



Republic of the Philippines
Department of Health
OFFICE OF THE SECRETARY

FEB 26 2016

ADMINISTRATIVE ORDER

No. 2016 - 0005

SUBJECT: National Policy on the Minimum Initial Service Package (MISP) for Sexual and Reproductive Health (SRH) in Health Emergencies and Disasters

I. BACKGROUND

The Philippines ranks second to Vanuatu as the most disaster-prone country in the world based on the World Disaster Risk Index of the 2014 World Risk Report of the UN University Institute of Environment and Human Security. Yearly, it experiences almost all forms of natural and human-induced calamities such as typhoons, earthquakes, floods, volcanic eruptions, landslides, fires, and armed conflicts. Statistics show that from 1900 to 2012, the Philippines was hit by 531 disasters, affecting more than 160 million people and causing USD 10.5 billion in economic damages. In 2013 alone, 16 disasters hit the country, the most destructive of which was Typhoon Haiyan (Yolanda) affecting 26 million people with at least 8,000 casualties (NDRRMC Final Report on Typhoon Yolanda: 2013). These data show the impact of natural disasters resulting in extensive damage to houses and facilities, loss of lives, livelihood and breakdown of services (CRED Crunch Issue No, 34 jcmc 2014).

In times of crisis, reproductive health concerns become even more significant as causes of new risks. In any affected population, it is globally estimated that about 4% of the total population are pregnant, another 3.5% are lactating women and 15% are adolescents. Around 15% of pregnancies may end up in complications while 5 to 15% will require a Caesarian section. Premature delivery among pregnant women may occur during times of displacement. Furthermore, the disruption of vital access to reproductive health care, information, and services would deprive pregnant and lactating women, their newborns, young people and men of essential health care services or interventions such as prenatal care, skilled birth attendance, postpartum care, newborn care, adolescent sexual and reproductive health care, family planning and STI, HIV and AIDS services. There is, therefore, a clear need for emergency health care for pregnant and lactating women and their newborns and to protect women, girls and other vulnerable groups from gender-based violence (GBV), unplanned/unintended pregnancies, or STI, HIV and AIDS during emergencies and disasters.

Chapter 10 of the 1994 ICPD Programme of Action states that "all migrants, refugees, asylum seekers and displaced persons should receive basic education and health services". This emphasizes that all people, including those living in humanitarian settings, have the right to reproductive health.

Due to the susceptibility of the country to disasters, the Philippine Congress passed Republic Act No. 10121 also known as the Philippine Disaster Risk Reduction and Management Act of 2010. This law aims to strengthen the Philippine Disaster Risk Reduction and Management System. It mandates the creation of a National Disaster Risk Reduction and Management Council (NDRRMC) and the institutionalization of the National Disaster Risk Reduction and Management Plan (NDRRMP) consistent with the National Disaster Risk Reduction and

Management Framework (NDRRMF), which envisions " a country of safer, adaptive and disaster – resilient Philippine communities towards sustainable development".

The NDRRMP covers four thematic areas, namely: Disaster Prevention and Mitigation, Disaster Preparedness, Disaster Response, and Disaster Rehabilitation and Recovery. Under disaster response, the National Disaster Response Plan (NDRP) adopts the global humanitarian cluster approach which designates cluster leads and ensures that there is predictable leadership and accountability in all the main sectors or areas of activity. Under the NDRP, there are currently eleven clusters: Food and Non-Food Items (FNI); Camp Coordination and Camp Management (CCCM); Health; Education; Protection; Search, Rescue and Retrieval (SRR); Management of the Dead and Missing (MDM); Logistics; Emergency Tele - Communications (ETC); Law and Order (LAO); and International Humanitarian Relations (IHR). Each of the cluster has a designated Government agency cluster lead and a UN agency or International Humanitarian Partner (IHP) co-lead.

The Department of Health (DOH) leads the Health Quad Cluster which includes Health; Nutrition; Water, Sanitation and Hygiene (WASH); and Mental Health and Psychosocial Support Services (MHPSS).

II. DECLARATION OF POLICIES

The Minimum Initial Service Package (MISP) for Sexual and Reproductive Health (SRH) is provided for in the Magna Carta of Women (RA 9710) enacted in August 2009, and in the Responsible Parenthood and Reproductive Health Law (RA 10354) enacted in December 2012. The IRR of the Magna Carta of Women under Rule IV – Rights and Empowerment, Section 13 provides that "there should be timely, adequate and culturally appropriate provision of comprehensive health services, including the implementation of the MISP for SRH at the early stage of the crises".

The IRR of the RPRH Law under Chapter 2 – Provisions and Financing of Care, Rule 4 – Service Delivery Standards, Section 4.15, on the other hand, provides for maternal and newborn health in crisis situations. In particular, "LGUs and the DOH shall ensure that a minimum initial service package for reproductive health, including maternal and neonatal health care kits as defined by the DOH, shall be given proper attention in crisis situations such as disasters and humanitarian crises. The minimum initial service package shall become part of the DOH response to crises and emergencies. Temporary facilities such as evacuation centers and refugee camps shall be equipped to respond to the special needs of the following situations: normal and complicated deliveries, pregnancy complications, spread of HIV and STIs and gender-based violence."

III. OBJECTIVES

- A. To provide guidelines to all concerned agencies and stakeholders on the implementation of the Minimum Initial Service Package (MISP) for Sexual and Reproductive Health (SRH) during emergencies and disasters.
- B. To define the core package that will constitute the MISP for SRH during emergencies to be integrated in the DOH essential service package for emergencies.
- C. To create the national Reproductive Health Coordinating Team (RHCT) that will coordinate the implementation of the MISP for SRH during emergencies.

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IV. SCOPE AND COVERAGE

These guidelines apply to all DOH Central and Regional Offices and its attached agencies, public and private health facilities, civil society organizations, private organizations and other international and local humanitarian partners that have mandates and interests in the delivery of SRH and GBV services in the preparedness, response, recovery and rehabilitation phases of an emergency.

V. DEFINITION OF TERMS

- A. Cluster Approach -a way of organizing coordination and cooperation among humanitarian actors to facilitate joint assessments, analysis, strategic planning, response, monitoring and evaluation of humanitarian situations. It establishes a clear system of leadership and accountability for response in each sector; and provides a framework for effective partnerships among national, local and international humanitarian actors in each sector.
- B. Disaster – a serious disruption of the functioning of society, causing widespread human, material or environmental losses which exceed the ability of the affected society to cope using its own resources.
- C. Disaster Risk Reduction and Management – the systematic process of using administrative directives, organizations and operational skills and capacities to implement strategies, policies and improved coping capacities in order to lessen the adverse impacts of hazards and the probability of disaster.
- D. Emergency – unforeseen or sudden occurrence, especially danger, demanding immediate action.
- E. Gender-Based Violence (GBV) – is a term for any harmful act directed against a person on the basis of gender. It includes acts that inflict physical, mental or sexual harm or suffering, threats of such acts, coercion and other deprivations of liberty (Inter – Agency Standing Committee on GVB Guidelines 2015)
- F. Humanitarian Crisis – an event or series of events that represent a critical threat to the health, safety, security of wellbeing of a community or other large group of people usually over a wide area. Armed conflicts, epidemics, famine, natural disasters and other major emergencies may all involve or lead to a humanitarian crisis.
- G. Inter-Agency Emergency Reproductive Health Kits – refer to twelve (12) standard kits primarily designed to facilitate provision of priority RH services to displaced populations without medical facilities or where medical facilities are disrupted during crisis. They contain essential drugs, supplies and equipment to be used for a limited period of time by a specific number of people.
- H. Minimum Initial Service Package (MISP) for Sexual and Reproductive Health (SRH) - a set of priority activities to be implemented in emergency situations with the goal of reducing maternal mortalities, morbidities and disabilities through specific interventions on coordination, prevention of gender-based violence, prevention of sexually transmitted infections-human immune deficiency virus/ acquired immune deficiency syndrome (STI, HIV and AIDS), maternal and neonatal care, and

- planning for comprehensive RH following the SPHERE standard. When implemented in the early days of an emergency, it can save lives and prevent illness, especially among women and girls.
- I. Project SPHERE - initiated in 1997 by a group of humanitarian non-governmental organizations and the International Red Cross and Red Crescent Movement, the project identified a set of minimum standards in key life-saving sectors such as WASH, food security, nutrition, non-food items, health and shelter that must be achieved in any humanitarian response in order for disaster-affected populations to survive and recover in stable conditions with dignity.
 - J. Provider of Last Resort – where necessary and depending on access, security and availability of funding, the cluster lead, as provider of last resort, must be ready to ensure the provision of services required to fill critical gaps identified by the cluster. The provision of last resort is activated when all three conditions below are met:
 - 1) The cluster agrees that there is an important life-threatening gap in the response;
 - 2) One or more of the agreed benchmarks for the response as a whole is not being met; and
 - 3) Evidence suggests that a significant proportion of the target population is at risk of avoidable death if the gap is not filled urgently.
 - K. Reproductive Health (RH) – is the state of complete physical, mental, and social well-being, and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and to its functions and processes. Reproductive health, therefore, implies that people are able to have a safe and satisfying sex life and that they have the capacity to reproduce and the freedom to decide if, when and how often to do so. It also includes sexual health, the purpose of which is the enhancement of life and personal relations.
 - L. Sexual Violence – any sexual act, attempt to obtain a sexual act, unwanted sexual comments or advances or acts to traffic a person’s sexuality using coercion, threats of harm or physical force, by any person, regardless of relationship to the victim, in any setting, including but not limited to home and work.
 - M. Trafficking in Persons – refers to the recruitment, transportation, transfer or harboring, or receipt of persons with or without the victim’s consent or knowledge, within or across national borders by means of threat or use of force, or other forms of coercion, abduction, fraud, deception, abuse of power or of position, taking advantage of the vulnerability of the person, or the giving or receiving of payments or benefits to achieve the consent of a person having control over another person for the purpose of exploitation or the prostitution of others or other forms of sexual exploitation, forced labor or/services, slavery, servitude or the removal or sale of organs.
 - N. Violence against Women – refers to any act of gender-based violence that results in, or is likely to result in, physical, sexual or psychological harm or suffering to women, including threats of such acts, coercion, or deprivation of liberty, whether occurring in public or in private life. It shall be understood to encompass, but not limited to, the following:

1. Physical, sexual, psychological and economic violence occurring in the family, including battering, sexual abuse of female children in the household, dowry-related violence, marital rape, and other traditional practices harmful to women, non-spousal violence and violence related to exploitation;
 2. Physical, sexual, and psychological violence occurring within the general community, including rape, sexual abuse, sexual harassment, and intimidation at work, in educational institutions and elsewhere, trafficking in women, and prostitution; and
 3. Physical, sexual and psychological violence perpetrated or condoned by the State, wherever it occurs. It also includes acts of violence against women as defined by Republic Acts No. 9208 and 9262.
- O. Vulnerability – can be defined as the diminished capacity of an individual or group to anticipate, cope with, resist and recover from the impact of a natural or man-made hazard. Vulnerability is most often associated with poverty, social group, gender, ethnic or other identity, age and other risk factors.
- P. Women’s Kits – (also called “dignity kits”) refer to a package of supplies and materials for distribution to women of reproductive age affected by disaster situations (see Annex A for contents).
- Q. Women of Reproductive Age (WRA) – refer to women ages 15-49 years old.

VI. GENERAL GUIDELINES

- A. The MISP for SRH shall be implemented in all humanitarian crises guided by the principles of humanity, neutrality and impartiality.
- B. The MISP for SRH shall be implemented at the onset of an emergency or disaster, without site specific needs assessment, utilizing national estimates on population data and health care, when available, and shall continue until comprehensive RH services are in place.
- C. All humanitarian partners providing SRH services during emergencies and disasters shall comply with the MISP for SRH as a SPHERE standard.
- D. The MISP for SRH shall include services on safe motherhood, family planning, STI, HIV and AIDS and gender-based violence in crisis situations.
- E. The DOH shall incorporate additional services to the MISP for SRH to include nutrition services for newborns following the Infant and Young Child Feeding in Emergencies (IYCF-E) and the Adolescent Sexual and Reproductive Health (ASRH) information and services, particularly on the coordination for ASRH concerns, assessment of needs, data management and provision of adolescent-friendly health services as provided by law.
- F. MISP for SRH shall be integrated in the following pillars of the health system during emergencies and disasters:
 1. Leadership and Governance – This involves ensuring committed leadership of the DOH through HEMB, FHO and DPCB to implement the MISP for SRH

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nationwide combined with effective oversight, coalition-building, regulation, transparency and accountability.

2. Service Delivery– MISP for SRH shall be part of the health emergency package of services to be delivered by LGUs. The DOH shall act as a provider of last resort, ready to provide SRH services to fill identified critical gaps of LGU and NGO partners during the emergency.
3. Capability Building - A module on the MISP for SRH will be included in the regular health emergency training. Localized versions of the MISP for service providers, local disaster risk reduction and management (LDRRM) teams and communities are also available. The HEMB, FHO and the DPCB will roll out the MISP trainings.
4. Regulatory – MISP for SRH shall be implemented according to global (SPHERE) and national standards and guidelines (see Annex B for SPHERE standards).
5. Financing – A budget shall be allocated at the national and local levels for logistical requirements in MISP for SRH implementation e.g. RH kits and women’s kits, for capacity building, compliance to standards, and monitoring and evaluation. At the national level, HEMB, FHO and DPCB shall allocate funds for the implementation of MISP for SRH. MISP will be promoted and advocated to the LGUs which will set aside funds from their DRRM budget for its local implementation.
6. Health Information Systems–Activation of appropriate reporting mechanism for quality and timely reports on the progress of MISP for SRH implementation and accurate information on MISP for SRH indicators to HEMB for integration into the Health Emergency Alert Reporting System (HEARS) to guide decision-making at all levels.

VII. SPECIFIC GUIDELINES

A. The services that shall be made available in all areas affected by emergencies and disasters shall include the following:

1. SAFE MOTHERHOOD
 - a. Make available skilled health personnel to provide Emergency Obstetric and Newborn Care (EMONC) services. Prenatal care and postpartum services should be made available as situation allows
 - b. Establish 24/7 referral system.
 - c. Provide clean delivery kits to pregnant women on their third trimester of pregnancy and to skilled birth attendants.
 - d. Raise awareness of community on the availability of services.
2. FAMILY PLANNING
 - a. Provide contraceptives to existing or current users.
 - b. Provide appropriate information on family planning.
3. STI, HIV and AIDS
 - a. Provide access to free condoms.

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- b. Strictly adhere to universal precautions, e.g. rational and safe blood transfusion.
 - c. Provide anti-retrovirals (ARVs) for those undergoing treatment
 - d. Provide syndromic treatment of STIs.
4. GENDER- BASED VIOLENCE
- a. Provide clinical and psychological care for gender-based violence (GBV) survivors through the establishment of Women and Child Protection Units in public secondary and tertiary health facilities.
 - b. Coordinate with DSWD on mechanisms to prevent and respond to sexual violence in emergencies such as the GBV Subcluster.
 - c. Coordinate for proper referral to existing local protection mechanisms such as the Local Committee on Anti-Trafficking and Violence Against Women and Children (LCAT-VAWC).

B. Implementing Mechanism:

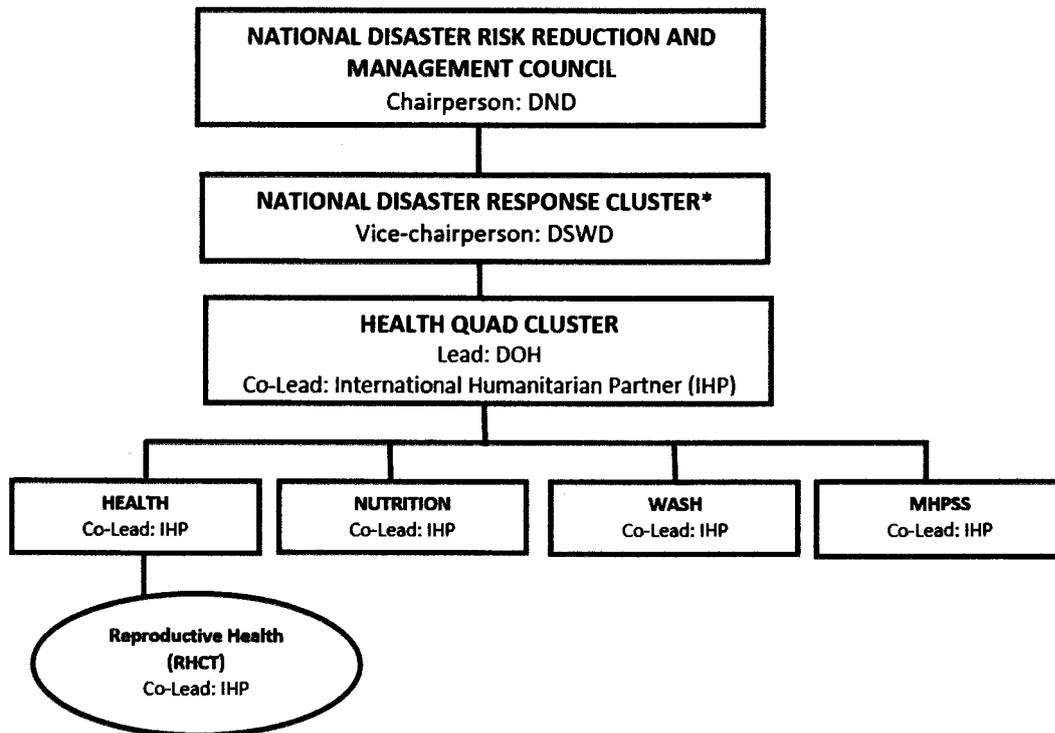
A. Composition. A national **Reproductive Health Coordinating Team (RHCT)** is hereby created to manage the implementation of the MISP for SRH. The RHCT is composed of the following:

Lead Agency: DOH

Co-Lead: International Humanitarian Partner

Members: DOH Central Office and Attached Agencies (HEMB, FHO, DPCB, BIHC, BLHSD, HFDB, LMD-AS, POPCOM, PHIC)
 Other International Humanitarian Partners
 Local NGOs

The Organogram below shows the RHCT in relation to the Health Quad Cluster and the NDRRMC Organizational Structure.



*refer to Annex C for the Organizational Structure of the National Disaster Response Cluster

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Functions:

The RHCT shall:

1. Coordinate the reproductive health humanitarian response to address the RH needs of internally displaced populations particularly pregnant and lactating women, newborn, adolescents, persons with disabilities, elderly and men during disasters and emergencies.
2. Improve effectiveness, efficiency and speed of response through linkages and coordination to enable strategic decision-making and operational problem-solving and to help avoid gaps and duplication in services within the framework of agreed objectives, priorities and strategies.
3. By phase of the emergency, the RHCT is responsible for:

3.1 Disaster Preparedness Phase:

- a. Development and issuance of RH-related humanitarian guidelines and tools.
- b. Prepositioning of RH kits, women's kits and other commodities, equipment and supplies in strategic disaster-prone sites.
- c. Mapping and listing of potential partners and other stakeholders for possible coordinative and programmatic support in time of emergencies.
- d. Collection of data on RH including ASRH and establishment of a database for the most-disaster prone provinces.
- e. Capacity building in the MISP for SRH.
- f. Mainstreaming of the MISP for SRH in the regular RH program of the DOH.

3.2 Emergency Response Phase:

- a. Coordination of MISP for SRH implementation with LGUs, other national government agencies, non-government organizations, UN and other international and local SRH humanitarian partners.
- b. Participation in rapid and comprehensive health assessments ensuring the inclusion of RH indicators in the assessment tools and the collection of data on the RH situation.
- c. Activation of the RH Response Plan to operationalize MISP in crisis situation.
- d. Participation in Health Cluster and other cluster coordination meetings.
- e. Registration of national and international partners with DOH for proper mobilization and deployment during emergencies.
- f. Mobilization and deployment of resources from development partners, international and national NGOs and the private sector.
- g. Monitoring of MISP for SRH implementation through the use of indicators and checklists and submission of situation reports and humanitarian bulletins to the RHCT.

3.3 Recovery and Rehabilitation Phase

- a. Support to LGUs in the re-establishment and re-equipping of birthing and other health facilities.

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- b. Support to capacity building of health service providers in the MISP for SRH, BEMONC, Family Planning Competency-Based Training (FP-CBT), etc.
 - c. Evaluation of the humanitarian response and documentation of best practices.
4. Meetings

The members of the national RHCT shall meet and convene on a regular basis. Meeting schedules will be communicated by the DOH-HEMB.

VIII. ROLES AND RESPONSIBILITIES

- A. The Health Emergency Management Bureau (HEMB) shall be responsible for the coordination of MISP for SRH implementation during the preparedness, response, rehabilitation and reconstruction phases of an emergency. As chair of the national RHCT, it shall:
1. Lead the assessments and analysis of the situation and provide the general framework for the RH response;
 2. Coordinate with the Regional Offices for the activation of the local RHCTs and all participating agencies to forge the RH response plan, strategy and priorities;
 3. Deploy RH kits, women's kits and supplies during the emergency and serve as provider of last resort;
 4. Monitor the implementation of the MISP for RH and ensure its compliance to standards;
 5. Conduct after-action review or evaluation of the RH response and document lessons learned and good practices;
 6. Allocate a budget for the coordination meetings and activities of the national RHCT and for the deployment of RH kits, women's kits and other emergency supplies and commodities;
 7. Provide Secretariat support to the RHCT.
- B. International Humanitarian Partner as co-lead shall:
1. Provide technical assistance support to the area of reproductive health and ASRH in emergencies.
 2. Augment the RH supply requirements of the DOH such as RH kits, women's kits, maternity tents, as needed.
 3. Allow deployment of the Emergency Maternity Unit (EMU) for normal and complicated deliveries, C- sections and other obstetric procedures.
 4. Support capacity building activities especially on MISP for SRH, BEMONC and Family Planning Competency-Based Training (FPCBT) of health service providers in disaster-affected areas.
 5. Assist the DOH in resource mobilization through the preparation of SRH proposals for submission to international humanitarian donors during the call for Flash Appeals or Consolidated Appeals.
- C. The Family Health Office (FHO) and the Disease Prevention and Control Bureau (DPCB) shall be responsible for programmatic preparedness, response and early recovery actions on the MISP for SRH. They shall:

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1. Provide technical assistance, consultative and advisory services on reproductive health (safe motherhood, family planning, ASRH, STI, HIV and AIDS, and VAWC), nutrition and mental health programs for emergencies.
2. Integrate MISP on RH during emergencies and disasters in existing policies and programs.
3. Allocate budgets for prepositioned supplies such as RH kits, women's kits, etc.
4. Assist in the development and implementation of MISP training modules, monitoring and evaluation tools and communication and advocacy materials.

D. The Bureau of International Health Cooperation (BIHC) shall:

1. Lead in the facilitation of international humanitarian assistance related to RH activities.
2. Assist the International Humanitarian Cluster of the Department of Foreign Affairs in the registration of all international health humanitarian agencies providing assistance during emergencies.
3. Assist in mobilizing funding support for MISP on RH by coordinating meetings and consultations with potential international humanitarian donors/partners.

E. The Bureau of Local Health Systems Development (BLHSD) shall:

1. Coordinate with the DOH Regional Offices to ensure integration and implementation, monitoring and evaluation of the MISP for SRH in the local health systems at the provincial, city, municipal and barangay levels.
2. Coordinate with other national government agencies engaged with LGUs in the implementation of the MISP for SRH.

F. The Health Facilities Development Bureau (HFDB) shall:

1. Provide guidance and assistance in the assessment of birthing and other health facilities damaged and rendered non-functional following the emergency situation.
2. Develop guidelines and policies on the minimum basic requirements for the continuous operation of birthing and other health facilities following an emergency situation and for the construction/rehabilitation of disaster-resilient health facilities.
3. Provide guidelines for the establishment of functional Women and Children Protection Units (WCPUs) in Levels 2 and 3 health facilities.

G. Logistics Management Division - Administrative Service (LMD-AS) shall:

1. Preposition an adequate supply of reproductive health kits, women's kits and other RH commodities for emergency situations.
2. Track the timely distribution of RH goods and commodities.
3. Develop partnerships with the private sector for the transport and safe warehousing of RH emergency supplies.

H. Commission on Population (POPCOM) shall:

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1. Assist the DOH in the operationalization of the ASRH program in emergencies, prepositioning, warehousing and distribution of RH commodities and supplies and in the monitoring and evaluation of MISP implementation.
2. Advocate for the adoption and implementation of family planning in the MISP for SRH.
3. Mobilize Population Officers and community volunteers in the execution of POPCOM's roles and responsibilities in relation to MISP implementation.

I. Philippine Health Insurance Corporation (PHIC) shall:

1. Develop reproductive health financing schemes and guidelines for disaster-affected facilities.
2. Allow the provision of special privileges to those affected by fortuitous events in disaster-affected areas especially for non-Philhealth internally displaced persons in all disaster-affected areas.

J. DOH Regional Offices and the DOH-ARMM shall:

1. Assist the LGUs in the creation and activation of the local RHCTs.
2. Designate regional RH focal points to the local RHCT who shall provide technical assistance to the affected LGUs in the implementation of the MISP for SRH.
3. Advocate for the integration of the MISP for SRH in local DRRM plans.
4. Monitor MISP for SRH implementation of the LGUs and provide feedback to the national RHCT.

K. Local Government Units (LGUs) shall:

1. Create and activate the local RHCTs.
2. Adopt and implement the MISP as deemed appropriate and feasible in their locality based on the mandate of this AO.
3. Provide a counterpart budget for prepositioning of RH supplies and commodities, capacity building of local service providers, meetings of the local RHCTs and other local MISP-related activities.
4. Ensure that community volunteers are mobilized during emergency situations.
5. Provide monitoring reports to the local Health cluster who, in turn, reports to the local DRRMC. The local RHCT also provides the same report to the national RHCT led by the DOH.
6. For evaluation, the local RHCT may call for its own after action review or they can be part of the province-wide after action review.
7. Provide documentation of MISP activities to the regional and national RHCTs.

L. Other Members of the RHCT shall:

1. Respect and adhere to agreed principles, policies and standards of the RHCT.
2. Participate in needs assessments and in the planning, strategizing and setting of RHCT priorities.
3. Implement the MISP for SRH according to set standards.
4. Provide information, report progress and identify needs and gaps in MISP for SRH implementation.
5. Mobilize their own resources and help build local capacities.

The programmatic interventions for Sexual and Reproductive Health in emergency situations require interagency collaboration with the Department of Social Welfare and Development (DSWD) for gender-based violence, with the Office of Civil Defense (OCD) as Secretariat of the National Disaster Risk Reduction and Management Council (NDRRMC) for the integration of the MISP in the national and local disaster risk reduction and management plans, and the Department of the Interior and Local Government (DILG) for LGU mainstreaming in multi-sectoral medium term development plans through Local Disaster Risk Reduction Management Plans (LDRRMP) integrated in the Comprehensive Development Plans.

IX. FUNDING SUPPORT

FHO and DPCB shall allocate funds in their regular RH programs for the implementation of the MISP for SRH. More specifically, they will provide a budget for the prepositioning of RH kits, women's kits, IEC materials and other RH commodities. They shall, likewise, provide funds for capacity building of key DOH central, field staff and key partners in the MISP and for monitoring compliance to MISP global and national standards and guidelines.

HEMB, on the other hand, shall allocate funds for the conduct of rapid and comprehensive RH assessments, cluster coordination meetings, monitoring and other activities related to the implementation of the MISP for SRH during the response phase. In the recovery and rehabilitation phase, HEMB shall, likewise, provide funding for the conduct of evaluation or after-action reviews of the RH response as well as the documentation of lessons learned and good practices.

X. REPEALING CLAUSE

All orders, rules, regulations, and other related issuances that are inconsistent with or contrary to this Order are hereby repealed, amended, or modified accordingly. All provisions of existing issuances which are not affected by this Order shall remain valid and in effect.

XI. EFFECTIVITY DATE

This Administrative Order shall take effect after fifteen (15) days following its publication in a newspaper of general circulation.


JANETTE LORETO-GARIN, MD
Secretary of Health

ANNEX A

CONTENTS OF WOMEN'S KITS (also called "DIGNITY KITS")

1. Malong
2. Bath soap
3. Laundry soap
4. Panties (S,M,L)
5. Brassiere (S,M,L)
6. Nail cutter (medium)
7. Face Towel
8. Bath Towel
9. Slippers
10. Toothpaste
11. Toothbrush
12. Pail 24 liters with cover
13. Chamber pot with cover
14. Cotton balls
15. Shampoo, 12 sachets
16. Alcohol
17. Tissue roll
18. Dipper
19. Comb
20. Solar lamp with charger
21. Whistle
22. Sanitary napkin (8 pcs/pack)

For pregnant women, provision of additional Maternity Pack with the following contents:

23. Maternity Pads (3 packs)
24. Baby rubber mat (1 pc)
25. Baby clothes (3 sets)
26. Baby mittens and socks (3 sets) and 1 bonnet
27. Baby blanket (1 pc)

PROJECT SPHERE GUIDELINES ON THE MISP

Source: The SPHERE Project

**Humanitarian Charter and Minimum Standards in Humanitarian Response
2011 Edition**

2.3 Essential health services – sexual and reproductive health

All individuals including those living in disaster-affected areas, have the right to reproductive health (RH). To exercise this right, affected populations must have access to comprehensive RH information and services to make free and informed choices. Quality RH services must be based on the needs of the affected population. They must respect the religious beliefs, ethical values and cultural backgrounds of the community, while conforming to universally recognized human rights standards.

Essential health services – sexual and reproductive health standard 1: Reproductive Health

People have access to the priority reproductive health services of the Minimum Initial Service Package (MISP) at the onset of an emergency and comprehensive RH as the situation stabilizes.

Key actions (to be read in conjunction with the guidance notes)

- Identify a lead RH agency within the health sector or cluster to facilitate the coordination and implementation of the MISP and ensure that an RH officer (nominated by lead RH agency) is in place and functioning within the health sector or cluster (see guidance note 1).
- Implement measures to reduce the risk of sexual violence, in coordination with other relevant sectors or clusters (see guidance note 3).
- Ensure services for clinical management of sexual violence, including access to mental health and psychosocial support and legal assistance (see guidance note 3 and Protection Principle 2, guidance note 7 on page 37).
- Establish the minimum set of HIV prevention, treatment, care and support services to reduce the transmission of HIV (see Essential health services – sexual and reproductive health standard 2 on page 328)
- Ensure that emergency obstetric and newborn care services are made available and accessible including:
 - at health centres – skilled birth attendants and supplies for normal births and basic management of emergency obstetric and newborn complications; basic emergency obstetric care (BEmOC) and newborn care
 - at referral hospitals – skilled medical staff and supplies for comprehensive management of obstetric and newborn complications; comprehensive emergency obstetric care (CEmOC) and newborn care
 - a communication and transportation system to manage obstetric and newborn emergencies is established and functioning 24 hours a day, seven days a week from the community to the health centre and between the health centre and referral hospital (see guidance note 4).



- Provide clean delivery kits to visibly pregnant women and birth attendants for clean home deliveries when access to a skilled health providers and health facility is not possible (see guidance note 4).
- Inform populations about the benefits and availability of clinical services for survivors of sexual violence and the emergency referral system for complications of pregnancy and childbirth (see guidance notes 3-4).
- Ensure that common contraceptive methods are available to meet demand (see guidance note 2).
- Plan to implement comprehensive RH services, integrated into primary healthcare, as soon as possible (see guidance note 1).

Key indicators (to be read in conjunction with the guidance notes)

- All health facilities have trained staff, sufficient supplies and equipment for clinical management of rape survivors services based on national or WHO protocols.
- All pregnant women in their third trimester have received clean delivery kits.
- There are at least four health facilities with BEmOC and newborn care/500,000 population.
- There are at least one health facility with CEmOC and newborn care/500,000 population.
- The proportion of deliveries by Caesarian section is not less than 5 per cent or not more than 15 per cent (see guidance note 4).

Guidance notes

1. **Minimum Initial Service Package:** The MISP defines those services that are most important for preventing RH-related morbidity and mortality among women, men and adolescents in disaster settings. It comprises a coordinated set of priority RH services that must be implemented simultaneously to prevent and manage the consequences of sexual violence, reduce the transmission of HIV, prevent excess maternal and newborn morbidity and mortality, and begin planning for comprehensive RH services as soon as the situation stabilizes. Planning for the integration of good-quality comprehensive RH activities into primary health care at the onset of the emergency is essential to ensuring a continuum of care. Comprehensive RH care involves upgrading existing services, adding missing services and enhancing service quality.
2. **RH supplies:** Supplies for the MISP must be ordered, distributed and stored to avoid delay in getting these essential products to the population. The Inter-agency Emergency Health Kit includes a limited quantity of medicines for patient post-exposure prophylaxis, magnesium sulphate and instruments and medicines for midwifery care, but not all supplies required for the MISP. The Interagency Reproductive Health Kits, developed by the Interagency Working Group on RH in Crises contain medicines and supplies for a three-month period.
3. **Sexual violence:** All actors in disaster response must be aware of the risk of sexual violence including sexual exploitation and abuse by humanitarians, and must work to prevent and respond to it. Aggregate information on reported

incidents must be safely and ethically compiled and shared to inform prevention and response efforts. Incidence of sexual violence should be monitored. Measures for assisting survivors must be in place in all primary level health facilities and include skilled staff to provide clinical management that encompasses contraception, post-exposure prophylaxis to prevent HIV, presumptive treatment of sexually transmitted infections (STIs), wound care, tetanus prevention and hepatitis B prevention. Women should be offered unbiased counseling so as to reach an informed decision. Survivors of sexual violence should be supported to seek and be referred for clinical care and have access to mental health and psychosocial support. At the survivor's request, protection staff should provide protection and legal support. All examination and treatment should be done only with informed consent of the survivor. Confidentiality is essential at all stages (see Health Systems standard 5, guidance note 4 on page 307 and Protection Principle 1, guidance notes 7-12 on page 35).

4. **Emergency obstetric and newborn care:** Approximately 4 percent of the disaster-affected population will be pregnant women. Approximately 15 per cent of all pregnant women will experience an unpredictable obstetric complication during pregnancy or at the time of delivery that will require emergency obstetric care and 5 – 15 per cent of all deliveries will require surgery, such as a caesarian section. In order to prevent maternal and newborn mortality and morbidity resulting from complications, skilled birth attendance at all births, BEmOC and neonatal resuscitation should be available at all primary health care facilities. BEmOC functions include parenteral antibiotics, parenteral uterotonic drugs (oxytocin), parenteral anticonvulsant drugs (magnesium sulfate), manual removal of retained products of conception using appropriate technology, manual removal of the placenta, assisted vaginal delivery (vacuum or forceps delivery) and maternal and newborn resuscitation. CEmOC functions include all of the interventions in BEmOC as well as surgery under general anaesthesia (Caesarian delivery, laparotomy) and rational and safe blood transfusion.

The referral system should ensure that women or newborns are referred and have the means to travel to and from a primary health care facility with BEmOC and newborn care and to a hospital with CEmOC and newborn care services.

Essential health services – sexual and reproductive health standard 2: HIV and AIDS

People have access to the minimum set of HIV prevention, treatment and care and support services during disasters.

Key actions (to be read in conjunction with the guidance notes)

- Establish standard precautions and safe procedures for waste disposal within all healthcare settings (see guidance note 2 and health systems standard 1, guidance notes 10-11 on pages 299-300).
- Establish and follow safe blood supply and rational use of blood transfusion (see guidance note 2 and Health Systems standard 1, guidance note 5 on page 298).

- Establish access to good quality free male and female condoms including information on proper condom use.
- Ensure that health facilities provide syndromic management of all patients presenting with symptoms of a sexually transmitted infection.
- Ensure that post-exposure prophylaxis (PEP) services are provided to individuals within 72 hours of the incident of potential exposure to HIV (see guidance note 3).
- Provide information in accessible formats and education on HIV prevention in both the general public and high-risk groups (e.g. sex workers).
- Ensure prevention of mother-to-child transmission (PMTCT) of HIV by ensuring access to contraceptives, clean and safe child deliveries (including emergency obstetric care and provision of anti-retroviral (ARV) drugs (see guidance note 4).
- Provide treatment, care and support for infants born from mothers known to be HIV positive, including guidance and counseling in infant feeding (see infant and young child feeding standard 2 on page 160).
- Ensure that people living with HIV (PLHIV) receive healthcare, including co-trimoxazole prophylaxis for HIV-related infections.
- Ensure that people who were previously on anti-retroviral therapy (ART) continue to receive treatment (see guidance note 4).
- Establish links between HIV and tuberculosis programmes where they exist.
- Ensure that people at higher risk of exposure to HIV have access to HIV prevention interventions for sexual transmission of HIV and access to clean injecting equipment for known injecting drug users where these services already exist.
- Initiate plans to broaden the range of HIV control services in the post-disaster phase (see guidance note 1).

Key indicators (to be read in conjunction with the guidance notes)

- People at most risk of exposure to HIV are targeted with a HIV prevention programme.
- Pregnant women known to be HIV-positive have received ARV drugs for PMTCT.
- 100 per cent of transfused blood is screened for transfusion-transmissible infections including HIV.
- Individuals potentially exposed to HIV (occupational exposure in healthcare settings and non-occupational exposure) have received PEP within 72 hours of an incident
- All primary healthcare facilities have antimicrobials to provide syndromic management to patients with symptoms of an STI.

Guidance notes

1. **HIV control:** The minimum set of HIV prevention, treatment, care and support described in the key actions for this standard is comprised of actions that the health sector must take to prevent HIV transmission and to provide care and support to PLHIV. They should be implemented during the early stages of any disaster response.
2. **Prevention of HIV transmission in healthcare settings:** The prevention of transmission of HIV in healthcare settings (e.g. hospitals, healthcare clinics,

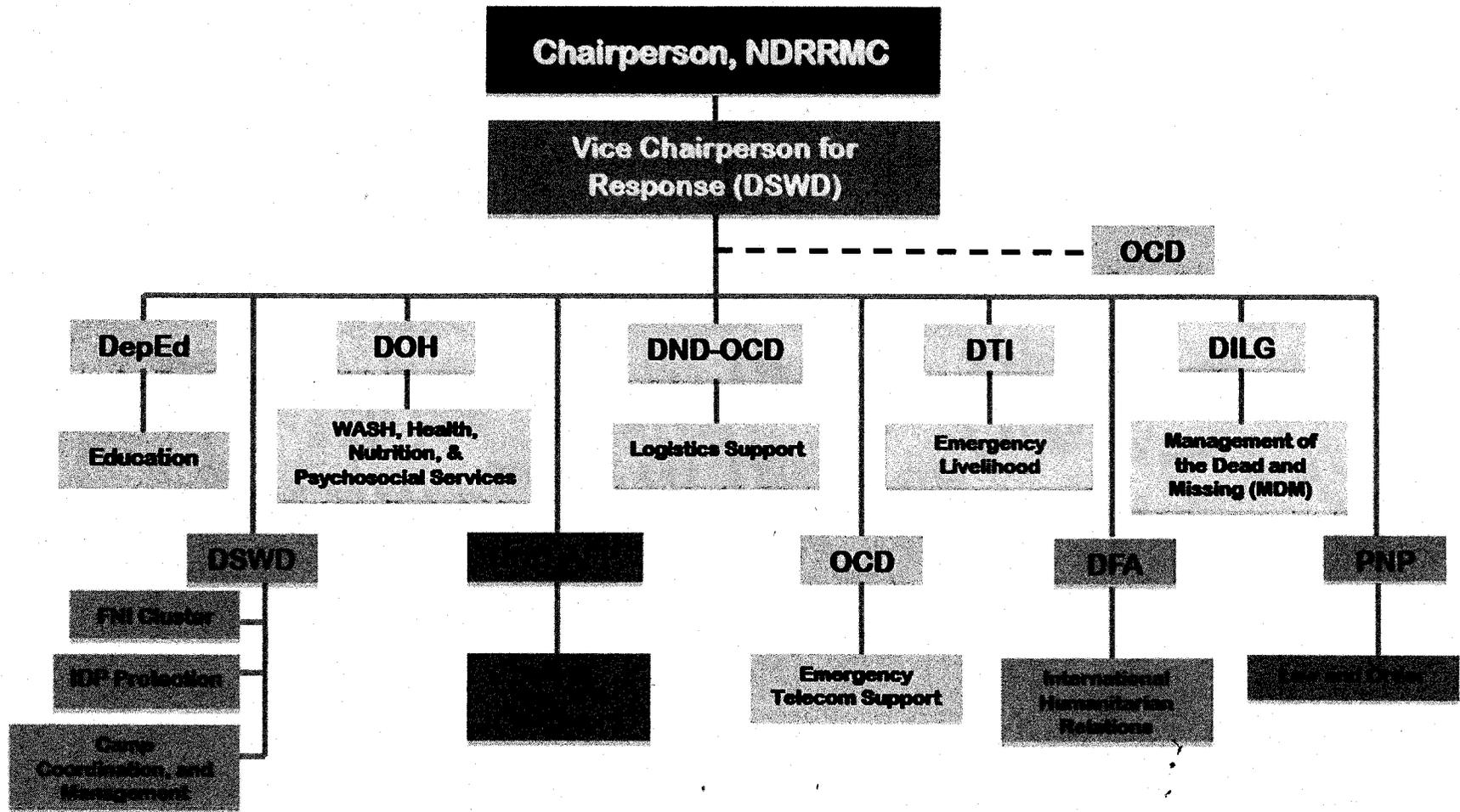



vaccination campaigns) is a priority during the early stages of disaster response. Essential actions are ensuring the application of standard precautions, establishing safe and rational blood transfusion practices and the correct disposal of healthcare waste (see Health systems standard 1, guidance notes 5, 10-11 on pages 298-300).

3. **Post-exposure prophylaxis:** PEP to prevent HIV infection includes counseling, HIV exposure risk assessment, informed consent, assessment of the source and provision of ARV medicines. However, PEP should not be provided to a person who is known to be HIV positive; counseling and testing should never be mandatory nor should the provision of PEP be delayed while waiting for the test results.
4. **Anti-retroviral drugs:** The provision of ARV for PMTCT, PEP and long-term ART in disaster situations is feasible. Continuation of ART for those already on treatment prior to the disaster must be considered a priority during disaster response. Pregnant women already taking ART should continue taking ARV without interruption. Pregnant women known to be HIV-positive should receive ARV for PMTCT according to the national protocol wherever possible.



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