and maintenance. The following figure presents the typical flow from fee collection to utilization.

Example of income generation:

- Fees are used for Rural Health Unit's consumables (e.g. newborn screening kits) maintenance (operations, electric, and water supply), incentives, and salary.
- On the average 40-50% is the municipal share for the maintenance and supplies of the health facility, and 50-60 % is the share provided for the Incentive for health professionals & CHT.

Figure 4: Flow of income generation



4) LGU's support experienced in Leyte Province in implementation of User's fee ordinances

1. Enactment of UF ordinance

- Delivery fee is set cheaper than hilots – Fee of P600 for first delivery and P400 for multigravida while hilots charge P 1,000. Affordable price is key word.(Bato)
- The service charge is very much low compared to nearby municipalities. Therefore, UF is well accepted of the ordinance.
- LGU does not rely much on the collected user's fee and still includes in the budget the necessary appropriations per medical supplies and equipment.
- Local Chief Executive is supportive of health workers by giving due incentives as stipulated in the ordinance

2. Support to indigent people

- An indigent patient can be exempted from the payment of service charge of the Rural Health Unit unless duly certified by the officer or his/her authorized representative or their corresponding chairperson.
- LGU shoulders the PhilHealth enrollment for indigent people
- Some patients have initiatives like asking help from a politician and were granted assistance.
- Also, some patients make promissory for the payment of fees with conditional terms like paying half of the amount and paying the remaining balance once they have the money. (Allow exemption)
- Some patients, especially the underprivileged, are handled by the officer with participation of the Local Chief Executive to settle their payments.
- Upon request, LGU supports the poor and the senior citizens who cannot pay the fees so that they can avail the services of the facility.

3. Constant sharing of User's fee to Health facilities and Community Health Team

- From the collected delivery fee, certain % is shared to the Community Health Team (CHT), professional health workers (doctor, nurse, midwives), medical supplies and maintenance of the facility.
(e.g. 10-20% CHT, 35-40% health workers, 20-30% medical supplies, 10-20% maintenance cost of the facility)
- LGU employed additional physician (1), midwives (3), and midwife aide assigned at birthing facility.

A good practice of Barugo

Barugo RHU has a noticeable practice in giving incentives to their Community Health Team members. According to Dr. Calzita, the Municipal Health Officer of the Rural Health Unit, they enacted the ordinance on the incentive for volunteer right after the Joint ILHZ board meeting in Manila in November 2011 in which all municipalities were requested to enact 3 in 1 MNCHN ordinance. The support of the Local Chief Executive and the Sangguniang Bayan is one important factor noted for the successful passing and implementation of the ordinance, especially when they explained that such would strengthen their advocacy in increasing maternal health.

A share of Php300 from the Php1500 delivery fee and MCP reimbursements will be given to the rightful CHT provided that he or she must be trained and must have tracked, brought, and referred the pregnant woman to the health unit for labour and delivery. However, there is no incentive given to the CHT whose pregnant woman failed to deliver in the RHU and was referred to higher facilities.

Distribution of the incentives is done quarterly considering the paperwork that needs to be accomplished. In addition, the RHU has a record book that keeps track of all the deliveries including the name of CHTs who brought the said pregnant woman.

Clearly, CHTs who have already received their incentives are elated and are more motivated to follow up pregnant women. Another notable factor in the success is the regular quarterly meeting with the CHTs conducted by the PHN, who serves as the CHT Supervisor. Thus the knowledge and skills of the CHTs are constantly refreshed and updated.

5) Summary and suggestions



In the future, income generation from user's fee should be followed based on the standard fees with reference to the provincial ordinance. For those who already enacted user's fee ordinance may continue with the implementation but amend the ordinance based on the standard fee. For those who still have to enact the ordinance, the standard fee must be followed.

Suggestions for LGUs on the implementation of user's fee ordinance

A) Income generation/distribution of fee

- Pool user's fee in Trust Fund. Use 100% of fee for health facilities, health professionals and CHT. People will pay the fee without complaint if they can get quality health services.
- Include the budget to maintain health facilities in the regular budget plan to keep the collected fee as resource for incentives. It is important to ensure the resource of incentives according to their workload.
- Include distribution of incentives clearly in the ordinance, especially for health workers and CHT..
- Improve equipment and staff of laboratory. It improves the access to laboratory exam and increases the income, as private clinic will use the laboratory.

B) Fee

- Set an affordable and realistic amount.
- Set the standard fee.

C) Support to indigent people/non PhilHealth members

- LGU must give reliable information to indigent people about the criteria on how to avail the financial assistance
- Conduct a survey to identify indigent people.
- Support Philhealth enrollment of indigent people and promote coverage.

5. Practices on Incentives for Volunteers (IV)

In the current health policy, *Kalusugan Pangkalahatan* (KP), the members of Community Health Team (CHT) take a very important role in reaching out to indigent households and advocate/support people in the community. In the DOH-CHD EV and JICA collaboration, SMACH-EV project, CHTs are expected to advocate/support all mothers on health.



Table 5: Expected tasks of CHT in Leyte Province

<i>Kalusugan Pangkalahatan</i> (KP)	SMACHS-EV project
Target: NHTS PR Families (National Household Targeting System for Poverty Reduction) -Indigent households	Target: All pregnant women & postpartum mothers in 18 target municipalities
Expected tasks of Community Health Team	
<ul style="list-style-type: none"> • Health Profiling of households 	
<ul style="list-style-type: none"> • Identification of Tuberculosis patient 	
<ul style="list-style-type: none"> • Promotion of Maternal Health: Pregnancy, Prenatal, Postnatal 	<ul style="list-style-type: none"> • Pregnancy Tracking
	<ul style="list-style-type: none"> • Education on maternal and child health with MC book
	<ul style="list-style-type: none"> • Postpartum & Newborn Tracking & Education with MC book
	<ul style="list-style-type: none"> • CHT monthly report & monthly meeting: to monitor the status of CHT performance
<ul style="list-style-type: none"> • Education on Family Planning 	
<ul style="list-style-type: none"> • Education on health in general with Family Guide 	

We have so many tasks to do.

I am eager to devote myself to work for people and see them happy and well.

However, I cannot afford all the costs to do these tasks.

We need allowance for home visits.

“ Incentives for Health Workers.”



In both the national health policy and SMACHS-EV Project, Community Health Teams (CHTs) are involved in and expected of many tasks since they are the fore players in accessing communities and linking them to health facilities. However, **under the name of volunteers issue regarding incentive is not discussed openly, neither are certain resources set.**

As a result, the members of the CHT have to pay necessary expenses such as transportation by themselves. It is clear that without systematic support, there is a limit in conducting many CHT activities. The LGU should identify and settle a stable financial resource to provide incentives to CHT. Hence, the ordinance on Incentives for Volunteers ensures great financial supports to CHT as well as stability of their mobilization in the community.

The following are the information from the municipalities that have Incentives for Volunteers ordinance. There are still some municipalities, however, which do not have specified criteria of CHTs nor specific amount of incentives in the resolution or implementing guidelines.

1) Current selection and qualifications of Community Health Teams (CHT)

The first step is how to select community health workers. As long as the LGU provides incentives, the process of selection and qualification of volunteers should be determined. The LGU needs to update the data of volunteers to make a budget plan for incentives. Then, the LGU has to set the amount of incentives, procedures of payment and frequency, etc. The following are the currently practiced in some municipalities.

Selection of Community Health Team

The members of Community Health Team((CHT) are selected mainly from recognized barangay volunteers, such as Barangay Health Workers (BHWs), Barangay Nutrition Scholar (BNS), Traditional Birth Attendants (Hilots), etc.

Selection of team members depend on the affinity of the person, either through political connections such as the Barangay Captains or through affiliation of midwives or MHO

- Through Barangay Captains and officials
- Midwife of BHS select CHT according to population and stance
- CHTs are selected based on their voluntarism and as BHWs
- RHU staff validates the volunteers who are selected at barangays.

Qualifications

- Barangay Health Workers (BHW) or Barangay Nutrition Scholar (BNS) since they know the community. BHW or BNS can be double entitled as CHT.
- Trained on health or has basic health knowledge is necessary.
- Active in the communities.
- Level of education: Be able to read and write, High School level
- Have willingness to perform the job as volunteers (strong commitment, voluntarism)
- Young, Physically fit

Renewal of registration

Only 5 municipalities renew volunteers. Other municipalities do not renew CHTs.

2) Sources of incentives

- LGU annual budget
- LGU Trust Fund from the user's fee
- Barangay budget
- MCP reimbursement of PhilHealth
- GAD (Gender and Development) fund: Usually this is used for training and support for women in the municipality, but it is sometimes used for other purposes like supporting the indigents in terms of financial assistance
- Chair of SB on Health is still on the process of sourcing out funds for the benefits. However, the LGU is utilizing its Assistance in Crisis Situation (AICS) to those poor families in need including the health workers. This budget line is for the office of the Social and Welfare Office of the LGU to provide assistance to those indigent who are in crisis.

3) Payroll

- RHU keeps the data on the number of referral per CHT as basis for the payroll and giving of incentives.
- CHT themselves or/and midwives calculate how many patients they handled, and go to the Municipal Office to receive money.

4) LGU's practices experienced in Leyte Province for implementation of Incentives for Community Health Teams

All municipalities distribute incentives as CASH. The amount of incentives is varied as below.

Type/source of incentives	Amount
Incentives as share of user's fee/PhilHealth reimbursement	<ul style="list-style-type: none">• Fixed rate of P 200 per month.• 75% of User's Fee is shared by doctors, nurses, midwives and Community Health Team (CHT) who handled the case.• 60 % of user's fee is allocated to skilled health personnel.• A minimum of P1,000 and a maximum of P 2,000 worth of medical assistance is given as incentive and P 5,000 cash will be given to authorized beneficiaries for burial assistance.• P 600 / month is given from the barangay budget There are also gifts given by the LGU, such as plates, etc. which are from the LGU savings.• 10% of the User's Fee goes to the CHT• 5% of User's fee goes to the CHT• P 400 share from the PhilHealth reimbursement received.

Incentives per delivery	<ul style="list-style-type: none"> • P 300/per delivery is given to Community Health Team (CHT) members who are able to bring pregnant women to deliver at the RHUs • P 300/ delivery is allocated as incentives for CHT • User's fee, P 2,000 of P2,500/delivery, is divided among 10 midwives and CHT. Less than P 200/delivery goes to the CHT who tracked and referred the mother. • Depending on the capacity of the barangay, a barangay health workers receives an incentive ranging from P50 to P200 per month
Incentives per ANC/PNC	<ul style="list-style-type: none"> • P200 for assistance of pregnant women having 4 antenatal care and laboratory exam
Incentives as bonus	<ul style="list-style-type: none"> • Every December or January P 500 is given as bonus. • Some barangays give incentives to Barangay Health Workers , Barangay Nutrition Scholar • Some CHTs were entitled to receive honoraria from their respective barangays • Volunteers will receive an additional P 500 from Gender and Development Fund (GAD) aside from incentive received from FBD ordinance.

5) Summary and suggestions



Recognize the members of Community Health Teams (CHTs) as Community Health Workers, and not volunteers. Ordinance can be Incentives for Community Health Teams or Community Health Workers.

Community Health Teams are main players in the communities. The development of a stable system to support CHTs will be a key to success.

- Standardize the selection and renewal process of Community Health Team (CHT).
- Selection should be consulted with the Mayor, Municipal Health Officer, and Barangay Captains.
- Develop database/master list with the number and information of CHT for budgeting.
- Budgeting must include at least transportation/cash/meal allowance to allow CHT to visit appropriate number of households
- Identify various sources of incentives for CHT.
e.g. Some health programs or support from private sectors
- Share certain amount of PhilHealth reimbursement/user's fee with workers.

6) More tips:

A) Determining the number of community health workers:

The national guide for Municipal Health Officers/City Health Officers¹⁶ shows the selection process of community health workers and the calculation base of community health workers in accordance to Universal Health Care (Kalusugan Pangkalahatan) strategy, which targets indigent households. The method of calculation can be applied to target the whole population of the community.

- Municipal Health Officer (MHO) should have the number and list of households per barangay.
- MHO should calculate the needed number of community health workers according to the condition (access to the family, density of population) of local barangays.

Standard barangay: **1 worker per 20 households**

Barangay with better access¹⁷: **1 worker per 50 households**

Barangay with poor access¹⁸: **1 worker per 10 households**

Calculation:

Number of households: Total population/ 5

Number of workers needed: Number of target families/10 or 20 or 50

Example of calculation

	Classification	No. of families targeted	No. of community health workers
A barangay	Standard	600	$600/20 = 30$
B barangay	Better access	800	$800/50 = 16$
C barangay	Poor access	300	$300/10 = 30$
D barangay	Standard	500	$500/20 = 25$
Municipality(total)		2200	$2200/20 = 101$

B) Selection and registration of workers

The process of selection and recruitment should involve both the political and technical side. Technical person should probably do the selection and consult with the political side.

- Inventory of available community health workers: MHO should ask midwives to list up available community health worker candidates per barangay.
- Select workers according to the following criteria.

Basic qualifications

- Able and willing to work on a regular home visits and /or monitor the families
- Able to read and write
- With inter-personal communication skills
- Able to work with officials

¹⁶ CHT organization, training & Development by DOH in 10/5/ 2011

¹⁷ Volunteers can reach less than 30 minutes ride, or barangay has available communication facilities such as cellphones and radio, or barangay with venues of monitoring families like 4P.

¹⁸ Barangay with difficult terrain or minimal available transportation, long travel time and high cost of travel

Preferable qualifications

- With experience working on health related or development-oriented activities in the community
- Sufficient years of experiences working in the community
- Finished at least 2nd year of high school education

- MHO/midwives will finalize the list of selected volunteers and submit it to the local officials or barangay captain.
- Local officials and MHO will validate the list together. The finalized list will be submitted to the Mayor for budget planning of incentive. The update can be done through the same process. The timing should be before October, before the municipality’s plan of next year’s budget.

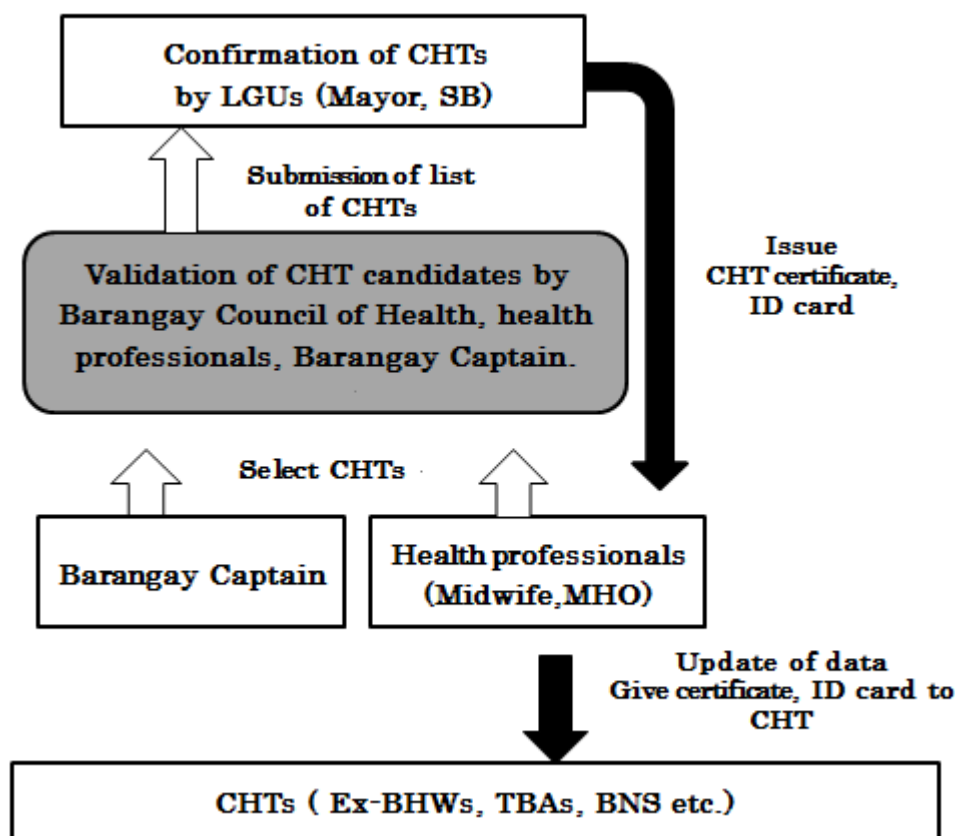
Table 6: Sample of master list of Community Health Workers

Barangay	Name of health workers	Address	Tel	Since (recent update)
Sta Ana	Ablaza XX	Purok 6, Sta Elena	0994568999	May 2011 (Oct 2012, renewal)
	Dela Cruz XX	10 Rizal St.	0902345626	Dec 2010 (Feb 2013, Quit due to illness)
	...	XXX	XXXX	XXX
Sub Total	18			
San Jose	Baboy Nene	XXX	XXX	XXX
	XXX	XXX	XXX
Sub Total	20			
Total	38			

- MHOs will keep the list of community health workers as database. If there are any changes (migration, death, resignation, etc.), he or she should update the data and submit to the LGU
- Regular update of the data and renewal can be done before October.
- LGU will confirm the list of community health workers yearly. LGU should register community health workers and issue a certificate or ID card for new members. Certificate or ID card will motivate community health workers as officially recognized people and assigned to a specific area.

The following chart is a sample flow on selection of workers

Figure 5: Flow of selection of members of Community Health Teams



C) Sources of incentives

The Project recommends that LGU should use different sources of incentives for community health workers. There is an urgent need to shoulder at least transportation cost of community health workers in conducting home visits. The following are the sources of incentives and recommended process to pay.

Table 7: Sources incentives for the members of Community Health Teams

Body	Resource	
Municipality	Annual budget	<ul style="list-style-type: none"> • Cash, Shoulder transport cost of Community Health Teams to conduct home visits as minimum requirement. (See the next line for the detail calculation) • Hold CHT Convention • In Kind, provide certificate, ID card, Notebook and pen for workers (yearly)

Municipality	User's fee	<ul style="list-style-type: none"> • Cash, Incentives when CHT takes care of women on ante post -natal care /Delivery. When CHT brings patient to Rural Health Unit (RHU) to deliver, they will receive incentives from some % of PhilHealth reimbursement.
	PhilHealth reimbursement	<ul style="list-style-type: none"> • Cash, Incentives when CHT takes care of women on ante post -natal care /Delivery. When CHT brings patient to RHU to deliver, they will receive incentives from some % of PhilHealth reimbursement.
Barangay	Barangay Budget	<ul style="list-style-type: none"> • In kind or cash, additional incentives depending on the barangay budget and situation.
Development partners	Program/ project, Irregular base	<ul style="list-style-type: none"> • Irregular base, in kind or cash, Can negotiate additional incentives which can motivate CHT such as T-shirts, bags, etc.



“Reference Materials on Maternal and Child Health Related Policy Issues for Inter-Local Health Zones (ILHZ) (Ver.1)”

Strengthening Maternal and Child Health Services in Eastern Visayas (SMACHS EV)

Contact persons:

DOH-CHD EV: *Tel. (053) – 323-6119*

Dr. Paula Paz Sydiongco, Chief of Local Health Support Division

Dr. Corazon V. Sabulao, Head of Family Health Cluster, MNCHN Coordinator

Dr. Verna Fernandez, Regional ILHZ Coordinator

Provincial Health Office of Leyte: *Tel. (053) – 323 – 3118*

Dr. Ofelia C. Absin, Acting Provincial Health Officer II

Dr. Edgardo E. Daya, Provincial Health Officer I

SMACHS EV Project office: *Tel. (053) – 323 -6114*

Ms. Satoko Ishiga, Chief Advisor

Developed and printed: August 2013

Production by: SMACHS-EV project

Requests for permission to reproduce or translate this manual for any purpose, should be addressed to the above contact persons.

