SB FILE

Sangguniang Panlalawigan
RECEIVED
Marissa Perez
07 AUG 2024
9:47
ILOILO

REPUBLIC OF THE PHILIPPINES
PROVINCE OF ILOILO
MUNICIPALITY OF PAVIA
-oOo-
OFFICE OF THE SANGGUNIANG BAYAN

Telephone Number: (033) 329-46-02
Email Address: sb_pavia@yahoo.com

==========

1st ENDORSEMENT
August 7, 2024

Respectfully endorsing to the Sangguniang Panlalawigan the herein ***MUNICIPAL ORDINANCE NO. 2024-23*** entitled:***"ORDINANCE CREATING THE PAVIA HEALTH CLUB IN THE MUNICIPALITY OF PAVIA, ILOILO",*** for information and appropriate action.

LIBERTY G. DENIOLA
LLSO III

CC: **HON. LAURENCE ANTHONY G. GORRICETA**
Municipal Mayor

HON. EDSEL G. GEROCHI AND
SANGGUNIANG BAYAN MEMBERS

DILG AND OTHER OFFICES CONCERNED

Date Enacted	July 15, 2024
Date Forwarded to the LCE	August 5, 2024
Date Approved by the Mayor	August 6, 2024
Date Transmitted to Sangguniang Panlalawigan	August 7, 2024
Date Posted	August 7, 2024
Date Published	
Date Furnished to Constituents	

Republic of the Philippines
PROVINCE OF ILOILO
MUNICIPALITY OF PAVIA
-oOo-
OFFICE OF THE SANGGUNIANG BAYAN

EXCERPT FROM THE MINUTES OF THE REGULAR SESSION OF THE SANGGUNIANG BAYAN HELD ON JULY 15, 2024 AT 9:00 A. M. IN THE SESSION HALL, MUNICIPAL BUILDING, PAVIA, ILOILO.

PRESENT

1. Hon. Edsel G. Gerochi	- Municipal Vice-Mayor Presiding Officer
2. Hon. Jo Jan Paul J. Peñol	- Municipal Councilor
3. Hon. Ariel B. Gerada	- -do-
4. Hon. Jose Maria D. Trimañez	- -do-
5. Hon. Leonardo L. Belasa	- -do-
6. Hon. Daniel S. Fajardo, II	- -do-
7. Hon. Roy H. Gorriceta, Sr.	- -do-
8. Hon. Rhia B. Sotomil	- -do-
9. Hon. Joshua Philippe B. Gumban	- -do -
10. Hon. Ludovico S. Alfaro	- Liga ng mga Barangay President Ex-Officio Member
11. Hon. Gerard Peter G. Zaldarriaga	- SK Municipal Federation President Ex-Officio Member

==========

ORDINANCE 2024-23

ORDINANCE CREATING THE PAVIA HEALTH CLUB IN THE MUNICIPALITY OF PAVIA, ILOILO.

==========

WHEREAS, Article 11 of the 1987 Constitution of the Republic of the Philippines declares that the State shall protect and promote the night to health of the people and instill health consciousness among them;

WHEREAS, the Local Government Code of 1991 (Republic Act No. 7160) accords every local government unit the power and authority to promote general welfare within its territorial jurisdiction, including the promotion of health and safety of its constituents;

WHEREAS, the Universal Health Care Act of 2019 (Republic Act No, 11223) directs local government units to enact stricter ordinances that strengthen and broaden existing health policies and implement effective programs that promote health literacy and healthy lifestyle among their constituents to advance population health and individual well-being. reduce the prevalence on non-communicable diseases and their risk factors, particularly tobacco and alcohol use;

WHEREAS, the Department of Health (DOH) Administrative Order No 2016-0014 issued implementing guidelines on the organization of Health Clubs for patient with

Hypertension and Diabetes, to strengthen the fight against Non-Communicable Disease (NCD);

WHEREAS, the Department of Health (DOH) Administrative Order 201 1-003, National Policy on Strengthening the Prevention and Control of Chronic Lifestyle related Non-Communicable Disease (NCD), prescribes the strategy or comprehensive approach the country has adopted in reducing the morbidity, mortality and disability rates due to chronic lifestyle-related no communicable disease (NCDs);

WHEREAS, the Department of Health (DOH) Administrative Order 2012-0029. implementing guideline on the Institutionalization of Philippine Package of Essential NC Intervention (PhilPEN) or the Integrated Management of Hypertension and Diabetes for Prime Health Care Facilities, an adaptation of the World Health Organization (WHO) guidelines managing non-communicable diseases;

WHEREAS, the Municipality of Pavia finds it necessary to establish and institutionalize the Hypertension and Diabetic Program to address the health concerns of its constituents, mitigate the increasing incidence of NCDs and their complications particularly of diabetes and hypertension.

THEREFORE, BE IT ORDAINED BY THE SANGGUNIANG BAYAN OF PAVIA, ILOILO, in a session duly assembled that:

SECTION 1. Title. This Ordinance shall be known as "PAVIA LGU Health Club Ordinance of 2024".

Section 2. Declaration of Policy. The prevention and control of chronic lifestyle related Non communicable Diseases (NCDs) shall be guided by the following statements:

1. The country shall adopt an integrated, comprehensive and community-based response for the prevention and control of chronic, lifestyle-related NCDs.

   The underlying causes of NCDs are multi-faceted and are deeply rooted into the community and individual's socio-economic status, cultural orientations and personal preferences. Key measures and interventions that help prevent and control NCDs lie beyond the health sector. An integrated, comprehensive and community-based approach shall be adopted in responding to these issues.

2. Health promotion strategies shall be intensified to effect changes that would lead to a significant reduction in mortality and morbidity due to chronic, lifestyle related NCDs.

   There are three major changes that need to take place in order to achieve significant reduction in the morbidity and mortality due to NCDs. These require (1) changes in lifestyle of the individual and of the population, (2) changes in the environment supportive to the desired improvement of lifestyles, and (3) change in the way the overall health care delivery system works. It is believed that these three changes can be realized through health promotion. Health promotion entails five (5) action areas which include (1) building healthy public policy, (2) creating supportive environments, (3) strengthening community action, (4) developing personal skills through information and education, and, (5) reorienting health care services toward prevention of illness and promotion of health.

3. Complementary accountability of all stakeholders must be ensured and actively pursued in the implementation of an integrated, comprehensive and community-based response to chronic, lifestyle related NCDs.

   With devolution, the primary mandate of delivering basic health services was transferred to the Local Government Units (LGUs). The DOH shall encourage LGUs to perform adequately in the area of NCD prevention and control.

   Also, since new directions in the health sector require maximizing the participation of the private sector and other stakeholders, public-private sector collaboration shall be explored in the area of financing, service delivery, surveillance, capability building and other areas as may be necessary.

Section 3. Definition of Terms.

- Action Planning refers to an activity that will be made by the Health Club to identify programs, projects or activities for the prevention and control of NCDs.
- Barangay Health Worker refers to a person who has undergone training programs under any accredited government and non-government organization and who voluntarily renders primarily health care services in the community after having been accredited to function as such by the local health board in accordance with the guidelines promulgated by the Department of Health (DOH) as defined in RA 7883.
- Barangay officials refer to the elected officials in the barangay that includes the *Punong Barangay, Sanggunian* Barangay and *Sanggunian* Kabataan (SK) officials.
- Diabetes mellitus refers to a group of metabolic disorders characterized by high blood sugar levels, i.e., a fasting plasma glucose concentration above 7.0 mmol/L (126 mg/dl) or a postprandial (approximately 2hours after a main meal) plasma glucose concentration above 11.0 mmol/L (200mg/dl) on two separate occasions.
- Health Facility or health center refers to the LGU facility that provide screening and management of diseases like hypertension and diabetes that may include, but not limited to, city health offices, rural health units (RHUs) and barangay health stations.
- Hypertension also known as high or raised blood pressure, is a condition in which the blood vessels have persistently raised pressure and can increase the risk of heart, brain, kidney and other diseases [WHO, n.d.].
- Lifestyle-related NCDs refers to chronic NCDs particularly cardiovascular diseases, cancers, chronic respiratory diseases and diabetes.
- Municipal officials refer to the elected officials in the LGU that includes the Local Chief Executive, *Sanggunian, Sanggunian* Kabataan (SK) Federation President, and the *Liga ng mga Barangay* or ABC President.
- Non-communicable diseases (NCDs) also known as chronic diseases such as cardiovascular diseases (heart attacks and stroke), cancers, chronic respiratory diseases and diabetes, tend to be of long duration and are the

result of a combination of genetic, physiological, environmental and behavioral factors (WHO, n.d.).

- NCD Registries refer to hypertension and diabetes registries of the health facility. This is a registry of patients diagnosed with hypertension and diabetes in the health facility.

- PhilPEN Protocol refers to the Philippine Package of Essential Non-Communicable Disease Interventions for low-resource settings adopted from WHO PEN. This protocol consists of guidelines for the integrated management of hypertension and diabetes through a total risk approach. The individual client/patient is assessed and managed based on the risk prediction chart. The prediction charts can estimate the client/patients risk of having a cardiovascular event (CV risk) in the next ten years. This will be applied to all patients screened for and found to have NCDs.

- Protocol on the Integrated Management of Hypertension and Diabetes refers to the first clinical protocol developed under WHO PEN that makes use of the total risk approach using hypertension, diabetes and tobacco use as the entry points. It specifically involves the use of the WHO/ISH risk prediction charts to determine the risk of developing a cardiovascular event, i.e., heart attack or stroke over a ten-year period and management guidelines for risk reduction appropriate referral, regular follow-up, core set of technologies and essential medicines.

- Risk Assessment is the key process of evaluating individuals for the presence or absence of common risk factors that expose them to increased likelihood of developing NCDs.

- Risk Screening is the presumptive identification of unrecognized disease or the presence intermediate risk factors by the application of test and procedures which can be applied rapidly.

- Risk Stratification refers to estimating the level of risks of individuals for a fatal or non-fatal cardiovascular event in 10 years.

- Senior citizen or elderly refers to any resident citizen of the Philippines at least sixty (60) years old as defined in Republic Act 9994.

- Social Marketing refers to the comprehensive information, education and communication (IEC) strategy aimed at different NCD audiences to promote awareness, understanding and Health Club co-ownership.

- Youth shall refer to those persons whose ages range from fifteen (15) to thirty (30) years old as defined in Republic Act No. 8044.

Section 4. Definition. The Health Club is an association of people who would like to take part in activities in a facility that is providing access to their needed health services to improve the health and wellness of the members. The facility refers to the Pavia Rural Health Unit or any health center owned and managed by the Local Government Unit (LGU).

The Health Club shall elect its own officers every year. Officers of the Health Club may involve the Chairperson, Vice-Chairperson, Secretary, Treasurer, and P.I.O. as may be deemed necessary by the members during the meeting for such purpose.

Section 5. Coverage. This Ordinance covers the following populations who are at risk of NCDs:

- High risk groups: Population with hypertension and diabetes
- Moderate risk groups: Working population involved in prolonged physical, environmental and psychological hazards such as those in the public transport, fishing, farming, etc.
- At-risk groups: All population aging 20 years old and above that may involve government employees, young professionals, LGBT+, educational sector, and health and fitness groups

All the above-mentioned groups of people who are *bonafide* residents of the Municipality of Pavia can become members of the Health Club. A *bonafide* resident is someone who has been recognized/certified by the *Punong Barangay* to be a resident of the LGU.

Section 6. Activities of the Health Club. Activities of the Health Club may include:

1. Annual risk assessment, screening, and recruitment for HC membership;
2. Periodic measurement of Blood Pressure (BP), cholesterol test, electrocardiogram (ECG), and fasting blood sugar (FBS) including reminders when these have to be repeated, e.g., through mobile phones;
3. Lifestyle improvement activities such as changes of diet, increased physical activities, cessation of smoking, reduction of alcohol intake; and, encourage the community to change their lifestyle;
4. Health education, advocacy and social marketing/IEC campaign activities especially on prevention of common infections and proper use of medications, among others;
5. Replenishment of free medications;
6. Mental health improvement and other social support activities including home visits to encourage bonding among members and to relieve stress;
7. *"Istoryahanay"* or peer group engagement in health education;
8. Social activities like regular walking activities, card games, *mahjong* sessions and other get-togethers to further raise the understanding of health messages (e.g., the meals served should be diabetic-friendly or hypertensive-friendly);
9. Fund-raising activities, networking and lobbying for medical check-ups;
10. Registration in the Securities and Exchange Commission to raise funds for Club projects and activities;
11. Meetings that will be agreed upon by the majority of the members who convened for this purpose. Meetings may be called by the Club President, through a notice duly received by the members at least 24 hours prior to the meeting. A simple majority will determine the quorum of the Health Club to transact its business.

12. Other activities as may be deemed necessary and agreed upon by the members during their action planning.

Section 7. Organization and Maintenance of the Health Club.

***7.1. Stage 1 Pre-Organization Phase:* Accelerated case finding among the highest risk group**

A. Identifying patients with hypertension and diabetes

1. Case Finding shall be done during **community campaigns, program orientations** or home visits;

2. Case Finding shall be done through:

   2.1 Blood pressure (BP) measurement of all persons 20 years old and above measured twice, 15-30 minutes apart, with a third reading as necessary, by a Barangay Health Worker (BHW); and

   2.2 Risk assessment of clients 20 years old and above who visit the health center for other clinical complaints, based on PhilPEN.

3. Those found to have BP≥140/90 shall be referred to the nearest local health center for verification as soon as possible, through the bhw or midwives in their area of assignment.

4. All those verified to have elevated BP ≥140/90 by the health center midwife or nurse shall be:

   a. Referred to the Municipal Health Officer (MHO) to confirm diagnosis of hypertension and examined for any sign or symptom of underlying causes (e.g. renal disease) and target organ damage. Using PhilPEN, risk prediction can be done to estimate the cardiovascular risk of the patient;

   b. Maybe started on oral antihypertensive therapy if indicated based on latest protocol and clinical practice guidelines set by the DOH.

   c. Test for blood sugar and cholesterol maybe done if indicated.

   d. Registered in the health center Hypertensive Patient Registry;

   e. Strongly encouraged to enroll in the Health Club; and,

   f. Assessed for secondary hypertension and/or signs and symptoms of some target organ damage and then referred to a hospital for further evaluation.

5. All other persons without hypertension but have a family history of Diabetes, are obese, and with signs and symptoms of possible diabetes shall also have their FBS/glucose tested.

6. All patients found to have high capillary FBS (≥7.0 mmol/l or 126 mg/dl) shall have their FBS retested using venous blood done by a medical technologist either in the health center laboratory, local hospital laboratory or a private laboratory and shall be:

   a. Referred to the MHO to confirm diagnosis of diabetes and examined for any sign or symptom of target organ damage. Using

PhilPEN, risk prediction can be done to estimate the cardiovascular risk of the patient;

b. Patient maybe started on oral anti-diabetic therapy based on latest protocol and clinical practice guidelines set by the DOH.

c. Registered in the health center Diabetic Patient Registry;

d. Strongly encouraged to enroll in the Health Club; and,

e. Assessed for signs and symptoms of target organ damage and then referred to a hospital for further evaluation.

B. Enrollment to the LGU NCD Registries

1. Newly diagnosed patients shall be registered in the specific Chronic Disease Registry of the health facility.

2. A patient who has both hypertension and diabetes shall be registered in both the Hypertension and Diabetes Registries of the health facility.

C. Health Education

1. All patients registered in the Hypertension and Diabetes Registries shall have their first health education session given by the health facility nurse or midwife.

2. Topics on first health education session shall be composed of, but not limited to, the following:

   a. Diet changes needed for their specific condition (e.g., increase intake of fruits and vegetables)

   b. Increased physical activity (at least 30 minutes brisk walking three times a week),

   c. Cessation of smoking and reduction of alcohol intake, when relevant, and,

   d. Prevention of common infections.

3. Subsequent health education sessions to reinforce the health messages may be given by the midwife or a BHW specially trained for this task.

D. Follow-up

1. All patients with hypertension shall have their BP taken by the BHW at least once a week to verify that their BP is under control. Follow-up of these patients with the physician shall be monthly until BP is controlled and 3 - 6 months thereafter. Those found to still have BP ≥140/90 shall be referred back to the physician who may decide to adjust the medications and request further tests.

2. All patients with diabetes shall have repeat capillary FBS testing every three (3) months. Those found to still have FBS≥7.0 mmol/1 or 126 mg/dl shall be re-evaluated by the health center physician or any physician who may decide to adjust the medications and request further tests.

3. Patient booklet shall be given to the patient and shall be used to monitor the dispensing of medications and health promotion activities. The booklet shall contain all the essential clinical information that should be assessed and monitored on a regular basis.

4. Clients who are 40 years old and above who still do not manifest any signs of hypertension or diabetes but are known smokers, have a family history of diabetes and/or are obese should continue to be followed up at least every 3 to 6 months since they are still considered low to moderate risk or with≤ 20% CV risk.

5. Summary of above-listed procedures (Annex A)

7.2. Stage 2: The Organization and Maintenance of Health Clubs

A. Enrollment

1. All patients with Chronic Lifestyle Related NCDs shall be encouraged to enroll in the Health Club.

2. Patients who agree to enroll in the Health Club shall fill- up the application form (Annex B) and will be issued an ID and patient booklet.

3. The Health Club member shall be informed of activities from which incentives can be provided if attended (e.g., 1 activity- 1 raffle ticket; total of 3 raffle tickets can be equivalent to a discount voucher for diagnostics/gift items).

4. There shall be only one Health Club for hypertensive and diabetic patients since many diabetics are also hypertensive and the activities to promote lifestyle changes are the same for both types of patients.

B. Membership Number. Each club member shall be given a unique chronological Club membership number in the following format:

1. DOH Heath Facility Code (FC) of the National Health Facility Registry System - Year of enrolment in the club, particular health club, and chronological number of patient.

C. ID

1. Each patient shall receive a unique identification (ID) card color-coded according to their clinical classification as follows:

   - YELLOW: (< 20% risk score) the patient has hypertension OR diabetes only (no signs or symptoms of target organ damage)
   - ORANGE: (20-30% risk score) the patient has hypertension AND diabetes without any sign or symptom of target organ damage;
   - RED: (>30% risk score) the patient has hypertension and/or diabetes AND signs of target organ damage.

2. When the clinical condition of the patient improves or deteriorates, he/she shall be given an adjusted color ID.

3. Red-coded patients shall also be enrolled in hospital-based health clubs but they will retain their unique facility-based Club membership number. They can be active in either club but shall claim their free medications only from their respective RHUs.

D. Medications

1. Newly diagnosed hypertensive and diabetic patients shall:

a. Receive a prescription from the local health physician (Municipal Health Officer, Medical Officer or Rural Health Physician); and,

b. Receive maintenance medications on a monthly basis from the Rural Health Units where they are registered.

2. Previously diagnosed hypertensive and/or diabetic patients who come to the health facility just to ask for free medications shall be:

a. Thoroughly evaluated: measure BP, test capillary FBS (glucometer), assess clinical signs and symptoms for target organ damage and underlying causes (e.g., renal disease for hypertensive patients) based on PhilPEN;

b. Registered in the appropriate Chronic Disease Registry in the health facility;

c. Strongly encouraged to enroll in a Hypertension-Diabetes Health Club;

d. Given health education reiterating the lifestyle messages mentioned in First Health Education; and,

e. Maintained on their current medications until the next follow-up.

3. Claiming of maintenance medications

a. Patients shall personally claim their medicines in their respective health center. Alternatively, other people may claim for them as long as with authorization letter and patient booklet.

b. Claiming of medications is subject to availability of the supplies in the health center.

7.3. Monitoring and Evaluation

A. The Local Chief Executive shall create a committee who will be responsible for monitoring and evaluating the implementation of this issuance.

B. The Health Club may be evaluated using the following indicators as guide:

a. Performance indicators to measure attainment of targets in terms of patients identified and treated, functionality, and NCD drug utilization; and,

b. Indicators of the effectiveness of health clubs in preventing adverse health outcomes.

Section 8. Responsibilities of the Parties.

- **Barangay Officials**

    a. Ensure the efficient and effective provision of health services in the barangay;

    b. Provide the necessary assistance, such as, but not limited to, annual budgetary allocation to support the creation and operation of the HC;

    c. Encourage the community to join the HC;

    d. Support health promotion and education campaigns of the LGU;

    e. Formulates policy to promote and ensure the health and well-being of the community;

    f. Ensure an inclusive and equitable implementation of this Ordinance.

- **BHW Federation**

    a. Conduct community profiling and relay information to local stakeholders to inform programs and policies;

    b. Assist the barangay officials in recruiting vulnerable/at risk populations for Health Club membership;

    c. Serve as liaison between hypertensive and diabetic patients and health care providers;

    d. Provide support to the Health Club which may include, but not limited to, the following: blood pressure monitoring, distribution of commodities to HC members, motivating patients to adopt healthy lifestyle, following up patients for medication refills, and recording of data;

    e. Provide culturally appropriate health education, promotion and advocacy to the community; and,

    f. Gather community feedback for the sunset review of this Ordinance.

- **Health Office**

    a. Spearhead the organizing of the facility-based Health Club using this Ordinance as guideline;

    b. Assign a focal person within the facility who will oversee the activities of the club.

    c. Be responsible for the assessment of HC members, referral of patients, distribution of medications, and the setting of protocols/standards based on the DOH guidelines for the management and care of patients;

    d. Provide health education, advocacy, and other health services to the HC members, as maybe necessary;

    e. Ensure sustainability of the HC through regular follow-up of patients and registry;

f. Prepare monitoring and evaluation reports on the functionality of HC; and,

g. Ensure close coordination with concerned stakeholders for NCD Program implementation in the LGU.

- **Local Law Enforcers**

  a. Enforce local ordinances;

  b. Provide assistance to the Health Club by: (1) ensuring public safety during HC activities and monitoring; and, (2) assisting in following-up defaulters;

  c. Participate in HC activities, e.g., healthy lifestyle activities including, but not limited to, Zumba and other fitness programs in the community;

  d. Endeavor to become role models in pursuing a healthy lifestyle;

- **Municipal Officials**

  a. Support the organization and **institutionalization** of the HC in the main health facility within the LGU;

  b. Provide support to the operation and effective functioning of the HC which include, but not limited to, the following: **annual budget allocation**, **manpower**, registration and accreditation, facilities and equipment, **incentives, awards**, and other logistics needed by the Club;

  c. Promote an inclusive and equitable implementation of this Ordinance; and,

  d. Ensure the implementation, monitoring and review of this Ordinance;

- **Senior Citizens**

  a. Provide support to the HC by: (1) serving as volunteers to assist in active case finding and/or recruitment and referrals among the elderly; (2) serving as resource speakers to share experiences to promote healthy lifestyle; (3) promoting membership into the health club among the elderly and in their respective families;

  b. Participate in health advocacy, planning, social mobilization, monitoring, and evaluation in the community;

  c. Participate in healthy lifestyle activities including, but not limited to, Zumba and other fitness programs in the community;

  d. Endeavor to become role models in pursuing a healthy lifestyle;

- **Youth**

  a. Provide support to the HC by serving as volunteers to assist in active case finding and referrals;

  b. Participate in health advocacy, planning, social mobilization, monitoring, and evaluation in the community;

c. Participate in healthy lifestyle activities including, but not limited to, sports activities, mental health awareness campaigns, Zumba and other fitness programs in the community;

d. Engage in adolescents and youth-friendly activities such as, but not limited to, responsible adolescent and youth sexual and reproductive health, environmental protection, food security, nutrition and other activities in response to SDH;

e. Endeavor to become role models in pursuing a healthy lifestyle;

Section 9.Administrative Provisions. Implementation and supervision of the Health Club shall be made by the Municipal Health Office through the NCD Focal Person. The SB on Health shall also serve as co-supervisor.

Section 10. Separability Clause. If any portion or provision of this Ordinance is declared as void or unconstitutional, the remaining portions not be affected thereby, shall remain in full force and effect.

Section 11. Repealing Clause. All municipal ordinances or parts of any municipal ordinance inconsistent with the provisions of this Ordinance are hereby repealed, revoked, or modified accordingly.

Section 12. Effectivity. This Ordinance shall take effect after ten (10) days from the date a copy thereof is posted in a bulletin board at the entrance of the municipal hall and in at least two (2) other conspicuous places in the LGU.

BE IT ORDAINED FURTHER, to furnish copies of this Ordinance 2024-23 to the Office of the Mayor, Municipal Health Officer, *Liga ng mga Barangay*, BHW Federation and the *Sangguniang Panlalawigan* of Iloilo for information, and appropriate action.

ENACTED this 15th day of July, 2024 at Pavia, Iloilo Philippines.

Approved.

I HEREBY CERTIFY to the correctness of the above-quoted ordinance:

GYNNYN G. GUMBAN
Secretary to the Sanggunian

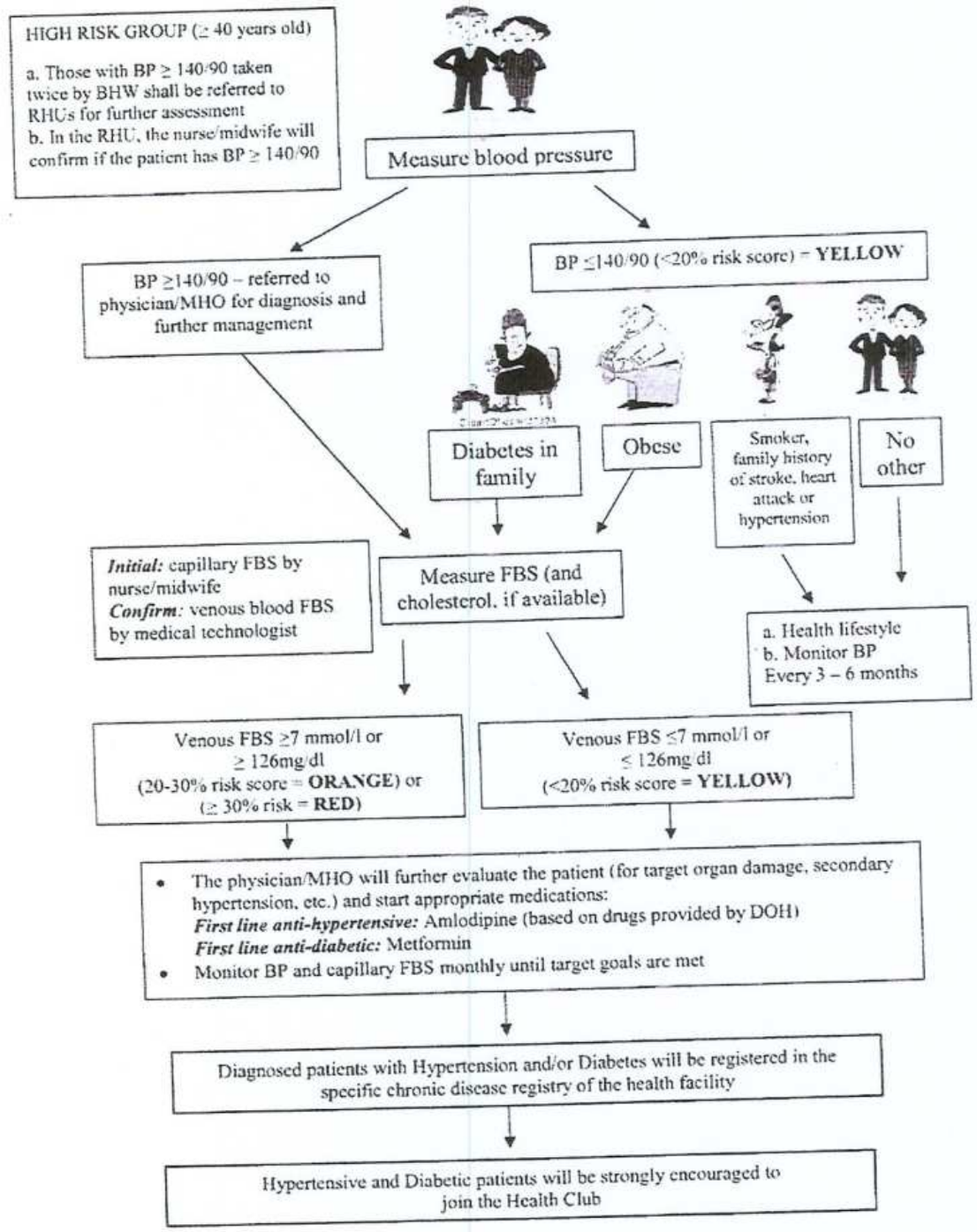
ATTESTED BY:

HON. EDSEL G. GEROCHI
Municipal Vice-Mayor
Presiding Officer

APPROVED:

HON. LAURENCE ANTHONY G. GORRICETA
Municipal Mayor

Annex A


HIGH RISK GROUP (≥ 40 years old)
a. Those with BP ≥ 140/90 taken twice by BHW shall be referred to RHUs for further assessment
b. In the RHU, the nurse/midwife will confirm if the patient has BP ≥ 140/90
Measure blood pressure
BP ≥140/90 – referred to physician/MHO for diagnosis and further management
BP ≤140/90 (<20% risk score) = YELLOW
Diabetes in family
Obese
Smoker, family history of stroke, heart attack or hypertension
No other
Initial: capillary FBS by nurse/midwife
Confirm: venous blood FBS by medical technologist
Measure FBS (and cholesterol, if available)
a. Health lifestyle
b. Monitor BP
Every 3 – 6 months
Venous FBS ≥7 mmol/l or ≥ 126mg/dl
(20-30% risk score = ORANGE) or
(≥ 30% risk = RED)
Venous FBS ≤7 mmol/l or ≤ 126mg/dl
(<20% risk score = YELLOW)
The physician/MHO will further evaluate the patient (for target organ damage, secondary hypertension, etc.) and start appropriate medications:
First line anti-hypertensive: Amlodipine (based on drugs provided by DOH)
First line anti-diabetic: Metformin
Monitor BP and capillary FBS monthly until target goals are met
Diagnosed patients with Hypertension and/or Diabetes will be registered in the specific chronic disease registry of the health facility
Hypertensive and Diabetic patients will be strongly encouraged to join the Health Club

Annex B

a. Sample Application Form

APPLICATION FORM

PAVIA HYPERTENSION AND DIABETES CLUB

Name of Patient: _____

LAST NAME FIRST NAME MIDDLE NAME

Birth Date: _____ Age: _____ Sex: _____

Address: _____

No. Street Barangay City/Municipality Province

Contact number: _____ Email (if any): _____

PhiliHealth Number: _____

PAVIA HYPERTENSION AND DIABETES CLUB

Patient No.: _____

Name:

_____

Address: _____

RHU:

_____

Birth Date: _____ Sex: _____

Contact number: _____

In case of emergency:

Name:

_____

Address: _____

Contact number: _____

_____

Signature of Number

Back