VI. Human Health Impact of Mindanao Conflict in the Philippines since the 1970s

September 2016

Preface

Whilst Asia is ranked as the most disaster-prone region in the world in terms of both natural and man-made disasters, research and training in the Asia-Pacific region is limited. Better understanding of the disaster epidemiological profile and human health impact will enhance response, preparedness and mitigation of the adverse human impacts of disaster. The concept of case-teaching method has been used extensively in research and teaching of disasters and humanitarian studies at schools of public health around the world, including Harvard School of Public Health, Johns Hopkins Bloomberg School of Public Health and London School of Hygiene and Tropical Medicine. Through the existing partners and networks of The Jockey Club School of Public Health and Primary Care, the Public Health Humanitarian Initiatives of The Chinese University of Hong Kong, and the Collaborating Centre for Oxford University and CUHK for Disaster and Medical Humanitarian Response (CCOUC), this disaster and humanitarian relief monograph series composed of eight case study reports has been developed using a standardised analytical and reporting framework. Methods for case study including literature reviews, stakeholder interviews and retrospective data analyses have been employed.

The main objective of this case study of the Mindanao conflict and the ensuing disaster in the Philippines is to highlight the key lessons learnt in disaster medical and public health response in the region. The goal is to develop Asia-specific teaching materials for public health and medicine in disaster and humanitarian response.

The "Guidelines for Reports on Health Crises and Critical Health Events" framework has been adopted as a reference for the literature search and the identification of key areas for analysis (1). We acknowledge that disaster management is a multidisciplinary area and involves much more than health issues, but we believe that the public health impact of all interventions should be appreciated across all disciplines.

This report is developed from a research conducted by Emily Ying Yang CHAN, Polly Po Yi LEE, Jamie

RODAS and Kevin Kei Ching HUNG in 2011 with the support of CCOUC fellows. Ms Rodas was then Graduate Fellow and Dr Hung Research Manager of the Collaborating Centre for Oxford University and CUHK for Disaster and Medical Humanitarian Response (CCOUC).

Authors

Professor Emily Ying Yang CHAN (陈英凝教授)

MBBS (HKU), BS (Johns Hopkins), SM PIH (Harvard), MD (CUHK), DFM (HKCFP), FFPH, FHKAM (Community Medicine), FHKCCM

Director, Collaborating Centre for Oxford University and CUHK for Disaster and Medical Humanitarian Response (CCOUC)

Associate Director (External Affairs and Collaboration) and Professor, JC School of Public Health and Primary Care (JCSPHPC), The Chinese University of Hong Kong (CUHK)

Honorary Research Fellow (Emerging Infectious Diseases and Emergency Preparedness), Nuffield Department of Medicine, University of Oxford, United Kingdom

Visiting Scholar, François-Xavier Bagnoud Center for Health and Human Rights, Harvard University, United States

Convener, Public Health Humanitarian Initiatives, JCSPHPC, CUHK

Convener, Climate Change and Health Study Group, JCSPHPC, CUHK

Ms. Polly Po Yi LEE (李宝仪)

RN, BN, MPH (CUHK)

Research Manager, CCOUC

Senior Research Assistant, JCSPHPC, CUHK

With the support of CCOUC fellows

Contact point: Professor Emily Ying Yang CHAN

TABLE OF CONTENT

Executive Summary

The armed conflict in Mindanao, the Philippines has been ongoing for over three decades. Millions of people have been affected by the fighting and by the subsequent displacements. Internally displaced people suffer from lower development indicators than the national average and continue to need humanitarian assistance despite the cessation of violent conflict in 2008. A peace agreement has been signed between the Philippines government and the insurgency groups lending an opportunity for peace and development in this region. Health programmes will have a golden opportunity to rebuild the infrastructure, as well as service provisional mechanisms and programmes. The purpose of this case study is to examine the health impact of violent conflict and analyze the response efforts of the country.

1. Introduction/Material/Methodology

1.1 Introduction

The health-care needs of the people affected by conflict have been summarised by Spiegel *et al.* in a *Lancet* article (2). A matrix has been proposed with two dimensions: low vs. medium-to-high income (and life expectancy), and urban, camp-like vs. rural, dispersed settings. As this case study will illustrate, the demographic and epidemiological profile of people affected by conflict is mainly young populations and disproportionately female, with high excess mortality and poor access to services.

Apart from psychological and reproductive health issues from violence, infectious diseases might also pose a significant burden depending on the localities and the endemic diseases. The challenges of the medical organisations and their responders are to provide the essential health services despite the poor accessibility and other barriers to health services. Possible solutions might include the use of temporary mobile health services and undertaking the mass campaigns when accessibility allows, as well as reducing any financial barriers to access. This case study will also discuss the issue of mental health from the child protection point of view and the model of resilience of children.

In the last few decades, millions of people in the Philippines have been internally displaced by armed conflict. In Mindanao, the government has fought insurgency groups since the 1970s. The conflict in Mindanao is rooted in many issues including poverty, poor governance, inequitable policies, and the marginalisation of the Muslim populations and indigenous people in a Catholic majority country. The government's "all-out war" against insurgency groups starting in 2000 resulted in the displacement of more than 400,000 people by 2003. An estimated two million people were displaced by conflict and associated human rights violations in the Philippines between 2000 and 2007. Low intensity fighting continues and displacement is common (3).

There is an abundance of research on the conflict in Mindanao through the lens of the fighting factions, the economic and natural burdens on the region, and the developmental progress that it threatens. However, less is known about the long-term health implications and health status of the affected population. This gap is partly to do with the extensive nature of the conflict, but especially to do with the trend of internally displaced people that is so common in Mindanao. This lends to a lot of population movement, hard-to-track-data, and rarely any follow-up. This study aims to expand knowledge and understanding of the human impact of the Mindanao conflict by examining the health impact of the conflict.

1.2 Material

Publicly available information to describe the background, disaster preparedness, health crises event, response and recovery in Mindanao in regards to the conflict was obtained from the following sources: disaster information systems (e.g. the Emergency Events Database (EM-DAT), DesInventar), United Nations agencies dealing with disaster, health, and development (e.g. WHO, UNDP, UN-ISDR, UNICEF), international organizations (e.g. World Bank), NGO's, government sources, news articles (e.g BBC World News, Mindanews), and a host of disaster community sites (PreventionWeb, DPNET, ELDIS) and academic databases that include (PubMed, Medline) and Google Internet.

Disaster statistics were all obtained from disaster databases and cross checked with government and NGO statistics. Progress reports, government statements, government policy papers, field reports and documents from organizations providing information on preparedness and response were also reviewed in this study.

1.3 Methodology and a theoretical framework for an armed conflict case study

To achieve a systematic examination of the case, major public health principles of disaster response and the disaster cycle model will form the theoretical framework for this analysis.

I. *Public health principles of disaster response*

According to the *Oxford Handbook of Public Health Practice*, the three main principles of public health response to disasters include securing basic human needs required to maintain health, determining the current and the likely health threats to the affected community, and acquiring and providing the resources to address the above two principles (4). The discussion in this case study will focus on the five basic human health needs.

The five basic requirements for health include food, health services, information, clean water and sanitation, as well as shelter and clothing. Securing the access to the basic needs is considered as the main goal of the emergency relief.

As a global effort in setting the standard for emergency relief, the international Sphere Project hosted by the International Council of Voluntary Agencies (ICVA) in Geneva is "a voluntary initiative that brings a wide range of humanitarian agencies together around a common aim - to improve the quality of humanitarian assistance and the accountability of humanitarian actors to their constituents, donors and affected populations." The Sphere Handbook, *Humanitarian Charter and Minimum Standards in*

Humanitarian Response, provides a level of standard that has been agreed upon by a multitude of front line agencies (5). It contains the minimum standards for most aspects of the basic requirements for health, specifically water supply, sanitation and hygiene promotion; food security and nutrition; shelter, settlement and non-food items; and health action. For each specific sector, it has distinct indicators to measure whether the minimum standards are being reached.

II. *Definition of health*

Health is a state of complete physical, mental and social well-being instead of the mere absence of disease or infirmity (6). Specifically public health is defined as "[t]he science and art of preventing disease, prolonging life and promoting health through the organized efforts of society", according to Sir Donald Acheson (7).

III. The disaster cycle model

Apart from the general public health principles, it is important to recognise the different actions required during the various phases of disasters. The disaster cycle model helps highlight the key stages in post-disaster emergency response. It can serve as a useful reference for different parties to take actions during disaster management.

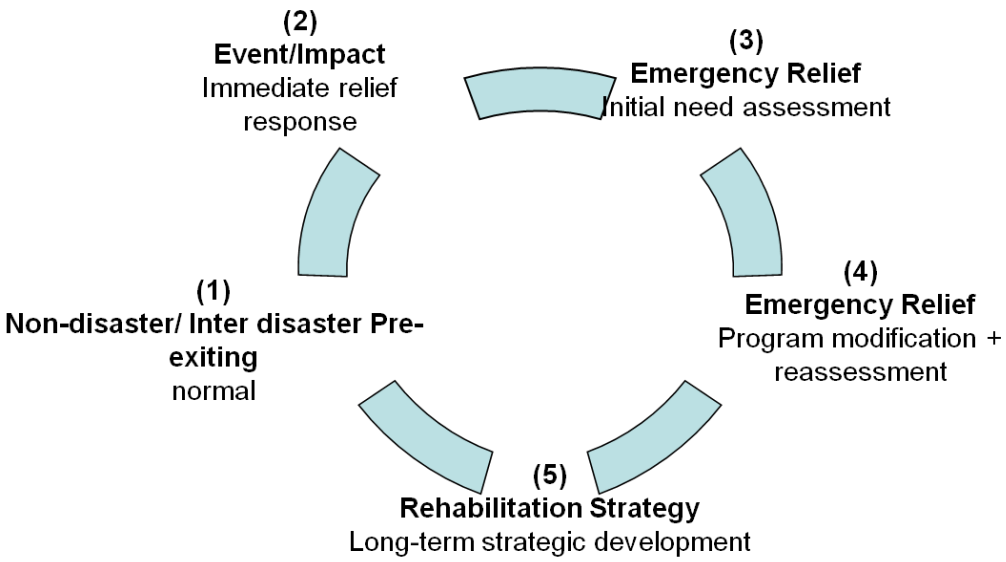


Figure 1 Disaster cycle

Source: Chan EYY, Sondorp E. Natural disaster medical intervention: missed opportunity to deal with chronic medical needs? An analytical framework. Asia Pacific Journal of Public Health. October 2007;19(Special Issue):45-51.

This case study report will examine the health impact of the Philippines, Mindanao conflict and will focus on the rehabilitation stage of the disaster cycle.

2. Pre-Event Status

2.1 Background

Mindanao is the second largest island of the Philippines in land mass and is made up of Mindanao Island itself as well as the Sulu Archipelago. The island group is divided into six administrative regions, and is further subdivided into twenty five provinces. Out of the twenty five provinces, six of them are more directly affected by the Mindanao conflict; four existing within the Autonomous Region of Muslim Mindanao (ARMM) (8).

The region's topography is characterized by high rugged mountains, volcanoes, and a surrounding shoreline and also swampy plains. This type of landscape is prone to a lot of the natural disasters that are common in Mindanao including flooding, cyclones and drought (9).

According to the National Statistics Office of the Philippines, there were 88,566,732 people living in the country in 2007. The population of Mindanao was approximately 21,582,540 and approximately 4,120,795 of those people lived within the ARMM in the same year. (10) The average household size is about 5 people in most provinces of the Philippines but is an average of 6 in the ARMM (11). Filipinos are of a majority religion; eighty one percent identified themselves as Roman Catholic while only five percent identified as Muslim in 2000 (10). Furthermore, Muslim Filipinos (Moros) mainly live in Mindanao and especially in the Autonomous Region of Muslim Mindanao (ARMM) although not everyone living there is Muslim.

Table 1 Area comparison

AREA	LAND AREA (Sq. Km.)
Philippines	343,282
Mindanao	106,378
ARMM	33,599

Source: 2008 Philippine Statistical Yearbook

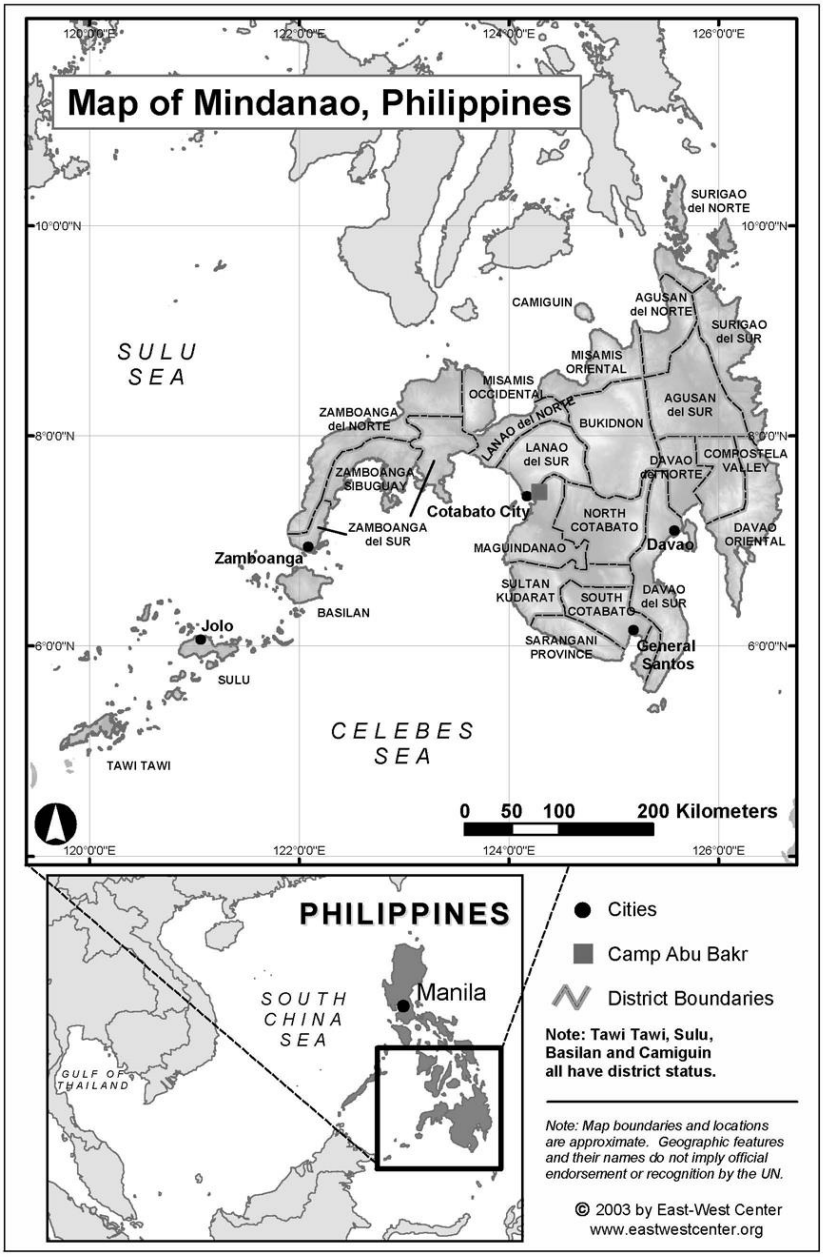


Figure 2 Map of Mindanao, Philippines

Source: Johns Hopkins Annual report, 2010

The crude death rate is Mindanao is markedly higher than the national average at 7.9 per 1,000 versus 5.1 per 1,000 (10). Other indicators also show low levels of development (see Table 2.)

Table 2 Development indicators of the Philippines and ARMM

Indicator	ARMM	National	Source
Infant mortality rate per 1,000 live births	56	24.9	UNDP MDG Progress report 2010, 2008 figures
Under-5 mortality rate per 1,000 live births	45	32	NSO 2011
Prevalence of underweight children, 5 and under	28.8	26.2	FNRI 2008 (Food and Nutrition Research Institution, 2008 National Nutrition Survey
Contraceptive prevalence rate (percentage)	15.1	50.6	NSO National Family Planning Survey 2005-2008
Life Expectancy (Female)	62.9	74.3	NSO Quickstat 2011
Life Expectancy (Male)	61.9	68.8	NSO Quickstat 2011
Measles vaccination rate (percentage)	79	86	DoH Field Health Service Information System 2008
# of government health workforce per 10,000 population	3.3	2.7	DoH Field Health Service Information System
Proportion of population with access	62	82	Field Health Service Information System 2008

to drinking water (percentage)			
Proportion of population with sanitary toilet facilities (percentage)	81	77	Field Health service information system 2008

Mindanao is recognised as being the most deprived region in the country. Years of protracted conflict and inequalities have made the area vulnerable to lower development standards, and inefficient health services. In 2009, the Philippine Human Development Report published that Mindanao had the lowest average life expectancy in 2006, highest infant mortality rate, and highest poverty incidence rate (12). Furthermore, only 21% of births in ARMM are attended by trained health personnel, the ARMM has maternal mortality rates that are double the national average and a male life expectancy that is eleven years lower than the national average (13).

During a Philippine's Human Development Report field trip in Mindanao by Johns Hopkins University, it was noted that there is a high prevalence of infectious diseases including, tuberculosis, malaria, yaws, scabies and gastro-intestinal diseases. In addition it was noted that people have poor access to health services including reproductive services, essential medicines, and good quality facilities (12).

Armed conflict has a huge impact on the health of the population. The most recognised impacts include physical injuries like wounds, crushing injuries, and death. Other direct health effects are psychological trauma, depression, and extended anxiety.

The internal displacement of people in Mindanao makes for a dire environment in which to collect data. The instability of communities lends for mistakes in denominator population counts, making some programmes seem more successful than they actually are or misrepresenting information. For example, the Department of Health often reports good immunisation coverage, however at evacuation centres measles are a common occurrence (14), suggesting that the mobile populations are not included in the population counts.

Health professionals working in Mindanao in the field are also of concern. A lack of regularity arises due to population movement and therefore follow-ups are rare. In addition, the religious affiliation of the health care worker can be a barrier to access since many Muslims report not wanting to visit a non-Muslim provider (15). Due to security concerns in the area, the retention of health care workers is difficult.

Health services in Mindanao require a lot of flexibility and accommodating to the mobile population. Health care workers should feel safe and protected, while also sensitive to the population's religious affiliation.

2.2 Preparedness

The government of the Philippines has always worked together with NGOs and INGOs to provide services, preparedness and response during major displacement episodes. More recently in 2011, the Technical Working Group (TWG) on Humanitarian Assistance in Mindanao was established with the United Nations (UN) Humanitarian Team and the National Disaster Risk Reduction and Management Council (NDRRMC). The working group also consists of other major players including the Office for the Coordination of Humanitarian Affairs (OCHA) and the Office of Civil Defense (OCD). The group aims to improve inter-cluster coordination and communication between all parties (13). NGOs work closely in the larger UN cluster teams to ensure that strategic plans are tailored for the needs of the local people. The

Mindanao region has adopted the cluster approach with eight clusters and three sub-clusters currently operational there. These are all supported by government cluster leadership.

The double combination of conflict and natural disaster make emergency preparedness critical for the government and for local communities. OCHA is the main supporter of emergency preparedness in Mindanao, mostly through planning and organizing multi-disaster simulation contingency plans and using them for training on how to coordinate the humanitarian response, conduct a joint rapid needs assessment, and provide technical assistance including reporting and information management support. The aim of this training is to reduce duplication and fill gaps among agencies.

2.3 Hazard, vulnerability and risk

Natural hazards such as flooding and typhoons present a threat to the stability of the region and Internally Displaced Persons (IDPs). According to the United Nations, the Philippines ranks third in countries with high disaster risk .The most common types of disasters include floods, typhoons, earthquakes, tsunamis, and others. Monsoon rains in Mindanao cause seasonal flooding. The latest disaster to cause large destruction was in 2011 when flooding affected some 860,000 people (13). An increasing number of people are exposed to the impact of natural disasters, while also being affected by conflict.

Conflict, violence, and displacement have been a grim reality of life in Mindanao since the 1970s. The acute and simultaneously protracted conflict by many of the aforementioned actors is the greatest hazard to the people of Mindanao. The possibility of outbreaks of violence and large scale conflict creates a dire humanitarian environment. However, IDPs are more vulnerable to the risks of conflict than other subgroups of the population. A comparative profile of people in the region by OCHA showed that people who are currently displaced have had the highest exposure to conflict related violence. They also showed that this group had the worst nutritional outcomes, poorest access to basic services including education, and sanitation facilities. In addition, about 60% of the population said their access to health care was bad

or very bad. Following current IDPs, people who had returned to their place of origin (returnees) also fared worse than those who had resettled elsewhere or never had been displaced before. (16)

Since the 2009 ceasefire no major outbreaks have been reported and peace negotiations have continued in hopes of coming to a resolution soon. However, while optimism is healthy, the latest peace progress was still awash with insecurity. Other types of violence (e.g. ridos and violence by extremist groups) tended to have a spillover effect to the Moro Islamic Liberation Front (MILF) and government issues, therefore undermining the fragile peace process. Without an official commitment and signing of a peace agreement by all parties, the region continues to face the possibility of further displacement.

The latest peace process was led by the Joint Coordinating Committee on the Cessation of Hostilities (JCCCH) which brought together representatives from both sides of the conflict to create an atmosphere conducive to the peace negotiation. There were also action groups to monitor and address terrorist activities, international monitoring teams to monitor peace building and civilian protection groups to secure the safety of civilian communities.

However, as is the experience of the past, the peace progress remains fragile. In 2012, OCHA estimated that there were still 698,251 people in need of humanitarian assistance in the region (16). Another outbreak in violence would be catastrophic. Reports by the protection cluster and with other partners have stated that a decrease in confidence in the peace process between the Government and the MILF may result in ceasefire violations and ridos could also trigger violence. In the case of further conflict, and the possibility of natural disasters, another 1.5 million people are at immediate risk of being affected (See Appendix I and II for the main actors and historical timelines).

Therefore, an outbreak in violence or a natural disaster will affect the different subsets of the population differently because of their place in the spectrum of development, poverty, and impact of conflict.

2.4 Resilience

The prevalence of displacement in Mindanao is sky high. Over the last ten years, 41% of people living in the region have reported experiencing at least one displacement episode, with some areas reporting as high as 82% of the population being displaced (17).

The enduring conflict has greatly decreased the resilience of the population while increasing the threats to their survival, well-being, and quality of life. The resilience of the people is undermined by the significant number of people who are cyclically displaced. Much of the basic infrastructure of the area has been destroyed or damaged; schools and hospitals need to be reconstructed. Many children who would otherwise be enrolled in school are vulnerable to recruitment by armed factions thereby continuing the cycle of violence and conflict (18). In addition, other factors such as food insecurity, lack of access to healthcare and sanitation facilities, prevalent infectious diseases, and poverty lead to a weak and vulnerable population that are less resilient to the prolonged nature of the problem.

Natural disasters exacerbate the IDP problem by creating new displacements and putting an extra burden on the living conditions. However these are the conditions which have been present in Mindanao for the last few decades. The population has suffered immensely, but has grown resilient at the same time in certain aspects. For example, there is a project called The Mindanao Resilient Communities Project that is carried out by the Alternate Forum for Research in Mindanao (AFRIM) through the Center of Psychological Extension and Research Services (COPERS) of the Ateneo de Davao University which examines the impact that conflict and natural disasters have had on the people of Mindanao and their coping mechanisms. They are currently collecting data on local preparedness and response measures, initiatives, and efforts in nine affected communities (19). Grassroots organisations like this are increasing in Mindanao and are an indication that community resilience is building.

A mixture of competing interests have helped to maintain a condition of "no peace, but also no war", leaving people anxious about their future and sceptical about development efforts. Fortunately, the Philippine government has just announced that they have reached a framework peace agreement with the MILF (20). The peace process has been long and often fragile in the wake of small scale violent outburst. However, after 40 years of conflict, and an estimated 120,000 lives lost, the agreement is expected to be signed on October 15th, essentially allowing the first discussions of lasting peace and rebuilding to begin. The deal is said to grant many of the MILF conditions including a larger autonomous region, steady decommissioning of MILF armed forces, a more equitable distribution of the regions natural resources, respect for human rights, and others (20). The United Nations stands ready to provide assistance to the parties, as needed, in implementing the Framework Peace Agreement (21).

The ground-breaking agreement will be a true test of the resilience of the people in their efforts to accept new changes, keep faith in the peace process, and essentially return to their "normal" lives.

In fact, there is indication that the population has already developed resilience on the social and institutional scale. For example, the same strong kinship ties that initiate ridos also help to keep families and social networks together because these ties are highly regarded and valued. Therefore at the community level, there are many sources of social support. Other factors that help build community resilience include religious leaders that promote dialogue regardless of affiliation, Barangay Justice Advocate (BJAs) that mediate and settle land disputes using cultural norms and values, local governments and the Coordinating Committee on the Cessation of Hostilities (CCCH) leaders that use traditional dispute resolution mechanisms to promote peace and co-existence, and some businesses have rehabilitation training and hiring programmes for ex-militants.

3. Health Crisis and Critical Health Events

3.1 Primary event

The underlying factors that have led to this crisis include MILF-government conflicts, ridos, natural disasters, and other violent clashes. The immediate effect on the population is mass internal displacements and while the majority of displacement is relatively short term, the cyclical nature of the displacements ensure there is a massive number of people in need of assistance all the time. IDPs require everything from food, shelter, support, protection, and livelihood aid.

3.2 Secondary events

Ongoing conflict in Mindanao is the critical event. OCHA estimated that in November of 2011, there were still an estimated 46, 000 internally displaced people. The IDPs included in those figures include people who were displaced by the 2008-2009 events and also more recent rido events (at least 85,000 in the beginning of 2011) and flooding events. Returnees since the 2009 ceasefire continue to struggle for livelihoods and development since their areas were also mostly affected by flooding (13)(22). Therefore, although not displaced, there still remain some few hundred thousand people in need of humanitarian assistance.

4. Damage & Consequences of Damage

4.1 Damage (Human)

In 2011 OCHA estimated that there still remains an estimated 46,000 IDPs in the Philippines. The IDPs were living in evacuation centres, makeshift sites ad shelters, and other relocation sites. This number does not actually reflect the actual number of people in need of humanitarian assistance (a projected 375,000) since many returnees and other residents are also affected by the conflict. The total number of people in need of assistance is estimated to be closer to 700,000 (13).

Overtime, violent conflict and displacement have worn down the resources necessary for development and sustainability in the region. The ARRM has increasing poverty incidence (from 25% in 2003 to 38.1% in 2009) (22).

The protracted violence in Mindanao has created an atmosphere of dire health consequences and a deterioration of the health sector. There is a great need to prioritise basic health services for IDPs, returnees, and others affected. Floods and other natural disasters will also affect health and the delivery of health services. Damage will include the continued deterioration of the health care system and the continued deterioration of the population's health livelihoods, and quality of life. The provision of healthcare is further complicated by a mobile IDP population, limited mobility of healthcare workers and increasing morbidity.

The damages attributed to the conflict include the continuous deterioration of the health status of the population.

Although the number of health facilities is in theory a good ratio to the population, many of these are non-operational facilities. Disrepair, structural damage, lack of resources, a shortage of staff, and a lack of appropriate medicines, equipment, and other essentials are just some of the reasons for the lack of access to the necessary services needed by the residents. The Department of Health Facility Enhancement Programme has listed 62 facilities in the ARMM alone to be in need of repairs, and the need for another 120 or so new clinics (23). In addition, health care worker availability and capacity is also limited. Staff at the emergency centres are usually deployed from local hospitals, are volunteers, and dependent on NGOs and UN agencies for equipment and supplies. Insecurity concerns leave health care workers at the local level reluctant to work in or visit remote locations. A lack of access to services and personnel leads to subpar health care, as seen by the number of indicators including births assisted by a trained professional. Around 90% of babies are delivered at home in the ARMM, leaving mothers and babies at high risk of mortality and morbidity (16).

In 2008, most evacuation centres launched mass immunisation against measles for infants and although this was successful in reducing measles incidence, disease surveillance remained weak at all levels, but especially at the barangay (village level). This was seen in 2011 when flooding caused disease outbreak and communicable diseases accounted for 30% of preventable deaths due to lack of surveillance systems. Most evacuation centres visited in 2008 by the IASC team did not meet the minimum SPHERE standards for WASH and common illnesses seen in evacuation camps include skin diseases, diarrhoea, and respiratory illness (23). Therefore in addition to mass immunisation, progressive strategies should include comprehensive WASH interventions.

In areas of affected by flooding, pneumonia and diarrhoeal illness were the leading causes of morbidity, and they were especially prevalent among children (23). There is also an alarming prevalence of severe acute malnutrition (SAM) in affected areas. From 2010 to 2011 a screening of 60,000 under-5 children in central Mindanao found that there was a SAM prevalence of 1-2%. In response to these findings, the Department of Health identified improved nutrition as a priority area for intervention in 2011 (24). According to the Nutrition Cluster, 80% of children with SAM resided somewhere with a lack of access to clean water, especially after the flood of 2008 and again relates back to the WASH programme being a priority. Pre-existing vulnerabilities to malnutrition, repeated displacement, and lack of access to care can aggravate the malnutrition of the population and any nutritional programmes. The protection and promotion of breastfeeding practices is central to this initiative since none existed at the time. In addition, UNICEF and community based volunteers and health care workers implemented the Community based Management of Acute Malnutrition (CMAM) programme although this has yet to expand to all IDP affected areas. Children with acute malnutrition can be identified through Community-Based Child Protection Networks (CBCPNs) which work to identify, refer, and enroll children to the most accessible CMAM sites if they are displaced (18).

The International Organization for Migration has reported that there are significant gaps in the provision of service in Mindanao's IDP camps and evacuation centres. The most serious cases are those affecting the most vulnerable subgroups of IDPs. For example, out of the 87 IDP camps, 95% were found not to offer programmes for disabled residents, 87% did not offer any programmes for elderly residents, and 84% did not offer programmes for women. In fact, gender based violence is under reported. In the ARMM and other regions in Mindanao, only 10% of health facilities have post-rape testing kits and lack staff to respond to these issues. In 2010 the Protection cluster received 78 reports of sexual violence against women and children (16).

5. Response

At the country level, response to conflict has followed established plans. The Municipal Disaster Coordinating Councils (MDCCs) manage the first response with the support, guidance and coordination of the Provincial Disaster Coordinating Councils (PDCCs). The PDCCs are supported by the Regional Disaster Coordinating Council RDCC (RDCC Region 10) with the entire operation managed at the national level from the National Disaster Risk Reduction & Management Council (NDRRMC), formerly known as the National Disaster Coordinating Council (NDCC). The tiered system allows for wide coverage among all levels of government and society although it has been reported that coordination between them has sometimes been problematic (25). Coordination with NGOs and other humanitarian actors has also sometimes been problematic and appeared to need strengthening. The main issue reported was the reluctance of government actors to allow NGOs to work independently (9). One of the main concerns when drafting humanitarian response was the confusion about the actual number of those displaced. Reports vary greatly in statistics; some count families, some counting total numbers, some estimating. Without a reliable figure of total number of IDPs, it is difficult to draw out an effective plan.

Throughout the history of the Mindanao conflict, the United Nations (UN) has had a minimal presence in the region. It wasn't until 2008 after the conflict increased in intensity that more UN agencies began to

engage in action in Mindanao. Beforehand, most agencies were based in Manila (John Hopkins,). In 2008, the United Nations Office for Coordination of Humanitarian Affairs (OCHA) opened an office in Mindanao; the World Health Organization (WHO) established a permanent presence in 2010. Since then, the UN has lead and continues to coordinate most of the preparedness, relief, and response activities in the region. The Humanitarian Action Plan for Conflict-Affected Provinces of Mindanao (HAP) is an international effort through the Consolidated Appeal Process (CAP)—a tool for aid organizations to jointly "plan, coordinate, implement, and monitor their response to disasters and emergencies, and to appeal for funds together instead of competitively" (16). See appendix 3 for more information on HAP.

6. Development

With the ongoing peace process in Mindanao, the humanitarian situation is said to be in its early recovery stage. As the number of IDPs is still significant, the situation calls upon shift of action from emergency response to sustainable development for the IDPs returning home and those already returned. The HAP can guide this process through strategic objectives that target the three biggest concerns of IDP: security, shelter, and livelihood prospects.

7. Discussion

The short lived peace agreement in 2008 was intended to be the beginning of stability, peace, and development. However, its failure to satisfy and its eventual failure proved just how fragile the process and the commitment to peace were. Although it showed a great amount of concessions from both sides, the people on the ground were not appeased and conflict broke out once again. Presently, another peace agreement has been drafted in the hopes of being the final leap in this enduring conflict. Public consultation has been central to the current peace talks to avoid a similar situation as the one in 2008. At this time, people are wary from years of conflict and all major actors are wary of each other, however, it is likely that exhaustion and stalled progress has lead them to concur that peace is necessary.

In the hopes that peace is established, a few issues still remain in dealing with the IDP situation.

7.1 Mental health and child resilience

According to the UN Convention on the Rights of the Child (2009) Article 39, "State Parties shall take all appropriate measures to promote physical and psychological recovery and social re-integration of a child victim of: any form of neglect, exploitation, or abuse; torture or any form of cruel, inhuman or degrading treatment or punishment; or armed conflicts. Such recovery and re-integration shall take place in an environment which fosters the health, self-respect and dignity of the child." Research has shown that three sets of factors thought to have related to the 'development of resilience' including attributes of the individual child, a child's family, and characteristics of the larger social environment (26). Child characteristics included high intelligence, internal locus of control, good coping skills, and an easygoing temperament. Other researchers proposed six themes for youths to overcome the trauma of war: sense of agency; social intelligence, empathy, and affect regulation; shared experience, caregiving features, and community connection; a sense of future, hope and growth; a connection to spirituality; and morality.

Attachment relationship to others is critical for helping children to cope with difficult circumstances (26). The existence of supportive relationship with at least one caring adult outside of a troubled home was associated with better social and emotional outcomes. Moreover, social support is defined in terms of its source, structure and function. The proposed three dimensions of social support include instrumental support, information support and emotional support. In particular gender plays an important role of social support in terms of both the importance and also the response, with social support moderated the impact of trauma exposure on distress in girls but not in boys.

7.2 Equity and provision of care

In 2012, UN clusters began to collect gender disaggregate information in order to better improve gender indicators. Gender mainstreaming is a priority in the Humanitarian Action Plan for 2012. Too many

inequitable gaps exist in the provision of aid due to the lack of information in the past. Clusters will need to ensure equal services are provided for men, women, and children. It should be a priority to provide disaggregated data to inform budgets, programmes, and implementation. Currently, it is difficult to tell the health impacts of the conflict on these vulnerable groups and therefore gender and age sensitive services are nonexistent. For example, WASH programmes rarely incorporate the special needs of women and children when designing their sanitation facilities therefore creating an insecure environment in IDP sites.

In addition to the traditionally recognised vulnerable groups (women and children), people with disabilities are also at a disadvantage in provision of care. It is estimated that there were about 942,000 people with disabilities living in the Philippines in 2011 yet they are often overlooked in emergency response and recovery efforts (13). This inequitable circumstance arises again from a lack of data on the need for disability sensitive programmes. UN clusters and the Humanitarian Action Plan need to prioritise needs assessment tools and data collection to include this priority group if it hopes to be equitable.

7.3 International aid

The government of the Philippines was one of two fighting factions in the major conflict in Mindanao for the last 30 plus years. This affiliation led to mistrust from a large percentage of the population in Mindanao (27). Any programme or service offered from the government would face the added barrier of doubt form the population it means to serve, sometimes hampering efforts altogether. In this context, the international humanitarian community has an important role to play in its service provision because of its independence from the government while still working under its auspice. However, it has been reported that some actors, mainly those involved in the Humanitarian Action Plan, were too compliant to government directives (13). In fact some clusters have indicated this to be so: the Child Protection Cluster stated in 2011 that their response plans were "based on nationally defined priorities" (13). The sustainability of health programmes will be dependent in part on the acceptance of the public, therefore

aid agencies should take this into consideration during their communications and dealings with the public.

7.4 From response to development

The peace agreement announced in 2011 between the government of the Philippines and the fighting factions of Moro National Liberation Front (MNLF) and MILF means that aid efforts need to switch their strategic planning from response to development as the IDPs may slowly return to their places of origin. This could provide a unique opportunity for rebuilding health infrastructure and programme plans from the ground up. Extensive needs assessment should be carried out at the community level and public consultation should be included in planning. If aid agencies can capture the moment to rebuild more efficient, equitable and sustainable health services, the people of Mindanao will benefit greatly in their health outcomes and can begin to "catch up" to the national average in health indicators at the very least. There will be a real opportunity for public health programmes also including education, promotion, prevention and community based initiatives.

7.5 Chronic disease management

An often forgotten area of service provision is the management of chronic diseases. Due to the lack of funds, resources and infrastructure during the emergency, many health services suffered. Chronic diseases were usually heavily hit with budget cuts and lack of priority in Mindanao whilst more acute health programmes received most of the attention and resources (17). Acute conditions and services are usually quantifiable and therefore more attractive for funding and provision. However, chronic diseases in Mindanao were of public health concern and deserve attention. The Department of Health has consistently ranked cardiovascular disease (CVD) as a leading cause of death in Northern Mindanao for the last decade. In addition to CVD, other chronic diseases prevalent were cancer, chronic respiratory diseases and diabetes. Long-term management programmes were difficult to be designed and implemented in the Mindanao region due to the high mobility of the IDP population and the lack of resources for long- term care. This inequitable distribution of service provision affected a large amount of

people, leaving them to suffer needlessly from highly preventable side effects and early mortality caused by unmanaged illness. With the newly announced peace agreement, chronic disease management should be a more feasible strategy for health providers and should therefore be considered and added to health plans.

7.6 Lack of reliable data

The available figures of the number of IDPs still remain a challenge. Their reliability is questionable due to factors such as the mobility of IDPs, incomplete data collection, lack of coordination and hidden populations. Some groups of IDPs, such as those that reside in host communities rather than evacuations centers, were not accurately captured in government data. The problem was so prevalent, it has been noted that "the lack of clarity, and limited application, of the definition of IDP by the authorities exclude groups who would be regarded as displaced within the international normative framework" (13). The lack of accurate data led to further issues. IDPs that were not living in formal aid centers were often forgotten both in action plans and in strategies. In addition, returnees were not considered IDPs any longer and were also excluded from aid strategies, leaving them in need but with no aid (28). Exclusion from IDP-based aid activities left thousands of people in need without any resources.

In response to the IDP figures discrepancies, the government has begun to use the Humanitarian Response Monitoring System (HRMS) to track population movements since 2010. Although the system was initially designed and used for natural disasters, it has been retrofitted to fit the conflict setting in Mindanao (29).

In addition to a general lack of accurate IDP figure data, there was also a lack of data on vulnerable groups, including children and women. Since many of the government figures used a system of estimation to calculate IDP numbers by average family size, there was a lack of disaggregated data on displaced children. However, it was estimated that about 30,000 to 50,000 children had been displaced by armed

conflict every year since 2005 according to the UN Committee on the Rights of the Child (30).

8. Lessons Identified and Actions Recommended

Health services and programmes in Mindanao have been shaped by the protracted conflict and the IPD population for decades. Many health service deficiencies exist due to the toll the conflict has had on resources, healthcare workforce, and the highly mobile population. However, given that the new peace agreement endures, there is an enormous prospect of enhancing the health sector in Mindanao. According to Spiegel et al the proposed health policies and interventions include four key areas (2):

(I) Delivery of health services to inaccessible conflict-affected people

- With mass-delivered interventions for maternal and neonatal health, airborne droplet diseases, diarrhoeal diseases, neglected tropical diseases and malnutrition.
- If possible, create humanitarian space for mass campaigns like for polio vaccination.

(II) Make chronic disease management a priority to reduce mortality and morbidity

- Include registration for prevalent cases of locally treatable chronic diseases
- Develop home-based care guidelines and treatment kits especially in settings of restricted health-facility coverage.

(III) Improve health services through capacity building

- With health education at the community level and utilisation of traditional clan organisations to effectively engage people, communities can be encouraged and empowered to practise healthy practices such as hygiene, immunisation and preventative screening.
- Focus on the retention of healthcare workers during this new time of peace. Equip health care facilities with equipment and adequate supplies to reduce the burden of workers.

- Increase access to primary health care through the use of community based health programmes to reach local populations.
- Design culturally sensitive health services with particular attention to the needs of IDPs, vulnerable groups, and women. Address gaps in the clusters in the provision of services for these groups such that it takes into account their vulnerabilities, dignity and protection.

(IV) Changes in surveillance, assessment and monitoring

- To recognize the importance of disaggregated data. Data collection, needs assessment, data synthesis, and programme planning will be paramount in planning for the returnee population and the influx of people who will depend on community health services
- Develop highly simplified methods for community surveillance of mortality and other key health outcomes

9. Conclusions

Mindanao has been greatly affected by a protracted conflict that has led to millions of internally displaced people and devastating effects on the economy, development, livelihoods, and health outcomes of the population. Long-term programmes addressing the needs of the people have had a difficult time providing even the basic needs due to ongoing conflict, mobility of the IDP population, a draining of resources, a highly volatile timeframe, and unreliable figures. The newly announced peace agreement gives hope that the environment will change from that of response to development lending aid agencies a more probable chance to improve health outcomes and other development indicators. An important health issue to push forward will be the integration of chronic disease management within the traditional aid programmes, as this has been largely ignored in the past. The issue of providing equitable care for vulnerable populations should also be addressed. The people of Mindanao are facing a brighter future ahead, and the actors

within the county are facing an unprecedented opportunity to design the most equitable, evidence-based programmes thus far.

10. References

. Kulling P, Birnbaum M, Murray V, Rockenschaub G. Guidelines for reports on health crises and critical health events. Prehospital disaster Med Off J Natl Assoc EMS Physicians World Assoc Emerg Disaster Med Assoc with Acute Care Found. 2010;25(4):377–83.

2. Spiegel PB, Checchi F, Colombo S, Paik E. Viewpoint Health-care needs of people aff ected by confl ict : future trends and changing frameworks. Lancet. 2010;375(Idmc):341–5.

3. United Nations Office for the Coordination of Humanitarian Affairs (OCHA). OCHA in 2010: Philippines [Internet]. 2010. Available from: http://www.unocha.org/ochain/2010/philippines.html

4. Paul B. Responding to disasters. In: Oxford Handbook of Public Health Practice. 2nd ed. Oxford University Press, USA; 2006. p. 383–5.

5. The Sphere Project. Humanitarian charter and minimum standards in humanitarian response [Internet]. The Sphere Project. 2011. 402 p. Available from: http://www.spherehandbook.org

6. World Health Organization. Preamble to the Constitution of the World Health Organization as adopted by the International Health Conference, New York. In: Official Records of the World Health Organization. 1946. p. 100.

7. Acheson D. Public health in England: the report of the Committee of Inquiry into the Future Development to the Public Health Function. Her Majesty's Stationery Office. London, England; 1988.

8. National Statistical Coordination Board. Philippine Statistical Yearbook. 2008.

9. Japan International Cooperation Agency, CTI Engineering International. The study on the nationwide flood risk assessment and the flood mitigation plan for the selected areas in the Republic of the Philippines: final report (Volume III: supporting report) [Internet]. 2008. Available from: http://open_jicareport.jica.go.jp/pdf/11881950_02.pdf

10. Republic of the Philippines National Statistics Office of the Philippines (NSO). Philippines in Figures 2011. 2011.

11. National Statistical Coordination Board. Statistics: family income. 2009.

12. Human Development Network (HDN). Philippine Human Development Report (PHDR): Provinces and human development. 2009.

13. United Nations Office for the Coordination of Humanitarian Affairs (OCHA). Humanitarian action plan for the conflict-affected provinces of Mindanao [Internet]. 2011. Available from: https://docs.unocha.org/sites/dms/CAP/2011_Mindanao_HAP_SCREEN.pdf

14. Pagliani P. Human Development Research Paper: Influence of regional, national and sub-national HDRs. 2010.

15. United Nations Development Programme (UNDP). Multi donor group support to peace and development in Mindanao: third assessment mission report. 2000.

16. United Nations Office for the Coordination of Humanitarian Affairs (UN OCHA). Humanitarian action plan Mindanao. 2012.

17. Integrated Regional Information Networks (IRIN). Sharp increase in IDPs after Mindanao bombings. 2009.

18. United Nations Children's Fund (UNICEF). Uncounted lives: children, women and conflict in the Philippines. 2006.

19. Alternate Forum for Research in Mindanao. Mindanao Resilient Communities Project. 2011.

20. BBC News. Philippines and Muslim rebels agree peace deal. 2012.

21. United Nations. Secretary-General welcomes "landmark" deal aimed at ending decades of fighting between government, rebels in South Philippines. 2012 [Internet]. Oct 8; Available from: http://www.un.org/press/en/2012/sgsm14569.doc.htm

22. Coletta NJ. The search for durable solutions: armed conflict and forced displacement in Mindanao, Philippines [Internet]. Conflict, Crime & Violence Issue Note. 2011. Available from: http://documents.worldbank.org/curated/en/2011/03/14831170/search-durable-solutions-armed-conflict-forced-displacement-mindanao-philippines

23. Inter-Agency Standing Committee (IASC) Country Team in the Philippines. Report of the IASC Country Team in the Philippines on the rapid initial needs assessment in Mindanao [Internet]. 2008. Available from: http://www.slideshare.net/Psdmn/microsoft-word-minadanao-i-a-s-c-initial-needs-assessemnt-report-4655241

24. Health Emergency Response Operations. Progress report No.8. 2011.

25. Citizens' Disaster Response Center (CDRC). Military operation in Basilan displaced 1500 families. 2011.

26. Betancourt TS, Khan KT. The mental health of children affected by armed conflict: protective processes and pathways to resilience. Int Rev Psychiatry [Internet]. 2008;20(3):317–28. Available from: http://www.scopus.com/inward/record.url?eid=2-s2.0-45849124251&partnerID=tZOtx3y1

27. Human Rights Watch (HRW). Lives destroyed: attacks against civilians in the Philippines. 2007.

28. Arguillas CO. Military says IDPs are "enemy reserve force" but gov't peace panel says "IDPs are not the MILF." MindaNews [Internet]. 2009 Jul 1; Available from: http://cbcsi.blogspot.hk/2009/07/military-says-idps-are-enemy-reserve.html

29. Integrated Regional Information Networks. New database to highlight IDP needs. 2010.

30. United Nations Committee on the Rights of the Child. Philippines report. 2009.

31. Writenet. The Philippines: conflict and internal displacement in Mindanao and the Sulu archipelago. 2009.

32. Reuters. At least 7,000 people remain displaced in Mindanao due to armed conflict and clan violence. 2010.

33. World Bank. Reaching for the gun: the humanitarian impact of small arms in Central Mindanao. 2003.

34. Integrated Regional Information Networks (IRIN). Clan violence adds to displacement in Mindanao. 2010.

35. National Disaster Risk Reduction & Management Council (NDRRMC). NDRRMC update: Progress reports on armed conflict in Kabacan, North Cotabato. 2011.

36. Vitug M, Gloria G. Under the crescent moon: rebellion in Mindanao. 2000.

37. Ressa M. Seeds of terror: an eyewitness account of Al-Qaeda's newest center of operation in Southeast Asia. New York: Free Press.; 2003;245.

38. Republic of the Philippines. Department of Social Welfare and Development. Classification of affected families and persons. 2009.

39. Notre Dame University & Commission on Population Region XII. Migration in conflict situation and its implications on local governance. 2004.

40. National Disaster Coordinating Council (NDCC). Complex emergency in Mindanao (NDCC Update No. 9). 2008.

41. United Nations Habitat. Urban safety profile in the ARMM. Auton Peace Rev. 2010;

11. Appendices

Appendix I: Main actors involved in the conflict

The population in Mindanao consists of many separate identities which play a background role in the conflict. Background information of these groups are provided below.

Muslims and other settlers

Beginning in the 14th century, Arab traders brought the people of Islam over to the Philippines, establishing a formal Sultanate in 1450. Following a rapid population by Muslims, the Spanish came upon the Philippines in the 1520s. At the same time that Muslim missionaries were converting large numbers of Filipinos (especially in the southern provinces of Mindanao), Spanish colonizers were looking to convert the population to Christianity (22).Whilst the Spanish were largely successful in their conversions in the northern provinces, Muslim Filipinos were driven south where in Mindanao, they sustained efforts to resist Christianity. Uneasy peace and intermittent fighting followed between the Spanish and Sultanate until the United States overtook the reigns of colonizer and continued to suppress the Moro people (the Spanish term for the Muslim people of Mindanao) and drive them further south. It is from this time period that the conflict can be said to originate, since the Moro people believe that they are of a separate identity than the rest of Filipinos and should have been given an independent state by the U.S. rather than be forced into the unitary country (15). Following years of largely nonviolent conflict, policies in the 70's opened up Mindanao to settlers of other islands, driving the population of Muslims in Mindanao down. Despite larger incidences of cohabitation, Muslim groups and Christians remain separate in religious practice but also political ideals. Within the Moro population, 13 ethnic groups exist, tied together in their solidarity for an independent Muslim state (22).

Moro National Liberation Front (MNLF)

Land status claims gave birth to a separatist group in 1971 called the Moro National Liberation Front (MNLF), a Muslim rebel group. Historically, a number of attempts at a peaceful resolution were attempted by the government and MNLF, most notably in 1976. This had limited success and led to a second agreement in 1996, which led to the establishment of the Autonomous Region of Muslim Mindanao (ARRM), a Muslim area with sole degree of autonomy and separation from the rest of the country (31).

Moro Islamic Liberation Front (MILF)

The Moro Islamist Liberation Front was created in 1984 as a splinter group by former members of the MNLF. The MILF is more aggressive in its approach to autonomy and independence. They continued the armed struggle for Moro self-determination after the MNLF reached the Final Peace Agreement with the GRP in 1996 and they are not supportive of the ARMM as a satisfactory solution. They enjoy support in many rural areas of Mindanao where rampant poverty has encouraged uprisings and their current member count is about 11,000 (32). The government of the Philippines has launched many attacks on this extremist group over the years. In March 2000, it led an "all-out-war" against the MILF leading to massive displacement. A ceasefire was followed by the signing of the Tripoli Agreement on Peace followed by the establishment of the Joint Coordinating Committee on the Cessation of Hostilities in 2002 which is the main monitoring group. The agreement established some degree of autonomy to thirteen provinces and nine cities in the Mindanao region(22)(32).

Moro (Muslim) peoples and indigenous groups

Moro people and other indigenous people in Mindanao have been disproportionally affected by conflict, leading to displacement. Indigenous people are mostly affected by displacement due to land grabs and development projects on their land whereas Moros are affected both by the Moro struggle and rido (IRIN, 2008). In the 2000 outbreak of violence, Oxfam estimated that of the 1,000,000 people displaced 85% were Muslim (33).

Rido (clans)

The word rido stands for a clan feud. Ridos in Mindanao are a major source of conflict and continued insecurity. In combination with the larger conflicts, rido causes increased internal displacement and although rido has separate root causes, it cannot be separated from the larger picture of conflict since it takes place in the same geographical area and usually affects the same people (34).

A rido usually occurs when a family or kinship has been violated by hurting one's sense of honor, dignity or self-respect leading to retaliation. Since conflict resolution usually comes from different authorities, including the MILF and the government, ridos can grow into larger political issues. In fact, political differences are a common source and consequence of ridos (12), as well as land disputes, and past offences. Ridos have been identified as one of the main challenges with respect to preserving stability in the region. Unfortunately, ridos are characterised by the larger environment which includes ongoing conflict, a dysfunctional justice system and governance, and the availability of arms. Therefore, alleviating ridos will have to be a part of a larger peace process that includes ceasefires and negotiations between the government and the MILF.

Some studies estimate that almost 1,200 incidences of rido have occurred in Mindanao since the 1930s (32). Even in times of relative peace, ridos continue to threaten stability. For example, after the July 2009 ceasefire between the MILF and the government, security improved significantly as armed confrontations between the warring parties came to a near end. However, rido incidents continue to be reported and create the most regular source of displacement since 2009. In 2010, 70,000 people were displaced due to ridos and fighting between rivals (35).

Indigenous peoples

A central driver of the conflict in Mindanao is conflicting claims over land and natural resources, between the government and Muslim and indigenous people. Historically, indigenous people held their land based on a communal system; however government policy has stripped away most rights of indigenous people, while favoring late Christian settlers). In 1997, the Indigenous People's Rights Act (IPRA) law was enacted. The law recognises the right of indigenous people to hold lands under ancestral claims or ownership (12). However for members of the MILF this was not a solution since they refused to be categorised as indigenous based on religion. Furthermore, the law has largely failed to secure land rights and claims for the people of Mindanao. Progress has been slow and poorly coordinated (15). Continued land disputes between families and clans therefore continued to present the problem of rido and obstruct peace negotiations between the MILF and the government, as rebels demanded that land in Mindanao be left to Muslim control.

The Communist Party of the Philippines

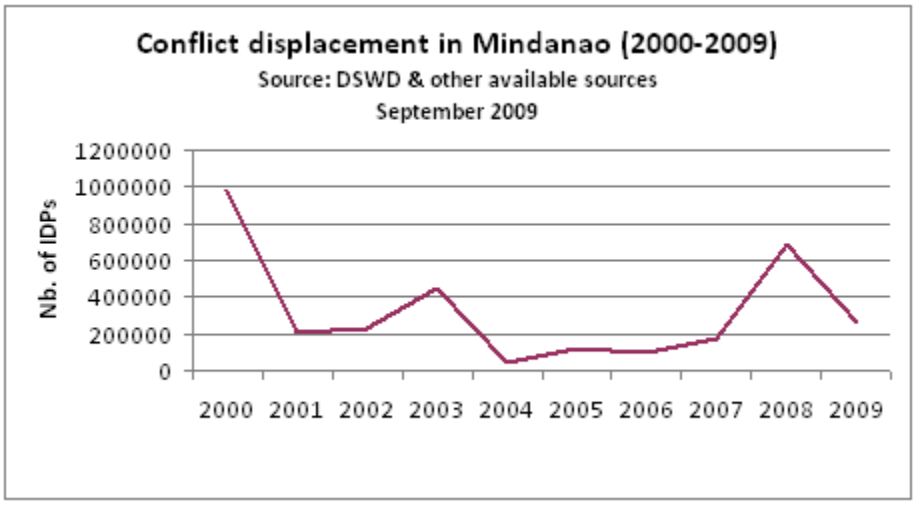
The Communist Party of the Philippines (CPP) was founded in December 1968 with its armed wing, the New People's Army (NPA) established only a few months later in March 1969 (32). They currently hold less than 9,000 members. The group is Maoist and their broad aim is to overthrow the government through guerrilla warfare (32). The group adds insecurity to the area by working as a terrorist extremist group. For example it is estimated that in 2009, more than 10,000 people were displaced by anti-NPA activities (33).

Relative to the overall violence and conflict between the government and other groups, clashes with the NPA are smaller, more remote, and cause limited displacement. However, with limited access to remote areas, clashes with NPA remain largely invisible and estimates could be much higher than previously thought.

Appendix II: A timeline of events and background context

The Mindanao conflict has been ongoing since the 1970s. However, violent outbreaks have been more common and large scale in the last decade or so. The last decade has also produced the largest number of internally displaced people (IDPs).

Table 3 Conflict-induced displacement in Mindanao, 2000-2009



Sources: DSWD, 2009

Protracted armed conflict in Mindanao has caused more than 120,000 deaths, and repeated displacements (36). The long term nature of the event has led to human suffering, violation of human rights, destruction and damage to the region's infrastructure, social structure, a massive financial strain, and stunting of development (37). All in all, the conflict has been an impediment for the government to provide the citizens of the province even the most basic services for health and human development.

Multi-ethnic tension has always been a driver of conflict. The government's past exploitations of Muslim and Indigenous people's resources and land has been a central factor in the conflict and in the resentment towards the government and late Christian settlers in Mindanao. When the ARRM was created in 1989, it

was meant to give Moros greater autonomy over the affairs that control their lives, however subpar efforts have been made to strengthen the capacity of ARMM governance (36).

1996-2003

In 1996, a peace agreement between the government of the Philippines and the MNLF was signed and was expected to end the conflict. However, as the MILF grew in capacity, the government led by President Joseph Estrada declared an "all-out-war" in 2000, and caused the displacement of 930,000 people (33). Disaster relief efforts were initiated by the government's Department of Social Welfare and the National Disaster Coordinating Council, alongside with national organisations and international aid (33). The all-out tactics used during this conflict caused major damage to property and livelihoods and while previous displacements tended to be short-term, the 2000 conflict carved out a pattern of longer displacement cycles due to more violent and ongoing fighting on both sides (15).

When Estrada was ousted, and the new president Gloria Macapagal-Arroyo took office, she declared a policy of "all-out-peace", with a commitment to peace negotiation and development of the Mindanao region. However, a show of the shallowness of peace came when the government once again began a major offensive in 2003 displacing another 411,000 people and returnees from the initial war in 2000 (38), causing mistrust across the region.

Internally displaced people in 2003 moved around from temporary evacuation centres in schools, public spaces, and other buildings including tents. The length of stay averaged anywhere from 2 months to more than 1000 days (39). Many people also moved to host communities with friends and family.

The pattern of displacement in 2000 was on a massive scale due to the intensity of the fighting. Aerial bombardment and surprise attacks made people evacuate their homes quickly, and with poor planning. As a result, IDPs usually left home with nothing and were often separated from their family networks, friends,

and neighbours. In contrast, during the 2003 displacement residents were given enough advanced notice to plan their evacuations. The media and local authorities played a role in warning people ahead of time and many of the IDPs benefitted from better coordination and assistance (39).

Negotiating peace

Following a heavy few years of displacements, talks and peace negotiations led to the cessation of violence in mid-2003. International monitoring teams, joint needs assessments, and negotiators from both sides were engaged to lay the foundation of a more peaceful future. Since this time forward, both parties have attempted to include international human rights instruments and laws into building principles of peace and development. There are differences however in the language of the constitution. Whilst the government speaks of the nation as a "whole" and of territorial integrity, the MILF speaks of a Muslim homeland and people. Reconciling these differences has historically been the weakest link in the negotiations and in sustaining peace (13)(32).

In 2008, the two parties, mainly the MILF and the government of the Philippines announced that they had had a breakthrough in negotiation and had agreed upon a memorandum of agreement (MoA) on the issue of the Moro autonomous homeland. This document outlined integral issues about the Moro people's "ancestral domain" by allowing more than seven hundred villages to vote in 2009 on whether to be included within the ARMM. However, following this revelation, strong criticism from the pubic caused the MoA to be suspended and be declared unconstitutional by the Supreme Court (31). Once again peace agreements were shattered and the MILF launched attacks on Christian communities and the ensuing violence led to the further displacement of hundreds of thousands of people across Mindanao.

2008-2011

Small scale conflict continued well into 2009 and peace talks were stalled. An escalation in violence was seen and new large scale displacements occurred, an estimated 750,000 people displaced from their

homes and hundreds of thousands of others who were still living in evacuation centers and in host communities were left to continue their time there. In July 2009, there was a ceasefire between the factions and IDPs began to move back home. In early 2010 there were still an estimated 130,000 people living in evacuation centres and camps, and by 2011 only an estimated 12,000 remained (13)(22).

Perhaps due to familiarity with the procedure and developments of becoming displaced, the people of Mindanao showed a pattern of displacement different than in earlier years. In 2008, most of the IDPs found shelter outside of the formal evacuation centers in the initial stages of the fighting. In most provinces the average percentage of IDPs initially living outside of evacuation centers ranged from about 80-85%, although this changed as time passed and more people moved to the centres (40). Between late 2008 and early 2009, of the 745,000 people displaced, an estimated 58% of them had moved to an evacuation center and by September 2009, the proportion of IDPs living in evacuation centers or other "sites" reached nearly 80 per cent.

The end of 2010 also saw displacements caused by ridos in several provinces in Mindanao. Since the ceasefire of 2009, these have become the major cause of new displacements. Ridos have the capacity to create havoc and fear in the communities, therefore causing large scale movements despite their smaller scale violence. An estimated 70,000 people were displaced in 2010 and another 20,000 in 2011 (13).

Other causes of displacement in the Philippines include fear of the counter-insurgency efforts against the New People's Army, the communist armed forces. IDPs fleeing clashes between the government and the NPA are largely excluded from any government statistics (41).

Displacements

The constant displacement of the people living in Mindanao has become a defining characteristic of the fighting between rebel groups, the government, and clans involved in ridos. Aside from the traditional

reasons for displacement (i.e. fear, violence, seeking safety, forced movements), displacement of large groups of people can at times also be used as a strategy for gaining control by all groups involved in the conflict.

In 2011 the World Bank noted that "In the conflict-affected areas of Mindanao, forced internal displacement is not only a derivative of armed conflict, but an objective of various interested parties to the conflict in and of itself. It is at the very heart of the political economy of Central Mindanao. It is in essence, a means to control strategic territory (land and natural resources) by influencing the movement and loyalties of the local population. The IDPs or local population are pulled and pushed in multiple directions as the primary means of asserting territorial control and political influence." (22)

In other words, depriving rebels of a local population who may sometimes lend support or sympathy to their case is a strategic maneuver by the government forces. Having large sections of the population in government controlled evacuation centers keeps a sense of control (28). For the MILF that means they lose out on a popular support base.

Appendix III: Humanitarian Action Plan

Humanitarian Action Plan for Conflict-Affected Provinces of Mindanao (HAP) is an international effort through the Consolidated Appeal Process (CAP)—a tool for aid organizations to jointly "plan, coordinate, implement, and monitor their response to disasters and emergencies, and to appeal for funds together instead of competitively" (13).

The four strategic objectives of HAP are to:

1. Support the Government to tackle the humanitarian needs of affected populations in an appropriate way;
2. To establish an enabling environment for the implementation of durable solutions for affected populations;
3. To develop the capacities of local Government and communities to respond to emergencies and manage their early recovery; and
4. To establish structures and mechanisms to ensure the protection of vulnerable individuals and groups. (13)

In accordance with the peace process in Mindanao in recent months, the humanitarian situation is no longer in the emergency phase but rather in early recovery. Although there are few deaths, the number of IDPs and recent returnees is still massive. Now that the peace agreement has been signed, it will again shift the humanitarian agenda from response to development for the IDPs returning home and those already returned.

The challenge of development initiatives will be paramount due to prolonged deterioration of the region's infrastructure livelihoods, health, economy, and access to basic services. It is yet to be seen whether or not the national government will play a key role in this phase or whether mistrust from the community

will hamper any efforts. The Humanitarian Action Plan document (2011) reported that the three biggest concerns of IDPs are: security, shelter, and livelihood prospects (13).

There is also a community driven response that is aimed at assisting IDPS by:

1. Providing immediate assistance to newly returned IDPs;
2. Building and strengthening people's capacities in planning and managing projects for IDPs; and
3. Efficiently and effectively implementing other community based sub-projects.

Community based approaches to response are mainly decided and voted on by community embers. They play an integral role in defining key decisions about their development options, the management of their resources, and their action plans. All these are geared toward creating self-reliant communities (13).

12. Keywords

Crisis event management; crisis management; critical health event; disaster; Disaster Case Studies Series; disaster cycle model; disaster management; disaster response; emergency; emergency medical service(s); health crisis; preparedness; public health evaluation

13. Abbreviations

AFRIM	Alternate Forum for Research in Mindanao
ARMM	Autonomous Region of Muslim Mindanao
BJA	Barangay Justice Advocate
CAP	Consolidated Appeal Process
CBCPNs	Community-based Child Protection Networks
CMAM	Community-based Management of Acute Malnutrition
COPERS	Center of Psychological Extension and Research Services
CVD	Cardiovascular disease
HAP	Humanitarian Action Plan for Conflicted-Affected Provinces of Mindanao
HRMS	Humanitarian Response Monitoring System
IASC	Interagency Standing Committee
ICVA	International Council of Voluntary Agencies
IDP	Internally displaced person
INGO	International Non-governmental Organization
JCCCH	Joint Coordinating Committee on the Cessation of Hostilities
MDCC	Municipal Disaster Coordinating Council
MILF	Moro Islamic Liberation Front
MNLF	Moro National Liberation Front
NDCC	National Disaster Coordinating Council
NDRRMC	National Disaster Risk Reduction and Management Council

NGO	Non-governmental Organization
OCD	Office of Civil Defense
OCHA	Office for the Coordination of Humanitarian Affairs, United Nations
PDCC	Provincial Disaster Coordinating Council
RDCC	Regional Disaster Coordinating Council
SAM	Severe acute malnutrition
TWG	Technical Working Group
UN	United Nations
UNICEF	United Nations Children's Fund
WASH	Water, Sanitation and Hygiene
WHO	World Health Organization