

WHO Update

Philippines

31 January 2009



Background

Skirmishes since mid-August 2008 between the separatist Moro Islamic Liberation Front (MILF) and forces of the government of the Republic of the Philippines (GRP) in the Philippine island of Mindanao have resulted in the death of 163 people, 123 injured (as of 15 January 2009) and the displacement of hundreds of thousands of civilians in Regions X, XII, and the Autonomous Region of Muslim Mindanao (ARMM). During the height of the conflict in 2008 as many as 500 000 were reported to have been displaced from their communities.

The nature of the conflict has made the situation of internally displaced persons (IDPs) fluid. What may be a safe haven one day for those displaced may be the site of an armed clash the next day or the next week, causing evacuees to move to safer grounds. This has led to confusing and oftentimes conflicting reports on the numbers and locations of IDPs and has made the planning and delivery of humanitarian services more difficult. Differences in religion and culture among the affected populace and security concerns faced by responders further add to the complexity of the situation.

Varying estimates put the number of IDPS at 300 000-350 000 with 20-25% housed in evacuation centers and the rest staying with relatives or in self-constructed bunkhouses in vacant lots or along roadsides. Health services to evacuees in camps is provided by understaffed and undersupplied mobile teams as the shortage of health human resources and supplies does not make possible the establishment of health outposts in evacuation sites. Many government health staff have been on 24/7 duty since the start of the crisis and show signs of fatigue. Security and safety

concerns hamper the delivery of essential public health services to the more remote areas. Diarrhea and respiratory illnesses remain the most common morbidities among IDPs inside and outside of evacuation camps.

Flooding in some parts of Mindanao has exacerbated the humanitarian situation. Heavy rains have caused rivers in the Cagayan de Oro and Lanao del Sur provinces to overflow their banks, while flash floods were experienced in the cities of Gingoog and Iligan.

There is already a significant number of local and international agencies providing humanitarian assistance in the conflict affected areas in Mindanao and their numbers are expected to increase. International humanitarian agencies feel the need to coordinate responses but many are hesitant to participate in the clusters led by government agencies as the government is seen to be party to the conflict. Regional government health emergency coordinators who chair such clusters themselves admit to a limited understanding of the cluster approach and the necessary tools for coordination.

The forecast of a continuation of the conflict well into the current year with possible spread to adjacent provinces mean an increase in the numbers of IDPs and the need for more resources and better coordinated humanitarian assistance.

Activities

1. Control of communicable diseases

Emergency health kits/supplies will be provided to augment the medicines and supplies of the rural health units (RHU) and *barangay* health stations (BHS) of Datu Piang, Mamasapano, Datu

Saudi Ampatuan, Sharif Aguak, Datu Unsay, Piagapo, Ampatuan, Datu Odin Sinsuat, Datu Anggal Midtimbang, the city health office (CHO) of Marawi City, the provincial health office (PHO) of Basilan – all in ARMM; the RHUs and BHSs of Aleosan, Midsayap, Pikit, Tuluhan, Maasim and Kalamansig – all in Region 10; and the RHUs and BHSs of Munai and Tangkal in Region 12. These identified areas have significant numbers of IDPs inside and outside of evacuation camps.

Strengthening health human resources is critical 1) to improve delivery of basic health services by enabling the establishment of health outposts in major evacuation camps and in those camps located far from RHUs and BHSs and/or by increasing the number of mobile health clinics; 2) to increase the number of health staff working on advocacy and health promotion activities; 3) to increase the presence of personnel for surveillance.

Health promotion information, education and communication (IEC) materials will be reproduced for distribution to families in evacuation centres and in the community.

2. Mental health and psychosocial support services (MHPSS)

An assessment and monitoring tool will be developed, based on the Inter-Agency Standing Committee (IASC) guidelines, for better understanding of the mental health and psychosocial support needs of the IDPs and to guide decisions on the forms of MHPSS that would be most appropriate to the local context. Technical experts on the IASC guidelines may need to be hired to provide support to local experts.

Local health staff will be trained on the use of the assessment and monitoring tool as well as in the provision of psychological first aid. Support will also be provided on the actual data gathering and analysis, and in direct service provision.

3. Coordination of sectoral activities

A field office will be established with the following staff: 1) a field officer who will focus on coordination of humanitarian activities with partners and will essentially be the focal person for the WHO to the Health Cluster in the affected regions, providing support to health ministry staff in their role as lead of the cluster under the national disaster management system; 2) an information management officer will ensure effective information sharing through regular situation reports and bulletins, web updates, distribution of

minutes of meetings and assessment reports with partners within the cluster and with other clusters; 3) an administrative support staff.

A MOSS-compliant vehicle is necessary to provide mobility around the affected regions for coordination and monitoring activities, and to comply with UN Department for Safety and Security guidelines on staff movement especially in Phase 3 areas.

Response plan

At the national government level, the main partner for this intervention will be the Department of Health-Health Emergency Management Staff (DOH-HEMS) and its offices in regions X, XII, and ARMM. Partners at the local government units (LGU) will be the PHOs and RHUs of the municipalities hosting the IDPs (mentioned above). Other partners will include members of the Health cluster like UNICEF, UNFPA, Medicines Sans Frontieres (MSF).

Estimated funding requirements (12 months)

1. Human resources:	USD
Coordinator	150,000
Information manager	20,000
Technical staff/consultants	120,000
Support staff	20,000
2. Emergency health kits/supplies	200,000
3. Support to health services	200,000
4. Coordination activities	50,000
5. MOSS compliant vehicle	50,000
6. IT supplies and equipment	20,000
7. Programme management & monitoring	83,000
Total	913,000

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