

WHO funding request

Health sector
response to the
complex emergency
in Mindanao
(The Philippines)

4 September 2009

Health Action in Crises



Background

Since mid-August 2008, skirmishes between the separatist Moro Islamic Liberation Front (MILF) and government forces in the Philippines island of Mindanao have resulted in the deaths of 318 people,¹ with over 150 injured and hundreds of thousands displaced in Region XII, the Autonomous Region of Muslim Mindanao (ARMM), and initially in Region X. There is, at the moment, a cessation of hostilities between the two groups. But with the likelihood of elections in 2010, possibilities of election-related violence and clan conflicts will inevitably result in many more internally displaced persons (IDPs) and the need for more resources and better coordinated humanitarian assistance.

During the height of the conflict in 2008, as many as half a million people were reported to have fled the violence. The fluidity of the fighting means these IDPs are frequently on the move, as what may be a safe haven one day may be the site of an armed clash the next day or week. This has led to confusing and often conflicting reports on the number of IDPs and their locations, and has hampered the delivery of humanitarian services. Religious and cultural differences among the IDPs, together with security constraints faced by responders, have further exacerbated the situation.

The number of IDPs is currently estimated to be anywhere from 350 000 to 400 000, of whom around a quarter are housed in 164 evacuation

camps spread out over six provinces in the two regions. The remainder are either staying with relatives or have taken refuge in makeshift bunkhouses on vacant lots and along roadsides. Health services in the camps are provided by understaffed and poorly supplied mobile teams. Public health services for communities in IDP areas have been adversely affected, as scant resources have been diverted to the camps. Many exhausted local government health staff have been on round the clock duty since the start of the crisis. Security and safety concerns are hampering the delivery of essential public health services to more remote areas.

Public health concerns

Diarrhoea and respiratory illnesses remain the most common cause of morbidity among IDPs both inside and outside the camps. A recent joint assessment by the Nutrition and Food clusters revealed alarmingly high rates of global acute malnutrition in children in the camps and host communities, with severe malnutrition a major contributing factor in most deaths of children under five. Local health authorities have noted an increase in the numbers of persons requiring mental health and psychosocial support. The threat of pandemic influenza A (H1N1) can only be expected to worsen the health picture among the IDPs and further strain the overburdened health system. Moreover, recent flooding in the wake of heavy monsoon rains, attributed by many to the effects of climate change, has led to an increase in the number of IDPs and has further exacerbated their dire situation. During the peak of the flooding, media and national health ministry reports

¹ Data as of 5 August 2009.

estimated that around 300 000 people had been affected. Repeats of this scenario can be expected now that the typhoon season has begun.

Previous funding

In September 2008, WHO obtained a humanitarian grant from the UN Central Emergency Response Fund (CERF) to provide essential medicines and health supplies to local health facilities and outposts in IDP camps. This helped ensure the uninterrupted provision of essential health services to affected communities and camps. Using the CERF funds, WHO donated water treatment supplies and water containers to families outside the camps, and supplied water testing devices to monitor water quality. A second grant from the CERF has allowed WHO to continue its humanitarian assistance to the ever-increasing numbers of IDPs. Aside from providing much needed medicines and supplies, WHO plans to procure equipment to maintain the cold chain and ensure immunization activities are able to continue with minimum disruption. Health human resources will also be augmented to ease the burden on local health staff. WHO also donated medicines and health supplies and equipment in the aftermath of the heavy rains earlier this year that resulted in a fresh wave of displacement and deteriorating conditions in the camps.

The Health Cluster

The cluster approach was initiated in the Philippines in November 2006 in the aftermath of typhoon Durian, and is now systematically used to coordinate all humanitarian action in the country. The Government has integrated the cluster approach into its national disaster management system: humanitarian clusters are led by national government agencies, with counterparts from members of the Inter Agency Standing Committee Country Team (IASC-CT). Together with the Department of Health, WHO acts as co-lead of the national Health Cluster.

A significant number of local and international agencies are already providing humanitarian assistance in the conflict-affected areas in Mindanao, and their numbers are expected to increase. The regional government health emergency coordinators who chair the regional humanitarian clusters themselves admit to a limited understanding of the cluster approach and the necessary tools for coordination.

Response plan

Goal

- To reduce the health consequences of the Mindanao complex emergency and minimize its social and economic impact.

Objective

- To ensure the continued provision of essential health services to displaced populations inside and outside evacuation camps and temporary settlements as well as to residents of the host communities in the conflict-affected regions of Mindanao.

Proposed activities

1. Coordination of health sector activities

- Establish a field office to coordinate overall health sector activities in Mindanao. This office will be staffed by a dedicated field coordinator and administrative support staff and supplemented by technical consultants as and when needed.
- Convene regular coordination meetings; conduct joint assessments with commonly accepted tools and methods; prioritize a needs and gap analysis; undertake evidence-based planning to ensure coordinated and complementary interventions; monitor activities and evaluate progress; conduct advocacy activities and mobilize resources.
- Purchase a MOSS-compliant vehicle (essential to both implement and monitor activities in the affected areas and to comply with UN security requirements).

2. Control of communicable diseases

- Provide emergency health kits and other health and medical supplies to augment stocks in rural health units (RHUs) and barangay health stations (BHS) in the following areas that have significant numbers of IDPs inside and outside the evacuation camps:
 - ARMM: 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
 - Region XII : RHUs and BHSs of Munai and Tangkal
- Recruit additional health personnel and/or strengthen the capacity of existing personnel in order to: 1) improve the delivery of basic health services by enabling the establishment of health outposts in major camps and increasing the number of mobile health clinics; 2) increase the number of health staff doing

advocacy and health promotion activities;
3) improve the quality of surveillance.

- Produce health promotion and information, education and communication IEC materials and disseminate them to IDP families in camps and in the community.

Cooperation with field partners

At national level, the project will be implemented in close collaboration with the Department of Health-Health Emergency Management Staff (DOH-HEMS), the government agency leading the national health cluster. WHO will also collaborate closely with the National Disaster Coordinating Council (NDCC), the IASC-CT and all local, national and international humanitarian NGOs and other UN agencies that are members of the national health cluster.

At regional level, the DOH Field Implementation Management Office (FIMO) will be WHO's main partner for overall coordination in Mindanao. DOH regional health emergency management coordinators who chair the regional clusters will be supported, consulted and closely involved in the project implementation.

Provincial health offices and municipal RHUs in the affected communities will be the main partners to implement the health activities outlined above. Non-government partners will include all members of the regional health clusters, i.e. local and international humanitarian organizations and NGOs including MSF, Save the Children, the Mindanao Emergency Response Network, and other UN agencies such as UNICEF and UNFPA.

Estimated funding requirements

WHO is requesting US\$ 914 176 to ensure the continued provision of essential health services to internally displaced populations inside and outside evacuation camps and temporary settlements as well as to residents of the host communities in the conflict-affected regions of Mindanao.

Items	US\$
1. Staff costs:	
Health Cluster Field Coordinator (x 3 months) (international recruitment)	45 000
National Professional Officer	74 000
Field Officer	42 800
Secretary	22 500
Driver	19 400
2. Contractual services:	
Health Services	200 000
3. Operations:	
Coordination activities	80 000
MOSS-compliant office rental/utilities	3 000
Vehicle maintenance	20 000
4. Acquisitions:	
Emergency health kits/supplies	200 000
MOSS-compliant vehicle	50 000
Information and communication supplies & equipment	20 000
Project management, monitoring and reporting costs	77 670
Sub-total	
Programme Support Costs (7%)	59 806
Total	914 176

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