
| RESEARCH ARTICLE**The Delivery of Health Services at the Barangay Sagonsongan Temporary Shelters as Perceived by the Internally Displaced Persons (IDPs)****Hosnie M. Gogo***Faculty of the Department of Public Administration, College of Public Affairs, Mindanao State University, Marawi City, Philippines***Corresponding Author:** Hosnie M. Gogo, **E-mail:** hosniegogo98@gmail.com

| ABSTRACT

This study examined the perception of the IDP respondents of the Temporary Shelters of Barangay Sagonsongan, Marawi City, on the health services provided by the City Health Office. This study used the descriptive methods of research to assess the health services delivered to the Internally Displaced Persons of the Temporary Shelters of Brgy. Sagonsongan, Marawi City. The total population of the study was the Internally Displaced Persons (IDPs) at the Temporary Shelters of Brgy. Sagonsongan, Marawi City. By using purposive sampling, only the accessible family households were taken as the sample respondents. Hence, by using the Sloven Formula, a sample of 80 family households was chosen from the total of 500 family households. In regard to significant findings of the study, it was revealed that the majority of the respondents were aware of all 10 major services provided by the City Health Office to the IDPs. In terms of the perception of the IDP respondents on the City Health Office delivery system utilized for the provided health services based on certain criteria such as availability, accessibility, and accountability, it was found that the availability and accessibility of the delivery of health services to the IDP respondents by the City Health Office was perceived as "almost never" by majority of the respondents. On the other hand, the accountability in the delivery of health services to the IDP respondents by the City Health Office was perceived by the majority of the respondents as "everytime". The researcher highly recommends that the local government, through the City Health office, must strengthen the services delivered to the IDP

| KEYWORDS

IDP, health services, Marawi City, natural crisis, administrative efficiency

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1. Introduction**1.1 Background of the Study**

The World Health Organization (WHO) averred that the coronavirus disease (COVID-19) is an infectious disease caused by a new strain of coronavirus. This new virus and disease were unknown before the outbreak began in Wuhan, China, in December 2019. Globally, as of 17 June 2020, there have been 8,061,550 confirmed cases of COVID-19, including 440,290 deaths, reported to WHO. On 30 January 2020, the Philippine Department of Health reported the first case of COVID-19 in the country with a 38-year-old female Chinese national. On 7 March, the first local transmission of COVID-19 was confirmed. As of 17 June 2020, there have been 27, 238 confirmed cases COVID-19, including 1,108 deaths, according to the Philippines Department of Health data.

The Philippines is among the most impacted countries by COVID-19 in ASEAN. According to a survey conducted in the Philippines, about 75 percent of Filipinos perceived that the coronavirus COVID-19 outbreak would affect the international economy, while 65 percent believed the national economy of the Philippines would be affected as of February 2020. To contain the spread of the virus, the Government put in place enhanced community quarantine, together with other containment measures. The government has also announced a fiscal package of enhanced social protection measures for vulnerable workers and affected sectors, including a cash aid programme for 18 million low-income households.

Related herein, health as a human right does not mean the right to be healthy nor does it assert an unlimited right to be treated for every medical condition. Rather, the right to health may be seen as having two components: a right to health care and a right to healthy conditions. The rights-based approach to health incorporates both a clinical, curative perspective focusing on health care and health services, and a public health, preventive perspective focusing on the social determinants of health—including water, sanitation, nutrition, and health education (Robinson, 2014).

The Liberation of Marawi City from Maute-ISIS group on October 17, 2017 has posed a major challenge to the Duterte Administration not only in terms of ending the battle between the ISIS-Maute Group and Armed Forces of the Philippines, but in responding to the urgent needs especially health and social services of the hundreds of thousands Internally Displaced Persons (IDPs). The Same crisis had reached the intolerable level of catastrophe on the part of the IDPs as evidenced by the physical transformation of the old Marawi City into a Ground Zero (Guro, 2017).

Traditionally, during the period of natural or economic crisis, the leading agency responsible in the delivery of basic and social services to the affected population is the Department of Health (DSW) particularly the City Health Office of the Marawi City. The agency provides assistance to other national government agencies (NGAs), local government units (LGUs), non-government organizations (NGOs), people's organizations (POs), and civil society organizations (CSOs) in the implementation of health related programs, projects and services that will alleviate the health status and empower disadvantage individuals, families, and communities to improve their quality of life. It is charged to implement statutory and specialized health services programs and projects.

Internally displaced persons (IDPs) have the right to health and other basic services, including the right to a standard of living adequate to maintain health and well-being. According to international definition, IDPs are persons or group of persons who have been forced or obliged to flee or to leave their homes or places of habitual residence, in particular as a result of or in order to avoid the effects of armed conflict, situations of generalized violence, violations of human rights or natural or human-made disasters, and who have not crossed an internationally recognized state border (Guiding Principles on Internal Displacement, 1998).

As mentioned earlier, it is the Department of Health through the City Health Office of Marawi City that is tasked by the National Government to see to it that the victims of natural or man-made calamities like the eleven-month Marawi Crisis would not suffer from health deprivation through the delivery of basic health services like, free medication, hospitalization, immunization, among others. Hence, the significance of the present study.

This study is designed to assess the delivery of basic health services by the Department of Health (DOH) through the City Health Office Marawi City to the IDPs of Barangay Sagonsongan, Marawi City and to identify the various health services being delivered by the agency. The same study is important because it will provide insights and inputs on the effectiveness and efficiency of the City Health Office in responding to the basic health services of the IDPs. It will also inform us as to whether the IDPs are satisfied with the delivery system of the City Health Office of Marawi measured in terms of several factors.

1.2 Statement of the Problem

Generally, this study focused on the delivery system of basic health services by the City Health Office of Marawi City as perceived by the Internally Displaced Persons (IDPs) of the Temporary Shelters of Barangay Sagonsongan. Specifically, this study tried to answer the following questions:

1. What is the level of awareness of the Internally Displaced Persons (IDPs) on the Health Services provided by the City Health Office of Marawi City?
2. What is the assessment of the IDP- Respondents on the Health Services provided by the City Health Office of Marawi in terms of the following criteria:
 - a) Availability; b) Accessibility; and, c) Accountability
3. What are the problems encountered by the respondents on the delivery of health services provided by the City Health Office of Marawi?

1.3 Theoretical Framework

This study was anchored on the following theories, perspective and laws that the researchers believed to give relevance and support to the study.

In the year 1991, the Philippine Government introduced a major devolution of national government services which included the delivery of basic health services through the introduction of the Local Government Code of 1991. The code devolved basic services for agriculture extension, forest management, health services, barangay (township) roads and social welfare to Local Government Units, the Philippine Government devolved the management and implementation of development programs and projects from national to locally elected provincial, city and municipal government down to the political structure, the barangays.

According to Ylvisaker as cited by Mass, liberty, equality and welfare are rationale for local government. To promote liberty it is essentials to provide additional and more readily available points of access, pressure and control. By means of promoting equality, local governments must provide for wide-scale participation and fostering, while on the part of government must have responsiveness and flexibility. In addition, local governments must provide welfare or service in terms of assuring that demands will be heard and that needs will be served (Quoted by Tapales et.al., 1998).

Basically, local governments are tasked with the promotion of the general welfare of the people and provide services that are administrative, corporate, regulatory, and developmental in nature. Through the provision of the Local Government Code of 1991, there are certain powers, functions and responsibilities that are devolved to local government with regards to municipality and barangays (Lina, Jr., 2003).

Under the code, the state shall provide a system of decentralization where the local governments are provided certain powers, functions and responsibility. Decentralization is the transfer of responsibility for planning, management and resource raising and allocation from the central government and its agencies to the lower levels of government (Brillantes et.al, 2003). According to the Code, Section 17:

"Local Government units shall endeavor to be self-reliant and shall continue exercising the powers and discharging the duties and functions currently vested upon them. They shall also discharge the functions and responsibilities as are necessary, as appropriate, or incidental to efficient and effective provision of the basic services and facilities enumerated therein."

However, there are some arguments on the idea of decentralization that will be emphasize by Tapales (1998). Accordingly, the power of government must be centralized because development requires unity of effort, rational allocation of resources to meet competing needs and speed in policy decision making. However, because of the crucial issue of development that the generation of a widespread initiative, effort, and social responsibility throughout the society, therefore it is argued that political power must be decentralized.

It is believed that decentralization will lead to democratization by allowing full participation of the citizen in the government affairs and that it will improve local self-reliance and administrative efficiency and suit official actions to local conditions. Thus, decentralization will give local governments and the communities a more active role in the economic, social, and political development.

Moreover, De Guzman and Reforma (1993) also pointed out that through the decentralization, lower levels are allowed to decide on issues that concern themselves directly not unlike the centralization where power and decision making are concentrated in the center. Thus, it democratizes the political system while ensuring that the governmental actions are responsive to the needs of the people. The introduction of decentralization increased involvement and participation of local units and the community in governance as well as in the decision-making. It is believed that development of the communities through power, service, facilities, and resource would create opportunities in the regions, promote employment and economic activities, and strengthen people's participation in the affairs of government.

This assumption offers the promise that decentralization processes would serve to better substantiate democratization and development of regional and local communities. It is important in this assumption the significance of intervening variables as leadership, skills, resources, and capabilities of local levels institutions.

In addition to this theoretical underpinning is the right of IDPs to health and other basic services, including the right to a standard of living adequate to maintain health and well-being, is affirmed in the Guiding Principles on Internal Displacement and is established in various instruments of international human rights and humanitarian law. Emerging standards in humanitarian action and practice seek to establish a regulatory framework for ensuring that the basic health and survival needs of displaced populations are met. The Guiding Principles reflect the convergence of clinical, curative perspectives and public health, preventive perspectives by affirming both the right to health and the right to an adequate standard of living.

The Universal Declaration of Human Rights (UDHR) Article 25(1) states that "everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and medical care and necessary social services, and the right to security in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond his control". The International Covenant on Economic, Social and Cultural Rights (ICESCR) affirms the right to an adequate standard of living in similar terms to the UDHR in Article 11. Article 12.1 of the ICESCR recognizes "the right of everyone to the enjoyment of the highest attainable standard of physical and mental health."¹² Numerous provisions of regional human rights treaties also set out the right to health and an adequate standard of living.

In 2000, General Comment 14 of the United Nations Committee on Economic, Social and Cultural Rights (UNCESCR) noted that "the right to health is closely related to and dependent on the realization of other human rights" and that reference to the "highest attainable standard of physical and mental health" extends "not only to timely and appropriate health care but also to the underlying determinants of health, such as access to safe and potable water and adequate sanitation, and adequate supply of safe food, nutrition and housing, healthy occupational and environmental conditions, and access to health-related education and information, including on sexual and reproductive health."¹⁴ The Committee also noted the evolution of "a wider definition of health [that] also takes account such socially-related concerns as violence and armed conflict."

Maslow constructs a hierarchy of human needs from the lowest which is physiological needs, self-esteem needs and topped with self-actualization. The physiological needs are those needs that help a person to be in the comfortable state in which his body is in a good state to enable him to perform well. After being physiologically fulfilled, a person will need a safe surrounding that will ensure his security. Then he ascends to the need to be loved and be shown a sense of belonging. Because of the attainment of love and belonging, the individual will develop a sense of self-esteem, self-respect, and competence and this finally leads to self-actualization where an individual knows himself better and know what he wants to do with his lives.

In this study, health care needs to be served well so that patients will feel they are given due care and attention. The attainment of good health is a basic need that once fulfilled will lead to the fulfilment of the other higher needs.

1.4 Conceptual Framework

The conceptual framework of this study illustrated the different concepts that were used. The first variable is the level of awareness on the health services delivered by the City Health Office of Marawi City in the left box. The second variable is the assessment of the respondents on the delivery system of the health services in terms of the following variables: Availability, Accessibility and Accountability indicated by the upper right box. And the third variable which is the problems encountered by the respondents on the delivery system of the health services of the City Health Office.

Conceptual Model

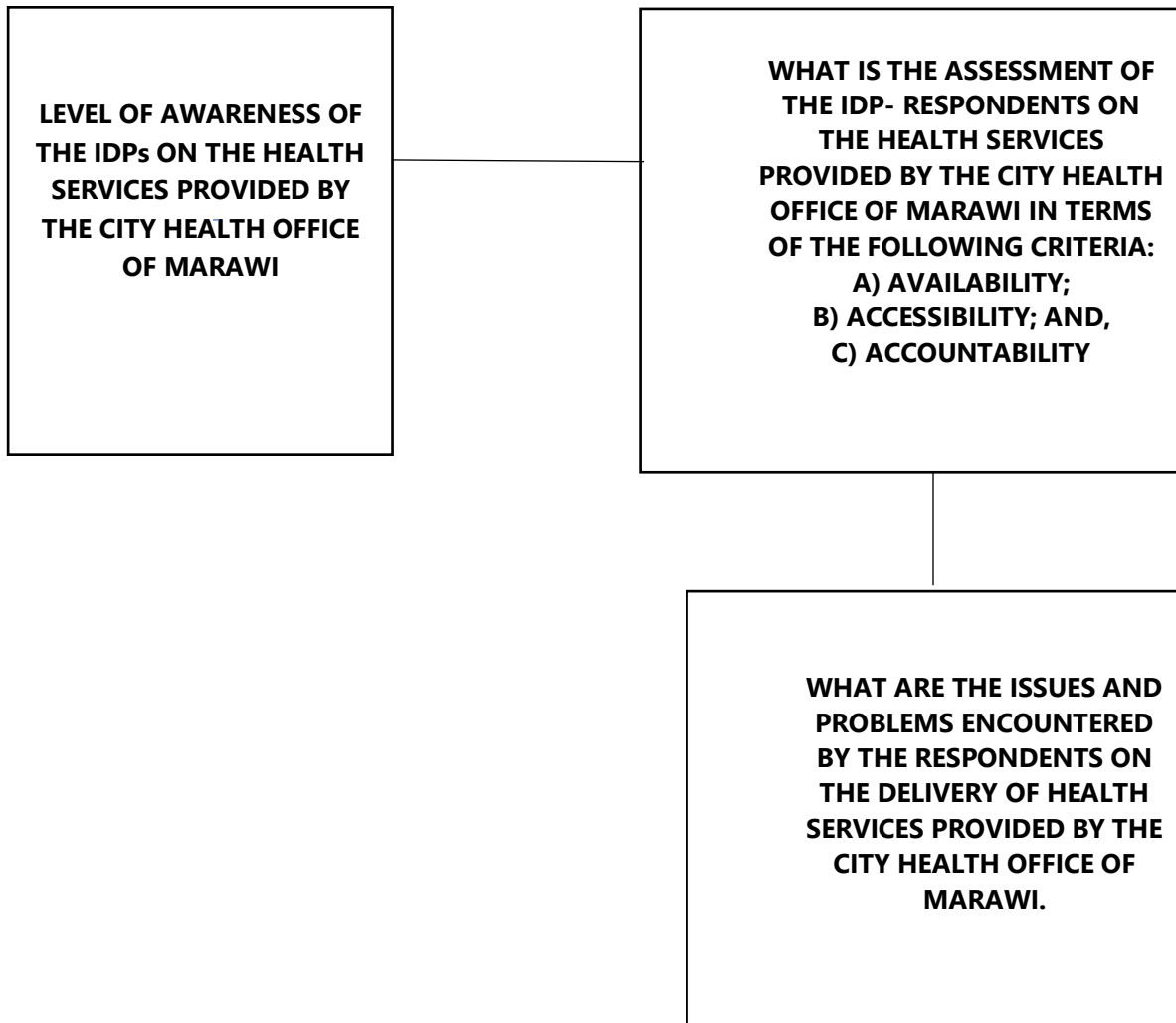


Figure 1. Analytical Diagram Showing the Concepts Used in the Study

1.5 Significance of the Study

The result of this study provides timely information regarding the assessment of the Internally Displaced Persons (IDPs) on the Health Services being delivered by the City Health Office of Marawi. Specifically, the following important points will be considered significance:

Department of Health. It is the principal health agency in the Philippines. It is responsible for the ensuring access to the basic public health services to all Filipinos through the provision of quality health care and regulation of

providers of health goods and services. The result of this study may serve as the important input in the formulation of strategy of what to be used in implementing a program to achieve higher levels of effectiveness.

To the Local Government of Marawi City. The findings of the study will serve as the mechanism of the improvement of the planning and implementation of health-related programs.

To the Internally Displaced Persons. The result of the study will give awareness to the Internally Displaced Persons of Brgy. Sagonsongan on the available services offered to them and will also provide additional insight on the administrative capability of the city government.

To the City Health Officers. The findings of this study will give knowledge to the city health services to know the comment and judgment of the people towards them and their services either positive or negative. Thus it can help them develop their performance.

To the Academe. This study will be beneficial to the academic community especially the student, faculty and researcher in the different social science disciplines like public administration student.

To the Future Researcher. The result of this study will serve as the guide and reference for further research in the field and practice of public services delivery.

1.6 Scope and Limitation

The study attempts to assess the health services delivered to the Internally Displaced Persons (IDPs) of Brgy. Sagonsongan, Marawi City. It sought to explain the IDPs' perception on the importance and status of the health rendered by the City Health Office.

In this study, questionnaires were given to the respondents who are the IDPs temporarily evacuated at Barangay Sagonsongan, Marawi City being the primary respondents of the study.

Limitation of the study is the failure to explore the mandates and functions of City Health Office who offered services to the Internally Displaced Persons of Brgy. Sagonsongan, Marawi City.

1.7 Definition of Terms

To ensure deeper understanding of the study, the following important terms are defined conceptually and operationally.

Accessibility. It is being able to be reached or approached (Webster's Comprehensive Dictionary). In this study, it referred to the accessibility of the locations of the health services.

Accountability. It is the quality or state of being accountable, an obligation or willingness to accept responsibility (Webster's Comprehensive Dictionary). In this study, it referred to the accountability of the City Health Officers on the delivery of basic health services.

Assessment. It is concerned in the achievement of the program objectives, its effect and impact (Webster's Comprehensive Dictionary). In this study, it referred to the effectiveness of the services delivered.

Availability. It is the quality or state of being available (Webster's Comprehensive Dictionary). In this study, it referred to the availability of the health services.

Delivery. It means putting into effect, fulfillment, or carrying through, as of ideas, a program and others (Webster's Comprehensive Dictionary). In this study, it referred to the availability, accessibility, and quality of the health services received by the IDPs.

Effective. Adequate to accomplish a purpose; producing the intended or expected result (Webster's Comprehensive Dictionary). In this study, it referred to the result of the services rendered to the Internally Displaced Persons (IDPs).

Health. It is a state of completely physical, mental and social well-being and not merely the absence of disease or infirmity (Concise Oxford English Dictionary). In this study, it referred to the condition or health of the Internally Displaced Persons.

Internally Displaced Persons (IDPs). It is someone who is force to flee his or her home but remains to his or her country's border. They are often referred to us a refugee (Webster's Comprehensive Dictionary). In this study, it referred to the people of Marawi City who have been forced to flee their homes suddenly or unexpectedly as a result of the last Marawi Siege.

Marawi Siege. This referred to the last eleven-month chaos between the Maute-ISIS Group and the Armed Forces of the Philippines in the city's poblacion resulting to hundreds of death on both sides, and the loss of billions of pesos of properties (Guro, 2017).

Perception. It is the organization, identification, and in interpretation of sensory information in order to represent and understand the presented information, or the environment (Webster's Comprehensive Dictionary). In this study, it referred to the awareness and ideas of the Internally Displaced Persons (IDPs) to the health services render to them.

Services. The action of helping or doing work for someone. It is the system of supplying a public need such as transport, communication, and utilities (Concise Oxford English Dictionary). In this study, it referred to the work or services rendered by the health officials to the Internally Displaced Persons (IDPs).

2. Review of Related Literature and Studies

This chapter dealt with the review of related literature and studies that discussed about the assessment of the health services to the Internally Displaced Persons (IDPs) of the Temporary Shelters of Brgy. Sagonsongan, Marawi City. This provides importance in strengthening the bases for conducting this study, and to provide more insights in the direction of the same study.

2.1 Devolution of Health Services

The Local Government Code of 1991 clearly specified the tasks that should be devolved to the local government units. According to Pimentel (1991), access to "secondary health services" means access to doctors for the treatment of diseases and provision of medicine for indigent patients. Access to "tertiary health services", on the other hand, means access to hospitals (Local Government Code 1991).

With devolution, the role of the Department of Health (DOH) changed from sole provider of health services to provider of specific health services and technical assistance for health to LGUs. The DOH designated as the national technical authority on health. As such, it is mandated to define and formulate programs and strategies that will ensure the highest achievable standards of quality healthcare, health promotions, and health protection, on which local government units, nongovernment organizations, other private organizations, and individual members of civil society will anchor their own health programs and strategies (Executive Order No. 102, 1999).

2.2 Social Welfare

In the book of Mendoza (2001), it is stated that "social welfare" covers practically everything that men do for the good of society. Gertrude Wilson (1949) characterizes social welfare as an organized concern of all people for all people. Walter Friedlander (1955) defines it as " the organized system of social services and institutions, designed to aid individuals and groups to attain satisfying standards of life and health. According to Elizabeth Wickenden (1965), social welfare includes those laws, programs, benefits, and services which assure or strengthen provisions for meeting social needs recognized as basic to the well-being of the population and the better functioning of the social order. These provisions may be directed toward strengthening existing arrangements; mitigating the hardships or handicaps of particular individuals and groups; pioneering new services; stimulating a better adaptation of the social structure including the creation of new programs as needed; or a combination of all these approaches to social needs.

2.3 Access to all health care setting

There is a wide range of recommendations in the literature on how healthcare services can be made accessible, safe, equitable, and efficient for people with disabilities. These range from accessible buildings, equipment, and examination table to accessible communications between healthcare professionals and patients and addressing misconceptions held by healthcare professionals about lives, preferences and abilities of people with disabilities. While it is evident from the literature that some elements of physical accessibility have been implemented in a healthcare setting, an important starting point is to ask a person with a disability about workable solutions (Iezzoni and O'Day, 2006) and to widen awareness that disability access is more than ramps (Panko et al 2004).

Five characteristics of access to healthcare, developed by Simmeonsson et al 1999 include the availability (type and extent of services), accessibility (physical barriers), accommodation (sensitivity to individual differences and disabilities), affordability (financial, time or energy costs) and acceptability (mutual acceptance and reciprocity). In a healthcare context accessibility includes the provision of accessible information and communications and awareness of how to accommodate the needs of people with disabilities in the provision of services (Michaels 2008, Courson 2009, British Medical Association 2007). In particular, improving the awareness of disability and challenging any negative attitude on the part of or staff can help to avoid a situation where health needs are not identified, or 'diagnostic overshadowing' when a person's health problem are viewed as part of the person's disability (Alborz et al 2005, Krahn et al 2006, Smit and Pressman 2010, Mason and Scior 2004). Some issues are raised in the literature about capacity and consent, including confusions and difficulties faced by healthcare staff in this area, and the need for clear procedures and protocols (Royal College Nursing 2011). Specific issues are also highlighted about the need to provide equal access to healthcare, improve the knowledge of healthcare professionals of the health needs of people with disabilities, provide accessible communications between the patient and the healthcare practitioners and promote positive images of people with disabilities. Key issues are raised about the duty of care address the healthcare needs of people with disabilities, and about staff attitudes towards people with disabilities (Jenkins and Davies 2006).

2.4 Prior to Displacement

The right to health and an adequate standard of living should be incorporated into national law for the entire population so that these basic rights can be more clearly articulated in the context of emergencies and disasters and other events involving internal displacement. As of 2005, at least thirteen states had codified the right to health into their national constitutions. The Ugandan Constitution, for example, commits the State to "endeavour to fulfill" key developmental and health-related rights. Uganda's National Policy for Internally Displaced Persons (hereinafter Uganda's IDP Policy), moreover, reflects these commitments through direct reference to the rights to adequate food, water and sanitation, basic shelter, appropriate clothing, and health (Guro et al, 2017).

The establishment of an integrated health support system should extend to the areas of mental health and reproductive health. The Inter-Agency Standing Committee (IASC) Guidelines on Mental Health and Psychosocial Support in Emergency Settings (the IASC Mental Health Guidelines) notes that "activities that are integrated into wider systems (e.g. existing community support mechanisms, formal/non-formal school systems, general health services, general mental health services, social services, etc) tend to reach more people, often are sustainable, and tend to carry less stigma." Similarly, the WHO recommends during all phases of conflict and displacement that:

reproductive health is treated as an integral component of primary health care, and the solutions to reproductive health needs are sought both in the health sector and elsewhere...Among refugees and displaced persons, an integrated approach means including the interactions between host and displaced communities in program planning. It also means that wherever possible, vertical programs, such as maternal and child health, family planning, and STI/HIV control and prevention should be linked or integrated to ensure that reproductive health care needs are met by the provision of a holistic service (Guro et al, 2017).

2.5 Eligibility for Services

In the acute phase of a disaster or complex emergency, IDPs should be considered presumptively eligible for priority public health interventions, including adequate supplies of safe water, sanitation, food and shelter, infectious disease control, basic clinical care, and disease surveillance to the maximum extent necessary through

national, international, and nongovernmental resources. It may be possible, in the case of some natural disasters or limited conflicts, for IDPs to return reasonably promptly to their places of permanent or habitual residence, where access to basic health services should be restored. In many more cases, however, it is likely that the acute phase of emergency will transition into a chronic phase, marked by longer-term displacement, with uncertain prospects of return or permanent settlement in new locations. In such cases, it may become necessary for national authorities to establish eligibility criteria for on-going access to health services for displaced populations (Robinson, 2014).

While eligibility criteria for IDP access to on-going health services in displacement may be subject to local conditions and circumstances, certain principles should apply, consistent with core obligations of the right to health. More specifically, eligibility and service-delivery criteria should ensure the following:

Basic health services are available in sufficient quantity. In the context of displacement, services should not be subject to arbitrary time limits and should be available such that displaced and resident populations are not placed in competition against one another. Health facilities, goods, and services are accessible to IDPs without discrimination. Health facilities, goods, and services are within safe physical reach of all sections of the IDP populations, including vulnerable groups and those in temporary shelter settings. Generally, however, establishment of special or parallel services for IDPs should be only a short-term, emergency measure; in the longer term, health services to IDPs and local populations should be integrated in such a way that any preference given is not on the basis of status but health needs. Payment for health care services—as well as water, sanitation, food, shelter, and other services relating to the underlying determinants of health—is provided on the basis of the principle of equity. IDPs should not be expected to pay for services in the acute phase of an emergency. Over time, however, as more durable solutions are being developed, it is appropriate to begin to harmonize payment (and ongoing social support) mechanisms with those available for local populations. IDPs have the right to seek, receive, and impart information and ideas concerning health issues. Such information accessibility should not impair the right to have personal health data treated with confidentiality. In the context of displacement, accurate and up-to-date information about availability of and access to health services—as well as eligibility criteria for such services—is essential to maintain appropriate use of services by those who need them. In particular, if eligibility criteria are changed over time, this should be done with full participation and involvement of IDP populations. Health facilities, goods, and services for IDPs are respectful of medical ethics and culturally appropriate, including being sensitive to gender and life-cycle requirements. Health information, as well as information collected for purposes of assessing eligibility for services, should be collected in a culturally sensitive manner and stored confidentially. This is particularly important in the context of reproductive health services, which may include the gathering and storing of information about such sensitive issues as fertility and contraception, HIV/AIDs and other sexually transmitted infections (STIs), and sexual and gender-based violence. Health facilities, goods, and services to IDPs are scientifically and medically appropriate and of good quality. This should include attention to the elements of patient safety, effectiveness of care, patient centeredness, and timeliness of service delivery, efficiency, and equity. Clear, streamlined procedures for IDPs and other affected populations are established to maintain necessary health documentation and eligibility for services. These procedures should be broadly disseminated through all available media with adequate opportunity for community participation and input (Egeland, 2014).

2.6 Role of Health and Relief Personnel

It is particularly important during displacement for a state to articulate a plan for deploying health personnel for both shorter-term and longer-term interventions, including how state personnel will interact with other actors such as national Red Cross and Red Crescent Societies and personnel from international and non-governmental organizations. Coordination is key in the health sector, as effective health care delivery in an emergency involves coordinated decision-making and information-sharing about prioritizing public health interventions, harmonizing health education messages, establishing consistent drug treatment protocols, and maintaining patient confidentiality.

In order to coordinate the roles and responsibilities of government agencies working at various levels with that of other actors, states should develop an Emergency Health Action Plan, either incorporated within or coordinated with a national health action plan. The Emergency Health Action Plan should lay out a clear regulatory framework for responding to the health needs of populations affected by disasters and complex emergencies. One model that

states should consider is that of the Committee for the Coordination of Services to Displaced Persons in Thailand (CCSDPT), which was first established in 1977 as a coordinating body for NGOs, international organizations, and government agencies and is still in existence. Another useful model is the Consortium of Humanitarian Agencies (CHA) in Sri Lanka, which has a national and international membership and a mandate (Galtung, 2005).

For a brief operational description of these problems, consider the hypothetical case of Mr. M who is rushed by ambulance to ward A where he is examined. From ward A he is taken to ward B, where he receives medical treatment. He is then taken to ward C for rest and observation. If wards A, B, and C are in different parts of town, operate on different schedules, or provide overlapping service—that is fragmentation. If the ambulance disappears after dropping him at ward A—that is discontinuity. If the distance between the accident and ward A is too far for the rapidity of services needed, or if Mr. M is not admitted to ward A because of social class, ethnic background, or the like, or he is taken to ward for mental patients—that is inaccessibility, and when any or all of these circumstances obtain and Mr. M has no viable course of redress—that is unaccountability.

These problems have many facets, are interconnected, and span a broader range of issue that I describe. Problems of inaccessibility concern obstacles to a person's entering the network of local social services: does bureaucratic selectivity based on social class, race, success potential, or other characteristics exclude certain persons from services? Problems of unaccountability concern relationships between persons served and the decision makers in service organizations: does the person need help unable to influence decisions that affect his circumstances? Are the decision makers in the service organizations turn to insensitive or unresponsive to his needs and interests?

At least six methods of solving these kinds of problems can be identified. They are coordination, citizen participation, role attachments, professional disengagement, development of new agencies, and purposeful duplication. To direct the description and analyses of these methods, three questions are posed in descending order of abstraction: what global properties of the delivery system do the methods seek to alter? In what specific forms are these changes manifest? What are their potential consequences?

Social service workers, along with members of other non-professional groups, are quick to declare their faith in the generic, the whole man, and the comprehensive method of serving persons in need. They recognize the complexity of social causation and the interdependence of mental, physical and environmental influences on people's ability to function and their chances in life. At the same time, professional workers are emphasizing specialization and the development of high-powered technical skill within narrowly defined fields of expertise. In one sense, they are advocating the coordination of services to mitigate the strains produced by the juxtaposition of specialization and the comprehensive method in the professional value structure.

Although it is in many respects a persuasive method, the consequences of access agencies may be more desired than assured: from the recipient's perspective, a possible effect of this method is to further fragment and complicate service delivery. Though access services are becoming increasingly important in complex urban societies, they are nevertheless among the least tangible of social services. The recipient thus may see the access agency merely another bureaucracy to cope with before the proper resources are matched to his needs.

This method is also likely to have certain influence on the other service agencies in the delivery system. The addition of an access agency suggests that the agencies providing other services will cut down on the access services they offer as a marginal function. For instance, pressure would be reduced on these agencies to make special referrals to other agencies for persons they are unable to serve; instead they would merely direct such persons to the access agency. The net effect of transferring the marginal access functions of many organizations to the core function of a single organization is presently unclear regarding the extent to which it lessens travelling time, expense, or confusion in a person's search for service. Moreover, though theoretically possible, may prove clumsy in practice (Guro, et. al., 2017).

The right of IDPs to health and other basic services, including the right to a standard of living adequate to maintain health and well-being, is affirmed in the Guiding Principles on Internal Displacement and is established in various instruments of international human rights and humanitarian law. Emerging standards in humanitarian action and practice seek to establish a regulatory framework for ensuring that the basic health and survival needs of displaced

populations are met. The Guiding Principles reflect the convergence of clinical, curative perspectives and public health, preventive perspectives by affirming both the right to health and the right to an adequate standard of living.

The Universal Declaration of Human Rights (UDHR) Article 25(1) states that “everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and medical care and necessary social services, and the right to security in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond his control”. The International Covenant on Economic, Social and Cultural Rights (ICESCR) affirms the right to an adequate standard of living in similar terms to the UDHR in Article 11. Article 12.1 of the ICESCR recognizes “the right of everyone to the enjoyment of the highest attainable standard of physical and mental health.”¹² Numerous provisions of regional human rights treaties also set out the right to health and an adequate standard of living.¹³

In 2000, General Comment 14 of the United Nations Committee on Economic, Social and Cultural Rights (UNCESCR) noted that “the right to health is closely related to and dependent on the realization of other human rights” and that reference to the “highest attainable standard of physical and mental health” extends “not only to timely and appropriate health care but also to the underlying determinants of health, such as access to safe and potable water and adequate sanitation, and adequate supply of safe food, nutrition and housing, healthy occupational and environmental conditions, and access to health-related education and information, including on sexual and reproductive health.”¹⁴ The Committee also noted the evolution of “a wider definition of health [that] also takes account such socially-related concerns as violence and armed conflict.”

In delineating actions to be taken by states, General Comment 14 noted that the right to prevention, treatment, and control of epidemic, endemic, occupational, and other diseases “includes the creation of a system of urgent medical care in cases of accidents, epidemics and similar health hazards, and the provision of disaster relief and humanitarian assistance in emergency situations.” General Comment 14 also set out a number of “core obligations” under the ICESCR that require immediate rather than progressive implementation. In its prior General Comment 3, the Committee affirmed that “a State party in which any significant number of individuals is deprived of essential foodstuffs, of essential primary care, of basic shelter and housing, or the most basic forms of education is, *prima facie*, failing to discharge its obligations.”

International humanitarian law also incorporates the right to health for victims of international and civil conflict. Protocols I and II of the Convention (IV) Relative to the Protection of Civilian Persons in Time of War (the Fourth Geneva Convention) state that “all the wounded, sick and shipwrecked...shall be respected and protected. In all circumstances they shall be treated humanely and shall receive, to the fullest extent practicable and with the least possible delay, the medical care and attention required by their condition. There shall be no distinction among them founded on any grounds other than medical ones.”²¹ Article 16 of the Fourth Geneva Convention states that “the wounded and sick as well as the infirm, and expectant mothers, shall be the object of particular protection and respect.”

2.7 Related Studies

Yolanda M. Nawal (1995) in her assessment of the devolved health services program in the province of Sultan Kudarat, found that the primary health care program was the most popular and the widely identified devolved health service in the province. She concluded on the following: that the health services in Sultan Kudarat were important especially when an epidemic arises; that there was a need for further information dissemination on the existence of tertiary hospital in a province in order to promote the accessibility of the clients on the health services, and that the health workers were capable and qualified to man the health centers in their area of responsibility. However, there were perceived problems in the administration of health services by the local government units like delay of salaries, inaccessibility to tertiary hospitals, and lack of financial assistance, according to the same author.

Also in the same line of concern, Abu Sweireh (1996), in his assessment of the devolved health services in the province of Lanao del Sur, concluded that majority of the beneficiaries and local officials agreed that health workers delivered health services daily and they did it in a full scale but a great majority of respondents said that health services extended were not adequate and they did not have access to tertiary hospitals. The study also found that

majority of beneficiaries and local officials were satisfied with the delivery of primary care health services in their communities but were not satisfied with other services delivery because the financial support or budget for health programs was insufficient. Thus, the said study further concluded that the dissatisfaction on the quality of health services was due to lack of technology, lack of facilities, and lack of support from the local government officials and executives.

In another study conducted in 2005 on "Leadership Capability in the Implementation of Health Services Program in Marawi City" by Salic Lao recommended the following: the Marawi City Health office should undergo some assessment for organizational development, change strategies to diagnose, implement, and effect some changes/needed modifications; recommendations of both CHO personnel and clients maybe looked into attain some degree of effectively in rendering quality health services; rational staffing and recruitment; conduct of different training to motivate workers; city health officers should work more aggressively (motivational techniques training);moral recovery training such as on the code of conduct and ethics of workers, moral standards and values, and T-group sensitivity training as well as effective leadership/administrative training.

Borlagdan, et. al., conducted a study in 1993 on the issues, problems, and prospects of the devolution of health services delivery function of the Department of Health to the local government units, particularly the municipal and provincial governments. The study was focused on the relationship between the Department of Health (DOH), the provincial government of Laguna, and the municipality of Los Banos in an attempt to provide greater substance and depth to devolution issues, and to provide a clearer picture of how the devolution process was expected to affect services delivery in the local communities.

The devolution of health services from the DOH to the LGUs elicited some sentiments from DOH employees and LGU officials; fear and anxiety. These sentiment reflected concern about the effect of the devolution on the quality of health service delivery. To the extent that deterioration in quality was expected, devolution was viewed as full of disadvantages. There were some, however, who saw the advantages that can accompany devolution (Borlagdan, et. al., 1993:22)

3. Methodology

This chapter presents the Research Design, Locale of the Study, Population and Sample, Sampling Technique Use, Methods of Data Gathering and Methods of Data Analysis. The different schemes, procedures and design were adopted in an effort to realize the objective of the study as briefly presented and described in this chapter.

3.1 Research design

This study used the descriptive methods of research to assess the health services delivered to the Internally Displaced Persons of the Temporary Shelters of Brgy. Sagonsongan, Marawi City. Hence, as a descriptive study, employed a structured questionnaire in collecting the primary data from the field as it is deemed appropriate in the analysis and in the interpretation of the data on survey about the awareness of the IDPs on the Health Services delivered by the City Health Office of Marawi City.

3.2 Locale of the study

This study was conducted in the Marawi City particularly at barangay Sagonsongan. Sagonsongan is one of the barangays in the city of Marawi. According to the data of the Task Force Bangon Marawi (TFBM), The government has built tent for the 500 family households who are Internally Displaced Persons which would rise on an 11 hectare land owned by the several Maranao families in the barangay of Sagonsongan.

Marawi City is formerly known as the municipality of Dansalan. Its name was derived from the Maranao tern 'rawi' which means reclining. Also, it refers to the lilies that bent northward on the bank of the mouth of the Agus River. Historically, the Municipality of Dansalan was established under the Moro Province in 1907. In 1940, Dansalan became chartered city, but was not inaugurated until 1950. In 1956, Dansalan City was renamed Marawi City through a Congressional Act. In 1980, it was officially renamed the Islamic City of Marawi with a 90 percent Muslim population. As Lanao Del Sur's capital city, Marawi serves as the province's commercial, educational, cultural, religious, and political center.

3.3 Population and Sample

The total population of the study were the Internally Displaced Persons (IDPs) at the Temporary Shelters of Brgy. Sagonsongan, Marawi City. However, by using purposive sampling, only the accessible family household were taken as the sample respondents.

The Data of the Task Force Bangon Marawi (TFBM) declared that 500 family household were given temporary lodge on the temporary shelter at Sagonsongan, Marawi City. Hence, by using Sloven Formula, a sample of 80 family households were chosen from the total of 500 family households.

3.4 Sampling Technique Used

To determine the sample respondents of the study, purposive sampling was utilized in choosing the 80 sample respondents using accessibility and availability of the respondents as the criteria for selection.

3.5 Methods of Data Gathering

This study made use of primary and secondary data. Through the use of questionnaire and interview method, the data were gathered from the Internally Displaced Persons of the Temporary Shelters of Brgy. Sagonsongan, Marawi City. Also, the researchers' first-hand observations were also used to supplement the questionnaire and the interview.

The structured questionnaire was divided into three (3) parts: The first part contains the level of awareness of the Internally Displaced Persons (IDPs) on the Health Services provided by the City Health Office of Marawi City. The second part deals with the assessment of the IDP- Respondents on the Health Services provided by the City Health Office of Marawi in terms of the following criteria: a) Availability; b) Accessibility; and, c) Accountability; and the last part is concerned with the perceived problems encountered by the respondents on the delivery of health services provided by the City Health Office of Marawi.

3.6 Methods of Data Analysis

The data collected were presented and analyzed with the use of frequency and percentage analysis method and the weighted mean.

The formulae are as follows:

1. **Percentage** = $(F/N) (100)$

Where:

F = frequency

N= total number of cases

2. **Weighted mean** = $X = \frac{\sum w(x)}{\sum w}$

Where:

X = main value

\sum = summation

W = observed frequency

X = frequency expected

For the scale measurement of the level of awareness, the following class interval (2) were employed:

Score	Interval	Remarks
1	1.0 – 1.50	Aware
2	1.51 – 2.0	Not Aware

For the scale measurement of the perceptions of the respondents on the delivery system of the Health Services by the City Health Office in terms of: Availability, Accessibility and Accountability, the following class interval (5) were employed:

Score	Interval	Remarks
5	4.24 – 5.0	E- Everytime
4	3.43 – 4.23	AE- Almost Everytime
3	2.62 – 3.42	OS- Occasionally Sometime
2	1.81 – 2.61	AN- Almost Never
1	1.0 – 1.80	N- Never

4. Presentation, Analysis and Interpretation of Data

This chapter shows the presentation, analysis and interpretation of data gathered by the researchers to answer the problems investigated in the following order: 1) The level of awareness of the Internally Displaced Persons (IDPs) on the Health Services provided by the City Health Office of Marawi City; 2) The assessment of the IDP- Respondents on the Health Services provided by the City Health Office of Marawi in terms of the following criteria: a) Availability; b) Accessibility; and, c) Accountability; and 3) the perceived problems encountered by the respondents on the delivery of health services provided by the City Health Office of Marawi.

4.1 Level of awareness of the IDP- respondents

This part presents the level of awareness of the IDP- Respondents on the health services provided by the City Health Office of Marawi. Table 1 shows the Frequency Count, Percentage Distribution and Weighted mean of the Respondents perceptions on the health services provided by the city health office in terms of their awareness on the health services provided by the city health office. They were asked to identify their awareness on the health services provided by the City Health Office of Marawi City. The same table disclosed that fifty percent (50%) or half of the health services provided by the City Health Office were known to the respondents such as: 1.) Medical Mission (wm=1.01), 2.) Procurement of Medicine (wm=1.18), 3.) TB DOTS (wm = 1.47), 4.) Immunization (wm= 1.12), and 5.) Presence of Health Professionals (wm= 1.15). on the other hand, some health services were not being known to the respondents such as: 1.a) Maternal New Boarn Program (wm=1.62), 2.) Family Planning Program (wm=1.76), 3.) Wellness of Person with Disability (wm=1.61), 4.) Nutrition Program (1.56) and 5.) Mental/Psycho-social Support Program (wm=1.63).

This foregoing findings imply that the implementation of the health services by the City Health Office were partly implemented and were partly enjoyed by the IDP-respondents. Also, the findings revealed that some health services that are expected to be conducted by the City Health Office to the IDPs in Barangay Sagonsongan were not realized and allegedly the Health Services provided by the City Health Office lack in terms of proper implementation.

Table 1: Frequency Count, Percentage Distribution and Weighted Mean of the Respondents Awareness on the Health Services Provided by the City Health Office

Health Services	Aware (1)		Not Aware (2)		Weighted Mean	Verbal Interpretation
	F	%	F	%		
Medical Mission	79	98.75	1	1.25	1.01	Aware
Maternal Newborn Program	30	37.5	50	62.5	1.62	Not Aware
Family Planning Program	19	23.75	61	76.25	1.76	Not Aware
Wellness of person with Disability	31	38.75	49	61.25	1.61	Not Aware
Procurement of Medicines	65	81.25	15	18.75	1.18	Aware
Nutrition Program	35	43.75	45	56.25	1.56	Not Aware
Mental/Psycho-social Support Program	26	32.5	54	67.5	1.67	Not Aware
TB DOTS	44	55.0	36	45	1.45	Aware
Immunization	70	87.5	10	12.5	1.12	Aware
Presence of Health Professionals	68	85.0	12	15.0	1.15	Aware
OVER-ALL WEIGHTED MEAN					1.41	AWARE

4.2 Assessment of the IDP-Respondents on the health Services provided by the City Health Office

For the perceptions of the respondents on the delivery system of the Health Services by the City Health Office in terms of: Availability, Accessibility and Accountability, the following findings were revealed.

A. Availability

In term of the availability of program and activities, table 2 show that out of the ten 10 statement, only statement one 1 "medical mission" was perceived as "occasionally sometimes" (76.25%, wm=3.02) of the respondents. The statement nine 9 and ten 10 "immunization" (72.5%, wm 2.28) and "presence of the health professionals" (75%, wm=2.65) was perceived as "occasionally sometimes" of the respondents. While the three statement was perceived as "almost never" available by the majority of respondents which ranked as follows: statement 5 "procurement of medicine" (70%, wm=2.37) are available; statement 8 "TB DOTS" (48.75%, wm=1.83) are available; statement 6 "nutrition program" (33%, wm=1.53) are available of the respondents. Finally, the remaining statements was perceived as "never"; statement 2 "maternal newborn program" (0%, wm=1.41); statement 3 "family planning program" (0%, wm=1.07); statement 4 "wellness of person with disability" (0%, wm=1.42); statement 7 "mental health and psychological social support program" (0%, wm=1.16) of the respondents. The total weighted mean for the ten statement indicators is 1.91 verbally interpreted as "almost never"

Table 2: Frequency Count Percentage Distribution and Weighted mean of the Respondents perceptions on the health services provided by the city health office in terms of availability

Legend: E- Everytime; AE- Almost Everytime; Occasionally Sometimes-OS; Almost Never-AN; and Never- N

HEALTH PROGRAMS	E (5)		AE (4)		O/S (3)		AN (2)		N (1)		Weighted Mean	Verbal Interpretation
	F	%	F	%	F	%	F	%	F	%		
1. Medical Missions	0	0	7	8.75	60	75	9	11.25	4	5	2.87	Occasionally Sometimes
2. Maternal Newborn Program	0	0	1	1.25	25	31.25	16	20	2	2.5	1.41	Never
3. Family Planning Program	0	0	0	0	15	18.75	19	23.75	3	3.75	1.07	Never
4. Wellness of Person with Disability	0	0	0	0	27	33.75	15	18.75	3	3.75	1.42	Never
5. Procurement of Medicines	0	0	2	2.5	56	70	6	7.5	2	2.25	2.37	Almost Never
6. Nutrition Programs	0	0	1	1.25	33	41.25	9	11.25	2	2.25	1.53	Never
7. Mental Health and Psychosocial Support Program	0	0	1	1.25	21	26.25	12	15	2	2.25	1.16	Never
8. TB DOTS	0	0	1	1.25	39	48.75	12	15	2	2.5	1.83	Almost Never
9. Immunization	1	1.25	2	2.5	58	72.5	11	13.75	6	7.5	2.68	Occasionally Sometimes
10. Presence of Health Professionals	1	1.25	2	2.5	60	75	8	10	3	3.75	2.65	Occasionally Sometimes
OVER-ALL WEIGHTED MEAN											1.89	ALMOST NEVER

Scaling:

4.24-5.0: Everytime 1.0-1.80: Never

3.43-4.23: Almost Everytime

2.62-3.42: Occasionally Sometimes

1.81-2.61: Almost Never

B. Accessibility

For the accessibility of the program/activities, the table three 3 shows that the statement one 1 "medical mission" (81.25%, wm=2.93) was perceived as "occasionally sometimes" accessible by the majority of the respondents. While the three statement was perceived as "almost never": statement 8 "TB DOTS" (1.25%, wm=1.91) are accessible; statement 9 "immunization" (0%, wm=2.60) are accessible; statement 10 'presence of health professionals" (0%, wm=2.61) are accessible of the respondents. Finally, the remaining six 6 statements was perceived as "never": statement 2 "maternal newborn program" (0%, wm=1.37) are accessible; statement 3 " family planning program" (0%, wm=1.05) are accessible; statement 4 "wellness of persons with disability" (0%, wm=1.35) are accessible; statement 5 "procurement of medicines" (0%, wm=2.38) are accessible; statement 6 "nutrition program" (0%, wm=1.46) are accessible and; statement 7 "mental health and psycho-social support program" (0%, wm=1.01) are accessible of the respondents. The total weighted mean of the ten 10 statement indicators is 1.86 verbally interpreted as "almost never".

Table 3: Frequency Count Percentage Distribution and Weighted mean of the Respondents perceptions on the health services provided by the city health office in terms of accessibility

	E (5)		AE (4)		O/S (3)		AN (2)		N (1)		Weighted Mean	Verbal Interpretation
	F	%	F	%	F	%	F	%	F	%		
1. Medical Missions	0	0	4	5	65	81.25	11	13.75	2	2.25	2.93	Occasionally Sometimes
2. Maternal Newborn Program	0	0	0	0	24	30	18	22.5	2	2.25	1.37	Never
3. Family Planning Program	0	0	0	0	14	17.5	20	25	2	2.25	1.05	Never
4. Wellness of Person with Disability	0	0	0	0	22	27.5	20	25	2	2.25	1.35	Never
5. Procurement of Medicines	0	0	1	1.25	57	71.25	7	8.75	2	2.25	2.38	Almost Never
6. Nutrition Program	0	0	0	0	33	41.25	8	10	2	2.25	1.46	Never
7. Mental Health and Psycho Social Support Program	0	0	0	0	18	22.5	13	16.25	1	1.25	1.01	Never
8.TB DOTS	0	0	1	1.25	39	48.75	15	18.75	2	2.25	1.91	Almost Never
9.Immunization	1	1.25	0	0	61	76.25	9	11.25	2	2.25	2.60	Almost Never
10. Presence of Health Professionals	1	1.25	0	0	62	77.5	8	10	2	2.25	2.61	Almost Never
OVER-ALL WEIGHTED MEAN											1.86	ALMOST NEVER

C. Accountability

As for the accountability of variables, table four 4 disclosed that all the five statement indicators were perceived as "everytime" by the majority of the respondents with the following ranking responses: friendly (82.5%, wm=4.67); approachable (82.5%, mw=4.66); sympathetic (81.25%, mw=4.55); responsive to their duties and responsibilities

assigned to them (77.5%, mw=4.55) and; transparent to the IDPs (75%, mw=4.32). The total weighted mean of the five 5 indicators is 4.55 verbally interpreted as "everytime"

Table 4: Frequency Count Percentage Distribution and Weighted mean of the Respondents perceptions on the health services provided by the city health office in terms of accountability

	E (5)		AE (4)		O/S (3)		AN (2)		N (1)		Weighted Mean	Verbal Interpretation
	F	%	F	%	F	%	F	%	F	%		
1.Approachable	68	85	7	8.75	5	6.25	0	0	0	0	4.66	Everytime
2. Friendly	66	82.5	9	11.25	2	2.5	1	1.25	0	0	4.67	Everytime
3. Sympathetic	65	81.25	8	10	2	2.5	0	0	1	1.25	4.55	Everytime
4. Responsive to their duties and responsibilities assigned to them	62	77.5	12	15	2	2.5	0	0	0	0	4.55	Everytime
5.Transparent to the IDPs	60	75	7	8.75	6	7.5	0	0	0	0	4.32	Everytime
Over-all Weighted Mean											4.55	EVERYTIME

4.3 Problems encountered

For the problem perceived by the respondents in relation to the delivery of health services provided by the city health office to the IDPs, the following ranking of responses were noted: problem 1 "not enough medical supplies" (61.25%); problem 2 "city health officials lack monitoring" (58.75%); problem 3 "delivery of services are late/not on time" (57.50%); problem 4 "lack of continuity of the health services provided" (65%); problem 5 "city health officials are not compassionate" (5%); problem 6 "health professionals lack training" (3.75%) and; problem 7 "medicines are expired" (3.75%).

Table 5: Frequency Count Percentage Distribution and Ranking of the Problems Encountered by the Respondents on the Health Services Provided by the City Health Office

	Response	Percent (%)	Rank
1. Lack of continuity of the health services provided	52	65	1 st
2. Not enough medical supplies	49	61.25	2 nd
3. Health Professionals lack monitoring	47	58.75	3 rd
4. Delivery of services are late/ not on time	46	57.50	4 th
5. City Health Officials are not compassionate	4	5	5 th
6. City Health Officials lack training	3	3.75	6 th
7. Medicines are expired	3	3.75	6 th

Note: Based on Multiple Responses

5. Summary of Findings, Implications and Recommendations

This chapter presents and discusses the summary of the study, the findings, implication and recommendation.

This study attempted to know the perception of the IDP respondents of the Temporary Shelters of Barangay Sagonsongan, Marawi City on the health services provided by the City Health Office. It also looked into the problems encountered by the IDPs in relation to the delivery of health services. For the study methodology, it adopted the descriptive research design wherein a structure questionnaire was employed in collecting primary data from a sample of 80 IDP respondents at the Temporary Shelters of Barangay Sagonsongan, Marawi City.

5.1 Summary of Findings

Based on the research problem and the corresponding data obtained from the field, a summary of the major findings are presented below:

In regard to significant findings of the study, it was revealed that majority of the respondent were aware of all the 10 major services provided by the City Health Office to the IDPs.

In terms of the perception of the IDP respondents on the City Health Office delivery system utilized for the provided health services based on certain criteria such as availability, accessibility and accountability. It was found that the availability and accessibility of the delivery of health services to the IDP respondents by the City Health Office was perceived as "almost never" by majority of the respondents. On the other hand, the accountability in the delivery of health services to the IDP respondents by the City Health Office was perceived by the majority of the respondents as "everytime".

Moreover, the IDP respondent encountered various problem such as: not enough medical supplies, lack of continuity of health services provided, city health officials lack monitoring, medicine are expired, health professionals lack training and delivery of services are late/not on time.

5.2 Implications

Some significant Implication can be drawn from the findings of the study. For instance, the high level of awareness reported by the IDPs respondents regarding the health services provided by the City Health Office to the IDP is an indication that CHO is performing its assigned role but not absolute. It also suggests that the IDPs are not in closed

contact with the City Health personnel.

For the IDP respondents' perception of the City Health Office health services delivery, it can be inferred that it has weaknesses. It was found not effective in terms of availability of health services which means that city health office has not always see to it that health services are available to the IDP. The delivery also is not effective in terms of accessibility, which means to say that the services are not accessible because of some requirements which were difficult to accomplish by the IDP. However, the delivery of health services was effective in terms of accountability which means to say that City Health personnel were approachable, friendly, sympathetic, and responsible.

5.3 Recommendations

Based on the research problem and the findings of the study, the following recommendations may be drawn:

Firstly, the researcher's highly recommending that the local government through City Health office must strengthen the services delivered to the IDP. The two elements or components of the health services provided such as: availability and accessibility components must strengthen because they were perceived as 'almost never' by the IDPs.

Second, The Local Government should allocate more funds to the City Health Office so that program and activities being provided by the City Health Office are sufficient. Through the appropriate agencies like Commission on Audit, the local government should also monitors, control and review funds as well as donation are spent for benefits of the victims of calamities such as Marawi Siege.

Finally, this study should encourage researchers to conduct similar studies in the future that will expound on areas not well-explained or answered by the study, and to prove or disprove some of the findings of the study.

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