2009

ARMM
Regional Health Research Capacity Assessment Report

Philippine Council for Health Research and Development
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AUTONOMOUS REGION OF MUSLIM MINDANAO (ARMM)

REGIONAL HEALTH RESEARCH CAPACITY ASSESSMENT REPORT

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PHILIPPINE COUNCIL FOR HEALTH RESEARCH AND DEVELOPMENT
VICAR INTERNATIONAL HEALTH AND RESEARCH GROUP, INC.

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ACRONYMS

ARMM	Autonomous Region of Muslim Mindanao
COA	Commission on Audit
DOST	Department of Science and Technology
DOH	Department of Health
HRC	Health Research Consortium
MSU	Mindanao State University
NAST	National Academy of Science and Technology
NUHRA	National Unified Health Research Agenda
PCHRD	Philippine Council for Health Research and Development
PNHRS	Philippine National Health Research System
RHRDC	Regional Health Research Development Councils
RICUP	Research Information Communication Utilization Programme
RUHRA	Regional Unified Health Research Agenda
SOME	Structure/Organization Monitoring and Evaluation

I. Introduction and Objectives of the Assessment

The Health Research Consortium of ARMM was organized in 2007. The autonomous government's Department of Science and Technology led a group of fourteen academic institutions and government agencies in forming a health research consortium. With funding support from PCHRD the ARMM health research consortium conducted a training course on basic research methods in October of 2007 and two workshops on research protocol development and technical evaluation of the research proposals generated in October, 2008 and May, 2009.

This assessment is conducted to strengthen research and development in ARMM. Specifically the assessment will (i) identify critical issues and gaps in health research and development in ARMM; and (ii) recommend measures that the health research consortium can use to improve the management and implementation of health research and development programs and activities.

II. Methodology and Activities Undertaken

The assessment was carried out by the members of the Structure/Organization Monitoring and Evaluation (SOME) with administrative and logistical support from PCHRD. The assessment team utilized the assessment framework and instruments developed by the committee for this purpose (see Annex A).

Two meetings were held as part of the assessment process. The first meeting was conducted on June 2 with health researchers and the second meeting on June 3 with the members of the Governing Board in attendance. The ARMM RUHRA, 2009 operational plan and organizational structure were reviewed as part of the assessment process.

III. Findings and Observations

Overall Findings and Observations

ARMM Health Research Consortium is one of the newly organized consortia in Mindanao and as such is facing a number of organizational and developmental challenges and issues.

One of the priority problems of the ARMM health research consortium is the lack of awareness of the regional health priorities among the region's health researchers. The ARMM RUHRA which was crafted in 2005 is not only poorly disseminated it is also underutilized. Another major organizational issue that needs to be addressed is the non-functionality of the working sub-committees and the lack of a full-time manager to provide management oversight to the work of the consortium. With respect to the issue of membership, the consortium needs to address the lack of adequate representation of the island provinces of Basilan, Sulu and Tawi-Tawi especially given the geographic isolation of the island provinces from the rest of the ARMM region. From a developmental perspective, the absence of a strategic plan makes it difficult for the consortium to identify the most critical and important activities and track the progress of its performance.

On the other hand, ARMM has a number of academic institutions that possess health research manpower and facilities that have the potential to address its priority health research issues and problems. The consultative session with the health researchers showed a high level of motivation and commitment among the researchers to contribute to the promotion of health research and development in the region and the achievement of its regional health research goals and objectives.

A. Preparation and Utilization of Health Research Agenda

1. The ARMM RUHRA (2006-2010) was developed in 2005. It contained a brief description of the priority research areas but not enough information to enable the document to have a lot of useful applications.

   In 2005, with assistance from PCHRD, a group of academe-based experts led the development of a health research agenda for ARMM. The preparation process involved the review of relevant documents and stakeholder consultations. The identified priority areas included the following: Infectious diseases, family health and health of special populations, health policies and legislation and the health of the ARMM indigenous populations.

   Despite the existence of (and assumed easy access to) this reference document many health researchers who were present during the consultation meeting expressed their lack of awareness and familiarity with its content. Most of the researchers agreed that the document was not well-disseminated. This sentiment was shared by the members of the members of the health research council.

2. Inadequate utilization of the health research agenda.

   A review of the accomplishments of the ARMM consortium showed little evidence of application of the health research agenda. No attempt was made to develop assessment instruments based on the research priorities. The consortium also failed to translate the agenda into a plan for capacity building and mobilize resources for health research.

3. Strong interest to review the research agenda and transform it into a more usable instrument

   Both the group of researchers and the governing board suggested that a review of the research agenda is in order and that the document needs to undergo a systematic analysis to facilitate the preparation of research proposals and enable easier access to interested users for other useful applications. Some of the other uses and applications of the RUHRA are described below.

B. Health research manpower, facilities and capacity-building

1. Researchers and governing board claim that ARMM has the capacity to undertake research and development activities. In the short-term the consortium needs a biostatistician to assist health researchers with refining their research designs.

   Even in the absence of a systematic inventory of health researchers and facilities, the health researchers and the governing board agree that ARMM possesses the capacity to undertake health research to address the identified health research priorities. This confidence stems from the presence of a number of state universities and privately owned institutions of higher learning that are recognized for their research capabilities. During the discussions, the members of the consortium articulated the need for a biostatistician to assist health researchers in the design of their research proposals.

2. Training of research manpower has been carried out but there is no long-term human resource development program and it is unclear if the training course was guided by the health research agenda.

   In 2008, the consortium through the Technical Working Group (TWG) conducted a training course on research design and protocol development

among health researchers. The training activity was designed to generate health research proposals.

Members of the TWG and the governing board acknowledged that the region does not have a capacity-building strategy in place. There was also no attempt on the part of the consortium to assess the manpower needs of the region based on the identified research priorities.

C. Funding and Logistical Support for Health Research

1. Institutional support for health research exists although funds for research are scarce and highly competitive.

   Health researchers claim that while some institutions have research funds, these funds are inadequate and in many instances the health researchers have to compete with researchers from other sectors. In addition to the provision of funding support some institutions reduce the teaching load of faculty members who are able to complete and publish their research studies. Faculty members who are invited to present their papers also get some funding support from the institution.

2. The consortium does not have a resource mobilization strategy

   The consortium has not attempted to translate the research priorities listed in the RUHRA into a cost estimate and use the results to formulate a resource generation/mobilization plan. This inadequacy makes the consortium totally dependent on PCHRD support and renders it highly vulnerable to the unpredictable changes in government budgeting.

D. Development of Research Proposals and Conduct of health Research studies

Starting in 2007, the consortium undertook a series of proposal generation activities that culminated in the development of 6 research proposals. The proposals were designed to address a wide range of research issues from infectious diseases, to the health of special populations and maternal and child health. In general, the submitted proposals are responsive to the identified priorities. The time that elapsed from the submission of capsule proposals to the review of the completed protocols is almost two years. Presently, the proposals have been reviewed and are awaiting approval for funding.

E. Organization, leadership and management

1. Advisory council and sub-committees

   The Health research consortium of ARMM is composed of 14 member institutions and agencies. The consortium has an Advisory Council that is responsible for the approval of policies, programs and plans. Four sub-committees comprise the technical and working ARMM of the consortium. While the consortium includes institutions based in the island provinces of ARMM, the Governing Board acknowledged that the participation of the provinces of Sulu, Basilan and Tawi-Tawi is minimal.

2. No provision in the organizational structure for day to day management responsibilities.

   A review of the organizational structure of ARMM shows that there is no one responsible for the day-to-day management of the activities of the consortium. This organizational flaw is common among the different regional research consortia and is often masked by the services performed by the secretariat staff coming from the DOST-ARMM. The lack of a full-time manager is one of the reasons for the delay in the implementation of the consortium's planned activities.

3. The consortium has an operational plan for 2009. However, there is no strategic plan for health research and development in the region.

   The regional plan prepared by the ARMM consortium does not provide adequate guidance on the long-term directions and of the consortium's goals and objectives. The planned activities only reflect those that can be accommodated under the program of assistance provided by PCHRD. This major shortcoming makes it difficult for the consortium to measure progress and track its growth and development.

4. The research and development sub-committee has been activated although only one member has been performing most of its tasks. The other sub-committees are non-functional.

The organizational structure of the consortium mentions the following sub-committees that are tasked with carrying out its research and related activities: research management, capacity building, information dissemination and utilization and ethics. Of these sub-committees, the research management sub-

committee is the only one that is functional. However, it was later revealed that only one member has been performing its assigned tasks. This situation may explain why it took almost tow years for the consortium to develop research proposals.

One of the reasons why the sub-committees are not working is that the designation of the working committees have not yet been formalized and made official.

F. Information Dissemination and Utilization

The ARMM consortium does not have a system for sharing research information. There is also no established system of disseminating research information to promote the utilization of research results.

G. Ethics

The consortium has identified members of the ethics committee. In January 2009, the consortium was invited to send its designated members of the ethics sub-committee to attend a course on ethics management. Due to scheduling problems the representatives from ARMM failed to take advantage of that opportunity.

IV. Recommendations

Recommendations to the ARMM Health Research Consortium:

1. Review and updating of the health research agenda.

The consortium needs to review and conduct a more systematic analysis of the identified health research priorities. The review and revision should not only update the list and render it more relevant but also provide enough description of the problems and issues to enable the participating institutions to determine the kind of contributions they can make to the research and development effort.

The revision should also include very specific recommendations and guidelines on how the agenda can be applied and put to better use.

2. Conduct an assessment of health manpower and facilities and development of a capacity building plan.

   ARMM needs to develop a long-term capacity building strategy to ensure it possesses the manpower and facility requirements to carry out the required studies. To do this properly, the consortium needs to conduct an inventory of the region's research manpower and facilities and assess their adequacy based on the identified priority needs.

3. Estimate funding requirements and development of a resource mobilization strategy.

   The consortium needs to develop a resource mobilization strategy and find alternative funding sources outside of PCHRD. The recommended approach would be to cost out the funding requirements based on the revised or updated health research agenda and use the results to formulate a resource mobilization plan.

4. Designation/Appointment of a manager or administrator who will be responsible for the day to day management of the activities of the consortium and activation of the different working sub-committees

   The full-time manager will make the consortium execute its plan more efficiently and relieve the secretariat from having to perform services and carry out activities that are not within its authority or mandate.

   One of the first tasks of the manager is to facilitate the issuance of a formal appointment to the members of the different sub-committees. The issuance of this appointment letter should trigger the activation of the committees and get them to start working on the planned activities for 2009.

5. Formulation of a health research and development strategic plan.

   The strategic plan should be based on a comprehensive analysis of the problems and issues and must be anchored on the research priorities listed and described in the RUHRA. The strategic plan should also include a capacity building, resource mobilization and information dissemination components.

   The strategic plan will be the basis for the formulation of the consortium's annual operational plans.

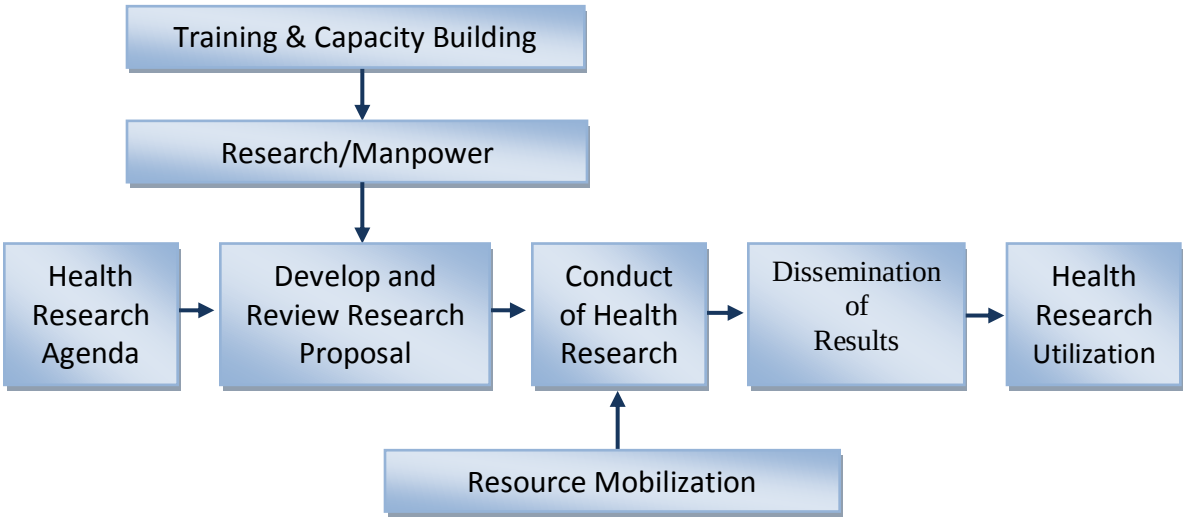
Annex A: Assessment Framework and Instruments

Framework for Developing Regional Capacity for Health Research

Under the PNHRS, the regions play an important role in undertaking health research activities to respond to the country's health needs and problems. Over the years, regional research activities were undertaken under the management and leadership of the Regional Health Research Development Councils (RHRDC). A recent evaluation of the RHRDC showed a wide variation in the performance of the 16 RHRDCs all over the country. The evaluation also recommended a number of strategies and approaches in order to improve the performance of regional capability to carry out and manage health research activities.

In line with this recommendation and in recognition of the strategic importance of the regions in supporting the PNHRS, the following framework is proposed to guide the PNHRS in strengthening regional capability to perform health research activities.

The framework consists of the different critical components of a research development program and a set of questions that identify key issues and problems as well as opportunities for strengthening the program.



Framework for Building Regional Health Research Capability

I. ***Preparation and Utilization Health Research Agenda*:** The health research agenda is a list of priority research areas in the region.

Some suggested principles and standards in the de3velopment of the regional research agenda:

- The research agenda should be based on local/national health problems
- There should be local evidence to support the research agenda
- The process of identifying the research priorities should be highly consultative and participative

A. Content

1. In 1998, was there a well-defined health research agenda for the region?
2. If yes, what was the basis for the identified research priorities? Is there evidence to support the priority research areas? Does the agenda respond to the health problems from a local as well as national perspective?
3. If no, what constrained the region from having one? What were the key problems and issues that prevented the region from developing an evidence-based regional agenda for health research?

B. Process

1. How was the research agenda developed? Who were involved in its development?
2. What were the problems and issues encountered in the formulation of the research agenda? What could have been done to make the process more effective?

II. ***Development of Research Manpower and Facilities*:** Refers to the availability of skilled manpower to conduct health research in the region.

Some suggested principles/standards:

- Number should be adequate to carry out the planned research activities
- There should be expertise in research methods and in the technical areas based on the priority list

1. Is there adequate research manpower (experts in research design and methodology and experts in specific content areas as defined by the health research agenda) in the region to carry out the region's health research plan?
2. If no, what is being done to address the lack of manpower? Is there a training program in place? Does the region possess the capacity to develop the skills of local researchers? What constraints are being encountered in the area of training and capacity-building?
3. Are there opportunities (institutions or individuals) that can be tapped to strengthen existing health research manpower?
4. What kind of support does the region expect from the national level to help develop the skills of local researchers?

III. ***Resource Mobilization*****:** Refers to the capacity of the region to mobilize funds and other resources for health research.

1. Are there enough funds to carry out the planned research activities?
2. If no, what are the constraints in mobilizing resources for research?
3. Are there potential funding sources within the region that can be tapped for health research?
4. What kind of support the region will need from the national level to develop regional capability to mobilize resources for health research?

IV. ***Development and Review of Research Proposals****:* Refers to the capacity of the region to appraise submitted research proposals for content, design, and methodology

1. In 2008, what is the quality of research proposals submitted in terms of content, design, and methodology?
2. Are the specific content areas as defined by the health research agenda?
3. If no, what were the reasons why?

V. ***Conduct of Research Studies*****:** Refers to the research output of the region both in terms of quantity and quality.

1. In 2008, were the planned research studies conducted?
2. If no, what were the reasons why?

3. Were the researches that were conducted of good quality?
4. If no, why? What can be done to improve the quality of health research in the region? What kind of support the region will need from national levels to make this happen?

VI. *Research Dissemination*

1. Were the researches that were conducted in 2008 disseminated? How?
2. If no proper dissemination was done, what were the constraints? Were the completed researches published?
3. Are there opportunities that can improve research dissemination in the future?

VII. *Research Utilization*

1. Were the research results utilized? How
2. If no, why? What were the constraints? What can be done to help improve the utilization of the research results?

VIII. *Leadership and Management*

1. Is the current composition of the governing council in the region adequate?
2. If no, what are the reasons why?
3. Is there a strategic plan in place for health research and development in the region? If none, why? What kind of assistance will the region need to make this happen?

ARMM - Guide Questions for Review of Documents

1. Guidelines for Research Agenda

1.1. Is the research agenda evidenced based?

☐ Yes ☒ No

Remarks:

The epidemiological information to describe the priority areas adequately is not presented in the ARMM-HRC RUHRA.

1.2. Does the research agenda cover the following?

1.2.1. Epidemiological	☐ Yes	☒ No
1.2.2. Sociological	☐ Yes	☒ No
1.2.3. Economic	☐ Yes	☒ No
1.2.4. Policy	☐ Yes	☒ No

Remarks:

There is some discussion on the background of the health issues in ARMM but there is no such discussion on the priority research areas.

1.3. Does the agenda contain the recommendations and steps to ensure its utilization?

☐ Yes ☒ No

Remarks:

2. Plan

2.1 What kind of plan do they have?

☐ Strategic Plan ☒ Operational Plan

Remarks:

_____

2.2 Does plan clearly contains the following?

2.2.1	Objectives and Goals	☐ Yes	☒ No
2.2.2	Indicators	☐ Yes	☒ No
2.2.3	Strategies	☐ Yes	☒ No
2.2.4	Activities	☒ Yes	☐ No
2.2.5	Budget	☒ Yes	☐ No

Remarks:

_____

2.3 Are the activities conducted as scheduled? ☐ Yes ☒ No

Remarks:

There are some delays due to the non-functional status of the subcommittees of ARMM-HRC.

2.4 What is the percentage of fund utilization? _____

Remarks:

_____

3. Organizational Structure

3.1 Does the organizational structure reflect the need for day-today management and oversight?

☐ Yes ☒ No

Remarks:

No full-time manager or administrator in the current organizational structure of ARMM-HRC.

ARMM - Guide Questions for Health Researchers

1. Formulation of Health Research Agenda

1.1. Are you aware of the existence of a regional and national health research agenda?

☐ Yes ☒ No

1.2. Have you seen or do you have a copy of these documents?

☐ Yes ☒ No

Remarks:

The RUHRA was prepared in 2005. An expert group was organized to lead the formulation of the RUHRA.

1.3. Were you able to participate in the discussions leading to the formulation of the NUHRA/ RUHRA?

☐ Yes ☒ No

1.4. Were you able to participate in a forum where the Regional Health Research Agenda was discussed?

☐ Yes ☒ No

1.5. Are you aware whether or not the Regional Health Research Agenda was used in the following?

1.5.1. Capacity building plan ☐ Yes ☒ No

1.5.2. Resource mobilization plan ☐ Yes ☒ No

1.5.3. Advocacy tool ☐ Yes ☒ No

2. Adequacy of Health Researchers, Research Facilities and Existence of Capacity Building Plan

2.1 Are there enough skilled researchers in the region to undertake health research based on the identified health research priorities?

☒ Yes ☐ No

2.1.1 If No, why?

2.2 Are there health research facilities in the region where research are conducted based on the identified health research priorities?

☒ Yes ☐ No

2.2.1 If No, why?

2.3 What needs to be done to strengthen health research manpower in terms of number and skills?

Training and upgrading of research facilities

2.4 Is there a long term capacity building program to continue to train health researchers in the region?

☐ Yes ☒ No

A training activity was proposed for 2009.

3. Adequacy of Funding and Logistical Support for Health Research

3.1 Where do you get funding support for your research activities?

From individual institutions and external funders.

3.2 Are these funds sufficient given what you need? ☐ Yes ☒ No

Remarks:

The amount available through the regional research fund (P100,000) is considered too small. The researchers expressed interest to collaborate with other regions.

3.3 Have you received funding support from the RHRDC through the RRF? ☐ Yes ☒ No

3.3.1 If no, why?

The proposals are still being reviewed.

3.4 Under PCHRD fund, there is a ceiling of PhP 100,000 per proposal. Do you think this is adequate?

☐ Yes ☒ No

3.4.1 If not, do you have any recommendations to make this funding mechanism more effective?

Increase the ceiling amount for RRF.

4. Preparation of Research Proposals and Conduct of Health Researches

4.1 How many research proposals have been prepared? **6**

4.2 How many health researches have you completed in the past two years (2007 and 2008)?

0

Remarks:

These researches refer to those that are to be funded by the RRF.

5. Health Research Dissemination and Utilization

5.1 Is there an existing system to disseminate the results of the research study?

☐ Yes ☒ No

5.1.1 If yes, how do you disseminate the results of the study?

5.2 What are the usual problems in the dissemination of your research findings?

There is not support from the consortium in terms of research dissemination due to the non-functional RICUP subcommittee.

5.3 Did any of your researches contribute to the formulation of policies or helped health managers or health workers make informed decisions?

☐ Yes ☐ No ☒ Do not know

5.3.1 Please elaborate.

There was a study funded by a source outside the RRF which gave feedback to the community where the study was done so that the community will take appropriate action.

ARMM - Guide Questions for Council Members

1. Health Research Agenda:

1.1. Is there a well-defined health research agenda for the region? ☒ Yes ☐ No

1.2. How was the research agenda developed?

A group of experts was commissioned to lead the development of the ARMM RUHRA.

1.3. Was the research agenda utilized? ☐ Yes ☒ No

1.3.1. How was it utilized?

_____

2. Manpower, Facilities and Capacity Building Plan

2.1 Do you have an inventory of health research manpower and research facilities based on your identified research needs?

☐ Yes ☒ No ☐ Don't Know

2.2 Is there adequate research human resource in the region to carry out the region's health research plan?

☐ Yes ☐ No ☒ Don't Know

2.2.1 In research design and methodology? ☐ Yes ☒ No ☐ Don't Know

2.2.2 In specific content areas as defined by the health research agenda?

☐ Yes ☐ No ☒ Don't Know

2.2.3 If no, what was the region's response to the lack of human resource?

Short-term training courses in research methodology and proposal design.

2.3 Do you have a plan to develop your health research manpower based on the needs of the region?

☒ Yes ☐ No ☐ Don't Know

Remarks:

Through short-term training courses.

2.4 Based on your requirement, does the region possess the capacity to develop skills of local researchers?

☒ Yes ☐ No ☐ Don't Know

2.4.1 If yes, please cite the training programs [consider also offerings at member institutions]

☐ Formal:

_____

☒ Informal:

Seminar in Research Methodology and Proposal Design

☐ Scholarship Grants:

☐ Study Tour:

2.5 Are there mentors who can be tapped for capacity building in research?

☒ Yes ☐ No ☐ Don't Know

2.5.1 If YES, please specify in what areas:

Research Methodology and Proposal Design

2.6 What kind of support does the region expect from national, regional and international levels to help develop the skills of local researchers?

Technical assistance

3. Resource Mobilization:

Refers to the capacity of the region to mobilize funds and other resources for health research

3.1 Do you know how much is your funding requirement for your priority research needs?

☐ Yes ☒ No

3.2 Are there enough funds to carry out the planned research activities? ☐ Yes ☒ No

3.3 Has an annual work plan and budget been proposed?

☒ Yes, when was it prepared? _____

☐ No

3.4 What kind of support does the region expect from the national, regional, and international levels to develop regional capability to mobilize resources for health research?

Resource mobilization planning

4. Development, Approval and Conduct of Research Studies:

4.1 In 2008, how many proposals were produced by the consortium? **6**

4.2 In 2008, how many proposals were reviewed in terms of ethics, methodology, content and utilization?

6

4.3 In 2008, how many research studies were funded? **0**

4.4 In 2008, how many research studies were completed? **0**

4.5 Were the proposals parts of the NUHRA/RUHRA? ☒ Yes ☐ No ☐ Don't Know

4.6 If the researches were not implemented or not part of NUHRA/RUHRA, what were the reasons?

5. Research Dissemination and Utilization

5.1. Does the consortium have an established system for dissemination of research results?

☐ Yes ☒ No ☐ Don't Know

5.2. Were the researches that were conducted/completed in 2008 disseminated?

☐ Yes ☐ No ☐ Don't Know ☒ Not applicable

5.3. Were the research results disseminated to the relevant stakeholders?

☐ Yes ☐ No ☐ Don't Know ☒ Not applicable

5.4. How were the results disseminated?

☐ Published in peer-reviewed journals:

☐ Policy Briefs:

☐ Public Presentations:

☐ Web-based media:

_____

5.5. Do member institutions integrate in their research forums dissemination of the results of researches in the region?

☐ Yes ☒ No ☐ Don't Know

5.6. What were the facilitating factors to research dissemination?

Inclusion in the proposal of clear activities for health research output dissemination

5.7. What were the barriers to research dissemination?

Lack of a local research publication organized by the ARMM-HRC. Non-functioning RICUP subcommittee of ARMM-HRC.

5.8. Is there an existing database of research studies conducted in the region?

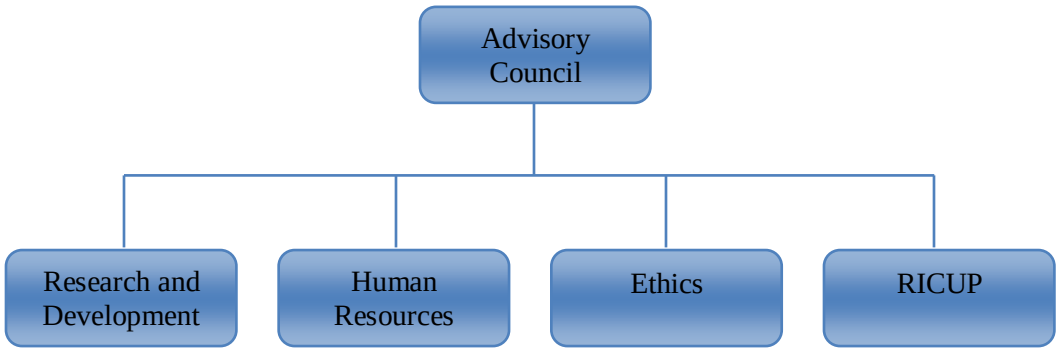
☐ Yes ☒ None ☐ Don't Know

Remarks:

RICUP subcommittee is not functional. PNHRS is awaiting response from ARMM-HRC on availability of participants for database training.

6. Leadership and Management

6.1. Describe/draw the organizational structure of the governing council:



6.2. Who is responsible for the daily operations of the consortium?

No one. The secretariat performs some of the administrative responsibilities.

6.3. Which of the following subcommittees are functional? Check appropriate boxes.

R&D	☒ Functional	☐ NOT Functional
Ethics	☐ Functional	☒ NOT Functional
HRD	☐ Functional	☒ NOT Functional
RICUP	☐ Functional	☒ NOT Functional
_____	☐ Functional	☐ NOT Functional
_____	☐ Functional	☐ NOT Functional
_____	☐ Functional	☐ NOT Functional

6.4. Define the roles and responsibilities of the members of the governing council:

1. *Provide central, leadership and coordination of all health R&D activities in the region*
2. *Establish policies ad guidelines, in consultation with stakeholders, in the identification of priority health R&D programs and projects in the region*
3. *Promote the development of research capacity and linkages on health R&D*
4. *Review and approve the sub-committees' programs, activities, including their attending proposals*
5. *Establish monitoring and evaluation mechanism to ensure long-term sustainability of the consortium*
6. *Oversee the overall implementation of ARMM-HRC programs and projects*
7. *Conduct periodic review of health research programs and projects*
8. *Serve as a clearinghouse of all health research proposals*
9. *Develop a databank on health research and resources including sources of funds and technical assistance*

Is there an existing Manual of Operations? ☐ Yes ☒ No ☐ Don't Know

Remarks:

ARMM-HRC has plans for developing its own Manual of Operations.

6.5. Do you have a five-year strategic plan? (Get a copy of the document)

☐ Yes ☒ No ☐ Don't Know

Remarks:

6.6. Do you have an operational plan for 2009? (Get a copy of the document)

☒ Yes ☐ No ☐ Don't Know

Remarks:

Annex B: Conference Proceedings and List of Participants

FLOWCHART OF ACTIVITIES

1) MEETING WITH RESEARCHERS FROM ARMM

Overview of PNHRS to ARMM researchers presented by Dr. Nanagas

Discussion with ARMM researchers facilitated by Dr. Rodriguez

2) MEETING WITH MEMBERS OF ARMM-HRC ADVISORY COUNCIL

Overview of PNHRS to ARMM-HRC Advisory Council presented by Dr. Nanagas

Metacards activity with ARMM-HRC Advisory Council members facilitated by Dr. Rodriguez

ARMM-HRC Organizational Structure and Annual Plan for 2009 presented by Dr. Evangelista

FINDINGS FROM ARMM-HRC RESEARCHERS MEETING

Summary of Responses to "Guide Questions for Health Researchers"

1. Formulation of Health Research Agenda
   - The RUHRA of ARMM-HRC was drafted in 2005 but its dissemination among the researchers in ARMM is not comprehensive enough as a few participants are unfamiliar with its contents.
   - The ARMM-HRC RUHRA was drafted by a group composed of people outside ARMM, thus it may not entirely reflect the health needs of the region.
   - The roles of member institutions in achieving the goals of the RUHRA are unclear.
   - It was agreed upon by the participants that the RUHRA of ARMM-HRC needs revisiting. Its needs more detailed description and should reflect the actual health needs of the region.

2. Adequacy of Skilled/Competent Health Researchers
   - Many institutions in ARMM, particularly academic institutions, are capable of carrying out health research projects on their own. Thus, the number of health researchers in ARMM is adequate.
   - Further training of health researchers is needed.
   - ARMM lack experts in biostatistics.

3. Adequacy of Funding and Logistical Support for Health Research
   - No motivation to pursue health research projects due to the lack of funding support from agencies and institutions in ARMM.
   - Approval of funding for research can be influenced by "connections."
   - Pzifer funding is being used in a number of health research projects in ARMM.

4. Health Research Conduct, Dissemination and Utilization
   - In 2007 and 2008, a "Research Proposal Seminar" was organized by ARMM-HRC. Invitations for participants were given to member institutions. Accomplished proposals were submitted to ARMM-HRC and were forwarded to PCHRD.
   - Currently, six research proposals are being reviewed for funding.
   - Participants consider the P100,000 funding by RHRDC too small.

- Realized the need for "linkages" with the planned beneficiaries of the research project as well as "profitability studies" for research output to ensure its utilization.
- Currently, there is no inventory of health researches from ARMM.

5. Leadership and Management
   - Subcommittees of ARMM-HRC are currently non-functional due to inactive members.
   - Lack of communication to institution representatives regarding membership in subcommittees.
   - In particular, the Ethics Subcommittee needs training.

FINDINGS FROM ARMM-HRC ADVISORY COUNCIL MEETING

Summary of Responses to "Metacards Activity"

1) What is the authority/mandate of the ARMM-HRC?
   - ARMM-HRC should assume a technical, administrative and managerial function
2) What is my role in ARMM-HRC?
   - Varied responses depending on their roles:
     - Researchers: Carrying-out research projects and sharing expertise.
     - ARMM-HRC chair: Provision of leadership, coordination and direction to the consortium.
     - ARMM-HRC committee members: perform activities related to functions of their subcommittees.
3) What is the role of ARMM-HRC in PNHRS?
   - ARMM researchers should provide PNHRS with an understanding of the health needs of the region in terms of its unique geographical, cultural, political features.
   - ARMM-HRC should contribute to achieving the goals of the NUHRA.
4) What does ARMM-HRC expect from PNHRS?
   - PNHRS is expected to support ARMM-HRC in addressing technical, financial and administrative issues.
   - Among these issues is the need for capacity building and the lack of funding for health research projects.
5) Given these roles and expectations, how would ARMM-HRC like to be monitored and evaluated?
   - Through guidelines mandated by PNHRS.

Presentation of Dr. Evangelista (ARMM-HRC Chair) of DOST-ARMM

1) Organizational Structure of ARMM-HRC
   - DOH-ARMM did not accept the position of lead agency for ARMM-HRC. Thus, DOST-ARMM assumed the leadership. Presently, DOH-ARMM has minimal participation in ARMM-HRC activities. .
   - ARMM-HRC Advisory Council meets only once or twice a year. Thus, function of ARMM-HRC is mostly done by the Research and Development Subcommittee and the ARMM-HRC Secretariat (DOST-ARMM).
   - Found the need for full-time personnel to oversee the daily activities of ARMM-HRC.

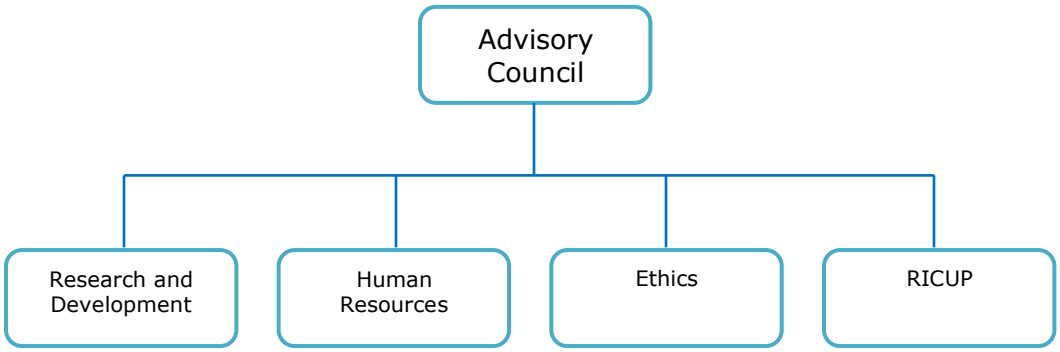


Figure 1. ARMM-HRC Organizational Structure

2) Membership of ARMM – HRC
   - Suggested the need to institute permanent representatives from member institutions.

Other Issues

- Research proposals to ARMM-HRC should acknowledge the individual researcher in addition to the member institution.
- ARMM-HRC should find a means to ensure participation of island provinces (i.e. Sulu and Tawi-Tawi) in health research.

Regional Consultation Attendance

1) Meeting with Researchers from ARMM

Profile

- Gender of Participants:
  - Male = 7
  - Female = 5
- Institutions Represented by the Participants
  - Academic = 2
  - Government = 2
  - Private = 0

Name	Institution
1. Husua Abdulla	MSU – Marawi
2. Carmelita Hansel	MSU – Marawi
3. Pendililang Gunting	MSU – Marawi
4. Abdullah Gunting	MSU – Marawi
5. Camar Ameril	MSU – Marawi
6. Ismael Abdullah	MSU – Maguindanao
7. Datucan Ali	MSU – Maguindanao
8. Rowena Caro	MSU - Maguindanao
9. Sali Blah	COA-PCHRD/NAST
10. Johnny Evangelista	DOST-ARMM
11. Bai Sakina Pendatun-Bernal	*DOST-ARMM*

Note: Non-researchers in italics

2) Meeting with Members of ARMM-HRC Advisory Council

Profile

- Gender of Participants
  - Male = 3
  - Female = 4
- Institutions Represented by the Participants
  - Academic = 2
  - Government = 1
  - Private = 0

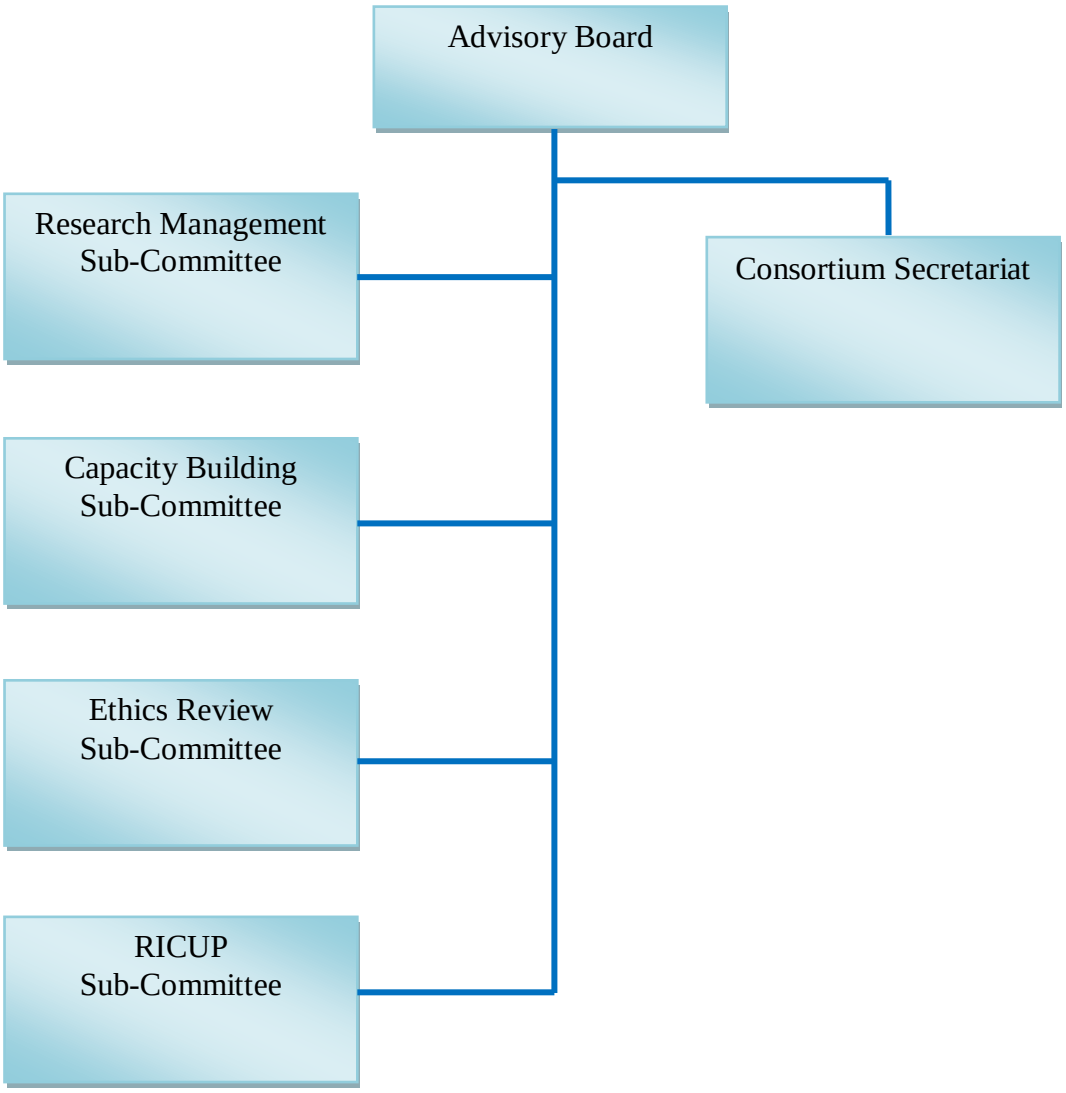
Name	Institution
1. Johnny Evangelista	DOST –ARMM
2. Ismael Abdullah	MSU – Maguindanao
3. Carmelita Hansel	MSU – Marawi
4. Camar Ameril	*MSU – Marawi*
5. Husna Abdullah	*MSU – Marawi*
6. Rowena Caro	*MSU – Maguindanao*
7. Bai Sakina Pendatun-Bernal	*DOST – ARMM*

Note: Non-Advisory Council members in italics

ASSESSMENT TEAM AND TECHNICAL STAFF

Name	Institution
1) Dr. Johnny Nanagas	SOME Committee member
2) Dr. Joe Rodriguez	SOME Committee member
3) Merle Opena	PCHRD
4) Annie Catameo	PCHRD
5) Veronica de Leon	ARMM Project Officer/PCHRD
6) Mark Tano	PCHRD
7) Belle Intia	PCHRD
8) Christopher Santiago	Process Documenter of SOME Committee
9) Ramla Lantong	ARMM-HRC Secretariat/DOST-ARMM

Annex C: ARMM Organizational Structure



ORGANIZATIONAL FUNCTIONS (ARMM):

Advisory Board

1. Provides central direction, leadership, and coordination of all health R & D activities in the region;
2. Establish policies and guidelines, in consultation with stakeholders in the identification of priority health R &D programs and projects in the region;
3. Review and approve health research programs and related activities of the consortium;
4. Oversee the overall implementation, monitoring and evaluation or programs;
5. Ensure resource generation and mobilization; and
6. Develop awards and incentives system.

Research Management Sub-Committee

1. Assist the Board of Trustees in the conceptualization, planning, and implementation of the various programs/projects and related activities of the CHRDC;
2. Promote the development of research capacity and linkages on health R & D
3. Establish monitoring and evaluation mechanism to ensure long-term sustainability of the Consortium; and
4. Conduct periodic review of health t=research and development programs and recommends the same to the Board of Trustees.

Sub-Committee on Ethics

1. Develop consortium's guidelines on ethical standards and practices in health research;
2. Facilitate the institutionalization of ethics review committees in health research organizations in ARMM;
3. Provide training and advocacy activities on bio-ethics for members of institutional ethics review bodies;
4. Review proposals as to compliance of ethical standards; and
5. Monitor compliance to ethical and other standards of on-going projects.

Sub-Committee on Research Information, Communication, and Utilization

1. Develop mechanism to facilitate dissemination and utilization of research information to various target clients;
2. Collect and package research information for database development; and
3. Collaborate with government, private sector, and non-government organizations for the use of health research results into policies, actions, products, and services.

Sub-Committee on Capacity Building

1. Assess the human resource requirements for health research of the institutions within ARMM;
2. Develop a comprehensive health research human resource development plan and monitor its implementation; and
3. Establish a sustainable mechanism for sharing of resources and exchange of expertise and information.

Annex D: NUHRA Region 12 and ARMM Agenda

(Downloaded from http://www.pchrd.dost.gov.ph/downloads/category/5-nuhra.html)

HEALTH RESEARCH AND DEVELOPMENT PRIORITY AGENDA SETTING CENTRAL MINDANAO AND THE AUTONOMOUS REGION IN MUSLIM MINDANAO OCTOBER 2005

Dr. Dolores Daguino
University Research Center
Notre Dame University
Cotabato City

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INTRODUCTION

Health is basic human right and is both a means and an end of development. In pursuit of health development, the status of the population, the health sector and the health-related sectors becomes crucial.

Relevant to the status of the population are the growth, fertility, age structure and distribution of populations in the region. With regards the public and private health sector, the status of the health services—promotive, preventive, curative and rehabilitative services, together with the provision of human resources, drugs and medical supplies are important. In addition, the socio-economic factors affecting and are affected by health such as trends in urbanization, industrialization, communication and transportation, environment and natural resources, education, science and technology, among others, are also crucial considerations.

The Philippine Council for Health Research and Development, in collaboration with the Philippine National Health Research System Assembly, launched several consultation fora in the different regions of the country to identify health research and development priority areas for the next five years (2005-2010).

In this context, the health research priorities are classified into two types-- the biomedical concerns and the operational/ service delivery/ policy concerns. The biomedical concerns include the areas of a) natural products development, b) development of pharmaceutical products, c) development of other technologies and processes, and d) development of telehealth. The operational/ service delivery/ policy concerns focuses on a) health care financing, b) local health systems development, c) public health issues/ programs, d) standards and regulations, e) hospital management and f) research ethics.

Cast against the backdrop of this orientation, the consultation forum aimed to obtain relevant information on the following:

A. health situation in the region
B. health gaps, problems and emerging concerns and
C. regional priority health research and development areas.

Several strategies and research techniques were employed in the process. The assessment of health situation was through desk review of existing documents and reports of relevant institutions like the DOH, DSWD, NEDA, etc., as well as key informant interviews of key personnel of the institutions. The identification of gaps, problems and the identification of priority research and development areas were conducted through consultative workshop with various public and private stakeholders on health development.

REGIONAL REPORT: REGION XII

Socio-Economic Profile

Region XII is composed of four provinces (South Cotabato, Cotabato, Sultan Kudarat and Sarangani) and five cities (General Santos City, Cotabato City, Kidapawan City, Koronadal City, and Tacurong City). It has a total land area of 20,566.26 sq.km., and with a total population of 3, 222,169 (as of 2000, NSO). Majority of its population are consisted of Ilonggo, Cebuano, Ilocano, and Magindanao. Some indigenous peoples such as T'boli, B'laan, Kalagan, Tiruray, Manobo, Iranon, Ubo, and Tagakaolo are found in the region. Most of them occupied the mountainous/hilly part of the area.

The region's population registered an average annual growth rate of 2.68% within the period of 1995 to 2000 which is a bit higher than Mindanao population growth of 2.44%. About 42% of the population are below 15 years old. The dependency ratio is 84

dependents per 100 persons of productive age group. This means that the very young population and high dependency ratio require bigger resources for basic services such as education, health, food, housing, and the like.

The simple literacy rate of the region's population 10 years and over in 2000 was 87.4% while the functional literacy was 77.1%.

The region is basically dependent on agriculture. Its major crops include rice, corn, coconut, pineapple, asparagus, cassava, sugarcane, and rubber. The region's export earnings contribute 27% of the total Mindanao earnings. About 35% of palay and corn production of Mindanao come from the area. Fish production also contributes 15% of the overall Mindanao production.

The Regional Development Plan for 2004 indicates that the poverty incidence rate of the region was estimated at 45 % in 2000. This figure was 11% higher compared to the national poverty incidence rate of 34%. Of the four provinces, Sultan Kudarat has the highest poverty incidence rate with 54.3% while the lowest was South Cotabato with 37.3%. The annual per capita poverty threshold of the four provinces in year 2000 ranged between Ph10, 338 to Ph11, 368.

The Health Situation/Resources

Out of the total barangays of 1,190 in the region, about 899 or 75.5% have barangay health stations. Based on the 2004 Annual Report, the region has 114 doctors, 190 nurses, 14 nutritionists, 58 medical technologies, 39 dental aids, 53 dentists, 802 midwives, 1 sanitary engineer, 95 sanitary inspectors, 6,760 active barangay health workers (BHWs), and 2,714 trained birth attendants. In terms of health office and facilities, the region has four (4) Provincial Health Offices, 27 government hospitals, 76 private hospitals, 3,237 hospital beds, 47 main health centers, and 899 barangay health stations. (Source: Region XII Annual Health Status Report 2003).

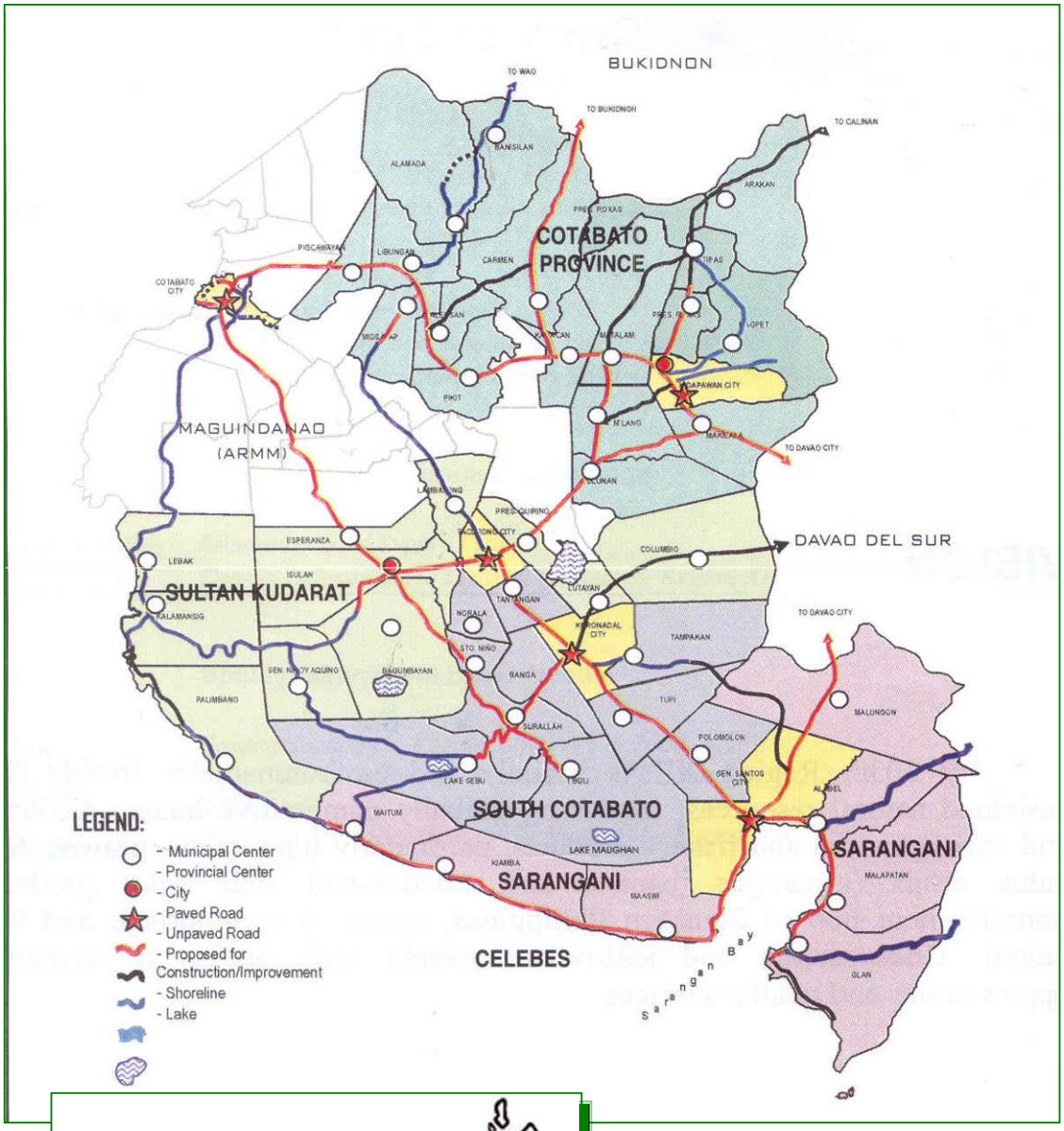
The health status of the region in 2003 showed the following information:

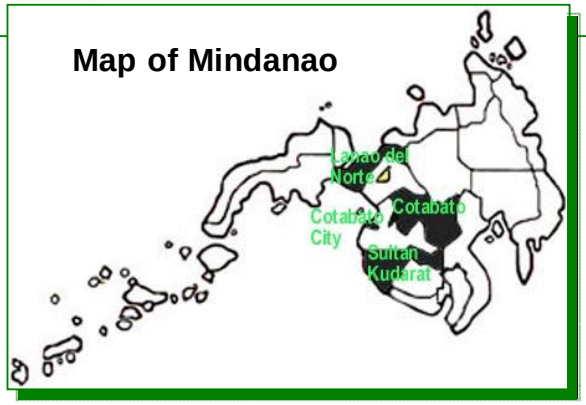
A. 81,977 or 76.82% of 12 months old children were fully immunized
B. 19.26/100,000 population died due to tuberculosis
C. 2.70/100,000 population died due to diarrhoea
D. 1.07/100,000 population died due to malnutrition
E. 18,310 or 4.22 of children 6-59 months old were moderately underweight
F. 2,170 or0.50% of children 6-59 months old were severely underweight
G. 479,752 or 74.99 households have sanitary toilets
H. 552,498 or 86.36% households have access to potable water supply

Crude Birth Rate

Region XII has a total of 70,562 live births in 2004. Compared to 2003 report, crude birth rate at 19.32 per 1,000 populations reported a decrease of 0.59 rate points. Approximately 8% of the total live births belong to low birth weight. Births attended by trained and untrained hilots accounted for 45.31% and 7.21% respectively.

Sarangani has the highest CBR among the provinces at 20.51 per 1,000 populations while North Cotabato has the lowest at 17.36 per 1,000 population. Among the cities, Gen. Santos City has the highest at 24.60 per 1,000 populations while Cotabato City has the lowest at 14.26 per 1,000 populations.





Map of Region XII

Crude Death Rate

The total deaths of 10,814 in 2004 resulted to a rate of 2.96 deaths per 1,000 populations, registering a very slight decrease of 0.03 rate points compared to 2003. Of the total deaths, 62% are males. Male mortality rate was 3.58 per 1,000 male population while that for females was 2.32 per 1,000 female population.

Infant Mortality Rate (IMR)

With a rate of 5.82 per 1,000 livebirths, infant deaths accounted for 3.8% of the total deaths of the region in 2004. This registered 0.53 rate points compared to 2003. South Cotabato has the highest IMR of 6.96 per 1,000 livebirths while North Cotabato has the lowest with 3.20 per 1,000 livebirths. On the other hand, Gen. Santos City has the highest rate with 11.32 per 1,000 livebirth while Kidapawan City has the lowest rate with 2.54 per 1,000 livebirths.

The leading causes of IMR were acute lower respiratory infection (rate is 1.05), septicaemia (0.94), prematurity (0.79), congenital anomaly (0.51), diarrhea (0.30). The others include bacterial sepsis of newborth, birth asphyxia, sudden infant death syndrome, malnutrition, tetanus neonatorum, and respiratory condition of newborn.

Maternal Mortality Rate (MMR)

Maternal deaths accounted for 0.54% of the total deaths in 2004, with a rate f 0.82 per 1,000 livebirths. An increase of 0.17 rate points compared to 2003. Sarangani has the highest MMR of 1.30 per 1,000 livebirths and Sultan Kudarat has the lowest with 0.48 per 1,000 livebirths. Kidapawan City has the highest rate of 1.02 per 1,000 livebirths while Cotabato City has the lowest with no maternal death reported.

The leading causes of MMR are post partum haemorrhage (0.38), eclampsia in pregnancy (0.07), injury of the uterus (0.06), amniotic fluid embolism (0.04) and congestive heart failure (0.04) and retained placenta (0.04). The other causes include congenital malformation, eclampsia in the puerperium, pre-eclampsia and puerperal septicaemia.

Leading Causes of Morbidity

The top five leading causes of morbidity in the region in 2004 were acute lower respiratory infection (rate is 2,653.52), influenza (965.87), diarrhoea (814.23), acute upper respirator infection (761.43), and bronchitis (355.91).Among the other leading causes are primary hypertension, accident/violence/wounds, anaemia, skin disorders, and tuberculosis.

Leading Causes of Mortality

The top five leading causes of mortality were pneumonia (rate is 29.22), cancer—all forms (27.58), accident/violence/wounds (26.81), atherosclerotic heart disease (22.68) and cardiovascular diseases (18.81). The other leading causes include respiratory tuberculosis NOS, hypertensive heart diseases NOS, diabetes mellitus, end-stage renal disease and septicaemia.

Health Issues and Emerging Concerns

1. Quality of Health Education

The incidence of children morbidity due to infectious diseases presents a concern for promoting quality health education among the school children. The cases of dengue, diarrhea, tuberculosis, substance abuse, smoking and others are among the health issues among the young populations. The dental health conditions of school children also showed that almost 70% of the children in schools have dental problems. These conditions indicate the need to promote general health awareness and knowledge and the need to integrate health education into the school curricula particularly in Science, Social Studies, etc. in the elementary, high school and even in tertiary level curricula.

2. Health Policies/Legislations

There are national and local health legislations and policies that are meant to promote health development. The health sectors need the knowledge on the different health policies already in place in the local government units. There are also concerns on the poor implementation of these health policies that place constraints in promoting health. Such examples are the nutrition policy, early child care development and others. There are health programs needing health legislations and health policy support to generally pursue health development.

3. Public Health Issues

In the region, the emerging public health issues include the acute respiratory infection, tuberculosis, diarrhea, dengue, and others.

There is a high incidence of acute respiratory infection among the poor and indigent children. The cases of TB among the school children and even among schoolteachers as reported in the department of education. There is the problem of inadequate supply of medicines. There is also the failure to submit to sputum test for proper diagnosis. The incidence of diarrhoea is primarily due to improper food handling and water handling in the households.

Dengue, as a communal disease, had been an endemic disease in the region and in the major cities. The prevalence demands continuous vigilance by the community and rigid campaign for environmental sanitation. The department of health discouraged the practice of fogging because of its adverse effects in simply driving the mosquitoes to other areas, in addition to the high cost of fogging operations. The problem is also complicated by the inadequate supply of available blood from the blood bank to respond to the requirements of dengue cases.

4. Health Care Delivery System/ Field Care Service

There is poor health care delivery system in the region due to the lack of medical personnel to provide the services to the people. The poor in need of health services cannot afford to avail of professional health providers like private doctors and health services so they depend so much on the public health services. The barangay midwives need to be fully trained and must be made permanent health workers to provide access to local health services.

5. Advance Local Health System (RHU giving augmentation/ assistance

The capability of the local health system in providing health services generally depends on the financial augmentation of the local government units. In most instances, the issue really is on augmentation although the Regional Office is trying to help the LGUs. The local health systems are encouraged to promote referrals to the regional hospital for health services since about 75% of the patients in the CRMC come from Cotabato City.

6. Hospital System

The Cotabato Regional Medical Center derives hospital funds from the national DOH. Currently, with its present fund constraints, it gets inadequate in providing quality care to its clients.

7. Environment Health Risks/ Disaster Management

Two emerging issues of environmental risks in the region are the avian flu and the exposure to hazardous agricultural chemicals in plantations. There is a need to strengthen our environmental disaster management system, particularly to strictly implement the quarantine rules and to intensify agency coordinations and advocacy campaign through the use of trimedia to prevent the bird flu from getting into the country.

Likewise, the health risks of communities exposed agricultural chemicals and pesticides in plantations Polomolok and North Cotabato include RFI, cancer, skin diseases, etc.

The personnel from the DOH and DA need to undergo training in Subic for environment and disaster management.

8. Rabies

In South Cotabato, the alarming cases of dog bites calls for massive education about rabies and rabies management. There are three stages of rabies infection—licking, scratch and bite. The dogbite presents greater seriousness. In the new rabies management, it is also important for the owner of the dog to be vaccinated. The DOH has established bite center throughout the country at CRMC and the CHO.

9. Healthy Lifestyle

The leading causes of mortality in the region are attributed to unhealthy lifestyles. The major diseases are hypertension, diabetes, kidney and lung diseases. There is a need for individual education and advocacy for healthy lifestyles.

10. Herbal Processing

In Region XII, the herbal processing plant has closed down due to the decreasing quality standards of its products, mainly lagundi and sambong. This presents the general lack of herbal medicines in circulation for the health needs of the people. The DOH is intensifying campaign on backyard planting of herbal plants.

11. Waste Disposal

The problem of garbage and disposal present a serious threat to the health of the people in the region, particularly in urban centers. The inadequate garbage collection services, in addition to the improper waste disposal practices of most households, contribute to this waste disposal problem.

Priority Health Research and Development Areas

Central Mindanao, Region XII

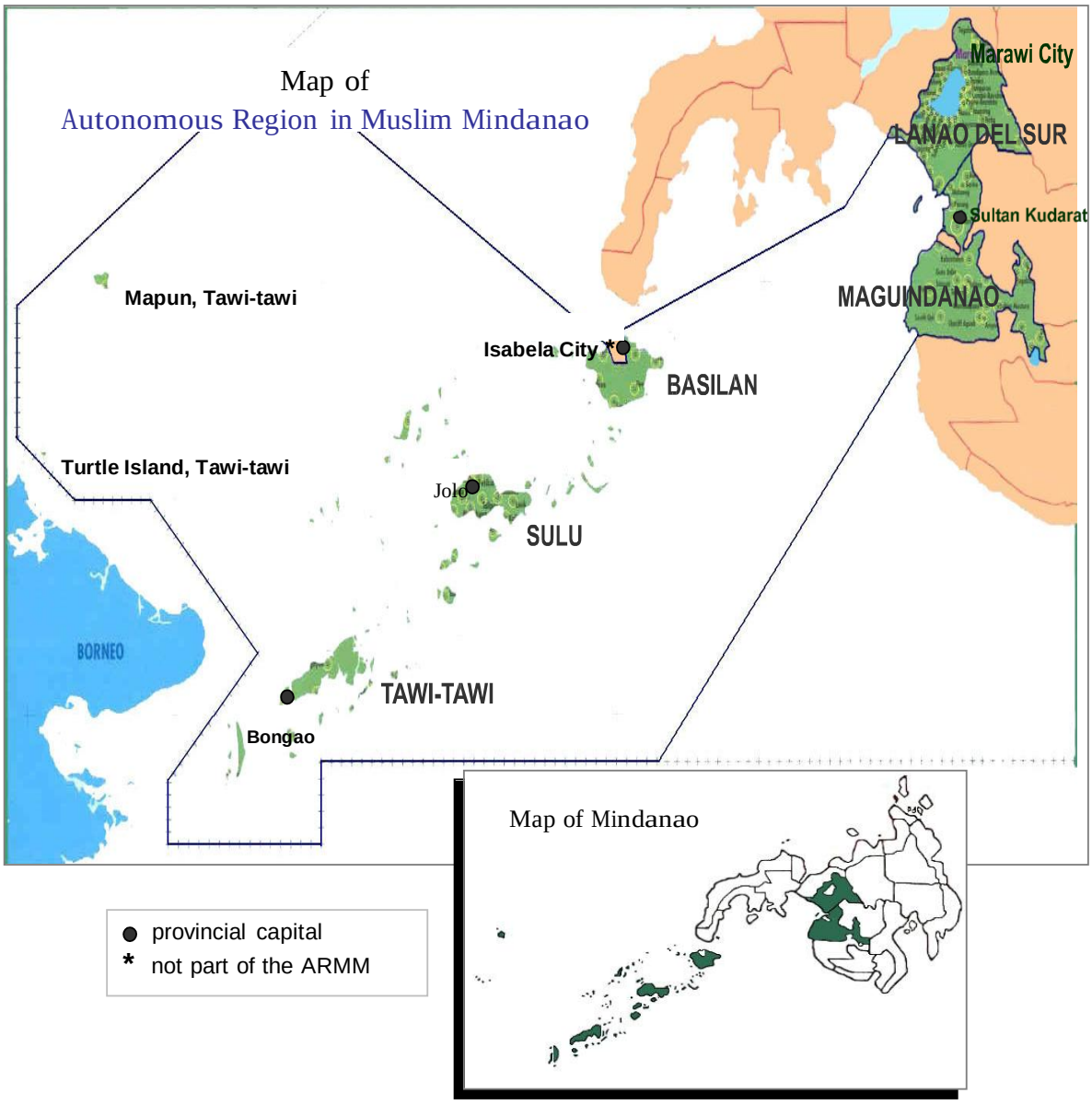
Health Research & Development Area	Research Specific Topic	Rationale	Specific Objectives	Agency
1. Healthy Lifestyle Concern - Substance Abuse	Factors Affecting Substance Abuse In Central Mindanao	- increasing incidence of criminality attributed to drugs - lack of Mental Health Facilities and Drug Rehab Centers in Cities of Region XII	- determine the extent of substance abuse and use of illegal drugs - Incidence of drug-related criminality - Causes and factors affecting drug addiction - Profiling users (PDEA, DSWD, NARCOM)	NGO
2. Quality Health Education	Extent of Integration of Health Education in School Curriculum in Region XII	- increasing incidences of children diseases - improve diseases prevention among children through increased health education for school children	- determine the nature, level and extent of subject integration of health education in the Elementary/ High School/ College - determine the teachers capability/ preparation for subject integration of health education	DepEd CHED DOH
3. Healthy Lifestyle Concern – Environmental Health Risks	Impact on Community Health of Chemical Exposures in Agricultural Plantations in Sarangani & Cotabato Provinces	- rising incidence of chemical exposure – related diseases in different plantation areas, especially in major agricultural communities	- determine the nature and effect on health of communities exposed to hazardous chemicals in agricultural plantations: (types of diseases assoc with chemical exposures, types of hazardous chemical used that is hazardous to health, profiling of affected communities/ plantations using chemicals, safety preventive measures of communities/ plantations)	DOH DENR DA- BAR NGO
4. Health Policies/ Legislations	Nature of Health Policies and Its Implementation in the Local Government Units	- improve the quality of health care delivery systems in the local governments	- determine and classify local health policies 1999-2004 of the national and local LGUs - identify its implementation issues and recommendations for strengthening health legislations role in health development of the region	DOH NEDA DILG

5. Local Health System	Functionality and Effectiveness of Local Health Boards in Health Promotion & Development	- strengthen and empower local health bodies for effective regional health development and delivery systems	- determine the funding, priority issues, collaboration mechanisms, board capacities/ needs, etc. - determine the functionality, effectiveness, efficiency of the local health boards for health development - - identify best practices of functionality	DOH DILG
6. Traditional Health Care Practices/ Norms	Health Practices, Alternative Medicines and Health Seeking Behaviors among Indigenous and Cultural Communities in Region XII	- inadequate information for health promotion and service delivery for the indigenous communities	- determine the health problems, health practices, alternative medicine, health seeking behaviors of indigenous and cultural communities in the region— Teduray, Bilaan, Tboli, Maguindanao, Maranao, etc.	NCIP DOH
7. Public Health Issues - Infectious Diseases a. Dengue	Dengue Immunization and Cure	- no vaccine/ medication cure for dengue	- Identify alternative sources of herbal/ chemical cure for dengue disease	RITM DOH
8. Family Health and Health of Special Populations – Mother and the newborn	Factors affecting Incidence of Neonatal Tetanus in Region XII	- high prevalence of neonatal tetanus	- Identify perceptions and practices of mothers and hilots leading to neonatal tetanus	DOH CRMC

REGIONAL REPORT: AUTONOMOUS REGION OF MUSLIM MINDANAO (ARMM)

Socio-economic Profile

The region has five provinces (Basilan, Lanao del Sur, Maguindanao, Sulu, and Tawi-Tawi) and one city (Marawi City). It has a total land area 13,451.5 sq.km. The total number of municipalities is 94 with 2,148 barangays.



As of 2000 NSO data, ARMM has 2,837,532 total population, with an average annual population growth rate of 2.44 percent. Majority of the 13 Filipino Muslim groups are found in the region. These are the Magindanao, Maranao, Tausug, Iranuns, Samal, Jama Mapun and the Badjao.

The regional economy is largely dependent on agriculture, fishery, and forestry sectors, which accounted for more than 50% of the region's gross domestic products. Palay, corn and coconuts (copra) are the major crops of the farmers in the area. Fishing industry thrives in the coastal areas of Maguindanao, Lanao del Sur, Sulu and Tawi-Tawi. Majority of its labor force derive income from agriculture.

The incidence of poverty in the region in 2000 was 62.9% while the average household income was Php 81,519.

The functional literacy rate of the region in 2003 was 62.9% as indicated by the Functional Literacy, Education and Mass Media Survey (NSO-FLEMMS, 2003). According to the World Bank Report (November 2003) ARMM trails behind all regions with respect to basic indicators of educational development. This condition is further aggravated by the disruption of education among school age children due to sporadic armed conflict in the area. This armed conflict has resulted directly in the destruction or abandonment of school buildings, used as evacuation centers, or served as headquarters for military troops.

Health Situation/Resources

The DOH ARMM Regional Annual Report in 2004 showed that of the 1,872 barangays about 238 or 12.7% have barangay health centers. In terms of health personnel the following figures were gathered from the report – 53 doctors, 83 nurses, 4 nutritionists, 19 medical technologists, 14 dentists, 299 midwives, 98 sanitary inspectors, 1,622 active barangay health workers, and 862 trained birth attendants.

In 2004, about 255,024 or 59.8% households have access to safe water and 165, 108 or 38.7% households have sanitary toilets. A total of 120,670 or 28.3% households were reported having satisfactory garbage disposal.

The data on the nutritional status of 6-59 months old children in 2003 showed that 20,236 or 5.4% were reported moderately underweight. Of this number, about 2,342 or 11.57% were rehabilitated. About 3,815 or 1.03% 6-59 months old children were reported severely underweight. Of this number, 344 or 9.02% were rehabilitated.

The region's crude birth rate (CBR) in the same year (2003) was 19.13 per 1,000 populations while the crude death rate (CDR) was 1.54 per 1,000 populations. These data were based only on the reported cases of births and deaths in the area.

The maternal mortality rate (MMR) was 1.57 per 1,000 populations while the infant mortality rate (IMR) was 5.91 per 1,000 populations in 2003.

The ten (10) leading causes of mortality in the region (per 10,000 populations) in 2003 as reported by the DOH – ARMM included the following:

A.	Accident/GSW	2.24
B.	Cardio-vascular diseases	1.72
C.	Unknown	1.58
D.	Pneumonia	1.42
E.	TB Respiratory	0.99
F.	Diarrhoea	0.97
G.	Hypertension	0.81
H.	Cancer, all forms	0.79
I.	Measles	0.67
J.	Old age/senility	0.67
K.	Myocardial Infection	0.19

The ten (10) leading causes of morbidity in the ARMM (per 1,000) in 2003 were:

- Influenza 12.86
- Diarrhea 11.14
- Skin Diseases 9.02
- Pneumonia 7.28
- Bronchitis 4.91
- Hypertension 3.78
- URTI 3.53
- Malaria 3.28
- Parasitism 2.05
- Schistosomiasis 0.83

The ten (10) leading causes of maternal mortality per 1,000 live births in 2003 were:

- Postpartum Hemorrhage 0.82
- Hypertension in Pregnancy 0.37
- Retained Placenta 0.09
- Postpartum Sipsis 0.05
- PP HPN 0.02
- Raptured Uterus 0.02
- Hemorrhage due to uterine atomy 0.02
- Epilepsy 0.02
- Toximia in Pregnancy 0.02
- Fatal Malpresentation with manipulation 0.02

The ten (10) leading causes of infant mortality per 1,000 live births in 2003 were:

A. Pneumonia 1.80
B. Diarrhoea 0.82
C. Unknown 0.50
D. Measles 0.32
E. Neonatal Tetanus 0.25
F. Prematurity 0.23
G. Malnutrition 0.14
H. Congenital Anomaly 0.12
I. Septecemia 0.09
J. Cord Bleeding 0.05

The 2001 data on the health system capacity of the ARMM indicate that the number of government hospitals per 100,000 populations was 0.46 while the private hospitals was 0.58 (World Bank Report, November 2003).

Health Issues and Emerging Concerns

1. Public Health Issue – Infectious Diseases

The most prevalent diseases affecting communities in the ARMM are hepatitis, scabies, diarrhea, food poisoning and dengue. The health sector has inadequate program management and delivery of health services of these diseases, in addition to the lack of awareness proper education of the vulnerable groups of the disease.

2. Violence against Women and Children

There is general low level of awareness of personal, maternal and child care among the mothers in the region.

3. Internally Displaced Persons Health

Due to the intermittent armed encounters in many communities in the region, the internal displacements that happen pose serious havoc on the health of children, women and elderlies in the communities. The conditions in the evacuation centers, both crowded and unsanitary, results to many incidences of health problems for children and women.

4. Health Policies/ Legislations

There is a need to conduct a documentation of health policies/ legislations in the region and determine the extent of its implementation to support the health development program of the government.

5. Postnatal and Health Services for the Indigenous Peoples

The Indigenous Peoples in the region are the sector with the lowest access to the health services of the government. They are also the sector with high incidence of maternal and child health problems, particularly postnatal health problems.

Priority Health Research and Development Areas

Research & Development Area	Research Specific Topic	Rationale	Specific Objectives	Responsible Agency
1. Public Health Issues – Infectious Diseases a. Hepatitis b. Scabies c. Diarrhea d. Water-borne diseases e. Food poisoning f. Dengue	Prevalence, Causes, Practices and Management of Infectious Diseases in the ARMM	- inadequate program management and delivery of basic health services - high prevalence of infectious diseases in the region - enhance the knowledge, attitudes and practice of disease management among vulnerable groups - improve the capacity of health service providers in the management of infectious diseases	- determine the prevalence of infectious diseases in the region - determine the knowledge, attitudes, practice (KAPs) among vulnerable groups to infectious diseases - assess the capacity of health service providers in the management of infectious diseases	DOH LGUs DILG DepEd DOST
2. Family Health and Health of Special Populations - Violence Against Women and Children (VAWC)	Prevalence, Degree of Occurrence & Effects, and Advocacy Situation on VAWC in the ARMM	- low level of awareness and knowledge of personal, maternal, and child care - need for advocacy through multimedia on RA 9262 - need to strengthen interfaith collaboration - need to intensify implementation of RA 9262	- conduct situational analysis of programs/services/ interventions on the prevention/ elimination of VAWC in the region - determine prevalence, types, degree of occurrence, effects of VAWC - determine the extent and	CHED DSWD RCBW (Regional Commission on Bangsa-moro Women) DILG
3. Family Health & Health of Special Populations - a. Internally Displaced Persons (IDPs)	Health Needs and Access to Health Care Services of the Internally Displaced Communities in the ARMM	- poor access, quality, practices on health promotion among IDPs - low level of health education/ awareness and their rights - inadequate mechanisms on disaster management	- determine the health diseases/ issues/ problems affecting the internally displaced communities - determine their access to quality health services - determine their health and sanitation practices and problems	DSWD DOH LGUs CFSI
4. Health Policies/ Legislations	Situational Analysis of Advocacy and Implementation of Health Policies/ Legislations in the ARMM	- need for advocacy and lobbying for more laws/ legislations on health promotion and development	- determine the nature and extent of implementation of the health laws in the region - determine the problems in the implementation of health policies - determine the health issues and concerns needing legislative aid in the regional and local levels	DOH DILG RLA LGUs
5. Family Health and Health of Special Populations - Indigenous Peoples	Maternal Health Practices & Diseases and Health Services for the Indigenous Peoples in the ARMM	- high incidence of maternal and infant deaths among the IPs - high prevalence of health diseases among the IPs - poor access to health services among the IPs	- determine health diseases/ issues among the IPs - identify IPs health practices and health seeking behaviors especially on the mother and newborn health - identify postnatal and health practices among IPs	DOH CFSI LGUs

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