<u>ORDINANCE NO. 2014-033</u>

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<u>AN ORDINANCE ESTABLISHING AND ADOPTING A SET OF MEASURES & SYSTEMS TO ENSURE EFFECTIVE AND EFFICIENT IMPLEMENTATION OF THE MATERNAL NEW-BORN CHILD HEALTH AND NUTRITION (MNCHN), INCLUDING THE SETTING UP OF MANAGEMENT STRUCTURES TO OVERSEE IMPLEMENTATION AND COORDINATING MECHANISMS TO IMPLEMENT MNCHN SERVICES, AND ENSURING COMMODITY SELF –RELIANCE</u>:-

Authored by: Hon. Joaquin “Chito” F. Perez, Jr.
Hon. David Casper Nathan A. Sergio

RATIONALE

Expressly provides under Section 15 Article II of the 1987 Philippine Constitution explicitly provides that “*The State shall protect and promote the right to health of the people and instill health consciousness among them*”; Thus, the MNCHN is an essential program of the Philippine Government, with its basic policy focusing on the maternal, newborn and child health care including the responsibility of couples to decide how many children to have, consistent with their religious belief, preferences and needs. Republic Act 7160, otherwise known as the Local Government Code (LGC) of 1991, the responsibility of providing basic health services, including Maternal Newborn Child Health and Nutrition (MNCHN) services, was devolved to the local government units; this is specifically provided for under Section 17 of the LGC.

The DOH AO 2008-0029, (*Implementing Health Reforms for Rapid Reduction of Maternal and Neonatal Mortality),* recommends the implementation of the Maternal Newborn and Child Health and Nutrition (MNCHN) Strategy, and states that the risk of mistimed, unplanned, unwanted and unsupported pregnancy which leads to maternal, infant and neonatal deaths, can be prevented if appropriate health interventions are introduced, such as interventions that support the achievement of couple’s desired family size. The DOH AO 1997-16-A states that Sexually Transmissible Infections (STIs) including Syphilis are high-risk factors for HIV transmission and that pregnant women with STIs can transmit the infection to their children, resulting in significant morbidity and mortality; it is therefore imperative that all pregnant women accessing Ante-natal Care (ANC) should be provided with information on STI, including symptoms, means of prevention and protection and risks of mother to child transmission of STI including Syphilis and HIV. The DOH AO 2010-0036 establishes the need to implement the Universal Health Care Program (UHC) that is directed towards achieving better health outcomes, sustained health financing and more responsive health system while ensuring that all Filipinos, especially the disadvantaged groups, have equitable access to affordable health care. The DOH AO 2010-0036 recognizes National Health Insurance (NHIP) as the prime mover of improving financial risk protection (particularly of the poor), generating resources to modernize and sustain health facilities and improve the provision of public health services to achieve the Millennium Development Goals (MDGs) of reducing maternal mortality and infant mortality.

The City of Naga supports families’ desire to attain desired number and spacing of children through the elimination of unmet needs in accordance with the provisions of DOH Administrative Order No. 50-A, series 2001 and supports critical policies and plans, complementary actions and supportive measures that are necessary to prevent disruptions in the delivery of health services with the phase-out of donated commodities by 2008. The City of Naga currently experiences some health problems with the following health indicators in 211:

- CPR 61.26%, compared to the Millennium Development Goal of 80% in 2015, with an estimated service utilization gap of 18.74%.
- ANC 70%, compared to the national benchmark of 80%, with an estimated service utilization gap of 10%
- FBD 42%, compared to the national benchmark of 80%, with an estimated service utilization gap of 38%.
- SBA 72%, compared to the national benchmark of 80%, with an estimated service utilization gap of 8%.
- FIC 91%, compared to the national benchmark of 95%, with an estimated service utilization gap of 4%.
- Maternal Mortality Ratio of 80 per 100,000 live births
- Infant Mortality rate of 12.8 per 1,000 live births
- TB case detection rate of 90%, compared to the national benchmark of 70%.
- TB cure rate of 78%, compared to the national benchmark of 85%.

Be it ordained by the Sangguniang Panlungsod of the City of Naga that:

ARTICLE I
TITLE AND DECLARATION OF PRINCIPLES

SECTION 1. TITLE. - This ordinance shall be known as "**AN ORDINANCE FOR EFFICIENT AND EFFECTIVE IMPLEMENTATION OF THE MNCHN/CSR STRATEGY OF THE *CITY OF NAGA*".**

SECTION 2. POLICY - It shall be the policy of this LGU to fully support and ensure effective implementation of the MNCHN and CSR strategy as part of its strong commitment to local health sector reform implementation. It shall support the engagement of all concerned health care facilities to form a coordinated MNCHN service delivery network, mobilize the participation of the community to be covered and served, and strengthen collaboration with other groups of stakeholders within and outside the health sector and also beyond its administrative jurisdiction.

SECTION 3. DEFINITION OF TERMS. - For purposes of this Ordinance, the following terms and phrases are hereby defined:

1) **MNCHN Core Package of Services or Integrated MNCHN Services** refers to a package of services for women, mothers and children covering the spectrum of (1) known appropriate clinical case management services in preventing direct causes of maternal and neonatal deaths, and which are within the capacity of the health system to routinely provide; and (2) known cost-effective public health measures capable of reducing exposure to and the severity of risks for maternal and neonatal deaths, that are within the capacity of the health system to routinely provide.

2) **MNCHN Service Delivery and Network** refers to the network of facilities and providers within the city-wide health system offering MNCHN Core Package of Services, including the communication and transportation systems supporting this network. The following health providers are part of the MNCHN Service Delivery Network:

    1. **Community level providers** refer primarily to Barangay Health Stations (BHS) and its health staff (e.g. midwife) and volunteer health workers (e.g. barangay health workers, traditional birth attendants) that typically comprise

the Community Health Team or Barangay Health Team. These teams implement MNCHN Core Package of Services identified for the community level. Their functions include advocating for birth spacing and counseling on family planning services; the tracking and master listing of pregnant women; assisting pregnant women and their families in formulating a birthing plan, early detection and referral of high-risk pregnancies, and reporting maternal and infant deaths. The teams shall also facilitate discussions of relevant community health issues, particularly those affecting women and children.

2. **Facilities both public and private with Skilled-Birth Attendants** are capable of attending to uncomplicated deliveries. These shall be appropriately linked to the nearest BEmONC- or CEmONC-capable facilities.

3. **Basic Emergency Obstetric and Newborn Care (BEmONC)-**capable facilities are capable of performing the following six signal obstetric functions: (1) parenteral administration of oxytocin in the third stage of labor; (2) parenteral administration of loading dose of anticonvulsants; (3) parenteral administration of initial dose of antibiotics; (4) performance of assisted deliveries; (5) removal of retained products of conception; and (6) manual removal of retained placenta. These facilities are also able to provide emergency neonatal interventions, which include the minimum: (1) newborn resuscitation; (2) treatment of neonatal sepsis/infection; and (3) oxygen support. It shall also be capable of providing blood transfusion services on top of its standard functions.

4. **Comprehensive Emergency Obstetric and Newborn Care (CEmONC)-** capable facilities can perform the six signal obstetric functions as in BEmONC facilities, as well as provide caesarean delivery services, blood banking and transfusion services, and other highly specialized obstetric interventions. It is also capable of providing neonatal emergency interventions, which include at the minimum, the following: (1) newborn resuscitation; (2) treatment of neonatal sepsis/infection; (3) oxygen support for neonates; (4) management of low birth weight or premature newborn; and (5) other specialized neonatal services. Province-wide or city-wide health system refers to the default catchment area for delivering integrated MNCHN services. It is composed of public and private providers organized into systems such as Inter Local Health Zones (ILHZ) or health districts for provinces and integrated urban health systems for highly-urbanized cities. Service arrangements with other LGUs may be considered if provision and use of integrated MNCHN services across provinces, municipalities and cities become necessary.

5. **Service Coverage Indicators** are parameters which reflect coverage or utilization of services. For MNCHN Strategy, the following indicators are monitored:

   a. **Antenatal care coverage (ANC)** is an indicator of access and use of health care during pregnancy. It constitutes screening for health and socioeconomic conditions likely to increase the possibility of specific adverse pregnancy outcomes, providing therapeutic interventions known to be effective; and educating pregnant women about planning for safe birth, emergencies during pregnancy and how to deal with them (WHO; Indicator definitions and metadata 2008)

   b. **Contraceptive Prevalence Rate (CPR)** is the proportion of married women aged 15-49 reporting current use of any method, i.e. pill, IUD,

injectables, male condom, mucus/Billings/ovulation, Standard Days Method (SDM), and Lactational Amenorhea Method (LAM).

c. **Facility-Based Deliveries (FBD)** is the proportion of deliveries in a health facility to the total number of deliveries

d. **Fully Immunized Children (FIC)** is the ratio of children under 1 year of age who have been given BCG, 3 doses of DPT/Pentavalent and OPV and measles vaccine to the total number of 0-11 months old children

e. **Skilled-Birth Attendant Deliveries (SBA)-** is the proportion of deliveries attended by skilled health personnel to the total number of deliveries Skilled health professionals refers exclusively to people with midwifery skills (for example, midwives, doctors and nurses) who have been trained to proficiency in the skills necessary to manage normal deliveries and diagnose or refer obstetric complications.

f. **Vitamin A supplementation coverage (VAS)** – is the proportion of 6-59 months pre-schoolers given Vit A capsules twice a year

6. **Traditional birth attendants** - traditional, independent, non-formally trained and community-based providers of care during pregnancy, childbirth, and postnatal period.

7. **Contraceptives** – pertain to the modern methods of family planning, such as, but not limited to, pills, condoms and injectables.

8. **Commodity Self-Reliance** – is a multi-sectoral effort which seeks to ensure the self-sufficiency in MNCHN services and commodities in its ability to sustain the provisions of affordable quality health services to eliminate unmet needs. It requires the capacity to forecast, finance, procure and deliver MNCHN services and commodities to all men and women who need them, when they need them.

9. **LGU/s** – refer to the Provincial Government and its component cities and municipalities.

10. **Commodities** - refer to the supplies to be used such as TB drugs, Vit A, zinc supplements, ferrous sulfate with folic acid, contraceptives, syringes and needles, STI screening supplies and medicines.

11. **NHTS families** – refer to individuals as determined and defined by the DSWD's NHTS-PR as the poorest of the poor and priority for the distribution of MNCHN commodities.

12. **NHTS-PR – National Household Targeting System for Poverty Reduction -**is a data management system that identifies who and where the poor are in the country. Specifically, the system aims to: (a) formulate a unified criteria for the selection of the poorest population, (b) facilitate the sharing of solid database for public and private social protection stakeholders; and (c) reduce leakages (exclusion and under-coverage of poor, as well as inclusion of non-poor).

13. **Pantawid Pamilyang Pilipino Program (4Ps)** - a poverty reduction strategy that provides grants to extremely poor households to improve their health, nutrition and education particularly of children aged 0-14. It provides cash

assistance to the poor to alleviate their needs (short term poverty alleviation) and invests in human capital to break the intergenerational poverty cycle.

14. **Kalusugan Pangkalahatan (KP)** –Universal Health Care (UHC); continuing health sector reform program which aims to primarily : (a) improve financial risk protection of the poor, (b) upgrade and modernize health facilities; and (c) implement key interventions to achieve health-related Millennium Development Goals

SECTION 4. - MNCHN/CSR Framework - The City of Naga believe that the goal of rapidly reducing maternal and neonatal mortality shall be achieved through effective population-wide provision and use of integrated MNCHN services as appropriate to any locality in the country.

MNCHN reforms, improvement and changes in local health systems shall, among others results, create the following intermediate results that can significantly lower the risk of dying secondary to pregnancy and child birth:

1. Every pregnancy is wanted, planned and supported
2. Every pregnancy is adequately managed throughout its course
3. Every delivery is facility-based and managed by skilled birth attendants
4. Every mother and newborn are provided with safe, effective, affordable post partum and post natal services

The City of Naga likewise believe that the Commodity Self-Reliance (CSR) Strategy shall create the following supply conditions necessary to eliminate the unmet needs and ensure the availability of MNCHN packages of interventions:

1. The phasing up of domestically provided supplies to replace those quantities of foreign-donated commodities;

2. The increase in levels of domestic supplies of commodities made available to meet the needs of additional future users of commodities;

3. The increase in levels of other commodities such as TB drugs, Vit A capsules, zinc supplements, ferrous sulfate with folic acid, syringes and needles, STI screening supplies and medicines to meet the needs of mothers and children;

ARTICLE II
MNCHN/CSR PROGRAM IMPLEMENTATION

The City of Naga shall institute measures towards establishing systems and mechanisms for an effective implementation of MNCHN strategy province-wide.

The City of Naga encourages facility-based deliveries either public or private, attended by skilled birth professionals , with the participation of traditional birth attendants (TBAs) or *"hilots"* in the community health teams. Community Health Teams (CHT) shall advocate for birth spacing and counseling on responsible parenthood; refer pregnant women to facilities; track and master list pregnant women; assist pregnant women and their families in formulating a birthing plan, early detection and referral of high-risk pregnancies; and report maternal and infant deaths to the CHO; participate in regular maternal and neonatal death review and discussions of relevant community health issues;

The City of Naga recognizes the great contribution of private professional health providers and private health facilities in meeting the MNCHN needs of local communities, these professionals are part of the referral and service delivery network for MNCHN, they are likewise expected to advocate birth spacing and counseling on responsible parenthood; referral of pregnant women in facilities; tracking and master listing of pregnant women; assisting pregnant women and their families in formulating a birthing plan, early detection and referral of high-risk pregnancies; and reporting maternal and infant deaths to the CHO; participate in regular maternal and neonatal death review and discussions of relevant community health issues;

The City of Naga realizes the need to support all efforts including public private partnership for MNCHN towards ensuring quality in the process of generating, maintaining, and reporting of all MNCHN indicators and that they are valid and can be utilized for LGU planning, financing and policy decision making the engagement of all concerned health care facilities and providers, both public and private to a coordinated MNCHN service delivery network, mobilize the participation of the community to be covered and served, and strengthened with other groups stake holders within and outside the health sector and also beyond its administrative jurisdiction.

The City of Naga fully supports the implementation of the MNCHN/CSR Strategy that includes among others the implementation of the following interventions:

MNCHN. This LGU recognizes that reforms in service delivery, governance, regulation, and financing are needed for a sustained improvement of the health status of mothers and children. The LGU shall undertake the following steps to implement the MNCHN/CSR Strategy:

1. This LGU shall organize the City-KP MNCHN Coordinating Council

Building the MNCHN/CSR Service Delivery Network and ensuring its sustainability would entail analysis of the existing situation in the locality and assessment of gaps in service delivery, utilization and health systems in general as well as identifying and planning appropriate interventions to address these gaps. To begin this process, the LGU shall organize a team coming from the City Health Office and other relevant members of the locality like DOH Center for Health Development, donors, non-government organizations (NGOs), civil society groups and the like. From this team, the LGU can assign a coordinating body to oversee the direction and progress of implementation of the MNCHN Strategy after assessment and initial planning.

2. This LGU shall know the MNCHN/CSR Situation

The MNCHN/CSR TWG's initial work shall be to assess the MNCHN situation in the LGU. Assessing the LGUs' current level of performance against national data would provide the city an idea of targets they should set to be able to contribute in achieving target MNCHN indicators. The MNCHN Management Team can use Health Outcome Indicators or Health Service Coverage Indicators to assess the LGUs' situation

Health indicators shall be collected and used to monitor the health status of a population. The City of Naga recognizes that these health indicators either (1) reflect impact or outcomes or (2) coverage or utilization of services. For MNCHN, health outcome indicators are Maternal Mortality Ratio (MMR), Neonatal Mortality Rate (NMR), Infant Mortality Rate (IMR), Underfive Mortality Rate (UFMR) and proportion of underweight 6 to 59- month old children while Service Coverage indicators are Contraceptive Prevalence Rate (CPR), Antenatal Care (ANC), Facility-based Deliveries (FBD), and Fully Immunized Children (FIC) and Vit A supplementation coverage. Note: will include STI/HIV/AIDS c/o Grace

This LGU shall likewise validate the data or report received from local health sources (both private and public). If the health information system has not been revisited or revised to comply with standards, available data may not reflect an accurate health situation of the locality

3. This LGU shall prioritize population groups and areas

   3.1 This LGU shall compare performance of the city with national targets using MNCHN/CSR Health Outcome or Service Coverage Indicators

4. This LGU shall designate facilities in the Service Delivery Network through public private partnerships

   4.1. This LGU shall organize the Community Health Team (CHT) and its Facility
   4.2. This LGU shall designate the CEmONC-capable Facility
   4. 3. This LGU shall designate the BEmONC-capable Facility
   4.4. This LGU shall designate the community based BEmONC Facility (ie lying in)
   4. 5. This LGU shall identify Skilled-birth Attendant Facilities

5. This LGU shall install Mechanisms to Ensure Access to MNCHN Services

   Aside from providing the MNCHN Core Package of services, this LGU shall ensure presence of support services that would ensure access by priority populations, a source of safe blood supply and health promotion activities to increase demand for services.

6. This LGU shall plan appropriate interventions for service delivery, governance, regulations and financing (as shall be reflected in the MNCHN/CSR Ordinance).

7. This LGU shall take the lead in implementing strategies and activities meant to improve health-seeking behavior among communities that will result in women and families seeking health care providers for their MNCHN needs

8. This LGU shall determine and manage funding sources for planned interventions

9. This LGU likewise support the implementation of key activities for MNCHN/CSR implementation covering key interventions in the areas of:
   1. Policy
   2. Financing
   3. Service Delivery
   4. Governance and Systems Development for Sustainability
   5. Monitoring and Evaluation

   To focus on key MNCHN/CSR interventions, among others, this LGU shall:

a. Organize, train and deploy community health teams (CHT) to transform needs to effective demand, specifically, help family members assess health risk, deliver key messages and formulate health implementation plan as well as guide these families navigate through the health system and provide adequate information to families on PhilHealth.

b. Build capacities of health staff for effective MNCHN/CSR service provision (FPCBT1, FPCBT2, AMSTL, LAPM, EINC, BEMONC, QAP).

c. Implement MNCHN integration to reduce unmet needs for and deliver key messages for mothers.

d. Provide orientation/information to LGUs on the DOH AO on ICV compliance, including the roles and key activities on ICV compliance.

e. Formulate the local NHIP plan that includes key interventions such increasing coverage/enrollment, accreditation of health facilities, provision of information to members and providers on benefits/ access to Philhealth benefits, improving claims management and effective implementation of “no-balance billing scheme”.

f. Allocate funds and procure MNCHN/CSR commodities and ensure free access of CCT and NHTS families.

g. Conduct regular data quality check (DQC) and generate reliable data on CPR as bases for planning, financing and policy development, and ensure sustained DQC activities and support through dedicated personnel and availability of forms.

h. Establish and implement the stock and inventory management system (SIMS) to build LGU capacities in tracking MNCHN/CSR commodities in health facilities, including related medical supplies.

ARTICLE III
FINANCING OF THE MNCHN/CSR PROGRAM

SECTION 1. FUNDING. - For its initial requirement in CY 2013, the Program shall allocate an amount of Three Hundred Thousand (P300,000.00) to be funded from the MNCHN Grants Facility, or from any of the following sources:

1.1 **Regular Budget of the City Health Office** – The City Health Office shall review its regular budget for CY 2012-2013 and identify existing appropriations which can be realigned for the purpose;

1.2 **Lump Sums and other trust funds**- The Program shall be included as a priority to be funded from the 20% Development Fund, Gender and Development (GAD) Fund, and PHILHEALTH capitation and reimbursement ;

1.3 MNCHN Grants, aids, donations and other forms of assistance from the National Government and the private sector.

Furthermore, for the funding for subsequent years The City Health Office shall integrate the Program as part of the regular services being delivered by local health facilities. As such it will continue to identify funding sources including but not limited to those identified above to be confirmed by the Local Finance Committee during the preparation of the LDP/AIP.

SECTION 2. COST RECOVERY SCHEME. - Within one (1) year from its implementation, the City Health Office in coordination with Local Finance Committee shall prepare and submit for consideration of the Sangguniang Panlungsod a scheme of cost recovery consisting of charges for services rendered and cost of supplies, provided that safety nets for the poor are properly observed.

Proceeds of cost recovery schemes shall accrue to the **MNCHN/CSR Special Account** under the General Fund which shall automatically appropriated for the Program in the subsequent year.

SECTION 3. REPORTING – To ensure monitoring and proper management of the funds, the City Accounting Office shall prepare a Program Report (preferably quarterly) detailing actual expenses for personnel, supplies, training, and other related activities.

A R T I C L E IV
PROGRAM MANAGEMENT

SECTION 1. CREATION AND COMPOSITION. - There shall be created a MNCHN/CSR Coordinating Council, hereinafter referred to as "Council", which shall be composed of the following:

Chairman	-	*Mayor*
Co-Chairman	-	*SP Chairman, Committee on Health*
Members	-	*City Health Officer*
		Naga City Hospital
		City Planning Office
		City Budget Office
		City Population and Nutrition Office
		City Social Welfare and Dev't. Officer
		General Services Officer
		City DepEd
		Local PhilHealth
		Local PNP
		Local Association of Barangay Chair/ ABC
		Sanggunian Kabataan
		DOH- Center for Health Development Bicol
		Civil Society Organization/ Academe
		➢ *Naga City People's Council*
		➢ *Naga College Foundation*
		➢ *University of Nueva Caceres*
		➢ *CamSur Medical Society*
		➢ *IMAP Naga*
		➢ *FPOP Naga/ CamSur Chapter*
		➢ *Naga City Council for Women (NCCW)*
		➢ *Isarog Family Health and Training, Inc.*
		➢ *HELP Learning Center*

SECTION 2. DUTIES AND FUNCTIONS. - The Council shall be the over-all coordinating and implementing body for the implementation of the MNCHN/CSR Strategy and Plan in the City of Naga In addition, the Council shall perform and exercise the following duties and responsibilities:

- Formulate and recommend to the Sanggunian the full implementation of a comprehensive MNCHN/CSR plan for the entire city in consultation with other stakeholders and oversee its implementation;
- Undertake program monitoring and evaluation and provide a program feedback mechanism;
- In close coordination with the barangay governments and other agencies concerned, conduct and update data on MNCHN;
- Provide support in strengthening capacities for MNCHN/CSR service provision through the conduct of training courses and other capacity building activities
- Provide support in the conduct of activities related to MNCHN education and counseling of clients about spacing and limiting and safe motherhood

- Perform such other duties and function as it may deem fit for the efficient and effective implementation of the program.
- Establish and maintain linkages with local, national or even international population-serving organizations or institutions;

SECTION 3. MEETING AND QUORUM. - The Council shall meet at least once in every quarter or as often as necessary at an expressed call of the chairman or at least fifty percent + one (50% +1) members of the Council. Provided, that a notice shall be sent to the members at least twenty-four (24) hours before the meeting will be held. The Council shall decide by a majority vote of all the members present during a meeting, with the existence of a quorum, on any matter before it.

Fifty percent + one (50 % + 1) of its members present shall constitute a quorum.

SECTION 4. PROGRAM SECRETARIAT AND MNCHN/CSR FOCAL PERSON. - There shall be constituted, within thirty (30) days from the approval of this Ordinance, a program secretariat to be headed by the MNCHN/CSR Focal Person.

The Focal Person shall be designated by the *Mayor* upon recommendation of the Council.

The Focal Person shall provide technical and administrative support, consolidating and documenting proceedings, and manage overall implementation of the MNCHN/CSR plans and complementary actions, and providing for such other assistance as may be required by the Council. Submit an annual report on all activities regarding the status of the program and its finances to the Mayor and to the Sangguniang Panlungsod.

ARTICLE V

PROCUREMENT AND DISTRIBUTION PROCEDURE AND PROGRAM BENEFICIARIES QUALIFICATIONS AND DISQUALIFICATIONS

SECTION 1. PROCUREMENT REQUIREMENT. - In the procurement of MNCHN commodities by the LGU, the policies, rules and regulations of Republic Act No. 9184 or the Government Procurement Reform Act and that of the Commission on Audit (COA) shall strictly be observed.

SECTION 2. IDENTIFICATION OF MNCHN COMMODITY REQUIREMENTS. - The City Health Officer shall identify the MNCHN commodity requirements using the forecast of commodities based on validated/verified current users data, as well as other related materials necessary in the implementation of the program.

SECTION 3. PRIORITY BENEFICIARY FOR THE PROGRAM. - The priority beneficiary of the Program shall be women and children who belong to the poorest of the poor. For this purpose, the Council shall utilize the DSWD list of NHTS-PR families and CCT/4Ps Families for identifying the poor.

The Council may employ other means-testing instruments or procedures to ascertain the qualifications of the program applicant.

SECTION 4. DISTRIBUTION OF MNCHN COMMODITIES. - To ensure constant availability of commodities to the poor, a workable system of distribution and dispensing of MNCHN commodities shall be adopted. Midwives and other authorized dispensers through the City Health Office shall be issued commodities and recorded accordingly through the LGU's Stock and Inventory Management System (SIMS).

A report on utilization, balances of stocks and monthly collections shall be submitted regularly to the City Health Office as a pre-requisite for subsequent issuance of commodities.

ARTICLE VI
MISCELLANEOUS AND FINAL PROVISIONS

SECTION 1. REPEALING CLAUSE. - All ordinances, resolutions and other issuances that are inconsistent with the provisions of this Ordinance are hereby amended, repealed or modified accordingly.

SECTION 2. SEPARABILITY CLAUSE. - If, for any reason, any part or section of this Ordinance inconsistent with the existing ordinance the same shall be declared invalid, no other part or sections of this Ordinance shall be affected thereby.

SECTION 3. IMPLEMENTING RULES AND REGULATIONS. - The Council shall, within a period of six (6) month/s after the approval of this Ordinance, formulate the Implementing Rules and Regulations and likewise shall form an integral part of this ordinance and the same shall take effect after proper dissemination and publication in the offices concerned and after posting at two (2) conspicuous places in the City.

SECTION 4. EFFECTIVITY CLAUSE. - This Ordinance shall take effect immediately upon approval.

ENACTED. June 17, 2014

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WE HEREBY CERTIFY to the correctness of the foregoing ordinance.

GIL A. DE LA TORRE
Secretary to the
Sangguniang Panlungsod

NELSON S. LEGACION
City Vice Mayor &
Presiding Officer

APPROVED:

JOHN G. BONGAT
City Mayor