DOH-NCIP-DILG JOINT MEMORANDUM CIRCULAR NO. 2013-01
19 April 2013

FOR : **All DOH, NCIP and DILG Units, Levels and Attached Agencies, Local Government Units, Indigenous Cultural Communities/Indigenous Peoples, and all concerned public, private and Civil Society Organizations**

SUBJECT: **Guidelines on the Delivery of Basic Health Services for Indigenous Cultural Communities/Indigenous Peoples**

I. Rationale

The Universal Health Care (UHC)/Kalusugan Pangkalahatan (KP) strategy of the Department of Health (DOH) is directed towards achieving better health outcomes, sustained health financing, and responsive health systems. It hopes to attain these by ensuring that all Filipinos, especially the disadvantaged groups, have equitable access to affordable health care. This means that essential health services must be given not only to those who can afford it but also to those who are financially and socially disadvantaged.

The strategy known as the Geographically-Isolated and Disadvantaged Areas (GIDA) Health Systems Development (HSD) aims to establish a health system that will address health inequity in GIDAs and improve availability and access to health resources and services, thereat. A key course of action of GIDA HSD is the extension of basic and regular health facility-based services to these far-flung areas and marginalized populations. Thus, an essential health package that integrates all basic health service programs, including resources and systems, among others, need to reach these disadvantaged groups.

The Indigenous Peoples, who are among the most disadvantaged of the Philippine populace, comprise around 13% of the entire Philippine population that are considerably vulnerable to inequities in health. The magnitude of poor health outcomes among IPs remains to be established since disaggregation of health data by ethnicity is not available and poses another form of inequity specific on health information. Current data from the DOH however reveals that municipalities and provinces considered to have a large GIDA and IP population have poor health indicators compared to municipalities and provinces that are more accessible. The isolation of IPs contributes to the barriers in their access to health services. This can be attributed to physical segregation and socio-cultural exclusion. Far distance of the health center is one of the top reasons that IPs sampled in a 2012 research stated for not visiting the health center. This contributes to IPs relying mainly on their indigenous health systems and practices, some in accordance and some contrary to safe health practices.

In order to bring culture-sensitive and safe health services to IP communities, the National Commission on Indigenous Peoples (NCIP) provides outreach health service activities in coordination with the DOH and Local Government Units (LGUs). At most, NCIP's health service outreach is a measure to address an urgent health need/gap with minimal long-term sustainability. If this situation will remain uncorrected, the health status of ICCs/IPs will

continue to deteriorate. The objective of providing Universal Health Care for all will not be achieved. There is, therefore, a need to integrate the culture-sensitive approaches of NCIP into the DOH and LGUs' health programs.

The delivery of health services are devolved to the LGUs. But delivery of health service to IPs may be complex. IP communities are geographically defined by their Ancestral Domains that may be covered by geographic areas of various sizes and at times under several LGUs. DILG is mandated to establish a system of cooperation among LGUs to ensure efficient and effective service delivery to the public and provide general supervision over LGUs, Thus, the collaboration with DILG is of paramount importance in the effective implementation of IP health programs.

The DOH can bring effective health service programs and NCIP can assist to design and promote it in a more culture-sensitive manner and DILG can provide supervision and monitoring of program implementation by LGUs.

In view of the above, partnership/collaboration between the NCIP, DOH and DILG is vital to the pursuit of better health service delivery and health outcomes for IPs. Such partnership is formally forged through this Joint Memorandum Circular

II. Statement/Declaration of Policy

This Circular supports the following national policies and policy declarations:

1. **Universal Health Care (UHC)/Kalusugan Pangkalahatan (KP) (AO 2010-0036)** seeks to improve, streamline and scale up previous health reform strategies in order to address inequities in health outcomes by ensuring that all Filipinos, especially those belonging to the lowest income quintiles, have equitable access to health care.

2. **The Indigenous Peoples Rights Act of 1997 (IPRA) RA 8371** guarantees the access of indigenous peoples to basic services, including health. Interventions towards the health development of IPs shall be implemented in a manner that promotes the important rights of IPs to self-governance, empowerment and cultural integrity.

   The Four inter-related Bundles of Right shall govern the development and implementation of health policies, programs and projects for IPs towards self-governance and self-determination towards sustainable development. These rights refer to a) rights to Ancestral Domains/lands; b) rights to self-governance and empowerment; c) social justice and human rights; and d) rights to cultural integrity.

3. **UN Declaration on the Rights of Indigenous Peoples 2007 (UNDRIP).** Indigenous peoples have the right to a), the improvement of their economic and social conditions without discrimination, including in the areas of education, employment, sanitation, and health, among others; b) develop priorities and strategies for exercising their right to development, and to be actively involved in developing health, housing, and other programs; c) traditional medicines, maintain their health practices, conserve their vital medicinal resources, and access health and social services without discrimination; d) the enjoyment of the highest attainable standard of physical and mental health, and; e) maintain, control, protect and develop their i) cultural heritage, traditional knowledge and

4. cultural expressions, and the manifestation of their sciences, technologies and cultures; and ii) intellectual property over such cultural heritage, traditional knowledge and cultural expressions, and science and technology.

5. **The Local Government Code (RA 7160)** provides for the establishment in every local government unit an accountable, efficient, and dynamic organizational structure and operating mechanism that will meet the priority needs and service requirements of its communities. LGUs need to ensure and support the preservation and enrichment of culture, promote health and safety, and enhance economic prosperity and social justice of its inhabitants, among others. Specifically, LGUs shall exercise powers and discharge functions and responsibilities appropriate or incidental to efficient and effective provision of basic services facilities that include health and sanitation.

6. **Primary Health Care (PHC)**, together with health systems strengthening and the agreed minimum essential health packages, is the core framework for achieving universal access to quality services for improved health outcomes for all. It shall enable IPs active participation and involvement for better health and self-reliance.

7. **The Traditional and Alternative Medicine Act (TAMA) of 1997 (RA 8423)** declares that it is the policy of the State to improve the quality and delivery of health care services to the Filipino people through the development of traditional and alternative health care and its integration into the national health care delivery system. It shall also be the policy of the State to seek a legally workable basis by which indigenous societies, i.e. IPs would own their knowledge of traditional medicine. When such knowledge is used by outsiders, the indigenous societies can require the permitted users to acknowledge its source and can demand a share of any financial return that may come from its authorized commercial use.

III. Objectives

This Circular aims to set the guidelines that will address access, utilization, coverage, and equity issues in the provision of basic health care services for ICCs/IPs to achieve better health outcomes.

Specifically, these guidelines intend to provide directions for:

1. Making basic health services available and culture-sensitive,
2. Providing equitable distribution of needed health resources,
3. Ensuring non-discrimination of ICCs/IPs in the delivery of health services,
4. Managing geographical, financial and socio–cultural barriers so that IPs can access basic health services, and
5. Strengthening recognition, promotion, and respect of safe and beneficial traditional health practices.

IV. Scope or Coverage

These guidelines apply to all units, levels and attached agencies of the DOH, NCIP, DILG ICCs/IPs, LGUs, IP organizations, Official Development Assistance (ODA) partners, private organizations and other entities that have mandates, stakes and interests on the delivery of health services to ICCs/IPs.

V. Definition of Terms

1. **Indigenous Cultural Communities (ICCs)/Indigenous Peoples (IPs)** – refer to, as defined by IPRA, a group of people or homogenous societies identified by self-ascription and ascription by others, who have continuously lived as organized community on communally bounded and defined territory, and who have, under claims of ownership since time immemorial, occupied, possessed and utilized such territories, sharing common bonds of language, customs, traditions and other distinctive cultural traits, or who have, through resistance to political, social and cultural inroads of colonization, non-indigenous religions and cultures, became historically differentiated from the majority of Filipinos. ICCs/IPs shall likewise include peoples who are regarded as indigenous on account of their descent from the populations which inhabited the country, at the time of conquest or colonization, or at the time of inroads of non-indigenous religions and cultures, or the establishment of present state boundaries, who retain some or all of their own social, economic, cultural and political institutions, but who may have been displaced from their traditional domains or who may have resettled outside their Ancestral Domains.

2. **Ancestral Domain (AD)** – refers to all areas generally belonging to ICCs/IPs comprising lands, inland waters, coastal areas, and natural resources therein, held under a claim of ownership, occupied or possessed by ICCs/IPs, by themselves or through ancestors, communally or individually since time immemorial, continuously to the present except when interrupted by war, force majeure or displacement by force, deceit, stealth or as a consequence of government projects or any other voluntary dealings entered into by government and private individuals/corporations, and which are necessary to ensure their economic, social and cultural welfare. It shall include ancestral lands, forest, pasture, residential, agricultural, and other lands individually owned whether alienable and disposable or otherwise, hunting grounds, burial grounds, worship areas, bodies of water, mineral and other natural resources, and lands which may no longer be exclusively occupied by ICCs/IPs but from which they traditionally had access to for their subsistence and traditional activities, particularly the home ranges of ICCs/IPs who are still nomadic and/or shifting cultivators. (RA 8371 Chapter 2, Section 3.a)

3. **Ancestral Domain Sustainable Development and Protection Plan (ADSDPP)** – refers to the consolidation of the plans of ICCs/IPs within an Ancestral Domain for the sustainable management and development of their land natural resources as well as the development of human and cultural resources based on their indigenous knowledge, systems and practices. Such plan shall be the basis of the Five Year Master Plan for ICCs/IPs. (NCIP AO No. 1 Series of 2004)
4. **Mobile Indigenous Peoples** – are IPs/ICCs whose livelihood depends on extensive Ancestral Domain and seasonal/weather cycles that make them periodically move and settle in livelihood-conducive areas within their Ancestral Domain. Mobile IPs include shifting cultivators or those who are traditionally nomadic.

5. **Geographically Isolated & Disadvantaged Areas (GIDA)**–Far-flung areas and marginalized populations which include islands, mountainous areas, conflict-affected areas (CAAs), internally-displaced persons (IDPs), and ICCs/IPs.

6. **Essential health packages (EHP)** – define the basic minimum health services covering the promotive, preventive, diagnostic and curative aspects of health care; determine the resources needed; and identify the functional and structural components for the best possible provision of these services that respond to the needs of the community, especially the poor and marginalized.

7. **Free Prior Informed Consent (FPIC)** – as used in RA 8371, it shall mean the consensus of all members of the ICCs/IPs to be determined in accordance with their respective customary laws and practices, free from any external manipulation, interference and coercion, and obtained after fully disclosing the intent and scope of the activity, in a language and process understandable to the community. (RA 8371 Chapter 2, Section 3.g)

8. **Indigenous Knowledge, Systems and Practices (IKSP)** – these are systems, institutions, mechanisms, and technologies comprising a unique body of knowledge evolved through time that embody patterns of relationships between and among peoples, their lands and resource environment, including such spheres of relationships which may include social, political, cultural, economic, religious sphere, and which are the direct outcome of the indigenous peoples, responses to certain needs consisting of adaptive mechanisms which have allowed indigenous peoples to survive and thrive within their given socio-cultural and biophysical conditions. (NCIP AO No. 1 Series of 2012)

9. **Essential medicines,- these are medicines that satisfy** the priority health care needs of the population and which are selected based on the evidence of their efficacy, safety, and comparative cost-effectiveness. These medicines shall be made available and affordable at all times. The prioritization of the health care needs shall be based on the burden of disease.

10. **Traditional health practice** – is any practice claiming to heal "that does not fall within the realm of conventional medicine"; is frequently grouped with complementary medicine or integrative medicine, which in general, refers to the same interventions when used in conjunction with mainstream techniques.

11. **Upgrading of health facilities** – refers to improvement of health facilities, in terms of infrastructure, equipment, human resource, processes and services

12. **Culture-sensitivity in health care** – means policymakers and health workers acknowledge and respect cultural diversity among the populace since this has an effect on values, learning, behavior, health practices and outcomes. This should be reflected in the performance of their functions.

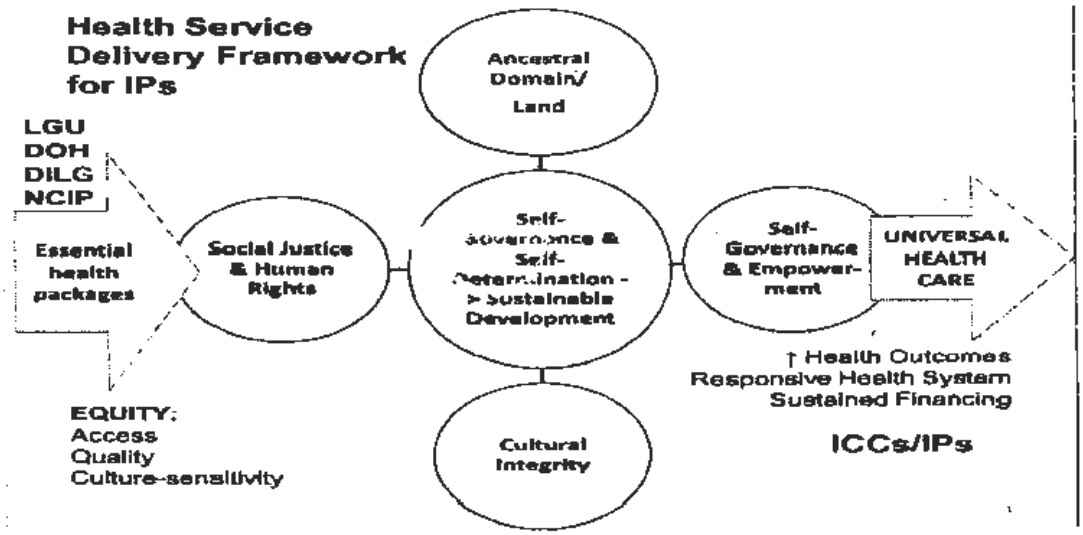
VI. General Guidelines

1. Service Delivery Framework for ICCs/IPs

The DOH's Universal Health Care hopes to ensure the achievement of the health system goals of better health outcomes, sustained health financing and responsive health system, by ensuring that all Filipinos, especially the disadvantaged group in the spirit of solidarity, have equitable access to affordable quality health care, and are protected from

financial risks. This goal must also be realized in ICCs/IPs. Universal Health Care envisions: 1) ICCs/IPs with improved health outcomes, 2) health systems responsive to ICC/IP culture, needs and concerns, and 3) health financing sustained for health services for ICCs/IPs. A key feature of ICC/IP Health Service Delivery is the extension of essential health packages to ICCs/IPs.

In the design and delivery of this essential health package, LGU, DOH, NCIP and DILG must consider the social and cultural determinants that affect health practices of an individual and his human rights and social justice. Indigenous peoples have four (4) basic rights under the IPRA. These are rights to 1) Ancestral Domain/land 2) social justice and human rights 3) self-governance and empowerment, and 4) cultural integrity that are all working toward self-governance and self-determination toward sustainable development. Health service delivery in ICCs/IPs needs to acknowledge and consider these rights.



While extension of essential health packages to ICCs/IPs are meant to address equity concerns on availability, access and quality, the delivery of EHPs in ICCs/IPs should recognize, promote and respect the culture and practices of ICCs/IPs that are safe and beneficial. There should be an effort to work towards interfacing medicine and science with ICC/IP culture, practices and rights, without compromising the achievement of favorable health outcomes.

The delivery of these health services must also be designed in a sustainable way. To achieve this, it should allow empowerment of individual ICC/IPs to influence the delivery of the EHP and integrate it into their existing community health delivery system. They should also be allowed for self-governance and management of such a system. The end goal is the realization of UHC through a concerted effort of the ICCs/IPs and relevant government agencies.

2. Guiding Principles

The following shall serve as the basic guiding principles in the delivery of health services to ICCs/IPs:

a. **Equity in health**

Essential health services must be given not only to those who can afford it but also to those who are financially and socially disadvantaged ICCs/IPs, particularly the poor. They shall be a priority beneficiary in the provision of logistics, technical and financial assistance on health, and have preferential access to health care that needs to be made available and affordable.

Promoting equity in health aims to ensure adequate access and increase in utilization of health services contributing to better health outcomes and decrease health disparities between ICCs/IPs and non-IPs through the extension of basic and regular health facility-based services to far-flung areas and marginalized populations.

b. **Favorable health outcomes as the primary goal**

Favorable and better health outcomes for IPs are the primary goal of health service delivery to ICCs/IPs. Goals of providing benefit, ensuring safety and quality (saving lives, improving health and quality of life) are of paramount concern, as well as health promotion/advocacy on and provision of basic and essential quality public health services and programs, standing on sound scientific process and evidence.

c. **Culture-sensitivity in health**

Culture-sensitivity acknowledges the existence of traditional/indigenous health systems and IKSP. It also takes into account the differences between the current and preferred cultural beliefs and practices on health care and IKSP, and the health services offered by the Local Government Units, DOH and other health care providers. Health care providers should not see traditional and cultural beliefs and practices and IKSP as an obstacle or barrier to health care.

Research shall be encouraged to identify IKSP, traditions and practices that are safe, beneficial and scientifically acceptable, against those which are dangerous, detrimental and harmful. There should be positive reinforcement and support of practices that are safe and acceptable, and provision of warning and caution against practices that might be harmful.

Culture sensitivity shall be promoted through culture-sensitive orientation/training to health workers, policymakers and other stakeholders.

d. **Respect for Human Rights, and Gender and Development**

The delivery of health services for ICCs/IPs shall reflect the development perspective and process that is participatory and empowering, equitable, sustainable, free from violence, respectful of human rights and supportive of self-determination and actualization of human potentials. It shall seek to achieve gender equality as a fundamental value that should be reflected in health development choices and contends that women are active agents of health development.

VII. Specific Guidelines

The EHP pillars identified in the WHO-commissioned study *Development of an Essential Health Package (08 September 2010)* shall be adapted/expanded for ICC/IP health service delivery. The following strategies intend to create the environment for the extension of

service delivery to IP areas and to ensure the sustainability of interventions towards IP health development.

A. Governance

Health governance shall establish the mechanisms for leadership, accountability, stewardship and meaningful participation of ICCs/IPs, in concerned levels of policymaking and decision-making, as full partners in their own health development.

1. To facilitate the implementation and institutionalization of this Circular, it is recommended that the Local Health Board (LHB) at the provincial, city and municipal levels of governance, elevate to the Sangguniang Panlalawigan, Lungsod, and Bayan the passage of an ordinance in support of this Circular.

2. Health programs/projects and activities in the ADSDPP shall be included in the local health plans like the Province/City-wide Investment Plan for Health (P/CIPH), Municipal-wide Investment Plan for Health (MIPH), and Annual Operations Plan (AOP) on health. Thus, the P/CIPH, MIPH, and AOPs shall incorporate the health service needs, and programs/projects for ICCs/IPs. LGU (province, city, municipality and barangay) counterpart/support for ICC/IP health development shall be incorporated in the LGU annual budget. This shall be reflected in the Annual Investment Plans (AIP) and the Local Development Investment Plans (LDIP).

3. IPs shall have representation/membership in LHBs, inter-local health zone/district health system (ILHZ/DHS) board, Regional Development Councils (RDCs), among other similar local, regional and national structures that include the health agenda. The *Department of Interior & Local Government Memorandum Circular No. 2010-119* "Mandatory Representation of Indigenous Cultural Communities or Indigenous Peoples in Policy-making Bodies and other Legislative Councils" shall be re-enforced for this purpose.

4. LGUs shall recognize, coordinate and co-manage health service delivery where there is overlap in inter-LGU boundaries of ICCs/IP areas and mobile IPs. Thus the ICC/IP health care system and structure shall be interfaced with the regular health system and structure. For such collaboration, the Provincial/City Health Officer and Center for Health Development may take the role of coordinator and technical assistance provider.
5. To promote self-governance, community-managed health care shall be encouraged in ICCs/IPs. The role of barangays on the health development of ICCs/IPs shall be identified and strengthened.

B. Human Resources for Health

Human resources for health shall address the shortage in quantity and quality of human resources by increasing the number, improving the capacity, and providing for other mechanisms that will manage such shortages.

A human resources for health plan for ICCs/IPs shall be developed recognizing the need for a comprehensive and strategic response to HR limitations in the health service delivery that affect most IP communities. The plan shall cover systems and capacity

building based on the nature of strategies to address shortage in quantity and quality of human resources.

1. **Systems**

ICC/IP health workers shall be encouraged to be a part of the Rural Health Unit (RHU) staff to promote further understanding the ICCs/IPs and participate as allies of the RHU to advocate for some needed behavior change among the ICCs/IPs.

1.1 Health facilities shall be composed of trained and culture-sensitive health workers providing locally adapted and culture sensitive care that will lead to increased satisfaction and utilization of health service.

a. LGUs with ICC/IP population shall be encouraged to have a mixed-culture workforce on health including IPs, in their health facilities
b. Extra effort shall be made to hire an IP health worker (doctor, nurse, midwife etc.) to be in the regular health workforce of the DOH and LGUs. LGUs are encouraged to give priority to an IP health worker to be hired if the post of assignment is in IP communities.

1.2 The following options to address the shortages in human resources for health in ICCs/IP areas may be considered:

a. Support for health workers in ICC/IP areas, e.g. regular provision of transportation allowance, organization and regular deployment of mobile health teams to deliver health services to ICCs/IP areas that have difficulty accessing health care, etc.
b. Expansion of DOH Human Resource Deployment Program. The Doctors to the Barrios Program (DTTB) program shall be expanded to cover more doctor-less ICC/IP areas. The DOH shall also consider developing extension service for nurses and midwives to ICC/IP areas with competitive remuneration package.

2. **Capacity Building**

2.1 Eligible IPs shall be supported to undergo formal education to become doctors, nurses, and midwives. Eligible IPs shall be trained and/or capacitated to become BHWs leading to their being part of the regular public health workforce. Eligibility shall be defined in a separate issuance.

2.2 Hilots and traditional birth attendants must also be trained to assume an alternative/complementary role in a safe and effective health system.

2.3 Scholarship opportunities shall be explored to be provided for IPs on health courses.

2.4 Eligible IPs shall be trained on basic health and emergency/first-aid services in support of a community-managed health care. Basic health and emergency/first-aid services are considered immediate health care that the community can respond to in the absence of a health worker.

2.5 Current and newly-hired health workers and health care providers at all levels shall be trained on culture-sensitivity in the performance of their regular work. The health care provider shall practice culture-sensitivity when offering the health services to ICCs/IPs following the LEARN method which includes:

- Listening carefully to the ICCs/IPs perceptions,
- Explain carefully the health service to be provided

- Accept the difference in perception if the explanation was not accepted
- Recommend and
- Negotiate for a mutually acceptable compromise.

C. Infrastructure and equipment

Infrastructure and equipment shall address the shortage in quantity and quality of facilities by increasing the number, improving the quality, and providing for other mechanisms that will manage such shortages. These should not require high technology and high cost or heavy equipment to be delivered or one that requires a significant supply of water or electricity that is often not available in these areas.

1. Construction and/or renovation of birthing facilities, BHS and establishment of health and nutrition posts/remote health stations shall be prioritized for ICCs/IP areas, and shall incorporate appropriate indigenous design and materials. A permanently staying health worker, at least a midwife, shall be provided in the birthing facilities/BHS/health and nutrition post/remote health station. Culture-sensitive birthing or care facilities may also be setup in RHUs, district hospitals or provincial hospitals.

2. LGUs shall work towards identifying and making available water, electricity and efficient communications system and/or alternatives in health facilities in IP areas. In referral health facilities like hospitals, IP wards with culture-sensitive health workers must be provided.

3. Health facilities in IP areas shall, likewise, include the following structure/system, as appropriate like:
   - mobile clinics
   - culture-sensitive birthing facility

4. Telemedicine, which expands the reach of medical specialist support services to strategic underserved communities through the use of information and communication technology (ICT) systems, shall be explored for ICC/IP areas.

D. Supply of essential medicines, rational use, delivery and its alternatives

Timely supply and delivery of essential medicines and its alternatives shall be ensured to all health care facilities and ICC/IP communities. It shall also recognize the development, safe and rational use of beneficial traditional and/or alternative medicines.

1. Essential medicines and other special packages shall be equitably allocated and distributed for ICCs/IPs with health needs through a mechanism that shall be developed for this purpose. Adherence to the Philippine National Drug Formulary shall be observed.

2. Delivery systems for, and the rational use of beneficial traditional medicines shall be developed and implemented. Research shall be encouraged on the following:
   - Effectiveness of herbal medicines
   - Search for more herbal medicines
   - Improving production of herbal medicines

3. Herbal medicines as well as IKSPs that are shown to be beneficial and safe shall be encouraged. Behavioral change intervention may be done for unsafe and ineffective herbal treatment and practices in a culture-sensitive manner.

4. Regular culture–sensitive training/education and information/communication materials on the rational use of medicines shall be designed and provided. Community health volunteers may be tapped for this purpose.

E. Service standards

Service standards shall serve as the quality control mechanism for the services rendered in the EHPs at all levels of health care facilities that will ensure access, adequacy and appropriateness for the ICC/IP population served. These shall cover operational procedures, protocols and guidelines of health programs and services that shall be in place and delivered to ICCs/IPs, and made culture-sensitive.

1. The EHP shall be delivered to the ICCs/IPs based on their need on a regular basis, like monthly for continuing care needs and immediately for acute care needs. It should he delivered and provided with standards that include safe and effective indigenous knowledge, systems and practices. Financial and technical assistance must be given to LGUs and IP communities for their health facilities to meet these standards.

2. In situations where ICCs/IPs are internally-displaced due to natural and/or human-made disasters and armed-conflict, among others, minimum health service package in emergencies and disasters shall be provided without undue discrimination and in a manner that is culturally appropriate and sensitive.

3. Health programs and services shall be reviewed and adapted to cultural and local conditions, and designed considering that ICCs/IPs are generally in GIDAs, with very minimal transportation and resources available. Such adaptation must not sacrifice the effectiveness and safety of health service delivery.

4. Environmental health and sanitation services shall be strengthened in consideration of climate-change and existing practices of ICCs/IPs.

5. Positive reinforcement approach/method shall be employed to promote acceptability and utilization of health programs and services.

F. Financing sources and management

Financing sources and management shall identify all possible sources of funds, as well as drafting the scheme for proper budgetary allocation of resources for IP health service delivery.

1. The DOH, through PhilHealth, and NCIP shall collaborate with the Department of Social Welfare & Development (DSWD) on the improvement of coverage in terms of enrolment, utilization and availment, among others, of financially-disadvantaged IPs to the PhilHealth Sponsored Program and qualification to the Conditional Cash Transfer (CCT/4Ps). Financially-disadvantaged/IPs shall be automatically enrolled in PhilHealth Sponsored Program subject to a validation system. Financially-disadvantaged IPs/ICCs shall be defined in a separate issuance.

Health facilities in ICCs/IP areas shall be made eligible for PhilHealth accreditation as appropriate. The LGUs shall initiate the development and implementation of a facilities upgrading and financing plan, with assistance of the DOH. Fund sources from DOH include Harmonized Resource Transfer (HRT) Funds, Emergency Response funds, among others, can be the source of fund allocation for ICC/IP health facilities.

2. Funds from the LGUs, DOH, NCIP, DILG and other National Government Agencies shall be tapped for funding of the implementation of the JMC. PDAF and other special funds may also be tapped

3. Other health financing options shall be explored and designed with free prior-informed consent (FPIC), such as the following:
   4.1 Community-based health financing complementary to PhilHealth Sponsored Program is foreseen to address the out-of-pocket cost of patients relative to the occurrence of illness in the family, which are not covered in the PhilHealth Sponsored Program. These costs may include medicines, traveling expenses to and from health facilities, living allowance for the companion during hospital admission, among others.
   4.2 Applicable public private partnerships (PPP) schemes may be encouraged with the consent of IP communities and with socio-cultural safety nets in place. PPP is foreseen to augment the limited financial and material resources required to deliver health services in IP areas.
   4.3 Resources and funding from partner Official Development Agencies (ODAs), Civil Society Organizations (CSOs) and Non-Government Organizations (NGOs) shall also be tapped and integrated to IP health service as described in this Circular.

G. Management systems

Management systems shall include processes/procedures, and tools for the development and organization of health service delivery for IPs that includes health information system, health facility system, referral system, health education, and monitoring and evaluation.

1. Health information

1.1 Health statistics and data, including medicine-reporting/recording, shall be disaggregated for IPs and non-IPs to guide prioritization for future program development and implementation.
   a. Civil registration of IPs shall be supported to establish health statistics/data on ethnicity.

1.2 Regular reporting of MDG-related indicators shall be covered to provide fresh data for timely and appropriate action of health leaders/managers at all levels of health care.

2. Referral system

2.1 Referral protocols shall be formally agreed upon together with concerned ICCs/IP areas with the indigenous health referral system interfaced with the

mainstream health referral system. The development of the referral system shall consider inter-LGU boundaries and reporting protocols during health emergencies, among others.

2.2 An IP health worker or an IP-oriented health worker shall be designated in health facilities to attend to referrals and facilitate provision of care to IPs.

2.3 Ensure access of IPs/ICCs to acute care/in-patient and emergency services through the health referral system.

2.4 Collaborative arrangement with other government agencies and people that have access to ICCs/IP areas, such as the Department of Environment & Natural Resources (DENR) or the Armed Forces of the Philippines (AFP)/Philippine National Police) (PNP) or any uniformed personnel, among others, shall be encouraged.

3. Health promotion and education

3.1 Safe and beneficial traditional home care shall be promoted in recognition of existing practices.

3.2 Health educational and promotional resources and references/manuals on field practice shall be reviewed and customized considering use of local language and simple/indigenous illustrations, visuals and concepts, for better comprehension, and clarity of instruction.

3.3 Active participation of IPs/ICCs shall be engaged in health promotion and education, especially in the development of related materials and resources.

4. Health facility/organization

4.1 A staff who will attend to IP needs and concerns shall be designated in health facilities covering a population of ICCs/IPs. Other qualifications of the designated staff shall be determined.

4.2 DOH regional offices and DOH-retained hospitals, health facilities at the provincial, city and municipal levels shall establish an IP desk/designate staff who will coordinate and/or attend to IP needs and concerns on health. An existing similar structure that can accommodate the said function may be tapped.

5. Monitoring & evaluation

A system for monitoring and evaluation of the implementation of the JMC shall be developed and pre-tested with the participation of ICCs/IPs and shall be designed for their own appreciation and utility.

H. Collaboration and partnership

Collaboration and partnership shall include community participation, health partners and government agencies partnerships, multi-sectoral partnerships, alliance-building, and networking.

1. The role of IP health workers and BHWs in ICCs/IP areas as ICC/IP community representatives shall be strengthened. Aside from their regular role as support health service providers. The IP health workers are envisioned to facilitate their communities through community organization/mobilization, among others, towards a community-managed health care.

2. Collaboration between Local Chief Executives, congressional representatives and other government agencies shall be encouraged to increase the available resources for ICC/IP health service delivery.

3. Public-private and IP partnership mechanisms shall be developed to augment the limited financial, material and human resources needed to deliver health services in ICCs/IP areas. These shall provide a more active role for ICCs/IPs in the PPP loop.

VIII. Implementing Arrangements

A. Main implementing agencies

1. The DOH, NCIP and DILG will be the main implementing agencies and shall oversee the implementation and monitoring of activities within this JMC.

2. Inter-agency Committees at national, regional and province levels to oversee planning, implementation, and M&E shall be organized. Existing similar structures that can accommodate the said function may be tapped.

B. Year 1 Activities

The following outlines the immediate activities for implementation in Year 1. Funding of these activities shall come from regular operations budget of concerned agencies consistent with their respective mandates.

Immediate Activities	*Agencies Responsible*
1. Policy advocacy/orientation on the JMC	DOH, NCIP & DILG
2. Development of a joint strategic & action plan on JMC implementation	DOH, NCIP & DILG
3. Organization/expansion of existing Inter-agency committees at national and regional levels and in selected provinces	DOH, NCIP & DILG
4. Listing/updating/mapping of ICCs/IPs	NCIP and LGUs (all levels)
5. Mobilization for the development of ICC/IP health data disaggregation system	DOH, DILG and NCIP
6. Local adaptation of this Circular	Pilot LGUs, DILG
7. Inclusion in 2014 Province/City-wide Investment Pans for Health/Annual Operational Plans of the extension/expansion of coverage of health facility-based services in at least one (1) ICC/IP area in provinces and cities with significant ICC/IP population	LGUs (Province and HUCs)
8. Design of culture-sensitivity orientation module for health providers	DOH and NCIP
9. Conduct of culture-sensitive orientation for selected DOH staff and IP Health Technical Team	DOH and NCIP
10. Inventory of CHD and LGU initiatives on alternative health service delivery projects specific for ICCs/IPs	DOH, NCIP, LGUs

C. Financing Health Service Delivery to IPs

Commitment from identified financial sources shall be established and strengthened to support health services for IPs.

1. The DOH, NCIP and DILG shall collaborate to ensure adequate financing to health infrastructure, health human resource and health and social services to ICCs/IP areas. This can be achieved by specific allocation in their annual budget through the General Appropriations Act enacted annually by Congress.

2. Other potential funding sources that are not limited to those listed in Section VII. F, such as existing DOH guidelines on classification and availment of government hospital services (AO 51-As2001).

3. The DOH, NCIP and DILG shall also advocate to the LGUs to increase IP health budget and utilize its gender and development (GAD) allocation to IP communities.

4. LGUs may also utilize its regular and other fund sources for health services for IPs.

D. Roles & Responsibilities

1. Functions of main implementing agencies

As the main implementing bodies of this Circular, the DOH, NCIP, DILG Central Offices are responsible for the following:

1.1 Development of strategies and action plan, issuance of related policies, and execution of a Memorandum of Agreement with other agencies/organizations, as necessary

1.2 Allocation of funds and logistics

1.3 Oversight function

1.4 Monitoring and evaluation

1.5 Capacity building and technical assistance.

2. Specific functions of main implementing agencies/bodies

2.1 DOH

a. Central Office

The DOH central office, through its program units and relevant attached agencies, shall also be responsible for the:

i. Development of the design and delivery of the culture-sensitive EHPs and essential medicines

ii. Development of culture-sensitive health education, health promotion and behavior change communication strategy.

iii. Development and implementation of facilities upgrading plan for health facilities in ICCs/IP areas, in partnership with LGUs.

b. Regional Offices

The Centers for Health Development/DOH Regional Offices, through its technical program staff and the DOH representatives, shall provide technical assistance to LGUs, conduct training and capacity building, advocate to LGUs and monitor and evaluate activities covered by the JMC.

2.2 NCIP

a. *Central Office*

The NCIP central office shall be responsible for the following:

i. Lead in the development of design / training module on culture-sensitivity in health care
ii. Ensure that the socio-cultural perspective of ICCs/IPs is incorporated in all aspects of the implementation of the JMC
iii. Listing/mapping/updating of ICCs/IPs in terms of socio-economic and demographic profiles, among others, as input to IP health program development

b. *Regional Offices*

The NCIP regional offices shall:

i. Provide technical assistance to Provincial Offices
ii. Assist in the conduct of training on culture-sensitivity for health workers
iii. Advocate to LGUs and
iv. Facilitate the conduct of FPIC when necessary
v. Monitor and evaluate the culture-sensitivity aspect of activities covered by the JMC

c. *Provincial Offices/Community Service Centers*

The NCIP provincial office/Community Service Centers shall:

i. Conduct or assist in the conduct of activities on ICC/IP health at the community level, in coordination with LGU health offices.
ii. Be responsible for getting community support and participation
iii. Gathering information necessary for monitoring and evaluation of implementation.
iv. Ensure inclusion of health activities in the ADSDPP in the AOPs on health
v. Facilitate representation of ICCs/IPs in Local Health Boards

2.3 DILG

a. *Central Office*

The DILG Central Office shall:

i. Issue enabling policies to its attached agencies and different levels of LGUs
ii. Monitor and evaluate the implementation of policies relevant to IP health by LGUs
iii. Re-enforce adequate participation of IP leaders in LGU governance in health.

b. *Regional Offices*

The DILG Regional Offices

i. Provide technical assistance to Provincial Offices
ii. Assist in the conduct of training
iii. Advocate to LGUs and
iv. Monitor and evaluate

c. *Provincial Offices*

The DILG Provincial Offices

i. Provide technical assistance to Municipal Offices under its jurisdiction
ii. Assist in the conduct of training

iii. Advocate to LGUs and
iv. Monitor and evaluate
v. Gather information on the implementation of ICC/IP-health related circulars
vi. Ensure LGU budget appropriation for ICC/IP health programs and services

d. Municipal Offices

The DILG Municipal Offices

i. Provide technical assistance to barangays under its jurisdiction
ii. Assist in the conduct of training
iii. Advocate to barangays
iv. Monitor and evaluate
v. Gather information on the implementation of IP-health related

2.4 Local Government Units

a. LGUs shall primarily implement/deliver health services for ICCs/IPs.
b. Provincial, City, Municipal and Barangay LGUs shall appropriate the necessary and available funding and resources for the conduct of activities in the JMC that are within their jurisdiction, including maintenance of related infrastructure and equipment.

2.5 LGU Leagues

The Leagues of Provinces, Cities and Municipalities shall advocate to LGUs the implementation of this Circular and shall carry the ICC/IP health in its sectoral agenda/activities. Promote LGU support and prioritization in allocation of funds

2.6 IP communities/organizations

IP leaders, communities and organizations being the beneficial recipient of activities related to the Circular shall extend their full support to the implementation of the activities. It shall encourage a sense of cooperation and voluntarism among its members.

3. Other Partners

3.1 Other National Government Agencies

The DSWD, CHED, NAPC, PNP, AFP and other NGAs shall be consulted for assistance in the implementation of the JMC, especially those concerning educational, social, cultural, financial and other issues that might prevail in the community and affect the implementation of activities within the JMC.

3.2 Official Development Assistance Partners

The ODA partners may also be consulted for assistance in the implementation and funding of the activities related to the Circular.

3.3 Other agencies/organizations

Other agencies/organizations shall be consulted and/or engaged, as necessary, for coordination and/or operationalization of this Circular considering the multi-sector concerns of ICC/IP health development.

Research and documentation

1. The evidence and literature on ICC/IP health and development shall be enriched through research and documentation of LGU and ICCs/IPs working strategies and initiatives towards ICC/IP health development. DOH, NCIP and DILG shall include

IP health and development in its respective research agenda. FPIC shall be observed in all research undertakings for this purpose.

2. Research shall be prioritized on the development of herbal medicines and safety of IP health practices. The academe and other research institutions shall be tapped to jointly undertake research on ICC/IP health and development.

3. Research shall be conducted on the effectiveness of ICC/IP health practices and culture vis-à-vis mainstream practice of medicine. Research outputs shall be used as inputs to policy development, program design, development and implementation.

IX. Effectivity

This Circular shall take effect immediately. A joint strategic and action plan providing specific directions and guidelines on implementation shall be developed following the issuance of this Circular. This Circular is an evolving document and shall be reviewed and updated as deemed necessary.

ENRIQUE T. ONA
Secretary, DOH

ZENAIDA BRIGIDA H. PAWID
Chairperson, NCIP

MAR ROXAS
Secretary, DILG

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