FRAMEWORK FOR THE COMPREHENSIVE PARTICIPATORY HEALTH AND DEVELOPMENT PROGRAM

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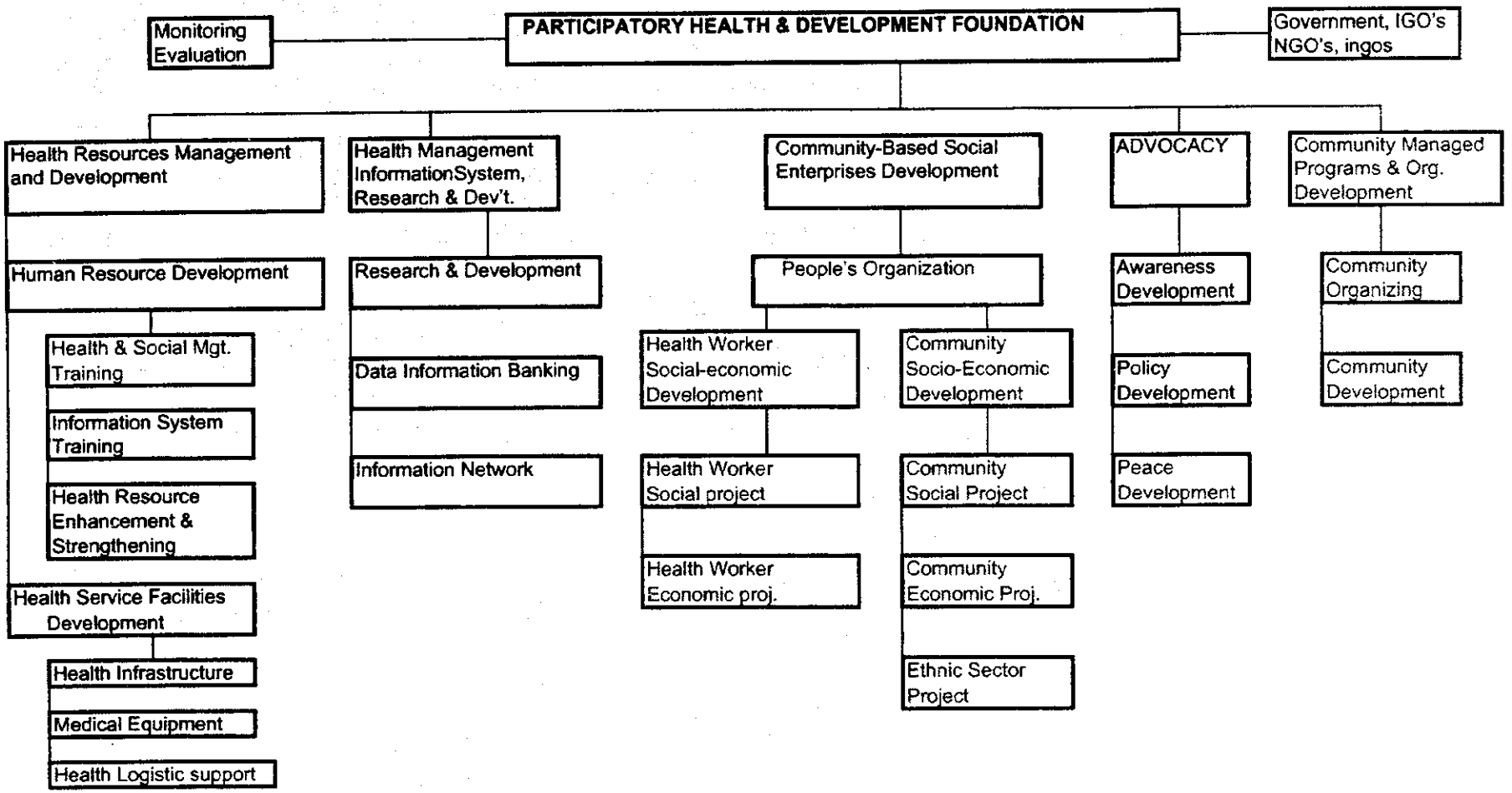


Comprehensive Participatory Health & Development Program for ARMM-SZOPAD and other regions in Mindanao, Philippines

Background Information

The creation of an autonomous region in Mindanao, particularly areas dominated by Muslims was first enacted under RA 6734 signed in August 1, 1989 by President Corazon C. Aquino. The granting of autonomy to some parts in Mindanao was in accordance with the Tripoli Agreement forged in Libya in 1976.

The present Autonomous Region in Muslim Mindanao (ARMM) was formally inaugurated in November 6, 1990. It comprised of four provinces, namely: Maguindanao, Lanao del Sur, Tawi-Tawi and Sulu. Out of the thirteen originally identified provinces to comprise the ARMM, these are the only provinces that opted to join the autonomous region through a plebiscite in November 16, 1989.

The signing of the Peace Agreement between the Moro National Liberation Front and the Government of the Philippines in September 2, 1996 and subsequent establishment of the Special Zone for Peace and Development or SZOPAD was envisioned to fast track the development in Mindanao. Through this legislation, the unique and relevant needs of the ARMM-SZOPAD can be focused. This will give the people in Mindanao an equitable opportunity to participate in planning and implementing appropriate developmental projects and in particular addressing one of the major issues- *the health and nutrition aspect.*

After years of the ARMM s existence, the region remained to be under-developed. The vicious cycle of poverty and illiteracy are clearly manifested in the health and nutrition status of the people. To date, the health and nutrition problem has become a major issue and requires an all-out war not only by government and non-government agencies, local and foreign, including the people or communities themselves. The social disadvantaged sector is growing in number and the effects on the Philippine socio-economic status has become so alarming. This has been recognized, likewise, by the International Communities.

Regional armed conflicts added up to the problem and worsened the present social and economic conditions adversely affecting, likewise, the health and nutrition status of the various regional communities particularly in the rural areas. Greatly affected are the delivery of health services and the sustainability of health programs in both the directly and neighboring communities where arm conflicts are taking place.

The Philippine government, for its part, has initiated or implemented various health programs and strategies utilizing both domestic and foreign resources, yet the health indices remain to be very unsatisfactory. There seem to be a missing link between implementation and people s acceptance or adoption and this is crucial to make development sustainable. **This missing link is**

the community, *the people s participation in the process of change.*

We, the Public Health Workers, alumni of the Participatory Integrated Health Administration Promotion in Mindanao-SZOPAD Training Course in Nagoya, Japan, form ourselves with other agencies/persons as partners who share the same vision into an NGO as an alternative community health movement to fill the gap between the government agencies and the community.

Vision

The Participatory Health Development Foundation for the Autonomous Region in Muslim Mindanao-Special Zone of Peace and Development (ARMM-SZOPAD) and other regions in Mindanao envisions to have a healthy, participative empowered people living in a peaceful and developed environment.

Mission

The missions of the Participatory Health Development Foundation are:

1. to promote, enhance and facilitate people empowerment process towards a comprehensive, participatory, self-reliant and people-centered health and development of all sectors.
2. to network and facilitate all sectors; government agencies, non-government organizations, religious institutions to be responsive, dynamic, transparent partners through a comprehensive participatory health and development endeavor of the community.

Goal

The goal of the Participatory Health and Development Foundation is to make health services accessible, affordable, acceptable and sustainable through effective, efficient and responsive health workers who are empathic and sensitive to the people s needs, with the community as decision-makers of health policies.

Objectives:

1. Develop a people-centered and participatory health and development Program/ project
2. Improve the management and utilization of health resources.
3. Upgrade medical logistics, funding scheme and delivery.
4. Strengthen local, national and international health information systems and networking.
5. Organize health workers and communities to engage in a productive and participatory social enterprise.
6. Increase people s and local government unit s awareness on health and

Develop policies, which are culturally appropriate and need-driven.

Program Components

The CPHDP-ARMM/SZOPAD is designed to institutionalize the community and/or people participatory approach which will involve not only planning and implementation but monitoring and evaluation of outcomes of each sub-project activities and introduce a new strategic policy advocacy, local governance and/or implementation scheme to ensure sustained adoption of health and related development projects.

The program has five major components, namely:

Component 1: Health Resources Management and Development
Component 2: Heath Management Information System, Research & Dev t.
Component 3: Community-based Social Enterprise Development
Component 4: Advocacy
Component 5: Community Managed Programs & Org. Dev t

Program Components Description:

COMPONENT 1: Health Resources Management and Development

The Health Resources Management and Development project component is composed of two sub-projects, namely: (1) the Human Resource Development, and (2) the Health Service Facilities Development.

I. the Human Resource Development Projects include the following activities:

A. Health and Social Management Training will undertake comprehensive in-house management skills training for health workers and administrators. Specially, the management and operation of rural hospitals and/or Barangay health centers in collaboration or pro-active participation of the communities/people. This will be carried our as part of capability building program for health workers and administrators.

1. *Training on PIME*
2. *COPAR training at all levels*
3. *Participatory health management training*
4. *CO-CD Training for service providers*
5. *Leadership training for RHO, Chief of Division/Section, Doha s, Mho s, Medical & Nurse coordinator.*
6. *PWD training*

7. *BHW training*
8. *PAR tools training*
9. *Training of health providers on PHC basic management*
10. *Training on ultrasound, ECG, & X-ray readings*
11. *Training on oriental medicine for heads of units*
12. *Dialysis & endoscopy training for MD s & nurses.*
13. *Cold chain management training for RHM*
14. *Disaster management and administration in armed conflict situation*
15. *Disaster management (Quick response team)*
16. *Organize evacuees training for RHM*
17. *Conflict management training*
18. *Stress de-briefing*
19. *Seminar-workshop on culture of peace*
20. *GG/NPM training*
21. *TOT on PTM*
22. *Gender and Culture Sensitivity training*
23. *SED training*
24. *Moral Recovery Training*
25. *Culture of Peace Training*

B. Health Information Systems and Utilization in-house Training is designed to improve the processing/handling of health problems, issues/concerns and other related information in the delivery or administration of health services to the communities particularly in Muslim dominated areas considered as depressed, disadvantaged and undeserved/unsaved.

1. *Health data processing (Admin. / Technical)*
2. *ICD-10 training for statistician, FHSIS coordinator, Mho s, PHN, Regional medical & nurse coordinator*
3. *FHSIS training*
4. *MBN training (CBIS) for Mho s & PHN*

C. Social Enterprise Development Training will include the designing and implementation of productive training activities for health workers and administrators for the optimum development and utilization of resources including indigenous medical resources.

1. *Orientation on accreditation*
2. *Cooperative orientation / re-orientation for health workers*

3. *Participatory enterprise management for BHWs cooperative member*
4. *Marketing strategy training*

D. Human Resource Enhancement and Strengthening Program

1. *Regular PIR for health workers*
2. *Organizational developments*
3. *On the job coaching*
4. *Observation study tours*

II. The Health Service Facilities Development Subcomponent include the following activities:

A. Health Infrastructures will involve the establishment or construction and rehabilitation of buildings, facilities and amenities to support the health programs. This will also include assessment of existing health infrastructures and facilities to determine the disparity of its distribution and access to communities/people in dire need.

1. *Inventory of health infrastructures*
2. *Construction of BHS Buildings*
3. *Construction of IPHO building in Lanao del Sur & Maguindanao*
4. *Electricity for Rhea s*
5. *Water system for Rhea s*
6. *Renovation of existing health facilities*
7. *Establishment of satellite clinics*
8. *Renovation & repair of hospitals (Provincial, district, & Municipal)*
9. *Construction of dormitories for health workers*

B.Medical Equipment sub-component will entail the upgrading and acquisition of modern medical equipment with corresponding training on its operation and operation and maintenance. The training will be arranged with either domestic or foreign institution / foundations.

1. *Hospital medical equipments*
    a. *Inventory of medical equipments*
    b. *Provisions of generators*
    c. *Provision of X-ray machines*
    d. *Provision of E-Cart w/ defibrillator*
    e. *Provision of Endoscope*

f. *Provision of Procto-sigmoidoscope*

g. *Provision of dialysis machine*

Provision of dental equipment (Chairs, x-ray, etc.)

h. *Provision of incubators*

i. *Provision of laboratory equipments (microscope, etc.)*

j. *Provision of BILI lights*

k. *Provision of major surgical instruments*

l. *Provision of diagnostic set*

m. *Provision of orthopedic bed w/ pulley*

n. *Provision of medullary plates, pins, screws. Fixators*

2. *Medical equipments for RHUs*
   a. *Provision of minor surgical set*
   b. *Upgrading of cold chain equipments*
   c. *Provision of refrigerators, nebulizers, & oxygen tanks w/ regulators*

C. HEALTH Logistic Support. This sub-project component will include activities to improve the medical logistic support for community-based health programs and infrastructures. Activities like collaborative project implementation between or among the Government Line

Agencies, International Health Organizations, domestic Non- Government Organizations and the Local Government Units.

1. *Provision of medicines*
2. *Provision of computers w/ printers*
3. *Provision of disposable syringes*
4. *Provision of ambulances, service vehicles, & motorcycles*

COMPONENT 2: Health Management Information System, Research & Development

This project component is strategically critical as a support project for the other two project components of the CPHDP for ARMM-SZOPAD. It has three sub-project components, namely: (1) Research and Development; (2) Data/Information Banking; and (3) Information Network.

A. Research and Development

1. **Community Participatory Research** will include specific activities like health assessment, designing and piloting of health-related researches to be participated in by the community, health agencies (GO and NGO) and the Departments of Agriculture and Environment & Natural Resources.
   a. *Community health survey—health workers / community*
   b. *Data gathering , evaluation & management—health workers / community*
   c. *C-files for MHOs, PHNs, & clients*

2. **Applied Health Research** will include activities like health scanning and actual study on epidemics, diseases, and illness commonly experienced by underdeveloped, depressed and disadvantaged communities.
    a. *Monitoring and evaluation*
    b. *Research on the performance of RHO, PHOs, & MHOs*
    c. *Research on local herbal plants—health workers / community*
    d. *Research on malaria drug resistant cases—community / BFAD*
    e. *Research on effects of K-Othrine on malaria control*

B. Data/ Information Banking

1. **Community-based Data Management.** This specific activity will focus on the gathering, documenting, processing and storage of data that include the socio-demographic profile and health- related information of the ARMM-SZOPAD municipalities, barangays and population.
    a. *Community data board*
    b. *Minimum basic needs data board*
2. **Participatory IEC Material Documentation & Production** will include activities like packaging of IEC into locally understandable forms and presentation formats. Packaging will entail training for translation, writing and production of relevant information in appropriate and usable forms/formats. Part of this sub-project component is the conduct of Pre-Test and Post - Test of IEC materials to ensure information and culture compatibility and message acceptability by target beneficiaries.
    a. *Billboards*
    b. *Video documentation*
    c. *Pre-recorded cassette training kit*

C.Information Network

1.Community-based Communication Network System.

This sub-component will strengthen formal and informal (interpersonal communication) communication exchange and feedback between and among Health Agencies, the Government, NGOs and communities. This will include the establishment of community-based information networking facilities and management information systems. This will closely be linked with the Monitoring and Evaluation activities of CPHDP.

    a. *Text messaging*
    b. *Two-way radio communication (HW / community, NGOs)*

c. *Homily messages (health workers / community)*

d. *Documenting indigenous community media (HW / community)*

2. Local Communication/Media Development.

This concern will focus on the study of indigenous communication channels to backstop modern communication/media channel. Indigenous media, wherever appropriate, population and communities in remote or far-flung areas.

Component 3: Community-based Social Enterprise Development

This third project component will focus on the productive participatory of both the Health Workers and the People in the communities. The primary objective of this project is to ensure a more permanent adoption

and/or sustained implementation of the CPHDP with equitable community initiatives.

There are certain projects that will be carried out or implemented jointly by the Health Workers and the Community/People like Income Generating Projects (IGP) and health education activities.

I. Peoples Organization

A. Community Socio-Economic Development

(a) Community Economic project

1. Community-based Cooperatives to spearhead the implementation of IGPs.

1.)Botika sa barangay

2.)BHW cooperative

3.)Satellite clinic

4.)Semi-processing seaweeds

5.)Micro-lending scheme

6.)Food and Nutrition livelihood project

1.1. BIG/FAITH

1.2. Iodized salt making/production

1.3. Animal dispersal

1.4. SLOPE agriculture land tech.

2. Rehabilitation project for PWD

2.1. IGP for the blind (massage)

2.2 Crutches making using local raw materials.

3.Herbal Pharmaceuticals Dev t project

3.1 Production of Raw Materials

4.Women s Dev t Projects

4.1 Mat weaving

4.2 malong weaving training

4.3 Handicraft

4.4 Dress Making

4.5 Dried Fish Enterprise

5. Project for the Youth

5.1 Skylab passenger (motorcycle)

5.2 Horse Renting

5.3 Duck raising for egg production

6Project for Elderly

6.1Traditional Food Craft/Native

(b)Community Social Project

1. Health Education Proj.ect(non-Formal)

a) couples class,nutrition/hygiene

b) Elementary,High scholl student (nutrition/hygiene)

c) Fisherman S group(non-Destructive)

2. Project for the elderly

a) Day care center

3. Project for the youth

a) Day care

b) Boys town

c) Rehabilitation (Drug dependent victims of violence/rape)

(C) Community Basic Social Services Improvement Projects

1. Rain Water Collector
2. Spring development
3. Tree Planting (Fruits)
4. Flower Gardening
5. Fish Pond

(water supply, road network, education, Facilities and environmental development)

B. Health Workers Socio-Economic Development

1. Health Worker s economic Project

a) Food & Nutrition Livelihood Project

1. *BHW basic commodities store (BHW)*
2. *BIG / FAITH (Community / RHU)*
3. *SALT (Sustainable Agriculture Land Technology) farming*

b) Rehabilitation projects for PWD

1. Crutches making using local raw materials

c) Herbal pharmaceuticals development project

1. Production of raw materials

2. Health Worker s Social Project

a) Health Education Project (non formal)

1. *Couple s class (nutrition/hygiene)*
2. *Elementary & High school students (nutrition/hygiene)*

C. Ethnic Sector Project

1. Ethnic Sector Economic Projects

a) Mat Weaving
b) Malong Weaving
c) Handicraft
d) Dress making
e) Dried Fish Enterprise
f) Brassware making
g) Pearl diving
h) Beads making

2. Ethnic Sector Social Projects

a)Cultural Presentation
b) Revival of ethnic musical instrument

COMPONENT4 –Advocacy

A. Awareness development

1. *Social marketing*
2. *Advocacy training for Ulama/LGU*
3. *Information dissemination*
4. *Create homepage (internet)*
5. *Feedback system institutionalization*
6. *New Public Mgt(all level)*
7. *Lobby to MHDO,PHDF, thru MOA(local summit)*

8. *Envite IPHC thru MHDO for orientation*
9. *Convince MHDO to visit site for survey.*

B. Policy development

1. *Local health board*
2. *Lobbying*
3. *Policy formulation*
4. *Institutionalize MHDO it s program &Activities.*
5. *Modification HRSA/SS to be applicable to ARMM.*
6. *Institutionalize PHDF(DOH-ARMM)*

C. Peace Development

1.Lobby for Philippine History revision

2.Revival of Mindanao History

3.Moral & Spiritual recovery thru Ulama &Clergy

4.Lobby for gunless society

5.Regulate violent movues &sale of toy guns to minrs

6Prohibit Moro-Moro exhibits

COMPONENT 5: Community Managed Programs & Organization Development

1.Community Organizing Dev t

a.Organize BDC

b.Organize People s organization

24.1. Organize Local sectoral board

24.2. Organize Botica sa brgy, Sattelite clinic& other SED

24.3. Organize BHW

2.Organizational Development

a.Strengthening BHW assn.

b.Strengthening BDC

c.Strenghtening existing BSD, SC & other SED

Guiding Principles/Concepts :

1. The provision of highly efficient PHC through a participatory development approach where sustainability becomes a co-responsibility of the government and the community/people beneficiaries. The concept advocates not only cost-sharing between and among stakeholders but also in planning, monitoring and evaluation, decision-making and implementation of any health and related development projects.

2. The implementation scheme proposes the capability building of communities to sustain

development projects through a gradual withdrawal of assistance (grants, loans, special assistance programs, etc). In the process the community s self-reliance is build up through a modified investment scheme.

The concept of a modified investment scheme means that the community will be assisted in establishing or organizing Income-Generating-Projects (IGP) whose capital requirement is built-in or part of the grant, loan or special assistance. The organizations of cooperatives will serve as the community umbrella structure to carry out the development efforts. A time frame of at least five years capability building is considered safe or sufficient to lay the ground works for a full- community implementation of development projects.

3. The Health Expanded Program Concept (HEPC). The HEPC considers the holistic interrelation or interplay of social, economic, political, spiritual and educational environments with health. The CPHDP has been formulated or conceptualized with this realization and justifies the inclusion of community-based social enterprise project approach.

Implementation Strategy

1. ***Institutional Arrangement***

The Program will be a joint endeavor of the Community and People with various line agencies of the Government of the Philippines specifically the Department of Health, the Non-government organizations, International Government Organizations and International Non-Government Organizations.

2. ***Management Scheme***

The partner agency is the ARMM-DOH with the Participatory Health and Development Foundation as the facilitating body for the ARMM-SZOPAD.

A Program Management Unit (PMU) will be organized to provide the operation and management of the program on a regional level. Municipal level PMUs will also be organized. The PMUs will be comprised of government representatives, Health Officials, local government representative (LGU) and people s organization representative. They will also monitor and evaluate at all levels.

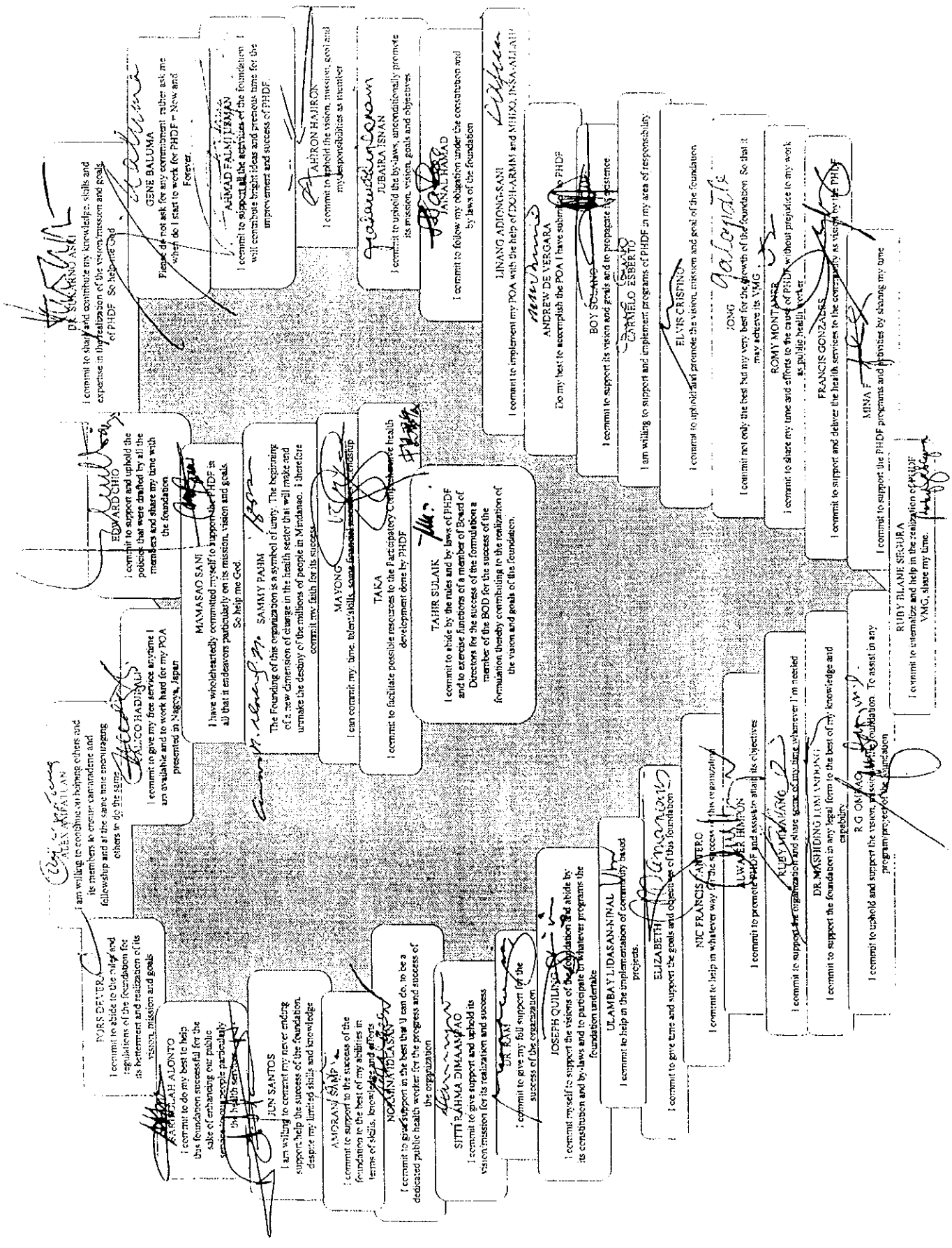
3. ***Time Frame of Implementation***

The time frame for the implementation will be by phase, to wit:

Phase I : Formulation of Plan Framework and Technical Project Preparation and Approval (June 2000-December 2000)

Phase II: Presentation of Evolved PHDF (April 19 - 20, 2001)

PARTICIPANTS INDIVIDUAL COMMITMENT TO PHDF

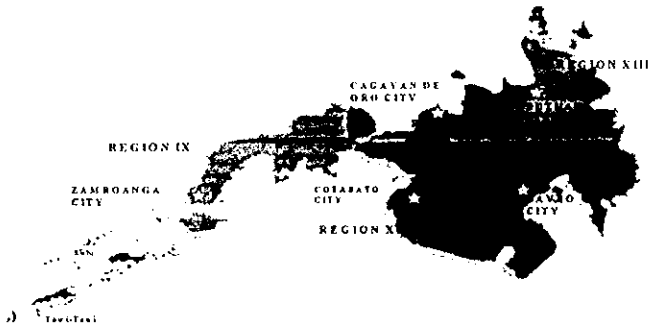


MINDANAO

HEALTH DEVELOPMENT PLAN

I. MINDANAO OUTLOOK

The island of Mindanao is the second largest in the archipelago with 24 cities, 25 provinces and 399 municipalities. It constitutes 34 percent of the total land area of the Philippines and is home to about 25 percent of the country's population.



For many years, Mindanao was a *"land of promise"* that attracted settlers from Luzon and Visayas. However, from the mid-1970s to the early 1990s, the peace and order situation in the island deteriorated. This was coupled with the limited attention and financial support from the national government. Despite its rich natural resources, the island experienced a sluggish and erratic economic performance, high poverty incidence, a vicious cycle of poverty, and lack of an integrated development plan.

Among the three (3) island groups in the Philippines, Mindanao has the highest incidence of poverty (Table 1).

Table 1: Mindanao Poverty Incidence of Families

Area	1985	1988	1991	1994	1997
Philippines	44.2	40.2	39.9	35.5	31.8
NCR	23.0	21.6	13.2	8.0	6.4
Luzon	39.9	41.1	39.5	36.7	29.8
Visayas	58.8	48.4	42.8	38.2	38.3
Mindanao	50.1	41.4	50.6	47.6	44.6
Region IX	*54.3*	*38.7*	*49.7*	*44.7*	*40.1*
Region X	*53.1*	*46.1*	*53.0*	*49.2*	*47.0*
Region XI	*43.9*	*43.1*	*46.2*	*40.3*	*38.2*
Region XII	*51.7*	*36.1*	*57.0*	*54.7*	*50.0*
ARMM	-	-	*50.7*	*60.0*	*57.3*

Source: TWG on Income Statistics, NSCB

From the period 1985 to 1997, the incidence of poor families has not substantially decreased. Luzon and Visayas had their poverty incidence levels decreased by at least 10 points. The national average, on the other hand, decreased by 12.4 percentage points during the 12 year period. On a regional perspective, the Autonomous Region in Muslim Mindanao (ARMM) had the highest incidence of poor families at 57.3 percent in 1997, while Region XII recorded the second highest incidence at 50 percent.

The lack of educational programs and facilities has greatly compounded the problem of poverty. In both the elementary and secondary levels of education, Mindanao fared poorly in participation as well as graduation rates. The armed conflict in some parts of the island has put Mindanao on center-stage in both national and international press. The hostilities have taken their toll on Mindanao's people and economy. The armed conflict resulted in closure of some business establishments and caused the decrease in investments from all regions of Mindanao

Nevertheless, Mindanao still holds much promise as the country's food basket. Mindanao is the country's leading producer of major agri-industrial crops such as banana, pineapple, rubber, coconut, and cacao. It contributes a large portion to the country's total livestock and poultry production. Moreover, it is the top producer of fish and fishery products, accounting for about 44 percent of the total national production.

In order to attain a genuine and lasting peace for Mindanao, the government is in the process of preparing the Peace and Reconstruction Initiatives for Mindanao's Enhanced Development (PRIMED) that proposes to increase support to social services in Mindanao.

It is therefore imperative to upgrade the health system in Mindanao through an integrated and convergent approach that will consider all levels of existing health service institutions. The improved delivery of the health services will lead to improved health status among children and adults by decreasing morbidity and mortality. Further, the improved health status will in turn lead to increases in the future productivity of the work force; decreases in curative health care expenditures; decreases in future absenteeism and dropout rates in school and subsequent higher returns to education; and, increases in future savings rates due to averted health expenditures.

II. MINDANAO HEALTH SITUATION

Health, as a right of all Filipinos, is embodied in the Philippine Constitution. Section 3 of the 1987 Constitution provides that *"the state shall protect and promote the right to health of the people and instill health consciousness among them."* Thus, the Department of Health has been directed to make sure that the department serves the people, especially the poor.

During the 4th National Health Assembly in 1998, it was reported that the Filipino people are healthier now than they were 10 years ago. Traditional health indicators such as infant and maternal mortality rate, crude death rate, as well as prevalence of nutritional deficiencies have posted downward trends. Improvements are likewise reflected in life expectancy, access to safe water and sanitary toilet facilities.

The armed conflict in Mindanao highlighted the need to provide support to the health sector in Mindanao. Beyond relief and rehabilitation support, the DOH set up the Zonal Office in Mindanao headed by an undersecretary and supported by an assistant secretary, as well as

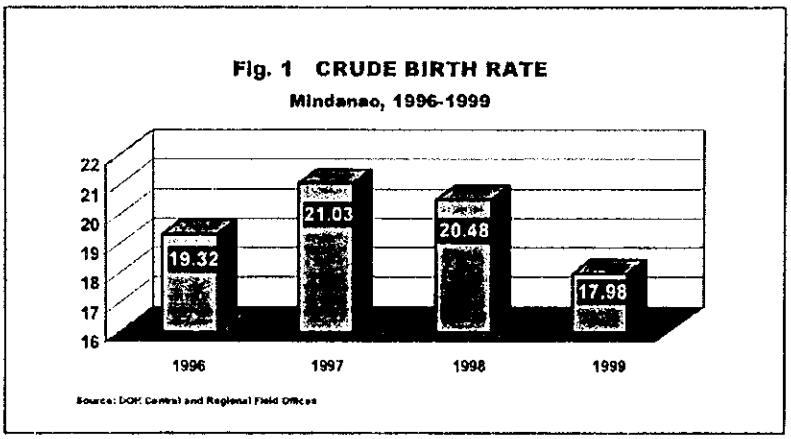
a small staff contributed by various regions of Mindanao. This team works in close coordination with the Centers for Health Development (CHD) towards the acceleration of the efforts in line with the Health Sector Reform Agenda (HSRA)

During the plan period, DOH Support is focused on program and projects designed to implement the Health Sector Reform Agenda. In Mindanao, this is expected to include 4.2 billion for regular programs (e.g. health regulations, health operations, local health assistance, health care financing and social health insurance).

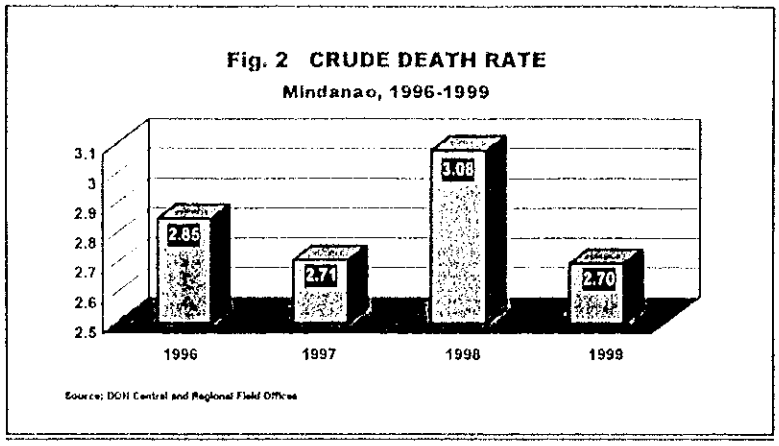
PERFORMANCE OF MINDANAO HEALTH SECTOR

Health Status Indicators

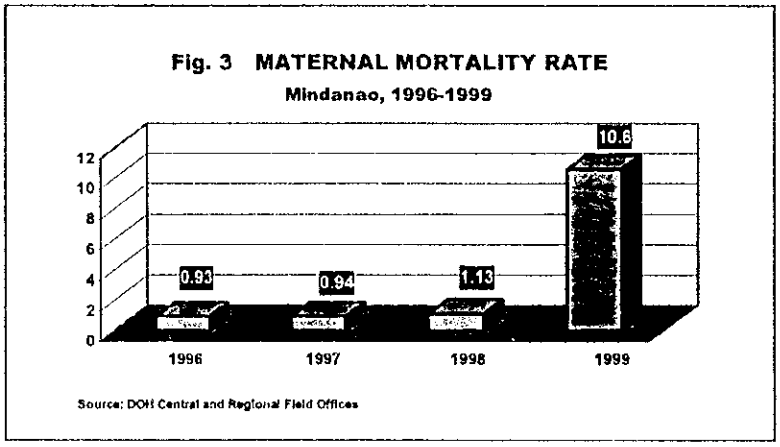
Crude Birth Rate (CBR) in Mindanao, which refers to the number of live births per 1000 population in a given year, decreased from a rate of 19.32 to 17.98 during the period 1996-1999 (Figure 1.) As of 1999, Region X registered the highest CBR at 21.01 per 1000 population, while ARMM had the lowest CBR at 11.30. Regions IX, XI, XII and Caraga reported CBR ranging from 17.13 to 19.54 per 1000 population.



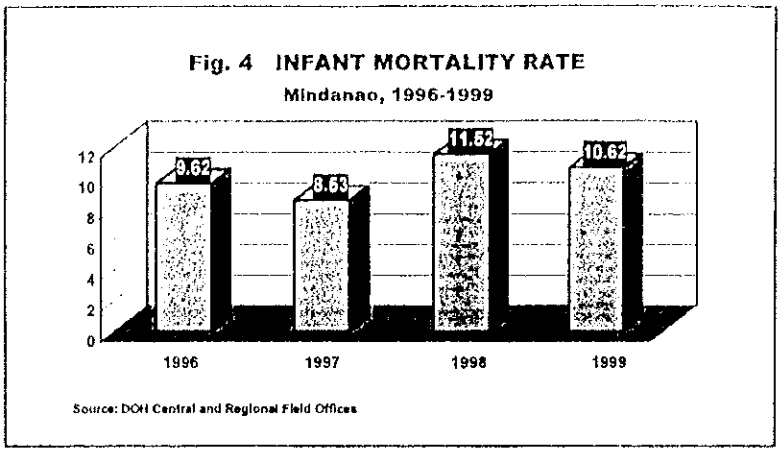
Crude Death Rate (CDR), on the other hand, which refers to the number of deaths per 1000 population in a given year, also registered a remarkable decline from a rate of 2.85 in 1996 to a high of 3.08 in 1998 which sharply declined in 1999 at a rate of 2.70 (Figure 2.) On the regional perspective, Region X registered the highest CDR at a rate of 3.89 per 1000 population, while ARMM had the lowest at 0.80. Regions IX, XI, XII and Caraga reported CDR ranging from 3.15 to 2.44 per 1000 population. This can change in the year 2000 as a result of the armed conflict.



Women's health is particularly vulnerable during pregnancy and childbirth. An increase in Maternal Mortality Rate (MMR) can be noted from 0.93 in 1996 to 10.06 in 1999 per 1000 live births (Figure 3.) The major causes of maternal deaths are post-partum hemmorhage, eclampsia and severe infection.



Between 1996 and 1998, Infant Mortality Rate (IMR) for Mindanao has increased from 9.62 to 11.52 percent. This would mean that for every 1000 live births, about 12 infant deaths occurred in 1998 compared to about nine (9) deaths in 1996. However, noteworthy is the slight decrease of IMR by 0.9 percentage points during 1998 to 1999 (Figure 4.)



Other than pneumonia, the current levels of IMR can be attributed to the following three (3) basic disease components: septicemia, diarrhea and respiratory disease syndrome. Moreover, obstacles to achieving declines in infant and child mortality include nutritional deficiencies in both mothers and children, inadequate access to safe delivery facilities, fall in immunization coverage and poor access to sanitary toilets and safe water. Other factor that may be considered is the decline in the number of prenatal visits among pregnant women, which may have put to risk the health of the babies in their first year of life.

Causes of Illness and Death

Most of the 10 leading causes of morbidity are communicable diseases from 1994 to 1999, which include diarrhea, URTI, influenza, pneumonia, bronchitis, malaria and tuberculosis, while the leading non-communicable causes are hypertension and heart diseases. The prevalence of communicable diseases is still very high although it showed a decreasing trend while that on non-communicable diseases is increasing.

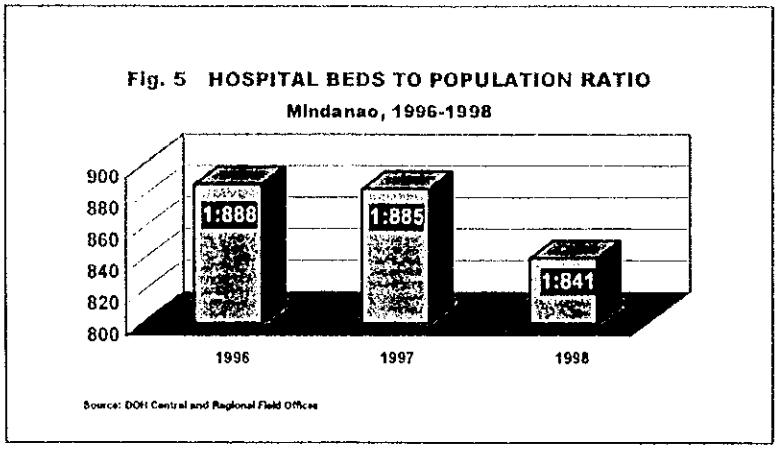
Majority of the areas in Mindanao are now going to industrialization and become more urbanized. Therefore, the disease burden is expected to shift to non-communicable diseases. Strategies must be in place to address current and future situations on disease burden.

On the other hand, causes of mortality are due to non-communicable diseases, which show an increasing trend. Diseases of the heart is still the top killer disease in 1999, while pneumonia, accidents, hypertensive and cancer diseases consistently remained the top leading causes of deaths.

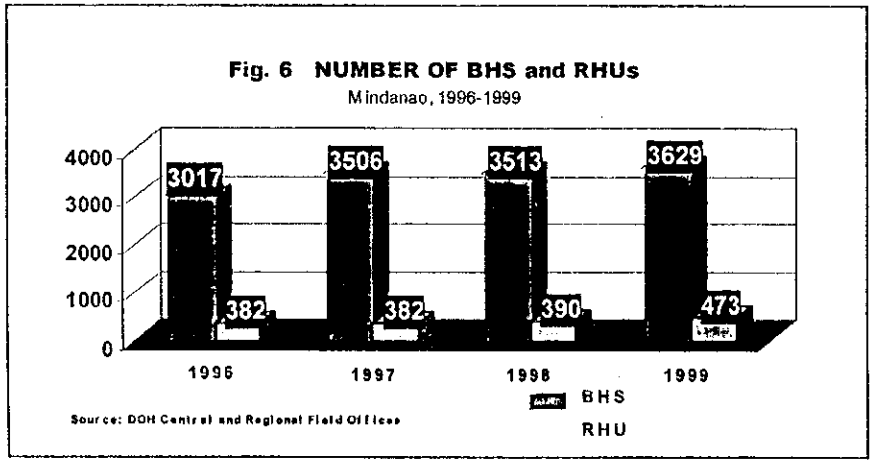
Health Facilities and Manpower

Population growth in Mindanao outpaced the provision of health services. As a result, more people competed for health facilities. In 1998, Mindanao has a total of 538 government and private hospitals serving the 17 million Mindanaoans. Hospitals are unevenly distributed across the regions with ARMM having the least physical access to hospitals. During this year, the bed-population ratio has improved with 841 patients sharing a bed compared to

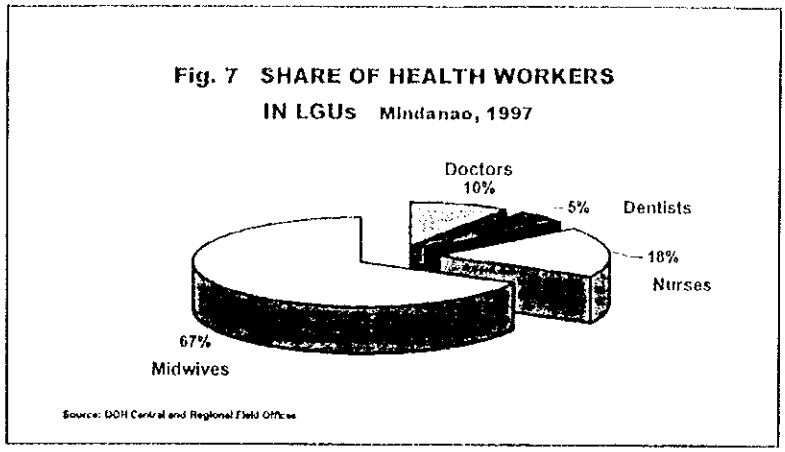
the 1996 data of 888 patients. Despite the decrease, it can be noted that this is still below the standard bed-population ratio of 1:500 (Figure 5.)



In addition, there were only about 473 Rural Health Units (RHUs) and 3,629 Barangay Health Stations (BHS) as of 1999 which were not enough to service all municipalities and barangays in the island (Figure 6.) The lack of these facilities is likewise compounded by the lack of basic equipment and medical supplies.

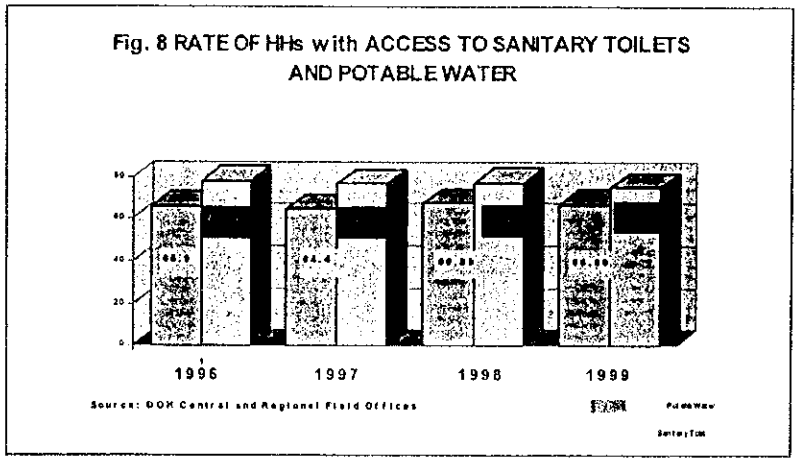


Relative to manpower complement, the number of doctors, nurses and midwives has declined over the years. Usually, the midwives are at the frontline of the health care delivery system as they comprise 67 percent of the health workers in the LGUs as of 1997. Hence, the clamor for *"more doctors in the barangays"* holds true considering that doctors make-up only 10 percent of the health personnel in the field units (Figure 7.)



Environmental Health

The Environmental Health Program of the DOH aims to reduce morbidity and mortality due to diseases caused by environmental factors such as poor water supply and sanitation. To achieve this goal, the program aims to provide safe water and sanitary facilities to the community.



Under the Sanitation Component of the DOH, plastic toilet bowls were provided to all the provinces and cities in the island. Although the figure showed improvement in the last few years, poor accessibility to sanitary toilets remains a serious problem in most provinces in Mindanao. In 1999, only about 66.59 percent of the total households in Mindanao had access to sanitary toilet facilities. Moreover, about 74.80 percent of the total households in Mindanao were provided with assistance in terms of construction materials for water source development projects (Figure 8.)

A research carried out by the University of the Philippines- College of Public Health, identified the presence of heterophydiasis as a major health threat in many poor communities. The intestinal flukes affect children and adults who ingested insufficiently cooked freshwater fish, shellfish, and frogs. Further tests indicated that this affected the provinces of Compostela Valley and Davao del Norte. However, the Saug River, where this was found, connects with the rivers and streams that flow into the Caraga Region. More tests are needed to determine the extent to which it had affected other parts of Mindanao.

Health Care Financing

In 1997, around 63 billion or 72 percent of the total health expenditure were spent on personal health care services. In Mindanao, personal health care services also account for a large percentage of spending on health. This leaves a very small percentage (13% of total health expenditure for the country) for public health services. LGU spending also tends to favor support to personal health care. This results in severe under-funding of promotive and preventive health services, which is severely under-funded. Out of pocket expenditure for health accounts for 46% of the total health expenditure. Only 7% come from the National Health Insurance Program.

The DOH annual spending on hospitals in Mindanao amounted to P 890 million in 1991. By 1998, the expenditure was P 780 million, showing a decrease of P 110 million. However, this continues to be a major part of the DOH budget for Mindanao. To promote self-sustainability and to improve the quality of services delivered, the DOH will support the corporatization of medical centers and regional hospitals. This program is designed to decrease the dependence of these medical centers and regional hospitals on the national budget, while ensuring that they continue to provide quality health care to the poor, those covered by health insurance, and the people of Mindanao in general.

The Mindanao Health Plan aims to address this problem. A major goal of the plan is to increase the number of enrollees to the Philippine Health Insurance Corporation (PHIC) and other health insurance programs within the plan period. The Investment Plan (2000 –2004) for Health Financing Reforms shows that a total of P 2,029 billion will be used for membership expansion and development of administrative infrastructure in Mindanao. Central to this plan is the improvement of the quality of services delivered in health facilities and the improvement of the package of benefits to make the National Health Insurance Program (NHIP) attractive.

Local Health Systems

The Local Government Code (LGC) of 1991 has propelled the devolution of numerous functions of the national government, including health services, to local government units (LGUs). Since devolution, the DOH, which is the primary government agency that directly managed public-sector health service delivery throughout the country, has retained direct management of only some health programs and service delivery facilities at central and regional levels. DOH continues to be responsible for ensuring the quality of care available to all Filipinos.

Notwithstanding significant health benefits brought about by decentralization, there were some imperfections in the implementation of the LGC. It was evident that there were mismatches between the distribution of costs of devolved functions and the distribution of increased revenues to cover the costs and imbalances in allocated functions between cities, provinces and municipalities.

The fragmentation of local health services resulted to the deterioration of integrative approach to health care delivery system and quality of local health care services. In most cases, local health units operate as stand-alone institutions, which are constantly plagued by lack of logistical support like manpower and equipment, as well as operating capital. Some of the LGUs remain unresponsive to local health needs, thus, giving health as a low

priority in budgetary allocations. Hence, under these conditions, the devolution to LGUs may not always be associated with better provision of services and wiser spending priorities.

However, many of the LGUs of Mindanao started to demonstrate their support to health. This was done through increasing budgetary allocations for health. This resulted in the upgrading of health facilities and equipments, improved capabilities of the health staff and increased availability of medicines and other supplies.

In Mindanao, models for inter-LGU collaboration are operational in the provinces of South Cotabato (CHD 11), Surigao del Norte (CHD Caraga), and Zamboanga del Norte and Zamboanga del Sur (CHD 9). These models demonstrate that cost sharing among LGUs and increased support of other local agencies in the executive and legislative branches of LGUs can result in marked improvement in the in the quality and accessibility of health services to disadvantaged groups.

Hospital Systems

As of 1997, there are about 538 *(excluding ARMM)* hospitals in Mindanao, 142 of which are operated by the government and 396 are operated by the private sector. With the implementation of the LGC, ***-no-*** of the 142 hospitals ran by DOH were devolved and ***-no-*** consisting of medical centers, special and regional hospitals were retained.

With the implementation of the LGC, the functions and operations of the provincial and district hospitals were devolved to the LGUs with the intention of bringing primary, secondary hospitals services nearer to the people. However, this intention was not fully attained since efforts in modernizing hospital equipment and facilities were limited due to lack of capital funds. Thus, most hospitals continue to be ill equipped with the current and emerging health needs of the population. The primary and secondary hospitals are unable to provide appropriate health services, which forced the patients to seek hospital care in the regional, national hospitals, and medical centers retained by the national government. Thus, congestions in these hospitals are apparent which aggravated the problem of understaffing. Improvement in the quality of services available in the hospitals are essential to the effective implementation of reforms in health care financing and local health systems installed.

III. THE BARRIERS TO ACCESS TO BASIC HEALTH SERVICES

Peace and Order

Since the 1970s, Mindanao has had its share of peace and order problems. The armed conflict in the year 2000 highlighted the need for improved health facilities. While some of these facilities were destroyed by the conflict, the lack of facilities and quality health services in these areas was also brought to light.

Mindanao requires rehabilitation/upgrading or construction of its health facilities. The chronic lack of skilled manpower also needs to be addressed specially in the war-ravaged zones. Mindanao has started to develop the capacity to respond to trauma and other emergies. While blood banks are in place in regions, a more intensive campaign for blood donors need to be carried out to meet demand for blood adequately during conflict.

Meanwhile, the conflict also caught the attention of various resource organizations. The President had declared her support to the rehabilitation of Mindanao. The Mindanao Health Plan provides substantial support to the rehabilitation of health services of the island group.

Accessibility

Health facilities, BHS, RHUs, Hospitals-District and Provincial, Medical Centers, Regional Hospitals, and other specialized hospitals, are distributed to various parts of Mindanao. Access to facilities are hampered by:

1. Impassable roads in interior barangays and municipalities. Some barangays of ARMM continue to have no barangay health stations. The high cost of transportation due to the difficult terrain, distance of the health facilities from their homes, and poor quality of roads inhibit others from availing of medical services.
2. The availability of quality services needed because of inadequate manpower, poor health facilities in rural areas.
3. Affordability of health services. Although basic health services are free, the cost of personal health services are considered unaffordable by the marginalized sectors; and the
4. Peace and Order situation.

Cultural and Religious Diversity

Mindanao, the "Land of Promise" has been home to several unique and diversified cultures and religious beliefs. This varied culture has made Mindanao a colorful, intriguing, and most sought-after paradise. But some of these diversities have somehow hindered the delivery and implementation of health services and programs. It is a fact that not all health programs are acceptable to the "culture-varied" populace. There is a need to give attention to the integration of cultural practices in the design of health services in Mindanao.

The challenge for the plan period is to harness the LGUs, the National Government Agencies and NGOs, should ensure that the needs of the minority groups in Mindanao are served and that due respect and protection are given to their culturally validated health practices while increasing their access to health services they require.

An initiative supported by Unicef is being implemented by the LGU of Saranggani can be viewed as the forerunner of setting up a model for Indigenous People's health program

Human Resource Development

Human Resource Development features training for devolved and non-devolved health personnel. The medical centers also serve as training hospitals to improve skills and knowledge.

In Mindanao, academic and training institutions have worked in partnership with the Department for more than a decade to design and implement innovative programs for health manpower development. This is a factor that should be optimized in the planning of Human Resource Development in the region.

Despite the various training of health workers, there is growing gap between the skills available and the skills required for the effectively delivery of basic and hospital health services.

It has been observed that health workers in Mindanao are the given the lowest priority as far as opportunities in international fellowship and study grants are concerned. These opportunities are not disseminated and offered to the regional offices and LGUs. Given this concern, the need for a program that will identify and implement human resource development programs, or access training programs specially designed for Mindanao, is indicated. In 1998, a JICA supported program focused on ARMM provided support for Fellowship in Japan specially designed to meet the health requirements of the area. This continues to be a challenge faced during the plan period.

Health workers view themselves as overworked, committed and dedicated, but underpaid. Some health workers, especially the devolved ones do not enjoy Magna Carta Benefits. The need for career pathing is also an area that needs to be addressed after the devolution of health services.

Health Manpower

One of the major blocks to the implementation of health service improvements is the lack of physicians in the district hospitals and the remote rural areas. While there are a number of medical graduates that may be available, there is no incentive program that can attract them to these remote areas. Due to shortage of doctors in rural hospitals, many doctors in these hospitals are on duty 16 hours a day ((if there are 2 doctors) or 24 hours a day if the hospital has only 1 doctor. This does not allow the doctors to upgrade their skills to ensure quality health services to the population served.

Population growth in Mindanao outpaced the provision of health service. As a result, more people completed for the services of health manpower, as well as health facilities. The number of doctors, nurses, and midwives has declined over the years. This dilemma has to be addressed in order to give way to a friendlier patient-health personnel relationship. This evolving partnership has to be strengthened for the provision of quality health care for all Mindanaoans.

Health Management Information System

Availability of accurate and updated information is vital to management, especially in planning, monitoring and evaluation.

Unfortunately, the data generated in health facilities in Mindanao is oftentimes incomplete, not up to date, and has not fully made use of advances in information technology. Data from the BHS has to be manually collated at the RHU level. Manual collation makes the summary tables from the RHU prone to errors, which can be magnified with further collation.

The first level-data gatherers (midwives at the BHS) are not adept at data analysis and interpretation. This result to poor quality of data used during planning.

On the other hand, a system was developed for computerization of the data. The systems are designed to meet information requirements for planning and monitoring. The system is being tested in only two of the provinces of Mindanao. This presents an opportunity for improving the management of health information in Mindanao. The challenge for the plan period is to seek a mechanism for Mindanao-wide health information to be readily available to guide planning, monitoring and evaluation.

Environmental Factors with Health Implications

In addition to the perennial problem of garbage disposal, Mindanao faces the emerging health related problems brought about by illegal logging, increase in mining areas, industrialization, and rapid urbanization.

Illegal logging has caused the drying up of water sources and flooding, thereby causing water-borne diseases and malnutrition due to destruction of crops by floods.

An increase in mining has resulted in the increase of mercury and cyanide poisoning. The mushrooming of nightlife establishments near mining areas has also caused a rise in the prevalence of Sexually Transmitted Diseases (STDs).

Air pollution brought about by factories and an increase in the number of motor vehicles has contributed to the rise in respiratory diseases.

Overcrowding associated with the burgeoning of cities and commercialization favor unhealthy lifestyles. This contributes to the increasing prevalence of Cardio Vascular Diseases (CVDs), diabetes mellitus, and other non-infectious degenerative diseases.

A new problem discovered through a study conducted by the University of the Philippines-College of Public Health. As indicated in the earlier section, there is a need for more attention in the problem of parasites in Mindanao.

IV. COMMITMENT TO HEALTH IN MINDANAO

The creation of the Mindanao Health Development Office (MHDO) is a major initiative of the DOH that promotes inter-regional cooperation for health in Mindanao. In January 2001, the office was formally set up. The staff was drawn from the CHDs of Mindanao. Some were drawn from the central office. In the four months it was in operation, the Mindanao Health Development Office carried out the following activities:

1. Coordinated the release of funds for infrastructure and non-infrastructure support to conflict affected areas. This included the repair and renovation of health facilities (RHUs, BHSs and Hospitals) as well as the provision of supplies for health centers and hospitals especially those in conflict-affected areas.
2. Conducted three zonal meetings and one zonal planning writeshop. These meetings were designed to promote the health sector reform agenda as implemented by the CHDs and the local governments within their regions. The meetings served as a venue for sharing innovative projects carried out by the CHDs and the LGUs. These became the venue for identifying common needs and to jointly prepare a Mindanao Health Development Plan for the years 2002 to 2004.

3. Developed concept papers and proposals for inter-regional projects such as the Indigenous Peoples Health Program in Mindanao, the War on Worms In Mindanao; and the Promotion of Inter-Local Health Zones.
4. Coordinated the preparation of a paper on the Health Sector in Mindanao supported by the UNFPA. This study was integrated into the Mindanao Framework Plan for Sustained Peace and Development prepared for the Government of the Philippines with the support of UNDP.
5. Coordination meetings with Mindanao Health projects such as the Belgian Integrated Agrarian Reform Support Project (BIARSP), the JICA-supported Participatory Health Administration Training for the SZOPAD and In-Country Course for Participatory Health Development, and UNICEF-Supported Programme Fostering Health and Nutrition Caring Behaviours through Child-Friendly Movement.
6. Represented the Department of Health in various coordinative bodies or meetings focused on Mindanao. These include multi-sectoral, Mindanao wide organizations such as the Mindanao Economic Development Council, InterAct-Mindanao and Kusog Mindanao.

International development organizations identified Mindanao as the priority geographical area for their programs. On-going foreign assisted projects are worth 13.2 billion pesos while pipeline projects and projects under negotiation are worth 6.6 billion pesos (*For a summary of these programs/projects, refer to Annex --).*

Partnership between LGUs, DOH, the acedeme, and professional organizations have been in place for more than 2 decades in Mindanao. All of these are committed to the vision of health sector in Mindanao.

Vision of the Health Sector in Mindanao

"Healthy and empowered Mindanaoans sustained by quality health care for a productive meaningful life".

Mission of the Health Sector in Mindanao

Providing quality health care to improve the quality of life of all Mindanaoans, especially the poor.

Goals and Objectives

1. To improve health status of Mindanao population

    - Improve Crude Birth Rate
    - Reduce Crude Death Rate
    - Reduce Infant Mortality Rate
    - Reduce Maternal Mortality Rate
    - Reduce Total Fertility Rate
    - Increase Life Expectancy and Quality of Life Years

2. To reduce morbidity and mortality of communicable and preventable diseases

    - Diarrhea
    - Pneumonia
    - Tuberculosis
    - Dengue
    - Schistosomiasis
    - Malaria
    - Leprosy
    - Filaria
    - STD-AIDS (Sexually Transmitted Disease – Acquired Immunodeficiency Syndrome)
    - Rabies
    - Bronchitis
    - Influenza

3. To reduce morbidity and mortality of non-communicable and degenerative diseases.

    - Heart Diseases
    - Hypertensive Diseases
    - Kidney Diseases
    - Cancer
    - Diabetes

4. To prevent and control of emerging and re-emerging of diseases.

    - Capilliariasis
    - Paragonimiasis
    - Heterophydiasis

5. To ensure quality improvement in all hospital services.

    - Decreased hospital admission rate
    - Decrease average length of stay
    - Reduce Death Rate
    - Reduce Infection Rate

Sources / References: *Report on various Health Indicators from DOH Central and Regional Field Offices in Mindanao*
National Health Plan (1995-2020)
Philippine Health Sector Reform Agenda 1999-2004
National Health Objectives (1999-2004)

PROGRAMS AND PROJECTS

As a result of the armed conflict in Mindanao in 2000, the island's socio-economic standing has been greatly affected, resulting in a grim picture of Mindanao as a war zone. Social infrastructure such as water supply and health facilities were damaged[1].

Upon the assumption of the Arroyo administration, two closely interrelated priority agenda has been identified, i.e., the reconstruction of the peace process and the upliftment of Mindanao. Relative to this, the Interagency Committee for the Relief, Rehabilitation, and Development of Areas Affected by Armed Conflicts in Mindanao (INTERACT-MINDANAO) was constituted pursuant to Executive Order (EO) No. 2 with the principal aim of formulating an action agenda to serve as the blueprint for Mindanao's enhanced development paying special focus on strategic interventions in conflict-affected areas.

A review of the health and health related programs and projects in Mindanao indicated that the projects amounting to ___pesos are on-going. Projects in the pipeline amount to___ pesos. Refer to Annex__ for the list of programs and projects in Mindanao.

---- *include data on LFPs and FAPs* ---

[1] Total cost of damaged water supply facilities amounted to P 13.5M in Sultan Kudarat, Maguindanao and Lanao del Sur; reported damage to medical facilities (i.e., rural health units and barangay health stations) in Maguindanao and Lanao del Sur amounted to P 16.175M (Note: Data from DPWH XII and ARMM and DOH ARMM).

MINDANAO HEALTH DEVELOPMENT OFFICE (MHDO) PRESENTATION

By: ASEC Nemesio Gako

MINDANAO HEALTH DEVELOPMENT OFFICE

* **Background/Rationale:**

- Ø 17.6 million people or 25% of countries population
- Ø Includes vulnerable groups
    - o IPs (27 major Lumads tribes)
    - o Families affected by armed conflict
    - o Urban poor
    - o Other disadvantaged sectors
- Ø Regions and provinces share same borders; share common water ways
- Ø Under investment – need for more resources to meet standards set for quality health services

* **HEALTH CARE FINANCING**

* **Background/Rationale:**

- Ø In 1997, 72% of the total health expenditures (around 63 billion) were spent on personal health care services
- Ø In contrasts, only 12 billion pesos used up for public health services representing 13% of the total expenditures for this year that is almost equal to the overhead services spending for the entire health system.
- Ø Under promotive and preventive health services due to out-of-the pocket expenditure of health accounts for 46% of the total health expenditures and only 7% from the National Health Insurance Program
- Ø DOH annual spending on hospitals in Mindanao amounting to P890M in 1981 and P780M in 1998, showing a decrease of P110M

* **Objectives:**

- To increase coverage of Universal Insurance Program in every LGU and Area Health Zone by 70%
    - Indigent program
    - Self-employed
    - Casuals and contractuals in government office

- To increase participation of LGUs in health care financing
- To develop 70% of SS health facilities to become "SS+" facilities in coordination with PHIC and LGUs
- To introduce an area based package of PHIC accredited OPD services based and/or establish a regional demonstration site by June 2001

* **Strategies/Activities**

Ø Health Passport and Health Care Financing
Ø Advocacy and Promotion to LGUs
Ø Capability Building
Ø Organization & Strengthening of Community Based Health Care Financing
Ø Technical/Financing assistance to CBHCF organization
Ø Monitoring and Evaluation
Ø Project Planning/development/designing for LGUs
Ø Advocacy of SS+ and accreditation of all SS certified HF to SS+

* **HEALTH REGULATION**

Background/Rationale:

Ø Issuance of Executive Order 119 in 1987
Ø Factors common in all regulatory Agencies:

- Lack of specific legal mandates
- Lack of an adequate number of qualified health regulation officers
- Lack of technical expertise and resources

Ø Pending bills to provide additional powers and resources to BFAD and BLR

* **Objectives:**

Ø To enforce and ensure compliance of standards and regulations to health facilities and establishments
Ø To strengthen legal mandate for regulation and enforcement; networking with LGUs, PhilHealth, and other stakeholders
Ø To establish baseline information of existing masseurs and embalmers
Ø To develop capacities CHDs/SLR staff on guidelines for issuance of license to operate

* **Strategies/Activities:**

- Ø Enforcement of standard and licensing activities
- Ø Retooling of staff
- Ø Hiring of additional staff/manpower/casuals
- Ø Provision of adequate equiptment /supplies/reagents/upgrading
- Ø Repair and expansion of regulatory office
- Ø Establishment of pilot regulatory unit
- Ø Roles clarification and functions
- Ø Reactivation and improving of mini BFAD
- Ø Social mobilization and advocacy
- Ø Coordination/collaboration with LGUs and Stakeholders
- Ø Master listing/ID of existing masseurs, embalmers including facilities
- Ø Organize taskforce for manpower support on SLR implementation and enforcement
- Ø Assessment and monitoring

* **HOSPITAL REFORMS**

* **Background/Rationale:**

- Ø In 1997, 142 government operated hospitals in Mindanao with implementation of the Local Government Code was devolved to the LGUs
- Ø Local Government Code intentions has not fully attained because of lack of funds and limited efforts in modernizing hospital equipment and facilities
- Ø Deterioration of devolved hospital services, congestion of national hospitals and the irrational delivery of hospital services due to paralyzed promotive and preventive aspects of health care
- Ø Hence, Health Sector Reform Program identified hospital sector reform

* **Objectives**

- Ø To institutionalization of hospital reforms
- Ø To upgrade critical capabilities of both retained and devolved government hospitals
- Ø To institutionalize hospital equipment maintenance program
- Ø To ensure upgrading of human resource, facilities and medical equipment to meet the standards of tertiary hospitals
- Ø Toe develop/improve existing hospital waste and solid waste management
- Ø To establish and maintain appropriate buildings and facilities at par with the private sector

- Ø To strengthen Hospital Emergency Preparedness and Response Program
- Ø To implement Public Health in the hospital
- Ø To rationalize the delivery of hospital service
- Ø Health financing for fiscal autonomy

* **Strategies/Activities**
  - Ø Upgrading hospital capacity in manpower, buildings, equipment and other resources
  - Ø Establish functional research units and strengthen existing quality circles/important committees
  - Ø Establish sub-specialty/collaborating centers, maintenance program, and expansion of major clinical services
  - Ø Health emergency preparedness
  - Ø Establish/sustain public health units
  - Ø Hospital Information System (computerization)
  - Ø Linkaging/Networking
  - Ø Monitoring control and evaluation

* **LOCAL HEALTH SYSTEM**

* **Background/Rationale**

  - Ø Existence of two- tier health system- hospitals services and public health services that are administered independently
  - Ø Disruption on exchange of technical resources between hospitals and health units
  - Ø Health services turned over to the LGUs did not match the Internal Revenue Allotment (IRA)
  - Ø LGUs low priority in budgetary allocations to health

* **Objectives**

  - Ø To institutionalize Local Health System in Mindanao

* **Strategies/Activities**
  - Ø Intensify advocacy to different LGUs/partners and social mobilization to various health sector's stakeholders on Local Health System Development
  - Ø Installation/maintenance of the following sub-system:
  - Ø Integrated Health Planning System
  - Ø Development and installation of District Health Sub-System
  - Ø Health Human Resource Development
  - Ø Benefit Monitoring and Evaluation of ILHZ
  - Ø Upgrading of health facilities and equipment
  - Ø Creation/operation District Health Board
  - Ø Installation/enhancement of the two-way referral system, surveillance system at all levels
  - Ø Provision of block/project grants to LGUs & NGOs
  - Ø Ancestral Village Health System Establishment

* **PUBLIC HEALTH**

* **Background/Rationale:**
  - Ø Evolution of health care delivery system from highly centralized form to its current set up, the decentralized health system
  - Ø Community's health through a two pronged interventions: disease control and prevention ; and health promotion and protection through Health Sector Agenda
  - Ø Regional concerns such as disaster and calamities, common problem in Central Mindanao and ARMM, in which in turn adversely affect other Mindanao Regions in Terms of evacuees and logistics availability

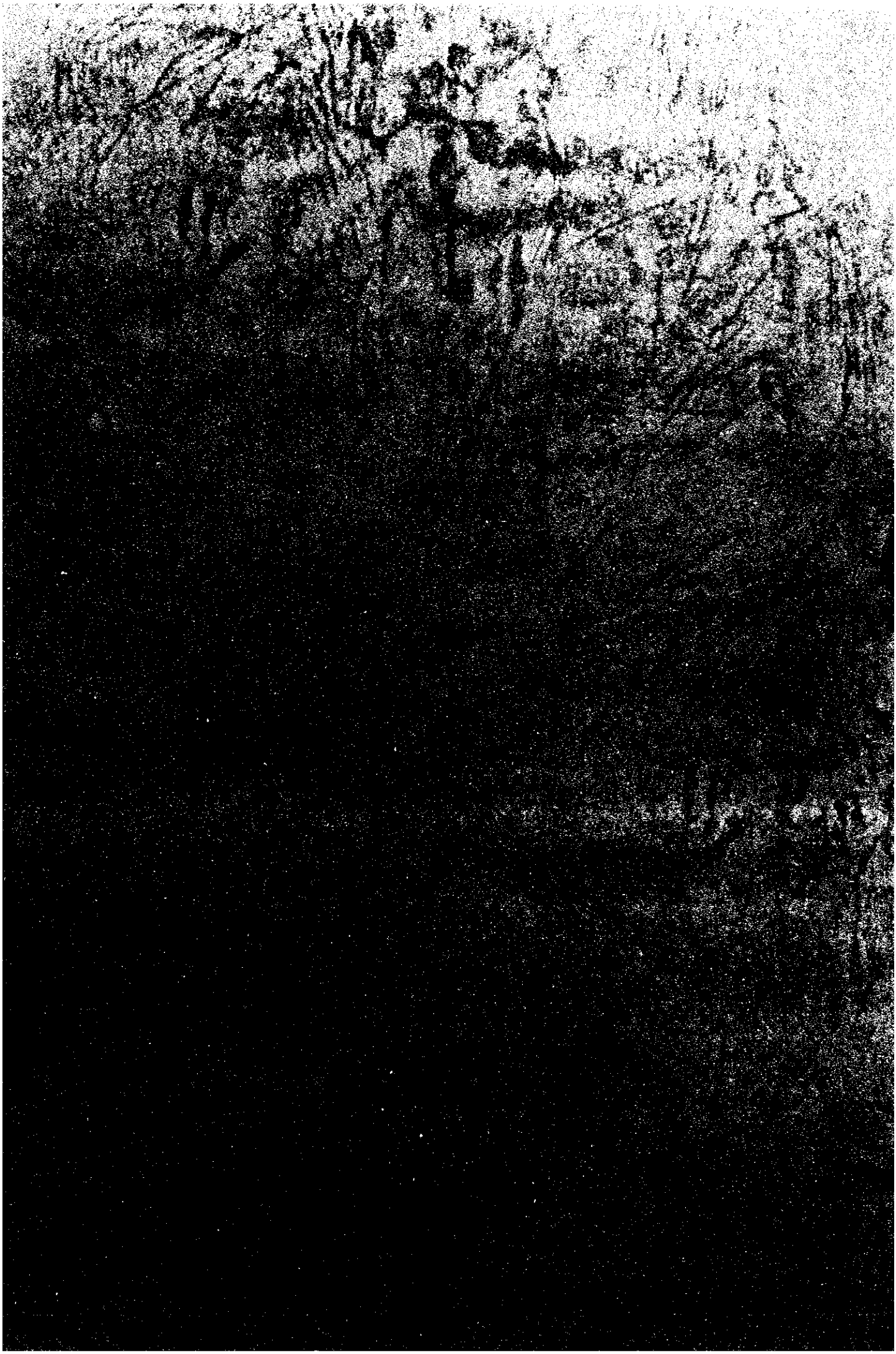
* **Objectives**
  - Ø To establish and institutionalize health collaborating centers in CHDs, retained hospitals/facilities within the zone
  - Ø To maintain healthy/good practices and innovations in the regions
  - Ø To provide and deliver promptly adequate and appropriate drugs/medicines and other logistics to LGUs
  - Ø To improve health and other related competencies for both retained and devolved health personnel
  - Ø To foster health promotion and protection measures on infections, degenerative, emerging/remerging diseases and environmental and work related health risks
  - Ø To develop and institutionalize health management information system and health research management
  - Ø To ensure quick, timely and appropriate response to man made and natural calamities and disasters
  - Ø To foster and institutionalize health research management and development

* **Strategies/Activities**

- Ø Adoption/establishment and sustain of Centers for Collaborations, health/good practices and innovations
- Ø Provisions of logistics support to other health programs, service delivery components of health programs
- Ø Proactive Human Resource Development and Management
- Ø Strengthen health emergency and response and preparedness operations
- Ø Provision of timely, appropriate and adequate assistance on technical, financial and administrative matters
- Ø Intensify/sustain mobilization, networking
- Ø Develop/ institutionalize health management information system and health research management
- Ø Disease Surveillance, continuous monitoring and evaluation

* **PROPOSED ACTIVITIES**

- Ø Convene inter- regional meetings to promote island-wide coordination for the improvement of health services in Mindanao
- Ø Assist in resource mobilization to support priority local and CHD programs
- Ø Facilitate the setting up of zonal health information system to facilitate reporting on specific diseases and other information on the health situation of Mindanao
- Ø Coordinate inter-regional and national response to disasters (including armed conflict) within Mindanao
- Ø Provide technical assistance for the conceptualization and implementation of new initiatives (e.g., small island health system, ancestral village system, collaboration centers);
- Ø Promote communication between health facilities across Mindanao



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