Capacity to deliver sexual and reproductive health in humanitarian crises in the Philippines: Lessons for preparedness

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ISBN: 978-0-9924191-3-4

Citation:

Beek, K., Dawson, A. (2019) Capacity to deliver sexual and reproductive health in humanitarian crises in the Philippines: Lessons for preparedness before and after Typhoon Yolanda, The Australian Centre for Public and Population Health Research, Faculty of Health, University of Technology Sydney, Australia

A report delivered for the World Health Organization

Executive summary

Sexual and reproductive health (SRH) is an important consideration for humanitarian managers and health service providers in crisis contexts. Global evaluations have shown that the internationally recognised minimum standards of response to SRH needs in humanitarian settings have not been comprehensively or consistently implemented to meet the needs of affected communities. This is the result of the insufficient preparation of the humanitarian workforce and mobilisation of organisational and political support to provide SRH services to girls, women, boys and men in the aftermath of disaster or conflict. To respond to crisis, preparedness is critical. This research examined the impact of the Australian funded "SPRINT" program that aimed to build supportive institutional structures and human resource capacity to better respond to SRH needs. Specifically this case study investigated the work of training participants from the Philippines and their partners to build supportive political and organisational structures and human resource capacity at multiple levels before the onset of Super Typhoon Yolanda in 2013. This report presents lessons learnt from the SRH response to Yolanda, and discusses efforts to address identified gaps against the changing landscape of humanitarian response in the Philippines.

Background

SRH in Emergencies: Unmet needs

In crises, meeting the SRH needs of women, girls, men and boys is an important public health concern. This calls for a range of essential interventions to prevent sexual violence and assist survivors, reduce the transmission of HIV, prevent excess maternal and neonatal morality, provide contraceptives, manage sexually transmitted infections and HIV care and distribute hygiene kits and menstrual protection materials.

The risk of sexual violence intensifies during periods of instability caused by conflict or natural disaster (UNFPA, 2016). In the absence of protection from legal, social and community support systems, the use of rape as a weapon of war, and the lack of access to resources for women can lead to an increase in sexual abuse, transactional sex, and rape.

The relationship between levels of HIV and other STIs and crises is complex, but displacement is recognised as an important risk factor for transmission. Social instability, the trauma of displacement, the presence of military or peace keeping forces, economic vulnerability of women and minors, and lack of work and educational opportunities and resultant boredom and frustration may contribute to risky sexual behaviour. Conflict and natural disasters may disrupt access to STI/HIV treatment and prevention services and lack of staff and resources may hinder adherence to safe work practices such as standard precautions and safe blood transfusion (Spiegel, 2004).

An estimated four per cent of any displaced population will be pregnant at a given time (IAWG, 2009). Of these women and girls, 15 per cent are estimated to experience life-threatening complications. In humanitarian settings, childbirth will often take place without trained assistance or essential resources, making women vulnerable to death or disability from preventable causes (WRC, 2006). In addition, malnutrition and epidemics often accompany crises and can increase the incidence of pregnancy complications. Lack of access to immediate newborn care caused by displacement and the interruption of health services also jeopardises infant survival.

Despite the growing acknowledgement that threats to sexual and reproductive health increase during humanitarian crises and significantly contribute to excess mortality and

morbidity, evaluations of programs responding to Sexual and Reproductive Health in Emergencies (SRHiE) reveal that, although progress has been made in areas such as institutional capacity (Tran et al., 2015), significant gaps in implementation persist. In 2004 a global evaluation of SRH in emergencies (IAWG, 2004) showed that key challenges explaining these gaps included a lack of preparedness for SRH in emergencies, and a deficiency of resources and capacity to implement an SRH response. More recently, assessments have confirmed that the development of individual, collaborative and systemic capacity continues to be a key challenge to effectively delivering the life-saving services outlined in the global standard of response-the Minimum Initial Service Package for Reproductive Health in Crisis Situations (MISP) (Chynoweth 2015).

The context of the Philippines

The Philippines is at high risk from cyclones, earthquakes, floods, landslides, tsunamis, volcanic eruptions, and wildfires. Since 1990, the Philippines has been affected by 565 natural disaster events that have claimed the lives of nearly 70,000 people and caused an estimated $23 billion in damages. At least 60 percent of the country's total land area is exposed to multiple hazards, and 74 percent of the population is vulnerable to their impact. In 2013, Typhoon Yolanda, the strongest storm ever recorded at landfall, caused over 6,000 reported fatalities and damaged 1.1 million homes in nine regions. The Philippines has experienced internal conflict for over four decades. This includes violence related to a communist-inspired insurgency and a separatist struggle in the southern Bangsamoro region. The risks to sexual and reproductive health outlined in the section above are acutely relevant in a country afflicted by both natural and human hazards. In particular, UNFPA Philippines highlights that

> *[i]n times of emergency and disaster, women- especially pregnant mothers- and girls, become more vulnerable to a range of health and social risks. Pregnancy complications due to lack of emergency obstetric care may arise, potentially leading to maternal or neonatal deaths. Family planning services may not be fully accessible, increasing the risks associated with unplanned pregnancies. Sexual violence as*

well as other forms of gender-based violence mostly affecting young women and young people also increases during times of instability (UNFPA 2017).

The Philippines has made strides in disaster and climate resilience over the past decade. Established in 2010 as part of the Philippine Disaster Risk Reduction and Management (DRRM) Act, the National Disaster Risk Reduction and Management Council is a working group of government, non-government, civil society, and private sector organizations. The Council is responsible for ensuring the protection and welfare of the people during disasters. The National Disaster Risk Reduction and Management Act of 2010 was a landmark piece of legislation that shifted the Government of the Philippines' focus from emergency relief to disaster risk reduction and prevention. The Philippine government formulated a National Disaster Risk Management Plan (NDRRMP) 2011-2028 plan to implement the requirements set out by this legislation. Key governmental partners in disaster risk reduction and reproductive health include the Philippines Department of Health (DoH), which includes the Health and Emergency Management Bureau (HEMB); Department of Interior and Local Government (DILG); Department of Social Welfare and Development (DSWD) and the Office of Civil Defence (OCD).

The SPRINT Initiative: Developing capacity in preparedness

In an effort to address the serious shortfall of health workers with the skills and engagement to prepare for and implement lifesaving components of the MISP the Sexual and Reproductive Health Program in Crisis and Post-crisis Situations (SPRINT) Initiative was first funded by the Australian Government in 2007. This flagship program has been a global forerunner in strengthening policy, advocacy and service provision at national, regional and global levels.

The SPRINT initiative is managed by the International Planned Parenthood Foundation (IPPF) and supported by international agencies such as UNFPA and local non-governmental organisations (NGOs) , including those who are member associations of IPPF. The first Phase of the SPRINT initiative saw the development and implementation of a series of capacity building strategies. Primary amongst these was the Initiative's training course on

Coordination of Sexual and Reproductive Health in Humanitarian Settings. The SPRINT Initiative training was first piloted in three sites (Kuala Lumpur, Sydney and Suva) in 2007 with the aims of strengthening in-country coordination capacity, prompting advocacy for policy change, and providing skills and resources for cascade training at a national level. From this beginning, country level training activities were planned and, guided by the 'country teams' established during the training course, advocacy and other preparedness activities were undertaken. The SPRINT Initiative has since cycled through its second phase and is currently in its third iteration.

As a nation with considerable humanitarian challenges, the Philippines has been involved with the SPRINT Initiative from the first series of pilot trainings. Representatives from the Department of Health, UNFPA Country Office and national NGOs participated in the initial training course and made efforts to meet the training objectives on return to their contexts. This report will explore the capacity development activities undertaken by SPRINT Trainees, their successors, and their in-country partners in the Philippines, with a focus on the contribution of preparedness activities to the SRH response launched in the aftermath of the country's most devastating natural disaster of recent years- Super Typhoon Yolanda (international name Haiyan).

Preparing to respond to SRH in Emergencies

International guidance on responding to sexual and reproductive health in humanitarian settings is encapsulated in the Minimum Initial Service Package on Reproductive Health (MISP). The services and resources included in this package were established to minimise death, disease, and disability from SRH causes among crisis affected populations, and developed in the understanding that SRH must form a critical component of any humanitarian response. The objectives of the MISP are detailed in Table 1 (below), with the objectives of the package as they stood during SPRINT's pre- and post-Yolanda capacity development initiatives, and the updated objectives of the MISP to the right.

Table 1: Objectives of the Minimum Initial Service Package

MISP Objectives of SPRINT Training in the Philippines pre & post Yolanda	Updated MISP Objectives (2017) (From Foster, A. et al. 2017).
Ensure health cluster/sector identifies agency to **lead implementation** of MISP	**Ensure** the health sector/ cluster identifies an organisation to lead implementation of the MISP
Prevent **sexual violence** & assist survivors	**Prevent** sexual violence and **respond** to the needs of survivors
Reduce transmission of **HIV**	**Prevent** the transmission of and **reduce** morbidity and mortality due to HIV
Prevent excess **maternal and newborn** morbidity & mortality	**Prevent** excess maternal and newborn morbidity and mortality
Plan for **comprehensive RH** services, integrated into primary health care	**Prevent** unintended pregnancies
Additional priority activities: Contraceptives available to meet demand; syndromic treatment of STIs; and ARVs available to continuing users.	**Plan** for comprehensive SRH services, integrated into primary health care as soon as possible **Work** with the health sector/ cluster to address the six health system building blocks **Note:** It is also important to ensure that safe abortion care is available, to the full extent of the law, in health centres and hospital facilitates.

Arrival at a point where sufficient motivation and capacity exists to implement action towards all of the objectives outlined above has proven elusive thus far. In fact, the MISP

has still not been fully implemented in any humanitarian emergency to date (Chynoweth 2015). A 2015 report on a global review of SRH efforts in humanitarian settings found that "[t]he way forward would benefit from applying dynamic approaches that knit together disparate elements of the emergency management universe, including pre-crisis preparedness and risk reduction efforts, crisis response interventions, and early recovery and rehabilitation activities" (Chynoweth 2015). The importance of action across the emergency management cycle- from mitigation and preparedness, through response and on to recovery- is clear in this recommendation.

The MISP provides direction on what should be accomplished in the immediate aftermath of a crisis. International guidance on the recovery phase, or the point of transition from the MISP to more comprehensive SRH services is provided in the 2018 update of the Inter-agency Field Manual on Reproductive Health in Humanitarian Settings (Foster et al. 2017), and in the *Granada Consensus on Sexual and Reproductive Health during Protracted Crises and Recovery*. In terms of pre-crisis preparedness, however, guidance on activities to be undertaken before a crisis so that a SRH response could be best supported in its aftermath comes primarily from grey literature from key organisations involved in SRH in humanitarian settings. A review of documents from the Inter-agency Working Group on Reproductive Health in Crisis (IAWG 2010), Women's Refugee Commission (WRC 2011), World Health Organisation (WHO 2011, 2012), and the United Nations Office for Disaster Risk Reduction (UNISDR 2015) revealed that key directives were divided into the different target levels of government, community and individual or organisation. This guidance includes:

Government level:

- Integrating SRH into disaster risk reduction/ mitigation, emergency preparedness and response plans;
- Addressing laws, policies and capacities that affect whether people in crises can access SRH services;

Community level:

- Identifying and reducing risks for vulnerable communities and SRH services by reducing underlying risk factors;
- Undertaking population-based health education around risk factors;

Individual and Organisation level:

- Identifying and preparing human resource capacity; and
- Addressing individual and organisational capacities that affect whether people in crisis can access SRH services.

Human resource capacity, albeit varied, is required for the accomplishment of each of these tasks and is, therefore, key to preparedness. Related to this, capacity development is broadly defined as a process of unleashing, strengthening, creating adapting, and maintaining capacity over time (OECD 2006). The development of capacity may have a broad focus- that is, be interested in systemic change at government or community levels; or may be more narrowly targeted at increasing individual or organisational capacity through training and trainee-supportive activities. Both of these strategy-types are important and mutually reinforcing. As noted above, human resource capacity is necessary for preparedness activities at all levels. Similarly, changes to policy and practice at the government and community levels support the work of individual trainees and their organisations as they conduct preparedness activities and implement a SRHiE response (Beek 2016).

SPRINT Training sought to integrate narrow focus capacity development with broad focus capacity development in the objectives of its training on *Coordination of Sexual and Reproductive Health in Humanitarian Settings*. SPRINT's expectations of participants in this training were three fold. First, trainees were expected to undertake advocacy to governments, organisational superiors or other stakeholders, to ensure the integration of SRH into national, regional or organisational emergency preparedness and response plans. In addition, there was a focus on increasing human resource capacity for MISP implementation through the organisation of in-country training workshops that were to 'echo' the training they had received. Finally, it was expected that trainees would work in teams to coordinate action for preparedness and response, including applying core concepts and techniques provided in the MISP.

Through this case study, we will work to highlight both broad and narrow preparedness activities undertaken by SPRINT trainees and partners within the Philippines, how these

efforts supported- or failed to support- the SRHiE response, and lessons for future preparedness activities evident in the aftermath of Super Typhoon Yolanda.

Methods

This case study examines how the preparedness activities of SPRINT Trainees, their successors and partners, supported the sexual and reproductive health response to Super Typhoon Yolanda (Haiyan). Interviews with training recipients, partners, coordinators and decision makers from international and national non-governmental organisations were undertaken to answer the following research questions:

1. How did government level, community level, organisational level and individual level preparedness activities support the SRHiE response to Super Typhoon Yolanda?
2. What gaps in preparedness activities were evident in the SRHiE response to Super Typhoon Yolanda?
3. What were the key lessons for SRHiE to come from the response to Super Typhoon Yolanda?
4. How have preparedness activities for SRHiE changed since Super Typhoon Yolanda?

As this case study focuses on the implementation and institutionalisation of a unique program, decision makers from organisations involved were interviewed as key informants to share their experiences. Twelve interviews were conducted, six with male respondents and six with female respondents covering a range of ages. Due to the small number of informants and unique area of work, respondents have been de-identified as much as possible to ensure confidentiality. To maintain anonymity, direct quotes included in this report are numbered in the order they appear and are not attributable to unique individuals.

Researchers undertook thematic analysis of interview transcripts. NVivo (QSR International) qualitative analysis software was utilised for storing, sorting and coding data. This research project has received ethical clearance from the University of Technology Sydney Human Research and Ethics Committee (approval number: UTS HREC REF NO. ETH18-2118) and the Philippines National Ethics Committee (application number: 20180416-29-NEC).

Findings

This case study traces the work of SPRINT trainees, their successors and partners before, during and in the aftermath of Super Typhoon Yolanda. In the section to follow, respondents from organisations directly involved in preparedness and response provide insight into their individual and organisational roles, collaboration between agencies, gaps identified from the preparedness phase, and how each of these aspects influenced the quality and timeliness of the response.

Preparing to respond to SRH needs in Emergencies in the Philippines: Before Yolanda

Government involvement is critical to ensure humanitarian preparedness and response in most settings. Prior to Typhoon Yolanda in 2013, the Philippines Government had adopted the cluster approach, which reflects the post-humanitarian reform structure recommended by the United Nations (UNHCR 2019). Despite this restructuring, one respondent commented that government led preparatory activities for humanitarian response at this time "were all but absent. A few provinces were ahead but not with respect to reproductive health, just the usual things, but not RH" (1). This reported absence of leadership from government actors involved in health and emergency response was said to result in the lack of a "clear platform for collaboration" (2) and was associated with ad hoc approaches to response when a disaster did occur.

Having undertaken training provided by the Australian funded, IPPF delivered SPRINT Initiative in 2008, members of the newly formed SPRINT Philippines Country Coordination Team focused their efforts on tackling identified gaps in preparedness by establishing a "joint re-entry action plan" (3). The Philippines country team was initially comprised of representatives from the Department of Health, UNFPA, Family Planning Organisation of the Philippines (FPOP) and the Philippines Red Cross. This partnership, driven by the commitment of those involved and the support of their organisations, sought to address collaboratively the absence of specific reproductive health services in government preparedness and response planning. In addition, it aimed to ensure that the MISP was integrated into the National Disaster Risk Reduction Management Plan, the Magna Carta for Women and the Responsible Parenthood and Reproductive Health Law of 2012. This Country Coordination Team and its subsequent members conducted advocacy and echo-

training in line with the SPRINT Initiative's capacity development objectives. As a result of these efforts, a key informant noted that, "SPRINT [in-country] trainees, having been made aware of the cluster system, sought out these clusters and became a member at the local cities, municipalities, provinces, regional and national levels" (4).

The advocacy work of the SPRINT trainees, their organisations and their partners, and the access members of this group had to decision makers within agencies that oversee the National Disaster Risk Management Plan, led to a degree of institutionalisation of the MISP. This was achieved by incorporating the MISP into the government's humanitarian response protocol. Responsibility for this task was assigned to the National Disaster Risk Reduction and Management Committees at all governmental levels- from national to local. Despite this achievement, organisations remarked that a clear "gap between institutionalisation and implementation" (5) remained. Limitations were noted such as the lack of priority given to reproductive health in local level emergency preparedness and response planning, and a lack of supplies to implement the MISP in the event of a crisis. It was reported that UNFPA allocated funding and supplies for FPOP to provide components of a reproductive health response, but that this was implemented in response to disasters and not the preparedness phase. In addition to sourcing and distributing supplies during the acute phase of the crisis, another informant noted that the governmental structures and key personnel who would be involved in the response were unclear at this stage.

At an organisational or health service level, FPOP formalised a specialist Humanitarian response unit in 2009 that was supported by SPRINT. One informant reported that this unit was established as a result of "the internal motivation of FPOP to do a response, the willingness of management" (6). This marked an organisational departure from the provision of family planning services in standard non-emergency settings and an official integration of the MISP and emergency preparedness and response into organisational structures and regular programming. MISP training was then rolled out across the organisation with the aim that "key staff and provincial chapters are trained in MISP and are part of the health and protection clusters in their respective areas…SPRINT training currently covers 100% of FPOP chapters" (7). However, it was reported that prior to Yolanda, there was a perception that if staff had undergone "training, this would be enough-

but it was not enough. The MISP training is not enough, we also need an implementation plan and standard operating procedures" (8).

Between 2008 and 2009, UNFPA also strengthened their in-country Humanitarian Unit. One respondent noted that

> *UNFPA wanted to ensure that the gains they had been making didn't go to nought when there's an emergency. That people should still have access to SRH services even in emergencies. Emergencies are not enough reason to justify women dying in childbirth because we can prevent it* (9).

Participants reported that the advocacy efforts of SPRINT trainees had guided the move towards a more formal integration of SRHiE into core business. As explained by one participant, "the [SPRINT] training was a trigger. It gave more of a direction to my work" (10). In 2009, a national level Reproductive Health Working Group was established as a consortium of relevant government and non-government and civil society organisations with the aim of moving toward full integration of the MISP into preparedness and response planning. FPOP and UNFPA were assigned co-leads of the working group and this cemented their working relationship for that period.

At the community level and in recognition of the government's move towards disaster risk reduction, there was greater discussion of the need to incorporate community-based approaches, and to work with a demonstration area to "organise the women and youth" (11) in mitigation and preparedness for reproductive health. The distributed, bottom up structure of FPOP and the Red Cross, and their strong engagement with youth and other volunteers was seen as an critical to this work at the community level.

Responding to SRH needs in Emergencies in the Philippines: The response to Yolanda

Despite the integration of the MISP into government and organisational policy alongside the integration of trained personnel into the relevant clusters, gaps between institutionalisation and implementation were described by participants in the response to Super Typhoon Yolanda. These gaps were reported to directly impact upon the quality and timing of this response in November 2013.

Participants explained that FPOP, UNFPA, Red Cross and others worked in partnership with the Department of Health to launch a sexual and reproductive health response to the large-scale disaster. This response included medical missions that provided prenatal care, newborn services, STI services, and health and gender-based violence information sessions. Clients were offered family planning information and services and given a hygiene kit as needed. These medical missions were coordinated by the city, municipal or provincial health office, staffed by clinicians from the Department of Health, and supported by agencies including UNFPA, Red Cross, FPOP chapters and by volunteers.

An important factor in this response according to the participants was inter-agency coordination between the above organisations. FPOP was a primary implementing partner for UNFPA, and also had a memorandum of association with Philippines Red Cross. Despite the establishment of the Reproductive Health Working Group as a potential coordination mechanism prior to Yolanda, the lack of preparedness, the 'ad hoc' nature of this association, and the absence of a formal platform for collaboration with government were reported as problematic, having:

> *A direct impact on the response. We would have been able to respond more clearly if structures had been in place. In the absence of [more formal structures and policies], that says that SRH is something that should be an integral part of the government's humanitarian response, we had to orient local government units affected. We had to orient health partners on the ground on the importance of SRH, on why the health cluster had to include SRH in its discussions, so things that could have been done as part of preparedness. So that affected our capacity to respond quicker* (12).

The primary role of the Department of Health and other government actors was reported to be unclear and many organisations lacked an understanding of when the Government should take the lead during the response. This was "one criticism that came from the government after Yolanda, that they felt they were being pushed around by international agencies coming in and calling the shots, instead of the other way around" (13).

A number of informants also described a lack of dedicated coordination skill building in the MISP trainings conducted during the preparedness phase. Participants stated that the contents of the training did not adequately address the roles and responsibilities of government and non-government organisations during the response. Missing from the training was an effective and well-facilitated "simulation exercise to understand who the players are and how to coordinate. This is different from just having the knowledge" (14).

Respondents from all involved agencies acknowledged the contribution of community-based and youth volunteers as supporters of the Yolanda response. These volunteers were engaged to "inform community to register and wait to see a doctor or other provider, and while they are waiting, give them information on sexual and reproductive health" (15). A source of these youth volunteers were local FPOP chapters, and it was reported that the experience of coordinating youth volunteers gained during two preceding disasters (Sendong and Pablo) allowed the successful integration of these young people into the Yolanda response. Many of the youth volunteers had received some training prior to their work in support of medical missions, but it was noted that "the number of youth volunteers balloons during a crisis" (16) as there is "no school and they are very active" (17). The Philippine Red Cross's model of community networks and engagement was also noted as beneficial to the response as it allowed geographic coverage, socio-cultural understanding and acceptability of information and services, and proximity of trained volunteers to affected communities (18).

The broad and narrow capacity development efforts of SPRINT trainees and their partners prior to Yolanda was perceived to support the SRHiE response. Evidence for this was reported across government, organisational, community and individual level efforts as described above. However, gaps were noted in preparedness at each of these levels prior to Yolanda and this was reported to restrict the timeliness and effectiveness of the response. The learning that emerged from this large-scale catastrophe was described as having been fed into subsequent efforts and approaches- by local non-governmental organisations, international organisations and the Philippines government alike.

Lessons learnt from the response to Yolanda: preparing for subsequent disasters in a changing landscape

1. Cascaded Integration

Participants reported that a number of developments at the governmental level have ensued in the period since Typhoon Yolanda. Many of these changes occurred in 2016 when the government "took on full responsibility for the implementation of the MISP" (19). During this year, the Philippine Department of Health implemented department-wide guidelines on MISP implementation. In the following year, the Philippines government signed a final Joint Memorandum Circular to facilitate cohesive MISP implementation between the Department of Health, Department of Social Welfare and Development, Department of Interior and Local Government, and the Office for Civil Defence. An outcome of this, mandated by an Administrative Order, was the establishment of Reproductive Health Coordinating Teams (RHCT) from national to local levels. The national-level RHCT was regarded as a positive step toward addressing the 'ad hoc' nature of the SRHiE response to Yolanda. It was also seen as a way of ensuring that "SRH are addressed in emergencies whichever administration is in place" (20).

FPOP and UNFPA were reported as having been involved in the initial establishment of the RHCT at a national level, and respondents from both organisations remarked that an ongoing challenge is establishing more local level equivalents. The Joint Memorandum Circular requires "the integration of the MISP for SRH into the National Disaster Risk Reduction Management Plan as well as into the Local Disaster Risk Reduction Management Plans of local government units" (UNFPA, 2017). The response to Yolanda showed the importance of having clearly defined structures that facilitate coordination between agencies. The government was described as leading these coordination mechanisms, and supplying clinical service providers to implement the MISP. One participant described the importance of the institutionalisation of the MISP and that it should be "cascaded to Local Government Units" (21).

Participants reported that UNFPA efforts emphasised the need to collaborate with all government levels to ensure that policy is translated into SRH information and service

provision for communities affected by crises. Strategies to support localisation were noted, including working with the Department of Interior and Local Government to integrate the MISP into local disaster management plans and budgeting and working with the Local Government Academy to incorporate MISP indicators into the manual used by local chief executives to prepare for emergency response. Including MISP indicators in this manual "would mean they include MISP as part of preparedness, which would include prepositioning as part of preparedness at the level of the municipalities or even Barangay, capacity building of their staff, of their teams, and that would include capacity building of the MISP and the mechanisms that need to be in place" (22).

Participants said that FPOP had developed integrated strategies to promote the local institutionalisation of the MISP into their current work plans. The organisation is undertaking "advocacy efforts supported by training of members of the local Disaster Risk Management Council on the MISP" (23). It was also noted that the structure of FPOP works to support this goal as "this coordination council do coordination at a local level, on level with our chapters. FPOP chapters were not originally included in these meetings, but after we orient them on the MISP, on programming the MISP, they know that FPOP is potential for that program and they [FPOP chapters] were included in being part of the meeting for coordination" (24). Training and orientation of local Disaster Risk Management Councils is seen as a "gateway that allows the response…and then lets local mechanisms work" (25).

Also recognising the importance of working at community level, it was noted that the Philippines Red Cross harnessed the potential of local volunteers to "give some practical solution, information or referral" (26) for reproductive health in humanitarian settings. Some particpants suggested that this could best be done by working with service provision organisations, such as FPOP chapters. In such a scenario, local Red Cross volunteers could be responsible for "bringing in people, telling people the services available in the reproductive health centres run by FPOP and Department of Health (DoH) and do a joint operation in that sense" (27). Developing the capacity of volunteers to undertake such work in the preparedness phase was seen as key: "the volunteers cannot be trained during an emergency. They have to be trained before" (28).

2. Government leadership

The involvement of government and the efforts to integrate SRHiE into programming at all policy levels was said to have become a significant directive of the work of FPOP, UNFPA, Red Cross and partners, particularly since Yolanda. As one respondent explained, "the government takes the lead and must feel that they are" (29). As noted previously, direction for the response to Typhoon Yolanda often came from outside the government, and as a result, "the government felt that they were being pushed around. [The government] always go back to that and they say we don't want a repeat of Yolanda…That was one reason why there's this sensitive balancing act we need to do post-Yolanda" (30).

Participants described the importance of engaging collaboratively with government and that maintaining a balance between contribution and leadership has become increasingly clear after the change of government in 2016. New policies of the current administration and some funders have meant that the ability of organisations, to utilise international donor funds for humanitarian response have been affected. High-level approval for the disbursement and use of such funds is now required. In addition to this, "the government must declare an emergency, request assistance and invite people to respond" (31) regardless of whether the agency is country-based or international. As explained by one respondent:

> *[t]his new administration is not that keen on automatically requesting international assistance in the aftermath of an emergency. Unlike the prior administrations who would immediately welcome any support from both international and local NGOs, …[the current administration] expect all humanitarian agencies to wait for the government agency partner to request for support before doing anything on the ground* (32).

For a number of informants, this different political landscape and the fallout from the Yolanda response reinforced the importance of integrated structures to support and sustain SRH response in humanitarian emergencies. Participants noted that the RHCT was a key component of MISP institutionalisation. The Reproductive Health Working Group, the

mechanism which was in place during the Yolanda response and which preceded the RHCT provided a:

> *partnership with the government agencies like DoH and DSWD on ensuring that RH and GBV were addressed during emergencies but there was no clear platform which we could use as basis for this collaboration with the government. So it was basically ad hoc….There was not a structure within which we could ensure that SRH are addressed in emergencies... That's why we were looking at ensuring that the MISP would be taken on by government and the RHCT would be established. Because that makes it a regular thing already. So even if there's a change in administration, with that in place, that structure in place, that ensures that SRH won't be out of the equation* (33).

Participants noted that in addition to providing a platform for coordination between involved government agencies, NGOs and INGOs, meetings of the RHCT afforded organisations an opportunity to be seen and remain engaged with government. As one informant explained, it is important to attend "meetings of the RHCT, make your presence felt, because it's important that the DoH recognises you, because it's the DoH that calls the shots" (34).

3. Pre-positioning supplies and funds

Reflecting on the response to Yolanda, many of the participants reported that they had learned the importance of launching a timely response, and the need for equipment and commodities to enable this. One participant remarked that this was "just not seen as so important before Yolanda" (35). After Yolanda, involved organisations have been involved in advocating to and assisting the government to preposition reproductive health equipment and supplies. Amongst these supplies are

> *dignity kits, reproductive health medical mission supplies used by mobile medical teams, emergency maternity tents including all equipment for normal deliveries, women friendly space tents with their own equipment…supplies for facilitators, solar radios with sirens and flashlights"* (36).

The supplies can be made available to "local government units, health staff and non-government organisations when needed" (37).

On-hand commodities were said to be critical for the implementation of the MISP and the importance of prepositioning these supplies within country was further highlighted in reference to the government's new requirements for the use of international funds. As one informant explained, "the use of internationally sourced funds is limited, but we are allowed to use in-country pre-positioned goods. This is one reason why the push toward pre-positioning has grown" (38). It was also suggested that, in order to facilitate timely response, pre-positioning be expanded from commodities to funding, because "of course cash should be ready always to buy supplies" (39).

4. Strengthening capacity

Individual and organisational capacity development efforts for sexual and reproductive health in crises in the Philippines were described as having been largely based upon the SPRINT Initiative's 'Training on the Minimum Initial Service Package (MISP) for Sexual and Reproductive Health in Crises: A Short Course for Coordinators'. Some issues with the training were noted by participants including that it did not sufficiently equip some trainees with an understanding of the key players within their own context or the skills to enable them to coordinate effectively with these organisations. In response, SPRINT is working to develop capacity development activities on "standard operating procedures, clear stakeholder mapping, finance, policy, approval mechanisms" (40) into the training so that "people feel more confident to respond" (41). Part of this is re-developing and increasing facilitation capacity for a "simulation exercise, simulation about coordination and implementation- who are the players and how to coordinate" (42).

In addition to this limitation in the training content, a participant from one involved organisation highlighted that the MISP itself is almost entirely service or supply-side oriented, with very little on "how people are going to reach out to [beneficiaries]" (43). This respondent made clear that while medical mission clinics which include RH services are being set up in humanitarian settings, a gap in the MISP is a lack of direction for community volunteers to "identify the cases and bring them up to us so the doctors and nurses don't

need to go to the community". This was reported as significant for service delivery in these contexts as, "if [doctors and nurses] have to reach out to the community, then they can maybe serve five per cent of their community only" (44). Participants described strategies to support and strengthen community mobilisation and preparedness that were being developed in collaboration between IPPF and the IFRC that would soon be piloted in the Philippines. The aim of this module is to develop the capacity of locally based volunteers to recognise signs and symptoms of sexual and reproductive ill health and direct members of their community to appropriate services in humanitarian contexts.

Across the organisations involved, changes in personnel, including service providers, implementing partners and decision makers, were seen to be accompanied by fluctuations in capacity, commitment and cooperation. Informants reported that changes in leadership and staffing of government agencies, NGOs and INGOs alike compromised capacity, perceptions of capacity, commitment to SRHiE and perceptions of commitment to SRHiE, and that this in turn strained formal partnerships. The commitment and drive, which had characterised the work of the original cohort of SPRINT trainees, their successors and partners, was broadly respected and appreciated. However, there was a strong understanding of the need for sustainable integration of policy and practice which addresses SRHiE into both government and non-state sector organisational structures, and that this was necessary in order to maintain the work of those who had come before, build structural resilience, and sustain growth and strategic momentum through staff and governmental changes.

More generally, it was noted that there is a lack of capacity to respond and that in the event of large-scale disasters such as Yolanda surge capacity was required. As explained by one informant, "there was a movement of humanitarian actors from Mindanao to areas affected by Yolanda" (45). This had consequences for both the ongoing humanitarian situation in Mindanao, and the integration of these actors within the government response mechanisms, who were sometimes seen as "too pushy, and didn't recognise local capacity" (46).

Despite the importance of volunteers to support the implementation of the MISP, as demonstrated during the Yolanda crisis, respondents from organisations involved in

community-level work with volunteers described the need for further training for volunteers to harness their potential. Youth and other volunteers were seen as being key to supporting medical missions and for bringing potential beneficiaries to MISP services. In order for this to be achieved, however, one respondent stated that, "volunteers need to be trained on key messages, danger signs and what to do. For example, for sexual violence, they need to be able to identify this and then know what to do. Volunteers bridge the gap between communities and evacuation centres" (47). Identification and training of potential volunteers is a key lesson to emerge from Yolanda, and yet the "individual capacity of volunteers is still an issue" (48).

Broader work to build capacity at the community level was reported to be unfinished business for many involved in SRHiE in the Philippines. Participants described the position of community-based organisations as an important entry point for community based disaster risk reduction as these groups are "already working with local government for normal programs and community members are already our clients" (49). To expand this work, "more planning is being done to establish community-based mechanisms [such as volunteer networks and pre-positioned goods], based at a local level" (50) in order to "develop capacity to the community level regarding the MISP" (51). In this way, organisations are attempting to integrate the Disaster Risk Reduction approach of government policy into community based programming.

Conclusion:

The drive and commitment of those who have sought to address Sexual and Reproductive Health in Emergencies in the Philippines has resulted in considerable progress toward meeting the SPRINT Initiative's broad and narrow capacity development goals and the global community's guidance on pre-crisis preparedness. At a government level, much has been done to integrate SRH into disaster risk reduction and emergency response plans and address laws and policies that affect whether people in crises can access SRH services. SRH organisations have strengthened their humanitarian response capacities, and humanitarian response organisations have integrated an SRH lens. Efforts to ensure the translation of this

progress up to the local government and community level are underway and remain a work in progress.

This case study of the SRHiE response to Super Typhoon Yolanda has revealed gaps in the preparedness work undertaken before this crisis, and provided insight into the strategic direction needed to improve preparedness efforts for future emergencies. The individuals who contributed to this research emphasised the importance of ensuring the institutionalisation of SRHiE at both non-state sector and government levels. Embedding SRHiE in such structures is vital to ensure the sustainability of preparedness efforts particularly in light of changing political, organisational and human resource landscapes. Government leadership remains critical for the instigation, delivery and maintenance of any SRH response in crisis settings in the Philippines.

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