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Emergency preparedness for sexual and reproductive health in the East and Southern Africa region

Results of the MISP Readiness Assessment 2022

UNAIDS

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for every child

World Health Organization

Contents

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Acronyms and abbreviations

BEmONC	Basic Emergency Obstetric and Newborn Care
CEmONC	Comprehensive Emergency Obstetric and Newborn Care
DMA	Disaster Management Authority
DRC	Democratic Republic of the Congo
DRR	Disaster Risk Reduction
ESA	Eastern and Southern Africa
ESARO	East and Southern Africa Regional Office
GBV	Gender-Based Violence
HIV/AIDS	Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome
IARH	Inter-Agency Reproductive Health [Kits]
IAWG	Inter-Agency Working Group [on Reproductive Health in Crises]
IEC	Information, Education and Communication
IPC	Infection Prevention and Control
IPPF	International Planned Parenthood Federation

MISP	Minimum Initial Service Package [for Sexual and Reproductive Health in Crisis Situations]
MoH	Ministry of Health
MRA	MISP Readiness Assessment
NGO	Non-Governmental Organization
OCHA	United Nations Office for the Coordination of Humanitarian Affairs
PEP	Post-Exposure Prophylaxis
PPE	Personal Protective Equipment
SOGIESC	Sexual Orientation, Gender Identity and Expression, and Sex Characteristics
SRH	Sexual and Reproductive Health
SRHR	Sexual and Reproductive Health and Rights
SRHiE	Sexual and Reproductive Health in Emergencies
STI	Sexually Transmitted Infection
UNFPA	United Nations Population Fund
WHO	World Health Organization

Executive Summary

Each year, more people are impacted and affected by natural disasters, conflict, instability and infectious disease outbreaks. The COVID-19 pandemic and the dramatic increases in climate-driven disasters demonstrate that every country is vulnerable to some form of crisis, and often to many simultaneous crises. The impacts of these shocks and stressors on health and societal well-being depend on how well countries and communities prepare for, respond to and recover from emergencies.

It is largely recognized that emergency situations exacerbate the vulnerability of women, girls and marginalized groups and reduce their access to sexual and reproductive health (SRH) services, even though SRH needs persist and often increase during crises. To save lives, access to essential SRH services as outlined in the global standards of the Minimum Initial Service Package (MISP) for SRH is essential.

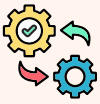
2gether 4 SRHR is a joint United Nations regional programme supported by the Government of Sweden (Sida) that combines the efforts of UNAIDS, UNFPA, UNICEF and WHO to improve the sexual and reproductive health and rights of all people in eastern and southern Africa, particularly adolescent girls, young people and key populations.

In 2022, the 2gether 4 SRHR programme engaged with 22 countries in the eastern and southern Africa region to conduct a MISP Readiness Assessment (IPPF, IAWG, UNFPA, 2020), which allowed countries to identify gaps in preparedness. Relevant stakeholders, including governments, communities, United Nations agencies and other partners, worked together to develop MISP preparedness action plans in each country to address these gaps. This region-wide assessment provided a unique opportunity to take stock of strengths and weaknesses regarding preparedness and will serve as a baseline for future targeted SRH preparedness work.

Whereas the overall results of the assessment highlight that countries may have provisions for preparedness and disaster risk management, activities and strategies specific to SRH preparedness are often limited, resulting in weak resilience capacity. Very few countries have a supportive legislative environment that supports specifically SRH in emergencies; SRH-specific data collection tools in emergencies are inadequate; coordination mechanisms rarely focus on preparedness issues, but are rather reactive, covering emergencies; and specific funding for SRH preparedness is very scarce and is to a very limited extent covered by domestic resources.

Regarding the provision of MISP-related services, the assessment reveals that there is a need to improve the availability of trained medical personnel, health facilities and safe spaces, and overall supplies and equipment. This is particularly the case for services to prevent sexual violence and respond to the needs of survivors, as well as the provision of safe abortion care. The MISP Readiness Assessment (MRA) shed light on gaps that already exist in stable times and the need to strengthen health systems to be able to cope with crisis situations.

The MRA has resulted in the following high-level recommendations:



Advocate for the integration of the MISP into national emergency, preparedness, recovery and disaster risk reduction policies and plans.

Advocate for the inclusion of disaster management and/or emergency response in SRH development policies.

Advocate for the inclusion of the MISP in national curricula for midwives, nurses, doctors and other health workers.

Use MRA results to inform and strengthen national, regional and international commitments.

Advocate for the humanitarian–development–peace nexus approach as a way of working towards resilient individuals, communities and systems.

Develop adequate, context-specific and inclusive information, education and communication (IEC) material on available MISP-related services.

Identify opportunities to implement the MISP readiness action plans within existing resources and programmes.

Encourage cross-country learning and sharing of good practices.

In addition to high-level recommendations, the assessment results allowed the formulation of recommendations for each subsection of the MRA. The subsections are deriving from major trends and gaps observed in the region.

Section I – National-level overall readiness: policies, coordination, data and resources

Policies and plans

- Integrate SRH and the MISP into national disaster, preparedness and response plans.
- Integrate SRH and the MISP into national recovery plans.
- Integrate emergency preparedness, response or disaster risk management into SRH policies.
- Understand the humanitarian–development nexus and how development- and humanitarian-related policies need to complement each other.

Coordination

- Strengthen coordination during preparedness and move away from reactive/ad-hoc coordination.
- Improve the meaningful participation of marginalized and underserved groups in coordination mechanisms.

SRH data

- Disseminate knowledge on existent assessment tools.
- Standardize and digitize data collection tools.
- Improve disaggregated data collection (e.g. disability).
- Improve data collection related to gender-based violence (GBV) through standardized comprehensive systems.

Resources

- Increase funds to support health and SRH emergency preparedness.
- Identify and establish mechanisms for the rapid mobilization of funds for SRH.
- Secure specific domestic funding to avoid shortages of supplies and inadequate pre-positioning of supplies.

Section II – Readiness to provide services as outlined in the MISP

General

- Reduce the economic, sociocultural and religious barriers impeding marginalized and underserved groups' access to SRH services, during stable times and during emergencies.
- Advocate for the integration of the MISP or health emergency management into the health-care training curriculum.
- Improve the availability of remote service provision.
- Improve supply chain management and procurement procedures to ensure the availability of essential commodities for SRH services during emergencies.

MISP 2

- Increase the availability and accessibility of confidential and safe spaces within health facilities to receive survivors of sexual violence and provide them with appropriate clinical care and referral.
- Translate IEC materials on services for sexual violence survivors for each linguistic group and make them accessible to people with learning disabilities and hearing and visual impairments.
- Address gender inequalities and the prevention of sexual violence, and invest in strategies that empower women and girls.
- Improve supply chain management for GBV-related commodities.
- Train and increase the availability of qualified medical personnel to deal with GBV issues.

MISP 3

- Increase the ability to provide safe and rational blood transfusion, including during stable times.
- Ensure that IEC materials and sexually transmitted infection (STI) and HIV counselling services are accessible and available, particularly for people with disabilities, and are translated into different local languages.

MISP 4

- Increase the availability of skilled medical staff and supplies at the referral hospital level for the provision of comprehensive emergency obstetric and newborn care (CEmONC).
- Increase the availability of skilled birth attendants and supplies for vaginal births and the provision of basic emergency obstetric and newborn care (BEmONC).
- Ensure the availability of supplies and commodities for clean delivery (e.g. clean delivery kits) and immediate newborn care where access to a health facility is not possible or is unreliable.
- Develop IEC materials on priority maternal and neonatal services for pregnant women and girls for each linguistic group of the most at-risk areas.

MISP 5

- Develop IEC materials on contraceptive choice (that emphasize informed choice and effectiveness, and that support client privacy and confidentiality and access to services) in local languages; ensure the materials are accessible for people with disabilities.

Safe abortion care

- Increase knowledge and awareness on abortion laws among the general population and service providers.
- Reduce stigma and discrimination around abortion services.
- Increase the availability of qualified staff.
- Develop IEC materials outlining the types of abortion services available.
- Increase access to safe abortion care services in all health facilities and remote areas, to the full extent of the law.

1 Introduction

Sexual and reproductive health and rights in emergencies and the need for preparedness

Emergency situations exacerbate the vulnerability of women, girls and marginalized groups, and reduce their access to sexual and reproductive health (SRH) services. During emergencies, SRH needs persist or even increase, because pregnancies, complications, risk of STI and HIV transmission, and the need for modern contraception do not stop when an emergency strikes. In addition, the risks of unsafe abortions, unsafe deliveries and gender-based violence increase during an emergency. To mitigate these risks, access to quality health care in emergencies is essential.

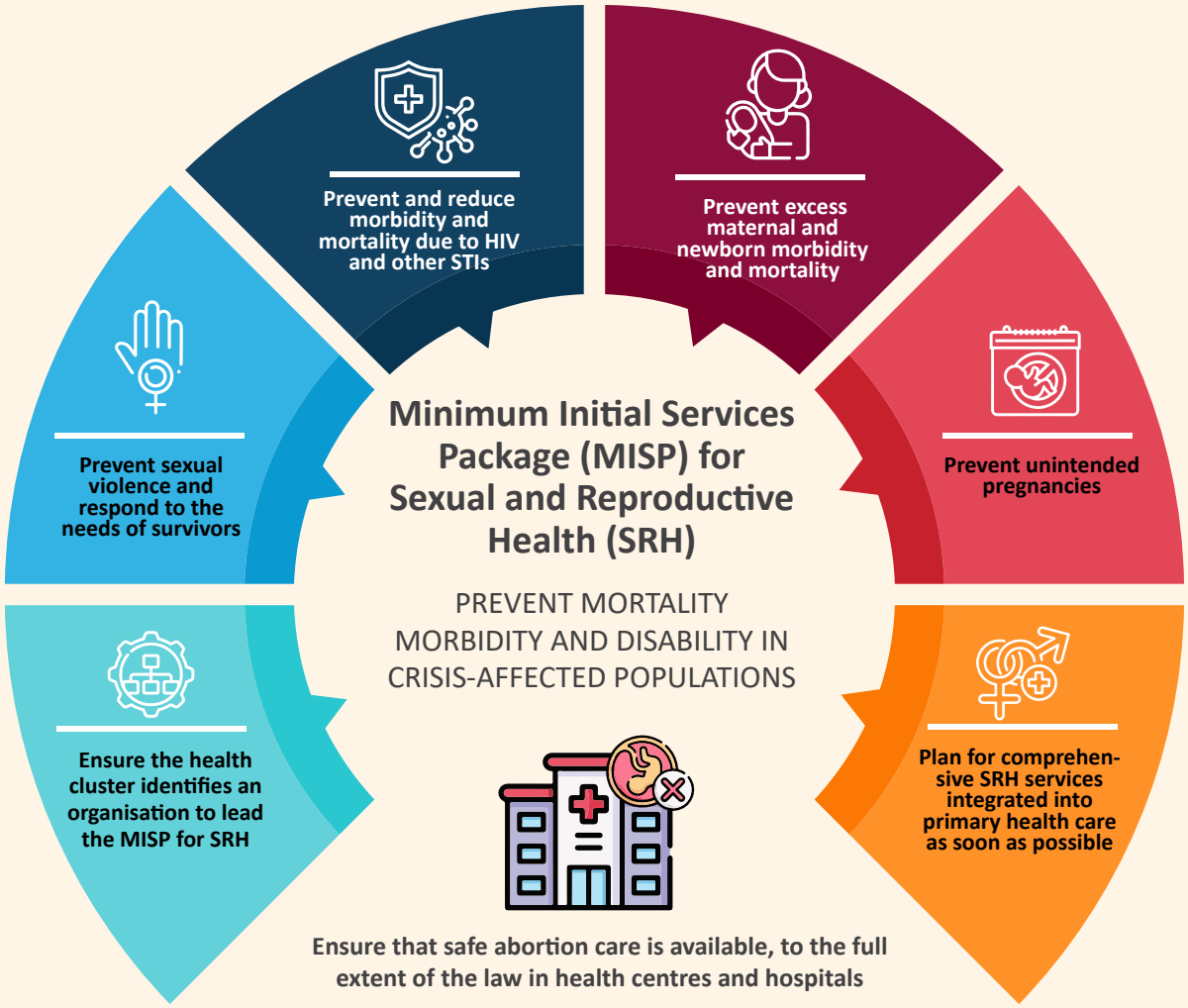
In 1995, the Inter-Agency Working Group (IAWG) on Reproductive Health in Crises was created. Its members developed a set of minimum reproductive health interventions to be put in place at the onset of a humanitarian crisis known as the Minimum Initial Service Package (MISP) for SRH in Crisis Situations. The MISP includes the SRH services that are most important in preventing morbidity and mortality while protecting the right to live with dignity in humanitarian settings. It is one of the chapters of the *Inter-Agency Field Manual on Reproductive Health in Humanitarian Settings* (IAWG, 2018), the authoritative source for global guidance on addressing SRH in emergencies.

What is the MISP?

The Minimum Initial Service (MISP) for SRH is a collection of minimum actions to be implemented at the onset of crisis- within 48 hours- to help reduce mortality and morbidity related to sexual and reproductive health. It is complemented by a list of Inter Agency Reproductive Health kits (IARH). The activities can be implemented without an implemented without an in depth SRH assessment

and must be in place before moving to implementation of comprehensive SRH services.

For mean information, see **IAFM MISP chapter 3**



MISP (Source: MISP Readiness Assessment, IPPF, 2020)

To date, humanitarian responses often underestimate the importance of SRH care, even though it has largely been agreed that availability of SRH services in emergencies saves lives and provides safety for women. The International Conference on Population and Development in Cairo in 1994 clearly recognized that reproductive health is a basic human right, and sexual and reproductive health and rights (SRHR) in emergencies is acknowledged in international standards such as the *Sphere Humanitarian Charter and Minimum Standards in Disaster Response* (Sphere, 2018).

Besides the importance of including SRH care in humanitarian responses, SRH has also been recognized as a key element to work on during preparedness and to step up efforts to strengthen the resilience of health systems. Important global frameworks and commitments such as the *Sendai Framework for Disaster Risk Reduction 2015–2030* emphasize the importance of preparedness. The framework demands the design of inclusive policies that provide access to basic health care, including SRH care. It also calls for increased attention to resilience, and it identifies health – including SRH – as a critical

aspect of strengthening individual and community resilience. SRH preparedness also supports the Sustainable Development Goals, in particular Goal 3 (ensure healthy lives and promote well-being for all at all ages) and Goal 5 (achieve gender equality and empower all women and girls). More recently, the World Health Organization's operational guidance on COVID-19[1] reiterated that SRH services should be prioritized and service delivery secured during disease outbreaks.Objectives

Several specific SRH preparedness tools and guidance documents have been developed, including *Ready to Save Lives: A Preparedness Toolkit for Sexual and Reproductive Health Care in Emergencies* (IPPF, IAWG, FP2030, 2021). The aim is to highlight existing learning and provide guidance for stakeholders to begin SRH preparedness work. Within the SRH sector, the field of preparedness is still relatively new, but it is growing. The recent COVID-19 pandemic and the dramatic increases in climate-driven disasters demonstrate that every country is vulnerable to some form of crisis and often to many simultaneous crises. There is hence a recognition that more collective efforts are required to further invest in preparedness strategies and evaluate the impact of them.

2gether 4SHR: A joint programme to strengthen emergency preparedness and response

Since 2018, the regional offices of UNAIDS, UNFPA, UNICEF and WHO have been implementing 2gether 4 SRHR, a joint United Nations regional programme, in partnership with and supported by Sida. The joint programme combines the comparative strengths and technical expertise of the four participating United Nations agencies to improve SRHR for all people in eastern and southern Africa (ESA) through using a regional approach with applied learning in 10 focus countries.

The MISP Readiness Assessment (MRA) process in the region was led by UNFPA, in close collaboration with UNAIDS, UNICEF and WHO at regional and national levels. The MRA uses the MISP, which is a compilation of actions that integrate HIV, GBV, SRH and family planning elements, as a framework. UNFPA is highly committed to ensuring the availability of SRH care during emergencies and works closely with other United Nations agencies. UNFPA and its partners are on the ground before, during and after crises, and work closely with governments, local non-governmental organizations (NGOs), United Nations agencies and other partners to ensure that SRHR and responses to gender-based violence are integrated into emergency responses.

The *UNFPA Strategic Plan 2022–2025* highlights the importance of expanding its work to the full spectrum of humanitarian action, with the aim of achieving "by 2025, strengthened capacity of critical actors and systems in preparedness, early action and in the provision of life-saving interventions that are timely, integrated, conflict- and climate-sensitive, gender transformative and peace-responsive". It also aims to "prioritize disaster risk preparedness and humanitarian response systems that are flexible, adaptable and resilient to future threats and uncertainties".[2]

To sustain such efforts and hold governments accountable, one of the focus areas is to work at the policy level to ensure the integration of SRH into national emergency-related policies and development frameworks, including policies related to resilience, preparedness and disaster risk reduction.

Regional background

The eastern and southern Africa region covered by UNFPA includes 23 countries: Angola, Botswana, Burundi, Comoros, Democratic Republic of Congo, Eritrea, Eswatini, Ethiopia, Kenya, Lesotho, Madagascar, Malawi, Mauritius, Mozambique, Namibia, Rwanda, Seychelles, South Africa, South Sudan, Tanzania, Uganda, Zambia and Zimbabwe.

The region is exposed to multiple risks, from large-scale humanitarian emergencies to the consequences of the global climate crisis.

In 2021 and 2022, conflict-related sexual violence remained a major concern in countries such as Ethiopia and South Sudan, coupled with issues of food insecurity. This resulted in millions of internally displaced persons, refugees and asylum seekers. The situation is similar in northern Mozambique,

[2] UNFPA Strategic Plan 2022–2025, https://www.unfpa.org/strategic-plan-2022.

which has been facing an armed conflict since 2017. Countries such as the Democratic Republic of Congo (DRC) face multiple emergencies: food insecurity, disease outbreaks (measles, Ebola virus disease, mpox) and various armed conflicts.

According to the *Global Report on Internal Displacement 2022*, conflict and violence triggered 11.6 million internal displacements in sub-Saharan Africa in 2021, the highest figure ever recorded for the region. This is due to, among other things, new waves of violence in eastern Africa. Violence also led to displacement in southern and central Africa, most notably in the Central African Republic, DRC and Mozambique. For instance, in Mozambique the number of internally displaced persons (IDPs) increased from 735,334 in November 2021 to 946,508 in June 2022 (a 28.7 per cent increase).

The region is not exempted from climate change consequences, with multiple countries being impacted by below-average rainy seasons. The 2020–2021 cyclone season in the south-west Indian Ocean and tropical weather systems brought heavy rainfall to southern Africa, including in Botswana, Eswatini, Madagascar, Mozambique, South Africa and Zimbabwe, causing death, displacement, flooding, landslides and damage to homes, infrastructure and livelihoods. In some parts of the region, such as southern Madagascar, southern Angola and Kenya, erratic and uneven rainfall caused severe drought.[3]

[3] UNOCHA (2022). ***Global Humanitarian Overview 2022.***

In 2021, due to conflict and violence

11.6 million

internal displacements in sub-Saharan Africa, the highest figure ever recorded for the region.

In Mozambique, the number of internally displaced persons (IDPs) increased from **735,334** in November 2021 to **946,508** in June 2022 (a **28.7 per cent increase**).

Indeed, many countries in the region are affected by the impacts of extreme weather events. According to the *Global Climate Risk Index 2021*, which analyses the extent to which countries have been affected by the impacts of weather-related loss events (storms, cyclones, floods, heat waves, etc.), 4 countries of the region rank among the 10 most affected. These include Mozambique (Rank 1), Zimbabwe (2), Malawi (5) and South Sudan (8).[4] In countries such as Madagascar, the environmental context is dominated by cyclical disasters, mainly climate hazards and epidemics.

COVID-19 jeopardized core health services in ESA, including SRH care. By the end of 2022, the region had recorded over 7.5 million confirmed COVID-19 infections, with close to 165,000 deaths. Fear, limited knowledge and preventive measures put in place by governments across the region severely impacted access to SRHR services. Governments and partners had to adapt to new and innovative ways to work around this new hazard.

The **INFORM Risk Model**, which provides structural risk information on hazards and exposure, vulnerability, and lack of coping capacity, indicates that **11 countries** of the ESA region rank as **very high and high risk**, **9 countries** as **medium risk**, and only **3 countries** as **low or very low risk.** This scoring also includes information on the coping capacities and vulnerabilities of the different countries, and **16 out of 23 countries in the region (69.5 per cent) have high or very high risks linked to vulnerability, while 14 countries (60.8 per cent)** present a high or even very high risk on the dimension "lack of adaptive capacity".

[4] Germanwatch (2021). Global Climate Risk Index 2021.

These risks and vulnerabilities and the lack of coping capacities have an impact on the well-being and survival of the population, particularly women, girls and marginalized groups. They also affect access to and availability of SRH care.

COUNTRY	COUNTRY CODE	INFORM RISK	RISK CLASS	HAZARD AND EXPOSURE	VULNERABILITY	LACK OF COPING CAPACITY
ANGOLA	AGO	4,8	Medium	3,0	5,2	6,9
Burundi	BDI	5,9	High	4,7	6,4	6,9
Botswana	BWA	3,1	Low	1,7	3,7	4,6
Congo DR	COD	7,6	Very High	7,4	7,4	8,1
Comoros	COM	3,8	Medium	1,5	5,3	7,1
Eritrea	ERI	5,8	High	5,3	4,6	7,8
Ethiopia	ETH	6,8	Very High	7,3	6,4	6,8
Kenya	KEN	5,7	High	5,3	6,0	5,9
Lesotho	LSO	4,1	Medium	1,7	5,8	6,8
Madagascar	MDG	5,1	High	3,9	5,0	7,0
Mozambique	MOZ	7,2	Very High	7,8	7,6	6,3
Mauritius	MUS	1,9	Very Low	2,0	1,3	2,8
Malawi	MWI	4,7	Medium	2,9	5,7	6,4
Namibia	NAM	3,9	Medium	2,5	4,7	5,0
Rwanda	RWA	4,6	Medium	3,0	5,9	5,1
South Sudan	SSD	8,4	Very High	7,2	8,8	9,5
Eswatini	SWZ	3,6	Medium	1,9	4,5	5,5
Seychelles	SYC	1,8	Very Low	1,5	1,2	3,0
Tanzania	TZA	5,3	High	4,3	5,6	6,3
Uganda	UGA	6,0	High	4,6	6,7	7,0
South Africa	ZAF	4,5	Medium	4,9	4,5	4,2
Zambia	ZMB	4,2	Medium	2,2	5,8	6,0
Zimbabwe	ZWE	5,1	High	3,7	6,1	5,9

Inform Risk Index 2022

Given this context, UNFPA ESARO, with the support of 2gether 4 SRHR, conducted the MISP Readiness Assessment in the countries of the region from January to December 2022. The MRA was a first for the ESA countries, except for Kenya, where an MRA was conducted in 2018. Recognizing that preparedness is essential and that most countries in the region face multiple hazards, including conflict and climate change, which manifest in acute and protracted contexts, the aim is to better equip the countries to respond to emergencies and provide life-saving SRH care as described in the MISP.

This initiative is also in line with several regional and international conventions, including CEDAW (Convention on the Elimination of Discrimination against Women), the International Conference on Population and Development, the Maputo Plan of Action, and the Strategy for Sexual and Reproductive Health and Rights in the SADC Region 2019–2030 of the Southern African Development Community (SADC). The 16 ministries of health of the SADC countries (Angola, Botswana, Comoros, Democratic Republic of Congo, Eswatini, Lesotho, Madagascar, Malawi, Mauritius, Mozambique, Namibia, Seychelles, South Africa, United Republic Tanzania, Zambia and Zimbabwe) endorsed this regional strategy.

Overview of the MISP Readiness Assessment

The MISP Readiness Assessment is a process to help governments assess their readiness to implement the MISP during an emergency, and it provides a unique opportunity for countries to assess and understand their current preparedness situation.

The assessment details a process of how to identify and prioritize areas. It is based on a questionnaire that looks at readiness regarding the policy environment, coordination mechanisms, data collection, available resources and service delivery across the MISP objectives at national or subnational levels. The MRA questionnaire builds on all MISP objectives and looks at existing SRH services (during stable times) to understand how these can be leveraged.

The assessment calls for a joint multi-stakeholder process that includes government departments such as the ministry of health, disaster management authority, ministry of social affairs, and others; United Nations agencies, NGOs, civil society organizations, community-based organizations and faith-based organizations; and donors and professional organizations. The MRA helps to identify and prioritize the MISP and SRH areas that need to be strengthened for services to be available during an emergency using an all-hazard approach. The results help countries develop sound and meaningful action plans to strengthen their readiness to provide the MISP at the onset of an emergency and ultimately to improve SRH responses in the region as countries recover and rebuild after crises.

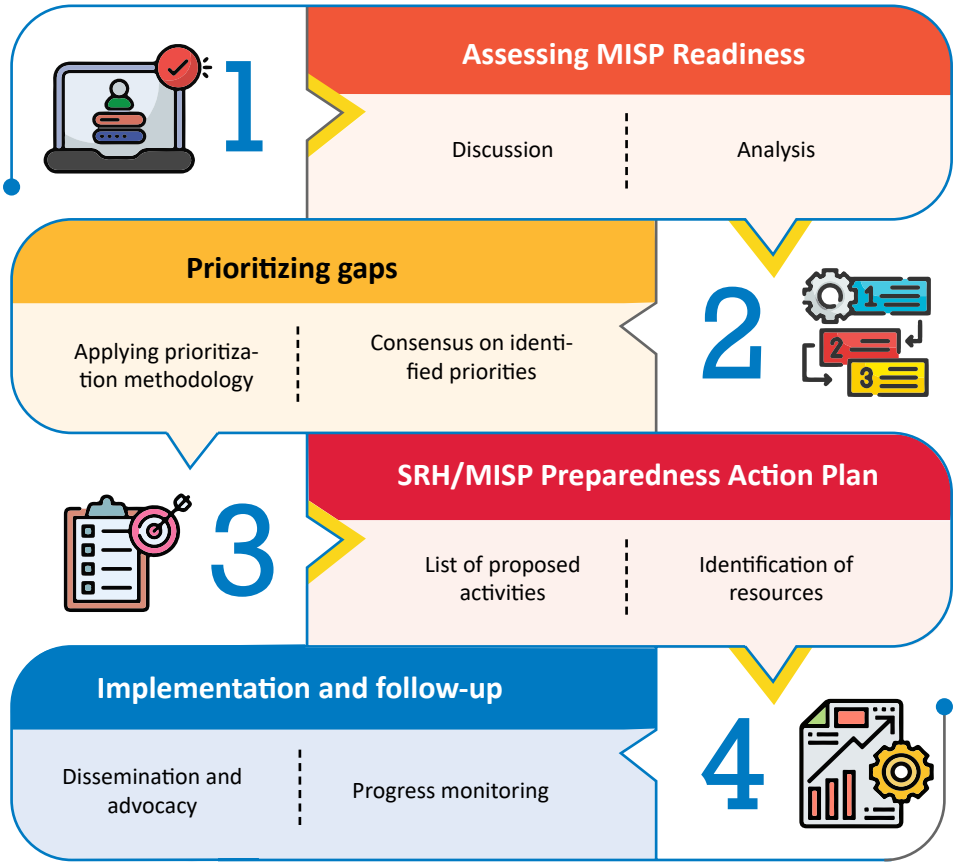
The MRA guidance document includes a detailed user guide, the MRA questionnaire, an action plan template and a guidance section that provides examples of SRH preparedness activities to consider.

The MRA process can be completed in six steps; the emphasis is on the use of a multi-stakeholder approach and strong ownership of national and subnational government entities.

The MRA questionnaire includes two sections (national-level overall readiness regarding policies, coordination and resources, and readiness to provide services as outlined in the MISP) and a total of 58 questions that assess the following elements:

- The enabling policy environment to secure SRH care during emergencies
- SRH coordination mechanisms during preparedness
- SRH data collection at different levels
- Resources for MISP preparedness and implementation
- Health service readiness for MISP implementation per objectives as outlined in Chapter 3 of the 2018 Inter-Agency Field Manual on Reproductive Health in Humanitarian Settings

Whereas most of the questions can be answered with ‘yes’ or ‘no’, the process calls for consensus building and in-depth discussions with partners. It is up to the group to decide if the existing structures and services in the country are comprehensive enough to be considered a strength or if gaps are remaining, hence the need to flag it as a gap. The questionnaire cannot be completed by one sole agency, but needs expertise from others, and their endorsement, to make the process as meaningful as possible.



The MISP Readiness Assessment process in eastern and southern Africa

The MRA in ESA was conducted between January and December 2022 with support from UNFPA ESARO and an international consultant who provided guidance and support to the UNFPA country offices.

Out of the 23 countries of the region, all except Eritrea completed the assessment using the MRA questionnaire and consequently developed a national action plan. In each of the 22 countries, the assessment was completed through a consultative process with national experts such as the ministry of health, the ministry of humanitarian affairs, disaster management authorities, SRH organizations, the UNFPA country office, United Nations agencies, the national Red Cross/Red Crescent Society, NGOs and community-based organizations. On average, around 20 different entities participated in the assessment in each country. (A list of participating institutions and organizations can be found for each country under Annex 1.)

At the national level, most UNFPA country offices worked with a national consultant to support the in-country work, and a few conducted the assessment with country office staff. All countries conducted a specific MRA workshop of one to three days. In most countries, the MRA workshop was followed by a validation workshop with partners to validate the questionnaire results and the action plan.

Regional MISP and SRH preparedness: Eastern and Southern Africa results from the MISP Readiness Assessment 2022

Overall snapshot of the results

The ESA region is the first region in sub-Saharan Africa that has rolled out the MRA as a regional initiative. Rolling out the MRA regionally allows for cross-country experience sharing and learnings.

Although the region is highly prone to various types of emergencies, such as fragility, protracted situations, conflicts and hazards, this was the first a preparedness-focused initiative conducted in the countries (except Kenya, which conducted an MRA in 2018).

The overall results of the assessment show that countries have several provisions regarding preparedness and disaster risk management, but SRH preparedness activities and strategies are quite limited, resulting in weak resilience capacity. Very few countries have a supportive legislative environment that supports SRH in emergencies; SRH-specific data collection tools in emergencies are not always comprehensive; coordination mechanisms are rarely focused on preparedness issues, but are rather reactive, covering emergencies; and specific funding for SRH preparedness is very scarce and is rarely covered by domestic resources.

Regarding the provision of MISP-related services, the assessment highlights that there is a need to improve the availability of trained medical personnel, adequate health facilities, safe spaces, and overall supplies and equipment. This is particularly the case for services to prevent sexual violence and respond to the needs of GBV survivors, as well as the provision of safe abortion care in accordance with national laws. The MRA underlines several gaps that already exist in stable times, along with the need to improve SRH service delivery to enable the provision of adequate humanitarian responses and to cope with shocks and stresses.

In all the countries, the assessment brought together partners from various backgrounds, which created a momentum around the importance of SRHiE and the need to shape a meaningful action plan to strengthen SRH preparedness and ultimately ensure better SRH responses. The MRA also helped to highlight strengths in different countries regarding specific preparedness activities, which provides opportunities for cross-country learnings.

A detailed analysis is provided in the following sections.

Note for the reader: The next sections will provide some insights about the regional results as well as some country-specific examples. The list of examples is not exhaustive, but is meant to provide a sample of what exists in the region. The detailed responses to each question are included under Annex 3.

For ease of reading, the MISP objectives and references to questions will be referred to as follows:

MISP-2	MISP Objective 2 – Prevent sexual violence and respond to the needs of survivors
MISP-3	MISP Objective 3 – Prevent the transmission of and reduce morbidity and mortality due to HIV and other STIs
MISP-4	MISP Objective 4 – Prevent excess maternal and newborn morbidity and mortality
MISP-5	MISP Objective 5 – Prevent unintended pregnancies
OPA-SAC	Other priority activity: Safe abortion care to the full extent of the law
QX (e.g. Q1)	Question X (e.g. Question 1)

The countries will be referred to in the diagrams with the following country codes (these codes are the ones used by the INFORM Risk Index):

Angola	**AGO**	Malawi	**MWI**
Burundi	**BDI**	Namibia	**NAM**
Botswana	**BWA**	Rwanda	**RWA**
DR Congo	**COD**	South Sudan	**SSD**
Comoros	**COM**	Eswatini	**SWZ**
Ethiopia	**ETH**	Seychelles	**SYC**
Kenya	**KEN**	Tanzania	**TZA**
Lesotho	**LSO**	Uganda	**UGA**
Madagascar	**MDG**	South Africa	**ZAF**
Mozambique	**MOZ**	Zambia	**ZMB**
Mauritius	**MUS**	Zimbabwe	**ZWE**

Section I –National-level overall readiness: policies, coordination, data and resources

Section I of the questionnaire focuses on the policy environment, coordination mechanisms, SRH data and financial resources to support the MISP implementation. It assesses if a country has an enabling environment that would allow the provision of SRH and/or the MISP in case of an emergency. This section of the questionnaire includes four subsections:

Subsection I – National and subnational disaster management policies and plans	Questions 1–7
Subsection II – Coordination mechanisms for SRH disaster management	Questions 8–13
Subsection III – SRH data at national and subnational levels	Questions 14–17
Subsection IV – Resources for MISP implementation	Questions 18–21

With 22 countries completing the MRA questionnaire in 2022, the results for Section I show that 59 per cent of the answers were rated as 'yes' regarding overall preparedness, which shows that there are some strengths but also several areas to strengthen disaster preparedness in the region.

All four subsections (Policies and Plans, Coordination, Data, Resources) rate slightly above average, with the sections on resources and data collection rating the lowest.

When looking at country-specific information, **Rwanda**, **South Sudan**, **Eswatini** and **Zambia** rate the highest on overall preparedness. The countries rating the lowest are **Botswana**, **Comoros**, **Mauritius** and **Seychelles**. But the results also highlight that countries are not all at the same level of preparedness.

Figure 1: Section I – Overview regarding overall preparedness by subsection in the region

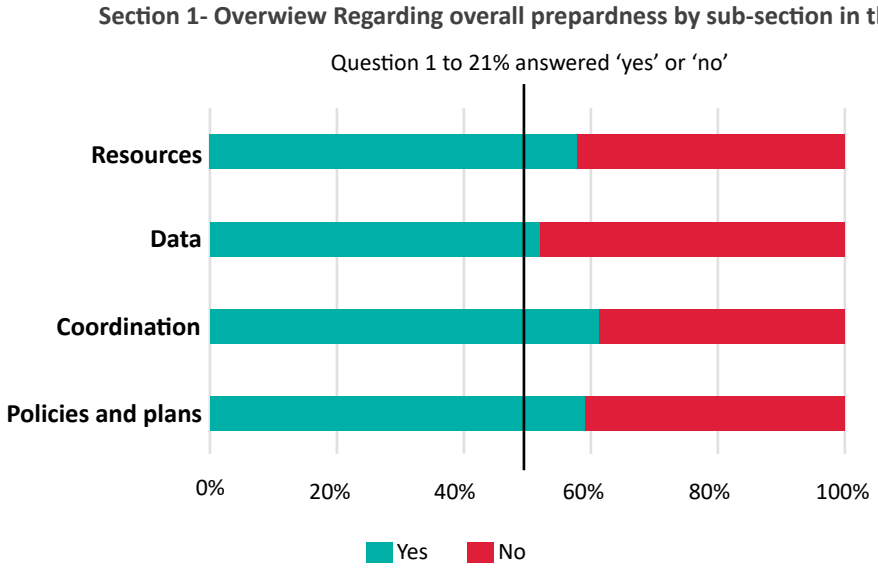
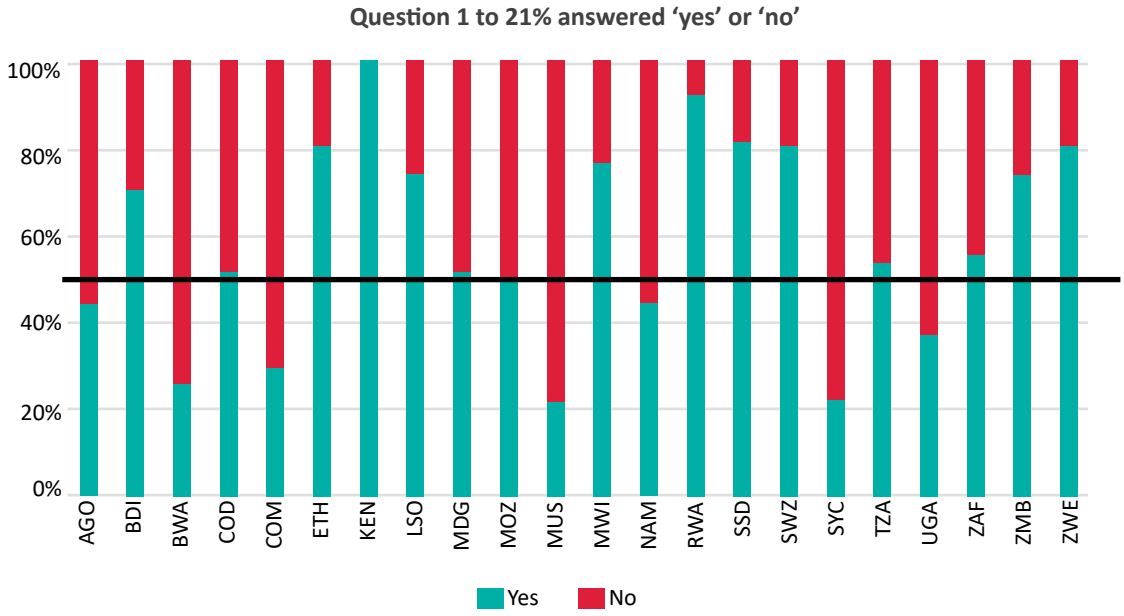


Figure 2: Section I – Overview regarding overall preparedness per country



Subsection I – National and subnational disaster management policies and plans

1	Does your country have a national emergency preparedness and/or response policy and/or plan?
2	Does your country have a national health preparedness and/or emergency response plan?
3	Are these plans rolled out at the subnational level?
4	Is SRH and/or the MISP integrated into any national or subnational emergency health response policy and/or plan?
5	Are there any SRH policies or plans that include provisions for disaster management and/or emergency response?
6	To your knowledge, are there national legislation and/or policies with provisions limiting access to SRH care for certain groups (e.g. migrants, undocumented migrants, refugees, youth, unmarried persons, people of diverse sexual orientation, gender identity and expression, and sex characteristics (SOGIESC), people living with HIV, sex workers, etc.)?
7	To your knowledge, is SRH included in recovery plans when response moves from acute to more comprehensive services?

The questions related to Subsection I assess the existence of overall national emergency preparedness and/or response plans and policies, as well as the existence of specific health-related preparedness and response policies. It assesses if SRH is part of any existing disaster management plans and if SRH policies consider disaster management elements.

Figure 3: Availability of national and sub-national disaster management policies and plans

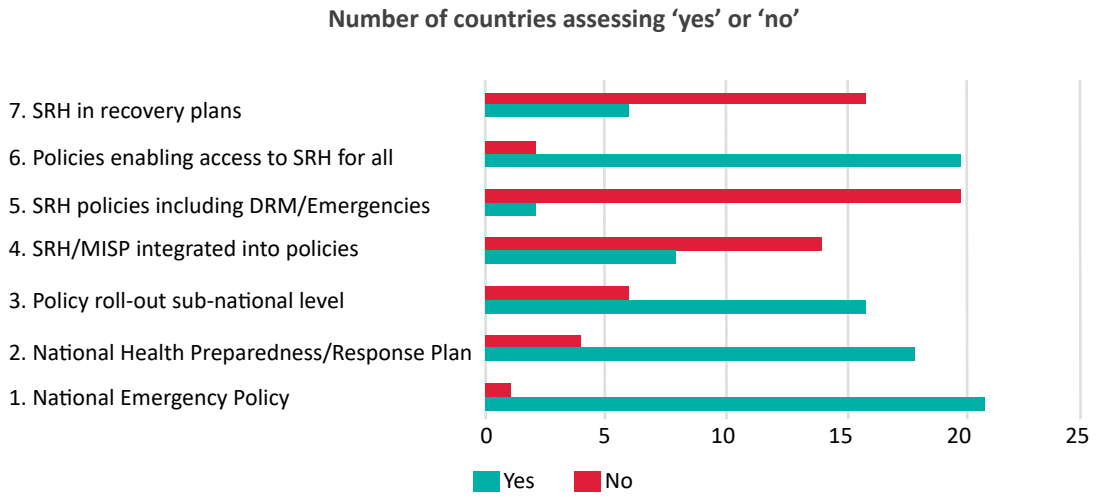
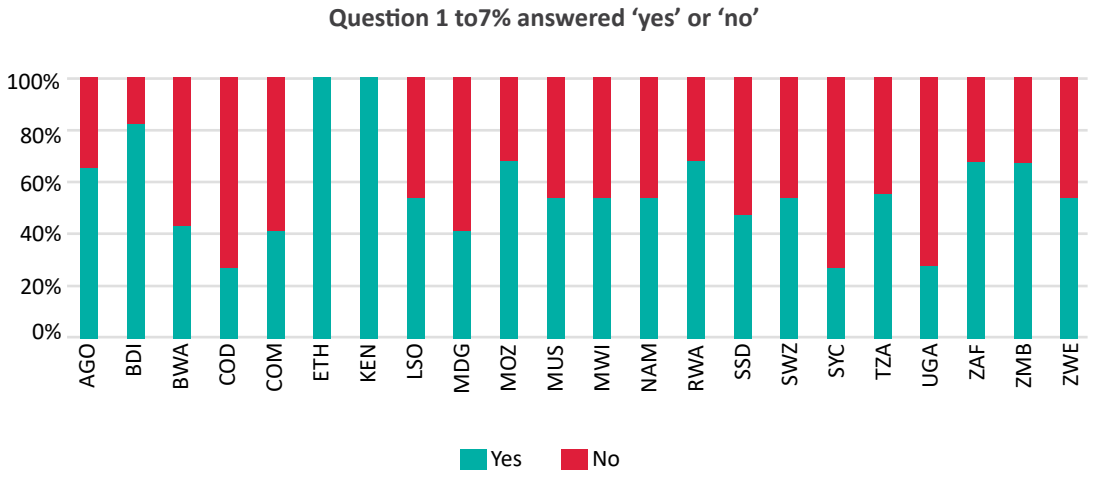


Figure 4: Policy landscape – Overview per country of availability of policies that enable the provision of the MISP during emergencies



The results regarding existing policies show that countries differ in terms of supportive policy landscape in the region, with **Ethiopia** and **Kenya** scoring the highest in terms of legislative environment and **Uganda, Seychelles** and **DRC** reporting having a less enabling environment. Most countries report having a national emergency preparedness and/or response policy or plan (Q1), and the vast majority also have a national health preparedness and/or emergency response plan (Q2). But very few countries have SRH provisions or the MISP integrated into these policies (Q4). Only eight countries mentioned having such provisions, and these policies do not reference the MISP per se, but rather include elements of the MISP. Analysis shows that the integration is often only partial and could be further strengthened:

- In **Angola**, SRH is considered by the National Civil Protection Commission to be part of universal health coverage and is included in the current Health National Development Plan, but the MISP is not specifically included. It is planned to have the MISP integrated into the forthcoming National Development Plan 2023–2027.

- In **Burundi**, the national risk management policy and plans integrate MISP/SRH themes.
- In **Madagascar**, the MISP is integrated as Annex 3 of the national health cluster contingency plan, which was developed by United Nations agencies, the government and major humanitarian actors.
- In **DRC**, the MISP is cited in the Humanitarian Needs Overview and the 2022 Humanitarian Response Plan.
- In **Rwanda**, the MISP components including SRH are integrated into the Rwanda Health Sector Strategic Plan 2018–2024 (HSSP IV), published in 2018. The MISP is not mentioned specifically, but the following elements are included: provision of SRH services; prevention and management of GBV cases and expansion of GBV services up to the health centre level; prevention of excess neonatal and maternal morbidity and mortality; prevention and management of HIV and STIs; and prevention of unintended pregnancies by promoting family planning service delivery. The Rwanda National Disaster Contingency Plan for population influx integrates SRH and GBV service provision during emergencies.
- In **Ethiopia**, the second Health Sector Transformation Plan (2021–2025) and the Health Emergency Recovery Plan (2021) in conflict-affected areas are health-specific national policies that partly address SRH in humanitarian settings.
- In **Kenya**, the MISP components on the prevention of sexual violence, the reduction of transmission of HIV, and the reduction of morbidity and mortality are integrated into the national emergency plan and standard operating procedures.

For the countries reporting not having such provisions, the assessment allowed them to take stock of what exists and which policies to update. Here are some examples:

- In **Uganda**, SRH and/or the MISP are not incorporated into emergency health response policies, although SRH, including reference to implementation of the MISP, is reflected in the Guidance on Continuity of Essential Health Services during the COVID-19 Outbreak (April 2020). At the subnational level, many of the SRH response activities are incorporated into the District Health Work Plans, although they are not explicitly reflected in emergency response plans. GBV service provision is not clearly outlined.
- In **Botswana**, there is a favourable legal and policy environment to enable disaster preparedness. This is evidenced by the availability of national emergency preparedness and/or response policy and/or plans, which include the National Disaster Risk Management Plan, the multi-hazard plan, disaster management teams and multisectoral rapid response teams. These plans are rolled out at the subnational level, where they are coordinated under the offices of the district commissioners. However, the assessment revealed that these national emergency preparedness plans do not specifically or adequately integrate SRH and/or the MISP. For instance, the overall national response for health emergencies is coordinated by the Ministry of Health. However, there is no entity that is specifically responsible for responding to SRH and GBV during a crisis.
- In **Lesotho**, the Disaster Management Authority (DMA) has a contingency plan, but this plan is not well owned by the stakeholders who participated in the MRA. This results in siloed work between the DMA and the Ministry of Health (MoH). The contingency plan and response plans do not sufficiently provide for SRH/GBV-related interventions in the context of emergency.
- In **Mozambique**, SRH/MISP is not fully integrated into national policies/emergency plans. The National Contingency Plan developed annually by the National Institute for Disaster Management and the health contingency plan developed by the MoH do not include all the aspects of the MISP. They only address some actions related to HIV/STIs.

SRH and the MISP are also very rarely included in recovery plans (Q7). The inclusion occurred only in **Burundi, Ethiopia, Kenya, Mozambique, Rwanda and Zambia.**

The results of the assessment also show, under Q5, that only two countries (**Kenya** and **Ethiopia**) have SRH policies that integrate or consider elements of emergency preparedness, response or disaster risk management. This highlights the reality that development policies do not consider emergencies in an adequate way and fail to cover the whole programme cycle and the bridge between development and humanitarian responses. For instance, some countries reported on some existing elements, but these policies do not cover an all-hazard approach:

- In **Zambia**, there is a General Guidance on Continuity of Essential Public Health Services including Reproductive, Maternal, Newborn Health during the COVID-19 pandemic, but this document is specific to COVID-19 and would need to be adapted for other types of emergencies. As a follow-up to the MRA in Zambia, UNFPA is supporting the Ministry of Health to review and develop a new Sexual and Reproductive Health Policy, and is advocating for the MISP to be reflected in this document.
- In **Uganda**, there are SRH policies and plans in place, such as the National Policy Guidelines and Service Standards for SRHR (2006), but they do not include provisions for disaster management and/or emergency response. The Health Sector Integrated Refugee Response Plan also does not capture or refer to the MISP.
- In **Mauritius**, the 2007 SRH policy is outdated and does not include any preparedness plan for SRH in emergency. However, a new SRH policy is being developed by the Ministry of Health, and the MRA process was an opportunity to advocate for the integration of the MISP into this policy.

The MRA allowed each country to identify strengths and weaknesses, and helped to identify context-specific provisions for improvement. These have been included in the national action plans that are owned by the government, UNFPA and civil society organizations involved in the process. All countries have included advocacy work around policy strengthening in their action plans and identified the partners to carry this work forward. Activities include the following:

- In **Madagascar**, they plan to finalize the national action plan for disaster risk reduction (DRR), which will help increase visibility for the MISP and SRHiE. They will advocate for a subchapter dealing exclusively with the MISP/SRH in the DRR national policy, and will also advocate for the allocation of the necessary resources for its implementation.
- In **DRC**, they plan to sensitize SRH stakeholders on the reciprocal linkages within the humanitarian–development–peacebuilding nexus and will advocate for the updating of relevant policies.
- In **Lesotho**, they plan to popularize the Multi-Hazard Contingency Plan and advocate for the revision of all emergency- and preparedness-related plans to ensure the integration of SRH and GBV interventions in emergencies.
- In **Mozambique** after the MRA exercise, a MISP training was conducted covering the three regions. One of the recommendations was to activate a SRH subcluster to address most of the gaps identified by the MRA. The MoH is also developing its own specific GBV protocol for the humanitarian context.

The assessment also helped identify gaps regarding the implementation of the humanitarian–development–peace nexus approach. In **Ethiopia,** there is a comprehensive national policy on disaster risk management, but there is no national policy supporting and adapting the implementation of the humanitarian–development–peace nexus approach. As a result, the involvement of development partners in humanitarian settings has not been very significant or sustainable.

Subsection II – Coordination mechanisms for SRH disaster management

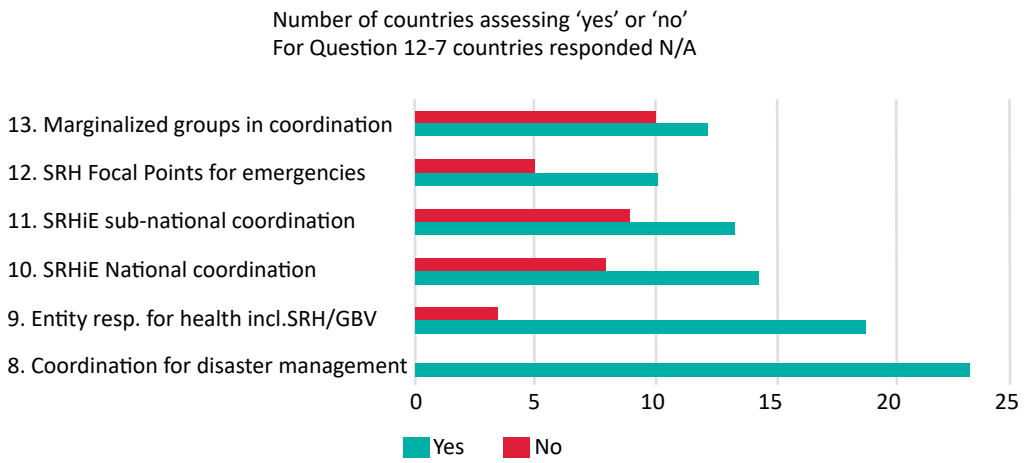
The questions included in Subsection II identify the existence of coordination mechanisms that will support SRH and MISP provision during emergencies. The toolkit ***Ready to Save Lives: A Preparedness Toolkit for Sexual and Reproductive Health Care in Emergencies*** states the following:

> Coordination does not happen overnight or spontaneously. Building strong and robust relationships takes time and commitment, and a sensitivity to the country context and enabling environment. There is no one right way to build coordination; there is a need for tailored and contextualized approaches and strategies that are aligned to existing national coordination mechanisms.

8	Is there a coordination mechanism responsible for disaster management during crises?
9	In this disaster management mechanism, is there an entity responsible for health, including SRH and GBV, during response?
10	Is there a coordination mechanism (e.g. SRH working group) to discuss SRH in emergencies at the national level when it comes to:
11	Is there a structure/coordination mechanism (e.g. SRH working group/disaster committee) to discuss SRH in emergencies at the subnational level when it comes to:
12	If there are no coordination mechanisms, are SRH focal points appointed at national and/or subnational level to assist with emergency preparedness and response?
13	Are civil society organizations and community-based organizations working with or representing marginalized and underserved groups (e.g. women and men with disabilities, people living with HIV, people of diverse SOGIESC, youth groups, religious leaders, sex workers, ethnic minorities, etc.) included in the coordination mechanisms?

All countries in the region report having coordination mechanisms that cover disaster management (Q7), and most countries have an entity in place that is responsible for health, including SRH and GBV, but SRHiE-specific coordination seems to be lacking in the region.

Figure 5: Availability of coordination mechanisms for SRH emergency preparedness



Eight countries report having no specific SRHiE coordination mechanisms in place (Q10). For instance:

- In **Mauritius**, a response coordination mechanism for health at the national level exists at the National Emergency Operations Command, but there is no entity (focal point) responsible for specific issues related to SRH in this structure.
- In **Namibia**, the National Disaster Risk Management Committee is responsible for addressing all matters related to disaster risk management, including health-related matters, but SRH issues are limited and not specified.
- In **Tanzania**, there is an SRH sub-working group operating in the refugee camps. At the national level, the existing coordination mechanisms include a reproductive, maternal, newborn, child and adolescent health technical working group and an adolescent sexual and reproductive health technical working group. However, emergency preparedness and response are rarely discussed in these groups.
- In **Botswana**, the assessment revealed that coordination mechanisms for SRH disaster management were inadequate, as coordination for disaster management during crisis does not specifically mainstream SRH. This has led to fragmented and reactive interventions. It was also indicated that SRH needs are not mentioned in national preparedness and response, and that previous emergency responses were topical (only addressing issues directly related to the crisis at hand) and reactive, but did not specifically address SRH emergency needs. Thus, coordination mechanisms for SRH – including SRH working groups/disaster committees, SRH focal points, and civil society organizations and other community-based organizations working with marginalized and underserved groups – are not included. It was noted that the current coordination mechanisms have largely remained at the national level, leaving out the subnational implementers.
- In **Mozambique**, the National Institute for Disaster Risk Management, in coordination with the MoH, is responsible for addressing all matters related to disaster risk management, including health-related matters, but does not cover SRH specifically. It only addresses some actions related to HIV/STIs.

In countries where SRHiE coordination mechanisms exist, these operate in different ways, depending on each country's context. For instance:

- In **Uganda**, it is the Ministry of Health that leads the SRHR working group, which meets regularly with the participation of partners and civil society, and emergency preparedness and response are discussed in this working group.
- In **Eswatini**, SRHiE coordination happens through the Public Health Emergency Management Committee at national and regional levels, with quarterly meetings.
- In **Lesotho**, there is a national SRH steering committee and a national SRH technical working group, which meet every quarter. The integrated reproductive, maternal, newborn, child and adolescent health and nutrition (RMNCAH&N)

strategy recognizes the SRH Technical Committee, which includes RMNCAH&N programme managers from the Ministry of Health and technical and financial partners, including United Nations agencies (WHO, UNFPA, UNICEF and UNAIDS). This team is activated during emergencies to ensure the continuity of essential SRH services.

- In **Rwanda**, preparedness is covered by the National Family Planning Working Group, which leads and coordinates preparedness activities for SRH in emergencies. The National Integrated Community Case Management Working Group coordinates response activities for SRH in emergencies. At the district level, there is a committee in charge of human security issues, which is composed of a gender monitoring officer, a district director of health, director generals of hospitals in the district, the Rwanda Investigation Bureau, which is in charge of disaster management at the district level, and the vice-mayor, in charge of social affairs. The committee meets regularly to discuss all relevant matters, including health and SRH issues.

- In **South Africa**, an SRH coordination mechanism and a national working group for SRHR are responsible for discussing SRH emergency preparedness and response.

- In **South Sudan**, there is a specific Sexual and Reproductive Health in Emergencies Technical Working Group. The working group addresses emergencies such as conflicts, natural hazards (e.g. floods) and pandemics. The working group meets monthly, and during the preparedness phase, pre-positioning of essential commodities such as reproductive health kits and dignity kits is discussed and implemented.

Figure 6: Existence of national coordination mechanisms for SRH emergency preparedness

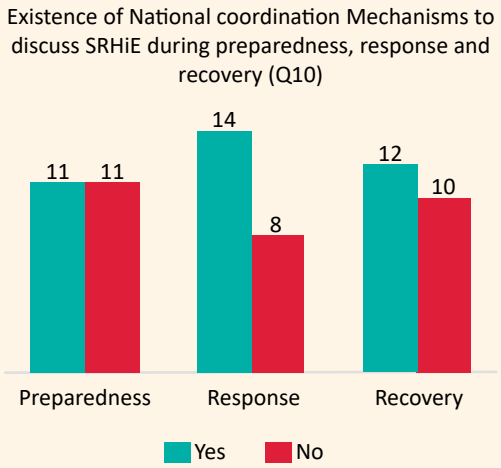
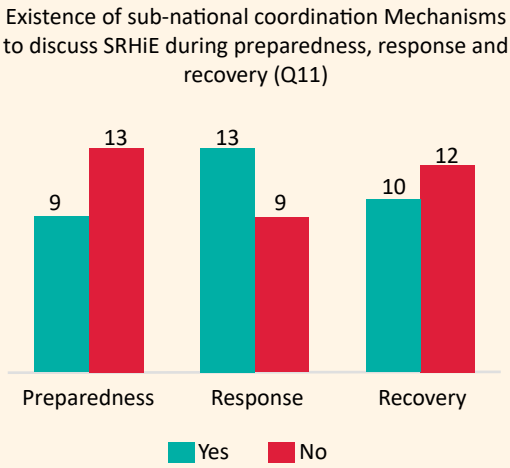


Figure 7: Existence of national coordination mechanisms for SRH emergency preparedness



From a regional perspective, countries such as **Kenya, Malawi, Rwanda, Eswatini, Zambia** and **Zimbabwe** seem to be champions in terms of coordination, and other countries could learn from them.

When looking at the inclusiveness of the existing coordination mechanisms (Q13), 10 countries report that additional efforts are needed to have better representation of community-based organizations and marginalized people, particularly people with disabilities. Some countries such as Rwanda have managed to have a variety of actors in their coordination mechanisms.

In **Rwanda**, civil society organizations working with or representing marginalized and underserved groups are included in the national coordination mechanisms. These include UPHLS (non-governmental Umbrella of Organizations of Persons with Disabilities), Rwanda NGOs Forum on HIV/AIDS and Health Promotion, RRP+ and ANSP+ (networks of people living with HIV), Kigali Hope Association, AFRIYAN (African Youth and Adolescents Network), ISANGE LGBTI Coalition Rwanda, etc.

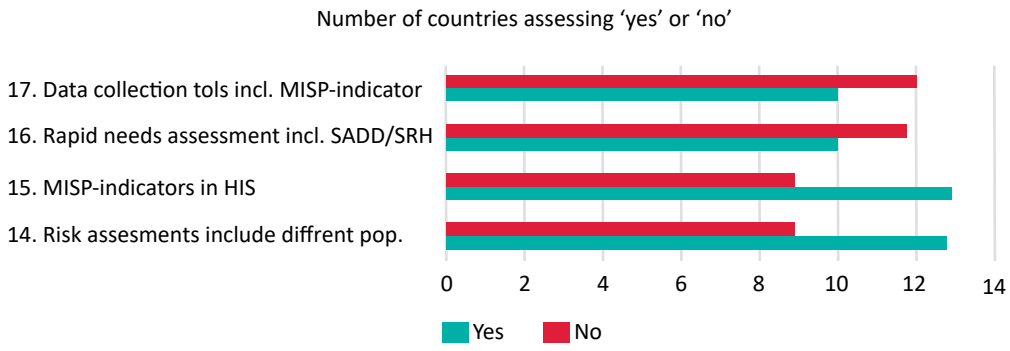
Subsection III – SRH data at national and sub-national levels

The questions included in this subsection identify if existing assessments and collected data include essential SRH data to shape a meaningful MISP response.

14	Do current risk assessments address impacts on different populations (e.g. women, people with disabilities, people living with HIV, people of diverse SOGIESC, youth, sex workers, ethnic minorities, etc.)?
15	Are MISP-related indicators (see MISP checklist) integrated within the existing health information systems?
16	Do rapid needs assessment forms for emergency response (rapid assessments and health sector assessments) include sex-, age- and disability-disaggregated data and key SRH questions?
17	Do data collection tools (e.g. health forms) for emergency response include MISP-related indicators (see MISP checklist)?

The results of the MRA in Subsection III show that this area is particularly weak for some countries in the region. Countries such as **Angola, Botswana, Mauritius, Uganda, South Africa** and **Zambia** rate particularly low. When conducting the MRA, country partners reported that there was repeatedly a lack of knowledge about the existence of certain assessment tools. Also, for data collection tools that include MISP-related indicators, partners mentioned a lack of standardized tools for risk assessments. For instance, in **Madagascar** they mentioned that data collection tools (e.g. health forms) are available, but they are not updated and are unfamiliar to some stakeholders.

Figure 8: Availability of SRH data collection tools specific to emergencies



When looking at country-specific data, Rwanda reports having a very strong data collection system in place.

In **Rwanda**, the country conducts surveillance and assessment activities to have SRH data at national and subnational levels. The Integrated Biological and Behavioural Surveillance Survey addresses impacts on different populations, such as female sex workers, men who have sex with men, and people with disabilities. The Demographic and Health Survey and HIV and syphilis surveillance assess impacts among pregnant women. The Rwanda Health Management Information System has integrated most of the MISP-related indicators, and the majority are collected from the lowest health facility level. They are reported into the system monthly for the central level to take necessary and timely actions. The rapid assessment forms for emergency response include questions related to age and sex, along with key SRH questions. However, the forms do not assess disability.

Some countries report having most of the provisions in place, but the comments and rationale provided in the questionnaire show that certain areas could still be improved. As mentioned in the example of Rwanda above, a recurring area for improvement is disaggregated data collection around disability.

- In **South Sudan**, MISP indicators are reflected in the South Sudan District Health Information System 2, including service delivery. South Sudan mostly deploys the Initial Rapid Needs Assessment tool, which captures very basic information in the early stages of emergency. This tool does not provide detailed disaggregated data information on disability.

- In **Tanzania**, MISP-related indicators are integrated into the existing health management information systems at national and subnational levels. In refugee settings, surveys are conducted through Joint Assessment and Monitoring, which include age and sex. However, data on disability is not captured.

- In **DRC**, disaster risk management and analysis of risks and vulnerabilities mainly focus on primary health care, without paying sufficient attention to SRH linkages.

GBV-related data (MISP-2) collection through a standardized system is also missing in some countries:

- In **Botswana**, most indicators of the MISP for SRH Monitoring Checklist have been integrated into the health information management systems (HIMS). However, most of the indicator sources remain in paper-based registers and forms. As a result, the current M&E framework is found to be cumbersome, as it requires the use of multiple tools to record and collate variables for the computation of many programmatic indicators. Monitoring and evaluation of Indicators 1 and 3 is not as strong as that of other indicators. Botswana is, however, embarking on a comprehensive strengthening of the HIMS in Botswana through a collaborative process that rallies the actors in M&E and health information towards a common HIMS system for purposes of efficiency, transparency accountability.

- In **Uganda**, indicators aligning to Sections 3, 4, 5 and 6 of the MISP are integrated into the Health Management Information System 2. For GBV, there is a separate national database where all cases are registered. The Health Management Information System 2 only captures data on the number of clients receiving sexual and gender-based violence services at health facilities.

For some countries, the issue around data collection is that it is not sufficiently digitized.

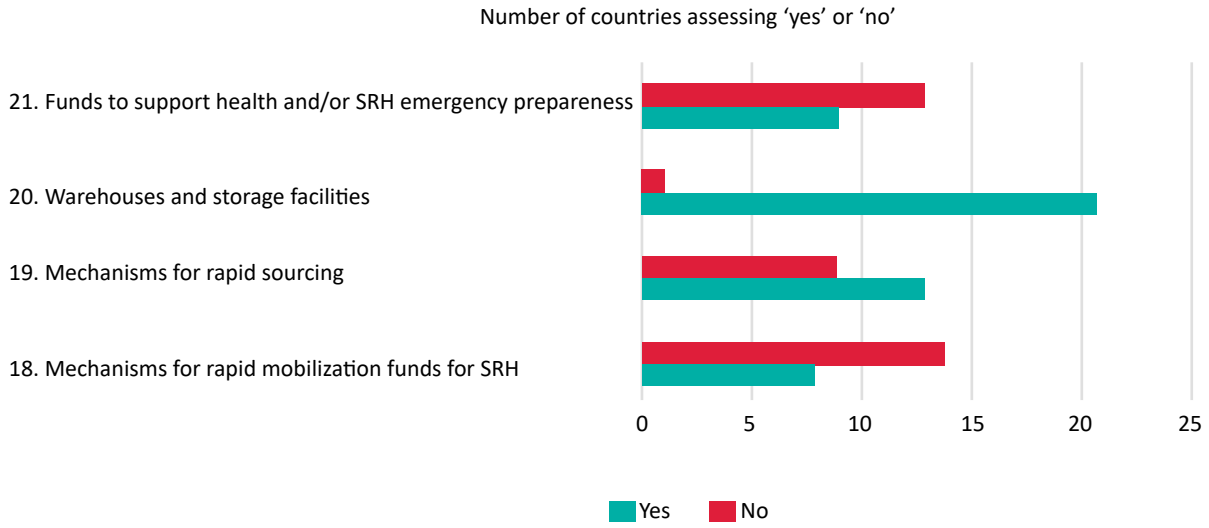
In **Mozambique**, the information around MISP-related indicators exists at the health facility level. The issue is that not all information is digitized, and if a disaster affects the health facility, it also affects the data. For example, during Cyclone Idai records were lost, and it was challenging to identify patients with chronic diseases. While there are digitized records of HIV-positive patients, during emergencies it is difficult to identify these patients and maintain the continuity of their medication regimen, particularly due to patients' fear of stigma and discrimination when moving from one area to another.

Subsection IV – Resources for MISP preparedness and implementation

The questions included in Subsection IV identify the capacity to shift in a timely manner from stable times to emergencies regarding availability of commodities, equipment, human resources and/or funding.

18	Do mechanisms for rapid mobilization of funds exist to support an SRH response (e.g. contingency funds, country-based pooled funds, etc.)?
19	Do you have a mechanism in place for rapid sourcing – at the national or international level – of SRH supplies and equipment and/or Inter-Agency Reproductive Health (IARH) kits (e.g. pre-positioning, buffer stocks, standing agreements, pre-identified suppliers, etc.)?
20	Do you have warehouses or storage facilities where medical supplies for SRH are prepositioned or could be stored?
21	Are there any funds to support health and/or SRH emergency preparedness at the national or subnational level?

Figure 9: Availability of resources for MISP preparedness and implementation



This subsection rates well regarding the availability of warehouses and storage facilities (Q20), and to a lesser extent the existence of mechanisms for rapid sourcing (Q19). Funds to support health and SRH emergency preparedness (Q21) and mechanisms for the rapid mobilization of funds for SRH (Q18) are weaker areas. In most countries, available funds are often external funds through United Nations systems or international organizations.

At the country level, **Kenya, Rwanda, South Sudan, South Africa** and **Zimbabwe** rate the highest for this subsection.

Overall, earmarked funding for SRH preparedness is lacking, as is specific domestic funding, which results in shortages of supplies and inadequate pre-positioning of supplies. Here are some examples:

- In **Uganda**, there is a National Contingency Fund, but it is not operational, as it requires the Disaster Preparedness and Management Bill to be passed. Currently, the Office of the Prime Minister uses ad hoc emergency finance allocation to respond to emergencies. The passing of the bill would enable emergency

financing to be part of core funding through the Ministry of Finance, which would facilitate preparedness and planning. As rapid national sourcing is missing, financial requests are made to multilateral organizations (i.e. UNFPA, UNHCR, WHO, UNICEF) to support rapid response.

- In **Botswana**, it was noted that stockouts of SRHR commodities are often experienced. During critical stockouts of commodities (for example, implants and condoms), the country has in some instances rapidly mobilized these with assistance from United Nations agencies (in the past, UNDPA has provided such support). Additionally, the Global Fund to Fight AIDS, Tuberculosis and Malaria and the Government of the United States of America often provide support when the need arises. The assessment revealed that, while emergency preparedness funding may exist at the national level, no special funds are specifically earmarked for SRH needs. It was indicated that there is capacity in the country to preposition and store medical supplies for SRH at national and district levels through existing warehouses and pharmacy facilities. However, there is a need to assess the capacity of the existing infrastructure to accommodate buffer stock during crises.

- In **Madagascar**, several humanitarian emergency funds exist, such as the National Contingency Fund included in the Initial State Finance Law and the OCHA Central Emergency Response Fund (CERF). However, these funds are not specific to SRH (except the UNFPA Humanitarian Fund). The country faces regular disruptions in supplies (medicines, equipment, products and prevention supplies), and pre-positioning needs to be strengthened.

- In **Lesotho**, a National Emergency Fund is available for national emergency responses, but health-related issues are handled at the MoH level, with support from its partners. The MoH also has an Emergency Contingency Fund, which covers health emergencies; however, no specific funds are earmarked for SRH emergency preparedness.

- In **Mozambique**, there is a National Contingency Fund, but the health sector prioritizes other endemic diseases such as cholera and malaria; the SRH component is not covered.

When looking at good practices, Rwanda has interesting procedures in place that could inspire other countries.

In **Rwanda**, UNFPA leads the international procurement of IARH kits. However, at the MoH level, they have buffer stocks and pre-identified suppliers to quickly procure SRH supplies and equipment in case of emergency. The MoH holds a budget to support health emergencies, including SRH preparedness activities; this budget is under the ordinary budget (funds provided by the government).

Snapshot of key recommendations for Section I

The table hereunder includes a summary of recommendations stemming from major gaps reported under Section I.

Policies and plans

- Integrate SRH and the MISP into national disaster, preparedness and response plans.
- Integrate SRH and the MISP into national recovery plans.
- Integrate emergency preparedness, response or disaster risk management into SRH policies.
- Understand the humanitarian–development nexus and how development- and humanitarian-related policies need to complement each other.

Coordination

- Strengthen coordination during preparedness and move away from reactive/ad-hoc coordination.
- Improve the meaningful participation of marginalized and underserved groups in coordination mechanisms.

SRH data

- Disseminate knowledge on existent assessment tools.
- Standardize and digitize data collection tools.
- Improve disaggregated data collection (e.g. disability).
- Improve data collection related to gender-based violence (GBV) through standardized comprehensive systems.

Resources

- Increase funds to support health and SRH emergency preparedness.
- Identify and establish mechanisms for the rapid mobilization of funds for SRH.
- Secure specific domestic funding to avoid shortages of supplies and inadequate pre-positioning of supplies.

Section II – Readiness to provide services as outlined in the MISP

Section II of the questionnaire focuses on readiness to provide MISP-related services. Most questions look at existing SRH services (during stable times) to understand how these can be leveraged. The section includes six subsections:

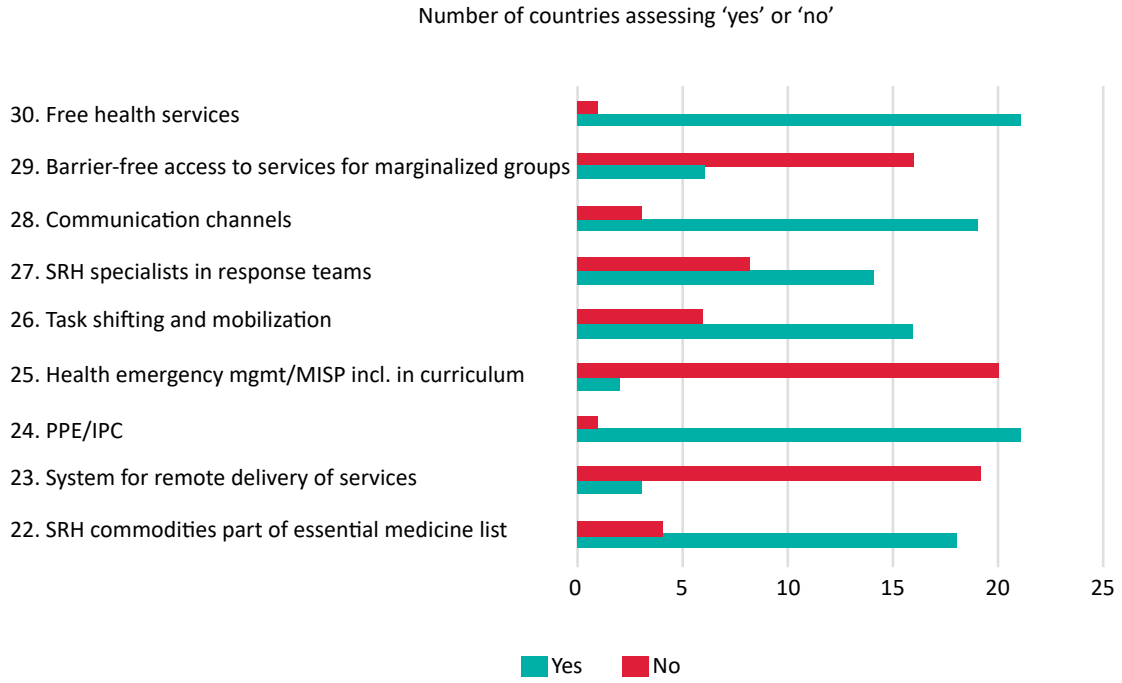
MISP Services – General
MISP Objective 2 – Prevent sexual violence and respond to the needs of survivors
MISP Objective 3 – Prevent the transmission of and reduce morbidity and mortality due to HIV and other STIs
MISP Objective 4 – Prevent excess maternal and newborn morbidity and mortality
MISP Objective 5 – Prevent unintended pregnancies
Other priority activity: Safe abortion care to the full extent of the law

MISP services – General

This section looks at the availability of supporting services for MISP implementation in stable times. It explores the following: the inclusion of SRH commodities into the national essential medicines list; the availability of systems to support the remote delivery of services; the availability of personal protective equipment and infection prevention and control materials; the inclusion of the MISP in official health-related curricula; the existence of mechanisms for task shifting; the availability of overall communication channels; the provision of free services; and access to services for marginalized and underserved groups.

22	Are all the SRH commodities needed for MISP implementation (see IARH kit booklet) as part of the national essential medicines list?
23	Do you have the systems in place to support remote delivery of services (e.g. digital health, telemedicine, online consultation, etc.)?
24	In the event of epidemics/pandemics, are there opportunities and plans for scaling up personal protective equipment (PPE) and infection prevention and control (IPC) materials for SRH facilities?
25	Do the health-care training curricula or other relevant trainings, including on online platforms, for health staff integrate health emergency management and/or the MISP?
26	Does a mechanism exist for health staff to be moved or take on new roles in times of emergencies to better support affected areas (e.g. surge or task shifting)?
27	Do health response teams contain specialist SRH providers?
28	Are there diverse communication channels (e.g. radio, text messaging, WhatsApp, etc.) available that can be leveraged to inform the community about the availability of MISP-related services in case of an emergency?
29	Are there any barriers for marginalized and underserved groups (e.g. women with disabilities, adolescents, sex workers, people of diverse SOGIESC, people living with HIV, refugees, migrants, undocumented migrants, ethnic minorities, etc.) to access SRH services?
30	Are there provisions for free access to health services (consider the MISP) for crisis-affected populations?

Figure 10: Availability of general provisions to secure the readiness to provide the MISP during emergencies



The region rates particularly well under the questions assessing the integration of SRH commodities as part of the essential medicines list (Q22), the availability of PPE and IPC materials (Q24), the availability of communication channels to inform the population (Q28), and the existence of free health services for crisis-affected populations (Q30).

As a result of the COVID-19 pandemic, most countries scaled up the availability of PPE and IPC materials for health professionals (Q24). Some countries report that a COVID-19 relief fund was established to pool resources for the response and to procure PPE and IPC materials (**Botswana**). Other countries saw the establishment of a task team with representation from the government, the national disaster management authority and development partners, including United Nations agencies and civil society organizations, to mobilize and coordinate resources during pandemics/epidemics (**Eswatini**) or through the national supply chain management office of the MoH (**Lesotho**). In Lesotho, a specific task team for COVID-19 interventions was established to link the MoH and the DMA, and support from all partners was coordinated through the team.

Three areas have been assessed as particularly weak: access to services for marginalized and underserved groups (Q29), the integration of the MISP into the health-care training curriculum (Q25), and the availability of systems to provide remote service delivery (Q23).

Even though most countries do not have legal barriers denying access for any groups to health-care services, including SRH services (see Q6), most countries report economic, sociocultural and religious barriers (Q29) and state that these barriers are often exacerbated during emergencies. The following are some examples of these barriers:

- Inadequate physical accessibility to health facilities for people with disabilities
- Lack of needed skills among health professionals to handle marginalized and underserved groups (e.g. sign language skills for the hearing and speech impaired)
- Cultural practices that hinder uptake of services
- Religious beliefs that are against the use of contraception
- Limited geographical coverage of health facilities
- High stigma and discrimination against lesbian, gay, bisexual, transgender, queer and intersex persons, sex workers, and people living with HIV
- Limited availability of youth-friendly services

Only two countries report integrating the MISP or health emergency management into the health-care training curriculum (Q25). In **Rwanda**, the national training curriculum for doctors, nurses and midwives includes components of the MISP and emergency preparedness. MISP components are also included in other relevant training such as the Field Epidemiology Programme, which prioritizes health staff from district hospitals. In **DRC,** the MISP has been integrated into the midwife curriculum thanks to a partnership with UNFPA. Such provisions are particularly important to ensure that health-care providers are trained and available to provide the MISP and contribute to a sustained pool of trained personnel.

Some countries report having several trainings already available, and many of the countries are planning to strengthen this area in their action plan:

- In **Namibia**, the pre-service training curriculum for nurses includes some content on health emergencies, but not specifically on SRH, and there is nothing on the MISP. The team that worked on the MRA identified the need to advocate for a revision when relevant curricula will be reviewed to ensure that health emergency management and the MISP are part of all pre-service and in-service curricula.

- In **South Africa**, there is an online training platform to build the capacity of health-care workers on national SRHR guidelines, but it does not include emergencies.

- In **South Sudan,** there is a curriculum for nurses, midwives, clinical officers, pharmacists and medical doctors. However, there is no mention of the concept of the MISP in the document, and it mentions only emergency medicines. The stakeholders identified the need to revise the curriculum and training materials.

- In **Uganda,** the curricula for doctors, nurses and midwives incorporate health emergency management; however, there is no reference to or content on the MISP.

- In **Botswana,** there is a curriculum review ongoing, with technical assistance from WHO to integrate emergency management, but there is nothing specifically on the MISP.

- In **Mozambique,** the MoH is developing a specific GBV protocol for the humanitarian context, and UNFPA is advocating for it to cover all aspects of GBV prevention and response, including reinforcement of case management and mental health and psychosocial support.

The last question in this section that rated low is on the availability of remote service provision (Q23). Only Rwanda, Kenya and Tanzania responded 'yes' and reported on initiatives other countries could learn from:

- **Rwanda** initiated toll-free telephone lines that are used for online consultations, telemedicine and referral. For example, Babyl provides digital health-care services, and clients can book an appointment via their phones. At the time of the MRA, Babyl reported having registered more than 2.5 million users, with more than 2.9 million consultations performed.

- In **Tanzania**, the government has established the Government of Tanzania Health Operations Management Information System (GoTHOMIS), which is a clinical case management system that is used for online consultation.

- In **Kenya**, online consultations, including via phone calls, are taking place even in emergency settings.

For the countries that do not have a system for remote services, this has been identified as a gap to be addressed in the action plan:

- **Madagascar** regularly faces emergencies due to the cyclone seasons, which are also hotbeds of cyclical epidemic outbreaks. The MRA highlighted the weak integration of new information and communication technologies into the existing tools and the need to strengthen that area.

- In **DRC,** as a follow-up to the MRA, stakeholders want to strengthen the institutional, technical and operational capacities of SRH programmes and integrate the remote delivery of SRH services (digital health, telemedicine, online consultation, etc.) at national and provincial levels.

- In **Angola,** digital health services started to be implemented very recently, specifically a youth digital platform and a youth digital app (Oi Kambas). As part of the action plan, it is planned to advocate for the creation of a digital platform for the provision of SRH services.
- In **Botswana,** there are some telemedicine services, such as dental services and online consultation for COVID-19 patients, but these are not specific to SRH services. There is a mobile service campaign to screen for cervical cancer in rural and hard-to-reach areas, but it does not provide telemedicine services. As part of the action plan, the team under the leadership of the MoH recommends the development of a policy and guidelines for telemedicine in Botswana – including standard operating procedures and models of care.

Readiness per MISP objective

The questions on the service to be provided under each MISP objective (Objectives 2 to 5 and Q31–52) and the safe abortion care priority activity (Q53–58) help to give a picture of the strengths and weaknesses regarding existing service provision. For each MISP objective, the questions are structured similarly.

The questions assess and explore the following elements:

A	B	C	D	E
Actors responsible for ensuring the needed provisions (GBV, HIV, STI, maternal and newborn services, contraceptive services, and safe abortion care)	The existence of up-to-date **referral systems**	The level of **health facilities** (type of health facility) that can provide the needed health services (assessing where the services can be found)	The **availability of MISP** elements (as described in the Inter-Agency Field Manual) in the current state of services	The existing medical and non-medical structures' (where applicable) **ability to provide services per MISP objective** (regarding qualified medical staff, facilities and supplies/ equipment)

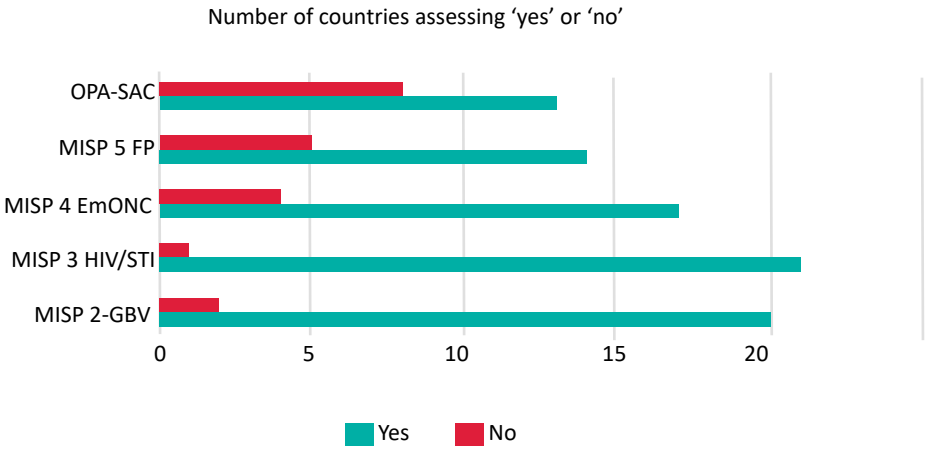
The results showed that partners involved in the MRA know the actors that are responsible for each of the MISP objectives (A). There is also a good understanding about which health facility level is responsible for each service (C). The information provided under these sections gives an understanding of 'who provides the services' and 'where they can be found'.

For the questions related to B (referral systems), D (availability of MISP elements) and E (ability to provide services), a detailed analysis is provided hereunder.

Referral systems

Overall, there seems to be a clear up-to-date referral system for most MISP objectives that could potentially be scaled up in most countries. Three MISP objectives rate lower than the rest: MISP-4, MISP-5 and safe abortion care.

Figure 11: Availability of up-to-date referral systems for MISP-related services in ESA



Availability of MISP elements in the current state of services

Q	**Given the current state of health services in your location, do you think the following MISP elements are adequate and readily available in case of an emergency?**

The questions 35 (MISP-2), 41 (MISP-3), 46 (MISP-4) and 51 (MISP-5) list the MISP elements for each MISP objective, as described in Chapter 3 of the Inter-Agency Field Manual, and assess if these are adequate and readily available in case of an emergency.

The results show that 76 per cent of the services for MISP-3 (HIV/STI) are rated as adequately available in the region. The fact that there seems to be a more enabling environment for HIV and STIs can probably be explained by the important investment in HIV through the Global Fund to Fight AIDS, Tuberculosis and Malaria.

The MISP objectives rating the lowest are MISP-2, followed by MISP-4 and MISP-5.

MISP Objective 2 – Prevent sexual violence and respond to the needs of survivors

The provisions related to **MISP-2** (Q35) rate the lowest, with only 51 per cent of services available. A particular weakness is the lack of confidential and safe spaces within the health facilities to receive and provide survivors of sexual violence with appropriate clinical care and referral (rated as inadequate in 14 countries).

In **Mozambique**, the lack of confidential spaces for survivors was one of the most critical gaps discussed during the assessment. It was considered a major concern, particularly in Cabo Delgado, as humanitarian partners are experiencing this gap in their emergency response. When it comes to provision of health care to sexually assaulted people, the lack of a confidential space reduces the demand for treatment. Therefore, the establishment of confidential spaces is imperative for the timely provision of sexual violence health services.

The lack of information, education and communication (IEC) materials on services for sexual violence survivors during emergencies for each linguistic group of the most at-risk areas (inadequate in 15 countries) is another area that rated particularly low for the region. Most countries reported that there is a need to translate IEC materials into additional languages and make them accessible for people with learning disabilities and hearing and visual impairments.

Overall, in most countries efforts are needed to prevent sexual violence and respond to the needs of survivors. In **Ethiopia,** stakeholders agreed that the humanitarian crisis in the country has fuelled the risk of sexual violence associated with social and cultural influences that hinder women and girls from ensuring their reproductive rights. Looking forward, interventions that do not address gender inequalities, prevention of sexual violence and timely response to the needs of the survivors are less likely to bring about positive impact in a population experiencing humanitarian crisis. Options were discussed around empowering women and girls and capacitating them for self-care interventions, as a complement to the continuum of care through the MISP standard, further enhancing access to quality SRH for crisis-affected populations.

MISP 3 – Prevent the transmission of and reduce morbidity and mortality due to HIV and other STIs

Under **MISP-3** (Q41), all countries except three reported that there is provision of co-trimoxazole prophylaxis for opportunistic infections for patients found to have HIV or already diagnosed with HIV, and almost all countries have provided post-exposure prophylaxis (PEP) to survivors of sexual violence as appropriate and for occupational exposure. **Uganda** reported that such provisions are inadequate. The assessment highlighted that this is theoretically in place; however, in practice access is impacted by the limited availability of PEP at accredited facilities and the long distances survivors must travel to reach Health Centre IIIs when PEP is not available at a lower-level facility. Facilities that are to date not accredited by the national health system in refugee settlements cannot provide this service.

The weakest area under MISP-3 is the ability to provide safe and rational blood transfusion, with less than 50 per cent of the countries reporting having this provision. For most countries, this is also an issue during stable times:

- In **Mozambique**, blood transfusion and standard precautions were reported as being a major gap beyond emergencies, as these services were considered to be not sufficiently available during non-emergency times.

- In **Botswana**, there are shortages of blood at the blood bank; the availability is already limited during stable times, which results in a serious challenge during emergencies.

The lack of IEC materials and STI/HIV counselling services (that emphasize informed choice and effectiveness, and that support client privacy and confidentiality) during emergencies has repeatedly been identified as a gap, particularly for people with disabilities. There is limited availability of these materials and services in different local languages.

OBJECTIVE 4: MISP 4 – Prevent excess maternal and newborn morbidity and mortality

1 Ensure **availability and accessibility of clean and safe delivery**, essential **newborn care**, and lifesaving **emergency obstetric and newborn care (EmONC) services** including:

At referral hospital level: Skilled medical staff and supplies for provision of comprehensive emergency obstetric and newborn care (CEmONC) to manage

At health facility level: Skilled birth attendants and supplies for vaginal births and provision of basic obstetric and newborn care (BEmONC)

At community level: Provision of information to the community about the availability of safe delivery and EmONC services and the importance of seeking care from health facilities. Clean delivery kits should be provided to visibly pregnant women and birth attendants to promote clean home deliveries when access to a health facility is not possible.

2 Establish a **24 hours per day, 7 days per week referral system** to facilitate transport and communication from the community to the health center and hospital.

3 Ensure the **availability of lifesaving, post-abortion care** in health centers and hospitals.

4 Ensure **availability of supplies and commodities for clean delivery and immediate newborn care** where access to a health facility is not possible or unreliable.

IARH KIT 2 | IARH KIT 6 | IARH KIT 8 | IARH KIT 9 | IARH KIT 10 | IARH KIT 11 | IARH KIT 12

Regarding **MISP-4 (Q46),** the areas that rate above average[5] for the region are the following:

- Provision of information to the community about the availability of safe delivery and emergency obstetric and neonatal care services and the importance of seeking care from health facilities
- Referral system for obstetric complications that is open all the time (24 hours a day, 7 days a week)
- Availability of post-abortion care in health centres and hospitals

Less than 50 per cent of the countries report that their country has skilled medical staff and supplies, at the referral hospital level, for the provision of comprehensive emergency obstetric and newborn care (CEmONC) and skilled birth attendants and supplies for vaginal births and provision of basic emergency obstetric and newborn care (BEmONC).

In **Ethiopia**, the assessment indicated that the referral system for emergency obstetric and neonatal care is not yet well coordinated, and that there is also a lack of coordination among partners. BEmONC and CEmONC services are available as per the national standard of the health facilities; however, MISP elements are not adequate or available during

[5] **Note:** This means that the majority of countries have such provisions, but this might still be a very weak area for certain countries.

emergencies. BEmONC and CEmONC services may be interrupted even in normal circumstances due to shortages of supplies and lack of qualified health workers.

The **areas identified as the weakest** are as follows:

- Availability of supplies and commodities for clean delivery (e.g. clean delivery kits)
- Immediate newborn care where access to a health facility is not possible or unreliable (inadequate in 15 countries)
- Existence of IEC materials on priority maternal and neonatal services for pregnant women and girls for each linguistic group of the most at-risk areas (inadequate in 16 countries)

MISP 5 – Prevent excess maternal and newborn morbidity and mortality

The weakest area under **MISP-5 (Q51)** is the lack of IEC materials on contraceptive choice (that emphasize informed choice and effectiveness, and that support client privacy and confidentiality, and access to services). These are inadequate in 14 countries.

Most countries (16) mention the availability of a range of long-acting (and reversible) and short-acting contraceptive methods (including male and female condoms and emergency contraception) at primary health-care facilities to meet demand.

In **Mozambique**, the assessment indicates that there is good coverage of family planning methods within the national public health system, with all hospitals and health centres, and even some community health centres, providing all types of contraceptives. Also, most of the community health workers are able to provide short-term methods such as pills and condoms (both male and female). MRA participants felt that the number of qualified health providers and the infrastructure, equipment and supplies available for family planning met the minimum standard. However, these services are not given the same level of priority or importance as food, shelter, non-food items and other health needs affecting the population.

Safe abortion care to the full extent of the law

Regarding the **other priority activity–safe abortion care**, abortion is available in most countries of ESA, with restrictions varying from one country to another. Only Madagascar responded 'no' to question 53, stating that abortion is not available at all in the country. This section of the questionnaire created sensitive discussion in some countries and presented the challenge of finding consensus between government and other partners.

IEC materials outlining available services remain weak, with 16 countries reporting that these are not adequately available.

The assessment shows that half of the countries have a referral system in place, but the operationalization of these seems to be an issue. Overall, the assessment shows that access to abortion services is often a challenge during stable times, and hence is extremely limited during emergencies. The results also reveal that there is a lack of knowledge among the general population about available abortion services and the law.

Ability to provide MISP services

Q	**Based on the above MISP services, how would you rate the existing health systems' ability to provide the services as outlined in the MISP for SRH in your location with regard to qualified medical personnel, facilities, supplies and equipment?**

Questions 36, 42, 47, 52 and 58 assess the level to which something is in place using the following rating:

□ **Insufficient** = Cannot meet current demand

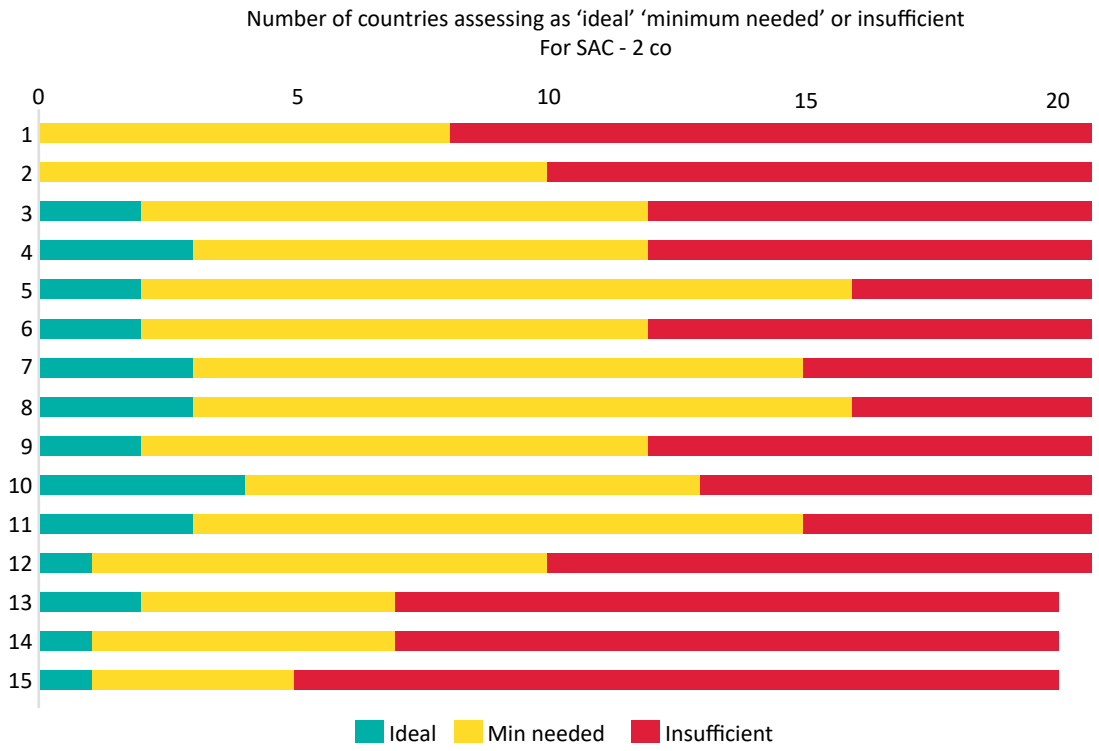
□ **Minimum needed** = Able to manage current demand

□ **Ideal** = Manages current demand well and could potentially manage small demand increases

The countries assessed the existing health system's ability to provide MISP services with regard to qualified medical personnel, facilities, supplies and equipment. The results clearly show that these elements are mostly rated as 'insufficient', meaning that the country cannot meet the current demand even during stable times, or only at a 'minimum needed', which means that it may manage current demand, but this cannot be scaled up.

The weakest area is related to 'equipment and supplies', with 53 per cent of the responses stating that the health system is unable to meet current demand. Supply chain management has been repeatedly mentioned as an issue in the region. This links also with the challenges in rapidly mobilizing resources for supplies, and hence stockouts are frequent. For instance, in Ethiopia the procurement process by the MoH through the Ethiopian pharmaceutical supply service has been reported as being very lengthy, and there are recurring delays regarding the availability of essential commodities for SRH services during emergencies.

Figure 12: Rating of the existing health systems' ability to provide services per MISP objective with regard to qualified medical personnel, facilities, supplies and equipment



One of the areas that rated particularly low (with a high percentage of 'insufficient') is the ability to provide the GBV-related MISP services (Q36). Countries reported that there are issues regarding supply chain management, qualified medical personnel to deal with this sensitive issue, and insufficient safe spaces or safe homes.

- In **Botswana,** the results showed that, although there are numerous actors responsible for the provision of GBV-related services in the country, overall collaboration/partnerships among these actors to put in place preventative measures at community, local and district levels is limited. It was revealed that understanding/interpreting policy and other related legislative frameworks to address SRH needs remains a gap across service providers.

- In **DRC,** even during stable times, health facilities still experience insufficient equipment and medical supplies, including drugs and laboratory tests. Safe spaces and helplines only exist through specific projects.

- In **Comoros,** these provisions have been rated as insufficient, and it was reported that all actors who are supposed to take care of rape cases are not trained, particularly caregivers.

- In **Tanzania,** qualified staff are insufficient compared to the demand, facilities are lacking, and most of the existing facilities are not offering quality services or have limited space, and they regularly face shortages of equipment, including forensic evidence collection tools and reproductive health commodities.

- In **Uganda,** supplies are generally available, if ordered specifically, but supply chain management is often a challenge. Lower-level facilities face more challenges and stockouts.

- In **Namibia,** there is a limited skilled workforce (doctors, nurses, social workers, legal advisers, etc.) to provide linkages and referral as appropriate. The MRA assessed that there are sufficient clinics, but safe spaces and hotlines are lacking.

- In **Mozambique,** there is an effort to ensure the provision of integrated services for victims of sexual violence, including protection, psychosocial support and health services. However, facilities with the capacity to provide integrated clinical management of rape services only exist at provincial hospitals that have police, social, legal and health services in one location. In Sofala Province, the social services are well integrated into the SRH working group within the health cluster. This shows that local authorities have the will for integration, but the expansion of these services is an ongoing and slow-moving process.

The ability to provide safe abortion care services (Q58) has also been identified as an area that needs to be improved. Qualified staff, equipment, facilities and supplies have been assessed as insufficient. Countries reported frequent stockouts and untrained personnel; services are extremely limited, as they are not available in all health facilities, and rarely in remote areas. Some countries such as **Mozambique** also shared that there is a lack of knowledge within the population on the law around abortion, and in **DRC** they mentioned that abortion services are often stigmatized, hence creating a barrier to access.

Snapshot of key recommendations for Section II

The table hereunder includes a summary of recommendations stemming from the major gaps reported under Section II:

General

- Reduce the economic, sociocultural and religious barriers impeding marginalized and underserved groups' access to SRH services, during stable times and during emergencies.
- Advocate for the integration of the MISP or health emergency management into the health-care training curriculum.
- Improve the availability of remote service provision.
- Improve supply chain management and procurement procedures to ensure the availability of essential commodities for SRH services during emergencies.

MISP 2

- Increase the availability and accessibility of confidential and safe spaces within health facilities to receive survivors of sexual violence and provide them with appropriate clinical care and referral.
- Translate IEC materials on services for sexual violence survivors for each linguistic group and make them accessible to people with learning disabilities and hearing and visual impairments.
- Address gender inequalities and the prevention of sexual violence, and invest in strategies that empower women and girls.
- Improve supply chain management for GBV-related commodities.
- Train and increase the availability of qualified medical personnel to deal with GBV issues.

MISP 3

- Increase the ability to provide safe and rational blood transfusion, including during stable times.
- Ensure that IEC materials and sexually transmitted infection (STI) and HIV counselling services are accessible and available, particularly for people with disabilities, and are translated into different local languages.

MISP 4

- Increase the availability of skilled medical staff and supplies at the referral hospital level for the provision of comprehensive emergency obstetric and newborn care (CEmONC).
- Increase the availability of skilled birth attendants and supplies for vaginal births and the provision of basic emergency obstetric and newborn care (BEmONC).
- Ensure the availability of supplies and commodities for clean delivery (e.g. clean delivery kits) and immediate newborn care where access to a health facility is not possible or is unreliable.
- Develop IEC materials on priority maternal and neonatal services for pregnant women and girls for each linguistic group of the most at-risk areas.

MISP 5

- Develop IEC materials on contraceptive choice (that emphasize informed choice and effectiveness, and that support client privacy and confidentiality and access to services) in local languages; ensure the materials are accessible for people with disabilities.

Safe abortion care

- Increase knowledge and awareness on abortion laws among the general population and service providers.
- Reduce stigma and discrimination around abortion services.
- Increase the availability of qualified staff.
- Develop IEC materials outlining the types of abortion services available.
- Increase access to safe abortion care services in all health facilities and remote areas, to the full extent of the law.

Challenges

Overall, the MRA process was considered to be a fruitful, interesting and meaningful exercise. A few challenges were shared.

- **Agreeing on a rating for the questions** – The majority of the questions in the MRA can be answered with 'yes' or 'no'. At the country level, this generated many discussions, as it was not always clear-cut for the stakeholders. The questionnaire on purpose does not provide the option 'partially' to avoid having most answers rated as such. The recommendation and guidance provided to the countries was to consider that the answer 'yes' means that the current provisions in place are sufficiently comprehensive. If this was not the case, or if important gaps still existed, countries were encouraged to answer 'no' and provide the needed rationale in the comment box.
- **A mismatch between what exists on paper and the reality** – Some countries recognized that many provisions existed in theory and on paper, but this did not always correspond to the reality on the ground. For instance, there might be procedures for the rapid mobilization of funds and reproductive health kits, but the reality is that it is difficult to make these funds or kits available within 48 hours, or even a week, after the outbreak of an emergency. It was recommended to countries to capture these nuances in the comment box and park them as potential elements to be addressed in the action plan.
- **Sensitivity around safe abortion care** – Some countries reported challenges discussing sensitive topics, particularly for the questions related to safe abortion care. In countries where abortion is illegal or restricted, it was often difficult to have in-depth discussions on this topic, and the tool did not focus on prevention of unsafe abortion through the provision of contraceptives and comprehensive post-abortion care. In countries where this issue was conflicting, these questions were often put on hold.
- **Identifying financial resources for the action plan** – When developing the action plan, stakeholders found it challenging to commit to or identify financial resources. Often, technical staff from the ministries were present or NGO programme managers who do not have the authority to commit any funding. The countries were encouraged to use the action plan as a tool to build their advocacy and develop targeted resource mobilization strategies.

3 Lessons learned from 2022 MRA in the ESA region

> The MRA process was an eye-opening exercise for the participants because it helped point out issues that are existing during stable times, such as issues around supply chain management which show that there is a lack of preparedness for responding to emergencies.
>
> ***(UNFPA Namibia Country Office, post-MRA workshop interview, June 2022)***

Contributed to building knowledge and capacity on the MISP – The MRA process, through the involvement of multisectoral stakeholders and the collective completion of the questionnaire, helped build capacity and knowledge around the MISP, particularly for Ministry of Interior partners, DRR partners and others. It helped provide an understanding of the required SRH services during emergencies, acknowledging that providing SRH services during emergencies is life-saving.

Helped understand the national emergency and preparedness policy landscape – In many countries, the MRA process has been considered an eye-opener regarding existing policies to support emergency preparedness and recovery. The exercise helped give a better understanding of the existing policy landscape and identified the gaps that need to be addressed.

Created a solid basis for advocacy towards SRH in emergencies – Working on the MRA with a mix of partners, which included SRH actors and non-SRH actors, has been considered in many countries an initial advocacy activity, as it helped sensitize key stakeholders on the issue. The outcomes of the MRA, particularly the action plan, helped create a solid basis for advocacy that identifies the most urgent needs and creates clear asks.

Helped break silos between the Ministry of Health, other relevant ministries, and the disaster management authorities – In many countries, the MoH and DRR actors do not coordinate with each other and often work in a siloed way. The MRA workshop brought together these different actors and contributed to a better understanding of what each entity is doing and how they can better collaborate and create synergies between their different mandates.

Shed light on recurrent issues related to SRH service delivery – The MRA helped assess readiness to provide the MISP during emergencies, but it also provided the opportunity to assess how well services operate during stable times and evaluate if these could be maintained or scaled up during emergencies. The assessment highlighted that important gaps still exist during stable times, particularly around supply chain management, and noted the need for development and humanitarian programmes to work closer together.

A snapshot of country highlights

The examples hereunder are not an exhaustive list, but provide some examples, observations and achievements at the country level.

Angola

The MISP Action Plan has been formally approved by the Executive Secretariat of the National Commission of Civil Protection.

Burundi

UNFPA managed to get the active involvement of the National Platform for Disaster Management, which was not a common partner for them previously.

Democratic Republic of the Congo

The participation of the Ministry of Humanitarian Affairs in the MRA workshop helped raise awareness about the MISP, which was not known by that specific ministry. Also, DRC shared that working on preparedness-specific aspects was quite innovative in their country, but highly needed.

Tanzania

The process helped initiate a conversation and partnership with the disaster management department, which is within the Office of the Prime Minister, to see how the MISP can be integrated into their policies, strategies and guidelines.

Madagascar

The MRA generated a lot of interest from stakeholders, including internally at UNFPA where the MISP was not well known by all. The workshop also helped raise awareness about the fact that the MISP is not solely the responsibility of UNFPA, but that collective efforts are needed to increase access to SRH in emergencies. In 2023, UNFPA and partners will advocate for the integration of the MISP into the national cyclone contingency plan.

Namibia

The MRA process helped point out issues that exist during stable times, such as issues around supply chain management, which show that there is a lack of preparedness for responding to emergencies. The terms of reference of the Technical Working Group on SRH are being revised, and it was recommended to have emergency preparedness and response integrated into these.

Zambia

The UNFPA Country Office is engaging the Disaster Management and Mitigation Unit to ensure that the 2022 Response and Recovery Plan includes SRH and the MISP.

Mozambique

The MRA exercise helped raise awareness about the fact that the MISP is not solely the responsibility of UNFPA, but that collective efforts are needed to increase access to SRH in emergencies. Training on the MISP has been conducted in all three regions (south, central and northern), and partners are willing to continue the training at the provincial level. An immediate action that the training initiated is the process of activation of the SRHiE working group at the national level, led by the MoH.

Comoros

The exercise highlighted gaps but also opportunities to better integrate the MISP into coordination and policy documents. Thanks to the MRA workshop, partners learned that UNDP is organizing a consultation to discuss coordination issues, and it was decided that UNFPA would bring the results of the MRA to that meeting.

Lesotho

The workshop helped stakeholders better understand how the disaster management authority operates, and they realized that the DMA is open to considering SRH. The DMA has a health desk in their offices, but this is not operational. As a follow-up to the workshop, the DMA and MoH, with the support of UNFPA, agreed to have a meeting to discuss their respective roles and how they can improve coordination.

Eswatini

The MRA exercise was a real learning experience that allowed introspection regarding what exists in the country and whether these provisions are implemented. It also helped to analyse how interventions are structured in the country.

Mauritius

The MISP for SRH in emergencies is a relatively new concept for this middle-income country, but the process helped stakeholders acknowledge the pressing need to incorporate the MISP into all disaster risk responses. The action plan has been formally endorsed by the Ministry of Health, which commits to engage positively for its implementation.

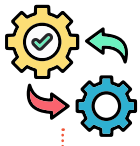
Uganda

The mix of health and protection stakeholders was seen as very positive. The protection partners learned a lot about the MISP, including the fact that GBV is part of it.

Key recommendations

These key recommendations are high-level recommendations applicable to most countries and the regional level.

> For more than two decades, humanitarian workers have carried out needs assessments each year, coupled with the humanitarian response plan, thus limiting themselves to the acute and post-acute phases of the crisis. The challenge is to deviate from this rule and to act before the crisis, i.e. to focus on preparedness and what it implies, namely the prevention and mitigation of risks.
>
> ***(UNFPA DRC Country Office, post-MRA workshop interview, September 2022)***



Advocate for the integration of the MISP into national emergency, preparedness, recovery and DRR policies and plans – The results show that most countries in the region have a national emergency preparedness and/or response policy or plan, and the vast majority also have a national health preparedness and/or emergency response plan. However, SRH and the MISP are very rarely integrated into these plans. It is recommended for 2gether 4 SRHR partners to conduct high-level advocacy and targeted actions to work towards a legislative environment that would support the provision of the MISP during any emergency, using an all-hazards approach. This work aligns with the UNFPA ESARO Strategic Plan output indicator: "*Number of ESA countries supported to integrate Minimum Initial Service Package in national disaster preparedness related policies and plans.*"

- **For national stakeholders** – Identify key emergency and preparedness policies that need to be updated; create a road map for advocacy actions with partners; and create strong partnership and collaboration with relevant government entities. In countries where policies are being reviewed, advocate for the integration of SRH and the MISP.
- **For United Nations regional offices** – Support national work by sharing guidance documents; facilitate learnings and create synergies between countries; and facilitate high-level advocacy meetings. High-level conferences contribute to increased knowledge and buy-in from key decision makers. They allow the creation of momentum around the topic of SRH emergency preparedness, facilitate networking among peers, and connect SRH and non-SRH actors.

Advocate for the inclusion of disaster management and/or emergency response in SRH development policies – The results of the assessment highlight that only two countries have SRH policies that integrate or consider elements of emergency preparedness, response or disaster risk management. Humanitarian and development policies and actors still work in a very siloed way. To create synergies, it is recommended to bridge development activities and humanitarian responses. Many countries of the region are considered fragile states, or they are in protracted situations, moving regularly from an acute emergency to recovery, to preparedness and back to emergency. All SRH policies should reflect this reality, and the MISP should be mainstreamed into any relevant policy or plan.

Advocate for the inclusion of the MISP into national curricula for midwives, nurses, doctors and other health workers – By institutionalizing MISP knowledge and training, countries will have a pool of trained medical professionals ready to respond quickly to SRH needs during an emergency. In countries where the MISP has been integrated into an official curriculum, the integration often came at a time when the training curriculum was being revised. It is recommended to build close relationships with relevant line ministries and sensitize them on the importance of having such modules on the MISP. In the ESA region, countries can learn from the experiences in DRC and Rwanda.

Use MRA results to inform and strengthen national, regional and international commitments – Most countries of the ESA region made International Conference on Population and Development or ICPD+25 commitments, made FP2030 commitments, and are signatories of the Maputo Plan of Action and the Regional Strategy for SRHR 2019–2030 of the Southern African Development Community. It is recommended to use the results of the MRA to strengthen various commitments and bring evidence for the need to strengthen SRH in emergencies. By aligning the tasks and objectives, SRH preparedness work will be more focused.

Advocate for the humanitarian–development–peace nexus approach as a way of working towards resilient individuals, communities and systems – The MRA process helped bring together humanitarian and development actors, and these established relationships should be strengthened and nurtured. The investment in preparedness offers a critical opportunity for humanitarian and development actors to coordinate and work together. Preparedness should be part of the work conducted under the humanitarian–development–peace nexus, and adequate funding should be allocated to it.

Develop adequate, context-specific and inclusive IEC material on available MISP-related services – The MRA clearly identified a lack of information, education and communication materials, particularly on services for sexual violence survivors in emergencies; on priority maternal and neonatal services for pregnant women and girls in the most at-risk areas; on contraceptive choice (emphasizing informed choice and effectiveness, and supporting client privacy and confidentiality and access to services); and on the types of safe abortion care services that are available, and where these can be leveraged during emergencies. For many countries, these materials need to be updated, translated into relevant local languages, and made accessible for people with disabilities. It is recommended to support that work at the regional level and tailor each IEC product to the local context.

Identify opportunities to implement the MISP readiness action plans within existing resources and programmes – The countries of the region have developed sound action plans to be implemented with partners. It is recommended to identify financial resources for the implementation of the actions. Where resources are lacking, countries should develop a resource mobilization strategy and ensure the monitoring of the action plan. Discussions on MISP preparedness should be included in existing standing meetings such as SRH technical working groups, health clusters, DRR platforms and any other relevant meetings.

Encourage cross-country learning and sharing of good practices – This regional initiative allows the highlighting of strengths and weaknesses for each country. Given some regional similarities, countries can learn from each other to speed up progress. It is recommended to identify the areas where countries can learn from each other and to support platforms where best practices can be shared.

Conclusion

The MRA in ESA created a unique opportunity to put a spotlight on the importance of SRH emergency preparedness, including the MISP. It also initiated collaboration between SRH, health, protection and other sectors and the disaster management authorities to better align priorities and create synergies for stronger and more resilient health systems that are able to better cope with emergencies.

This initiative is only a starting point and provides a region-wide baseline for SRH preparedness. The implementation of the action plans will be critical to seeing impacts in the upcoming years. The 2gether 4 SRHR programme and UNFPA ESARO remain committed to continuing to support the region in its efforts to strengthen the humanitarian–development–peace nexus approach as a way of working towards building community and institutional resilience, which is critical for greater preparedness to respond to increasingly frequent and cyclical shocks in the region.

ANNEXURES

Annex 1 – List of ministries, organizations and institutions involved in the 2022 MISP Readiness Assessment

The table hereunder is a list of the ministries, institutions and organizations involved in the MRA process at the national level.

Angola (12)	MINAGRIF – Ministry of Agriculture and Fisheries
	SPCB/MININT – Civil Protection and Fire Service
	MINFIN – Ministry of Finance
	MINDENVP – Ministry of National Defence and Homeland Veterans
	MIREMPET - Ministry of Mineral Resources, Oil and Gas
	MINSA – Ministry of Health
	MINTRANS – Ministry of Transport
	MAPTSS – Ministry of Public Administration, Labour and Social Security
	MINOPOT – Ministry of Public Works and Spatial Planning
	MEP – Ministry of Economy and Planning
	UNICEF
	UNFPA
Botswana (26)	Botswana GBV Prevention and Support Centre
	Botswana Christian Health and AIDS Intervention Programme
	BOFWA – Botswana Family Welfare Association
	Botswana Network on Ethics, Law and HIV/AIDS
	Botswana Council for the Disabled
	Botswana Police Service
	Botswana Red Cross Society
	Botswana Society for the Deaf
	CLINIC
	Central Medical Stores
	Greater Gaborone District Health Management Team
	Kgatleng District Health Management Team
	Men & Boys for Gender Equality
	MOH
	National Health Lab, MoH
	National Disaster Management Office
	Princess Marina Hospital
	Sentebale
	Sisonke Botswana
	Statistics Botswana
	Tebelopele
	UNFPA
	UNICEF
	University of Botswana (School of Medicine)
Burundi (18)	Agence Burundaise de Régulation des Médicaments et des Aliments
	Association Burundaise pour le Bien Etre Familial
	Bureau de District Sanitaire de Kiremba
	Bureau de la Province Sanitaire de Cankuzo

	Bureau Provincial de Makamba
	Bureau Provincial de Santé de Rumonge
	Bureau Provincial de Santé de Ruyigi
	Central d'Achat des Médicaments Essentiels du Burundi
	Centre Humura de Gitega
	Centre Seruka
	Croix Rouge du Burundi
	Direction du Système National d'Information Sanitaire
	Hopital de Ruyigi
	Ministère de la Solidarité Nationale, des Affaires Sociales, des Droits de la Personne Humaine et du Genre
	Ministère de l'Interieur, du Développement communautaire et de la Sécurité Publique
	Programme National de Lutte Contre le Sida/IST
	Programme National de Santé de la Reproduction
	UNFPA
Comoros (10)	Direction Santé Familiale
	Direction Régionale de la Santé Ngazidja
	Directeur Nationale de Lutte Contre le VIH/SIDA
	Association des Sages-Femmes Ngazidja
	MINISANTE (Ministry of Health)
	Intégration du Genre
	Responsable Promotion du Genre/Ngazidja
	Croissant Rouge Comorien
	Association Comorienne pour le Bien Etre de la Famille
	UNFPA
Democratic Republic of Congo (23)	Association pour le Bien-Etre FamilialAmbassade du Canada (Bailleur)
	CIDA Canada
	Croix Rouge
	Croix Rouge/Croissant Rouge
	Ecole de Santé Publique de Kinshasa (MESU)
	MAJ
	Ministère de l'Enseignement Supérieur et Universitaire (MESU)
	Ministère de la Santé Publique Hygiène et Prévention
	Ministère des Affaires Sociales, Solidarité et Action Humanitaire
	Ministère du Genre, Famille et Enfant
	Momentum Health Integrated Resilience
	ONIC – National Order of Nurses in DRC
	Pathfinder
	Réseau des Adolescents et Jeunes Congolais
	en Population et Développement (RAJECOPOD)
	SANRU (ONG/N)
	Save the Children International
	Save the Children International
	UN Women
	UNAIDS
	UNFPA
	VillageReach (ONG/I)
	WHO

Eswatini (10)	Cabrini Ministries (NGO)
	Deputy Prime Minister Office (DPMO), Gender – Government
	Federation of the Disabled in Swaziland – FODSWA (NGO)
	Ministry of Education and Training (MOET), Planning – Government
	Ministry of Health SRH Programme – Government
	Ministry of Labour and Social Security (MOLSS) – Government
	Pact (INGO)
	Swatini Action Group against Abuse – SWAGAA (NGO)
	Umhluma Foundation (NGO)
	UNFPA
Ethiopia (23)	CARE Ethiopia
	Ethiopian Disaster Risk Management Commission
	Ethiopian Midwives Association (EMwA)
	EngenderHealth
	Ethiopian Public Health Institute (EPHI)
	Ethiopian Society of Obstetricians and Gynecologists (ESOG)
	International Red Cross
	IPAS Ethiopia
	International Rescue Committee
	Maternity Foundation
	Mothers and Children Multisectoral Development Organization (MCMDO)
	MoH
	Marie Stopes International Ethiopia (MSIE)
	Medical Teams International (MTI)
	Project HOPE
	Refugees and Returnees Service (RRS)
	St. Paul's Hospital Millennium Medical College (SPHMMC)
	UNOCHA
	UNFPA
	UNHCR
	UNICEF
	WHO
	World Vision
Kenya (36)	Amref Health Africa
	Council of Governors
	CREAW – Centre for Rights Education and Awareness
	Damu Sasa
	Delivering Sustainable and Equitable Increases in Family Planning (DESIP)
	FIDA Kenya – Federation of Women Lawyers in Kenya
	Gender-Based Violence and Recovery Centre (GBVRC)
	Grace Agenda
	HAK – Healthcare Assistance Kenya
	International Rescue Committee
	Kenya Healthcare Federation
	Kenya Police Service
	Kenya Red Cross Society
	LVCT Health
	Marie Stopes Kenya
	Ministry of Health

	National AIDS Control Council (NACC)
	National AIDS and STI Control Programme (NASCOP)
	Network for Adolescent and Youth of Africa (NAYA)
	National Council for Population and Development (NCPD)
	National Drought Management Authority (NDMA)
	National Disaster Operation Centre (NDOC)
	National Gender and Equality Commission (NGEC)
	SRHR Alliance Kenya
	State Department for Gender
	This Ability Trust
	UN Women
	UNAIDS
	UNFPA
	UNFPA Youth Advisory Panel
	UNICEF
	WHO
	WOFAK – Women Fighting AIDS in Kenya
	World Vision
Lesotho (11)	Disaster Management Authority
	Gender Links
	Lesotho Planned Parenthood Association (LPPA)
	Lesotho Red Cross Society
	MoH
	Ministry of Gender, Youth, Sports and Recreation (MGYSR)
	Partners In Health
	PSI
	UNICEF
	UNFPA
	World Vision
Madagascar (23)	Assemblée Nationale
	Association Tanora Iray
	Bureau Nationale de Gestion de Risques et de Catastrophes
	CARE
	COMARESS (Consortium Malagasy de Recherche et Etude sur le Système de Santé)
	Fianakaviana Sambatra (FISA)/International Planned Parenthood Federation (IPPF)
	HFA Options WISH
	MDM (Médecins du Monde)
	Ministère de la Jeunesse et du Sport
	Ministère de la Population, de la Protection Sociale et de la Promotion Féminine (MPPSPF)
	Ministère de la Santé /MSANP
	MSF Suisse
	MSM (Marie Stopes Madagascar)
	Ordre National des Sages-Femmes (ONSF)
	PPHM (Plateforme des Personnes Handicapées de Madagascar)
	Présidence de la République
	SALFA (Branche Santé de l'Eglise Protestante Luthérienne à Madagascar)
	Secrétariat d'Etat de la Gendarmerie Nationale
	Secrétariat Exécutif du Comité National de Lutte contre le Sida

	UNFPA
	UNICEF
	USAID/Jhpiego
	USAID/PSI
Malawi (17)	Chikwawa Social Welfare
	Chikwawa District Hospital
	Chikwawa Magistrate
	Chikwawa Police
	Department of Disaster Management Affairs
	Ministry of Gender and Social welfare
	Ministry of Health Headquarters
	Ministry of Health Reproductive Health Directorate
	Mulanje Magistrate
	Mulanje District Hospital
	Mulanje Police
	Mulanje Social welfare
	Nsanje District Hospital
	Nsanje Magistrate
	Nsanje Police
	Nsanje Social welfare
	UNFPA
Mauritius (37)	Action Familiale
	Alliance for Children
	Alliance of Women
	Association for Population and Development
	APEIM
	Collectif Arc-en-Ciel
	Befrienders
	District Council Black River
	District Council Moka/Flacq
	District Council Pamplemousses
	District Council Rempart
	District Council Savanne
	Gender Links
	Mauritius Council of Social Services (MACOSS)
	Mouvement d'Aide à la Maternité (MAM)
	Mauritius Family Planning and Welfare Association
	Mauritius Police Force
	Mauritius Prison Services
	Ministry of Health and Wellness
	Ministry of Education
	Ministry of Environment
	Ministry of Gender
	Ministry of Local Government
	Ministry of Social Integration
	Ministry of Social Security
	Municipality Curepipe
	Municipality Port Louis

	Municipality Quatre Bornes
	Municipality Beau Bassin-Rose Hill
	Municipality Vacoas-Phoenix
	National Children Council
	Pedostop
	PILS – Prévention Information et Lutte contre le Sida
	SLIWF
	UNFPA
	Women Entrepreneurial Council
	Young Queer Alliance
Mozambique (24)	Ministry of Health
	Ministry of Gender, Children and Social Action
	Ministry of Interior
	Ministry of Justice
	Ministry of Education and Human Development
	National Institute for Disaster Management
	Central Medical Warehouses – Ministry of Health
	Maputo Municipality
	Provincial Directorate of Health of Maputo
	Provincial Directorate of Health of Sofala
	Provincial Directorate of Health of Nampula
	Provincial Directorate of Health of Zambézia
	Provincial Directorate of Health of Cabo Delgado
	Pathfinder
	PSI
	Associação Moçambicana para Desenvolvimento da Família – AMODEFA (International Planned Parenthood Federation affiliate)
	National Association of Midwives
	UNFPA
	UNAIDS
	National Institute of Medicine
	WHO
	Embassy of Canada
	Ariel Glaser Pediatric AIDS Healthcare Initiative
	Centres for Disease Control and Prevention
Namibia (16)	African Youth and Adolescents Network (AfriYAN)
	Central Medical Stores, Ministry of Health
	Disaster Risk Management Unit, Office of the Prime Minister
	Independent Midwives Association of Namibia (IMANA)
	Ministry of Gender Equality, Poverty Eradication and Social Welfare
	Ministry of Health and Social Services Directorate of Special Programmes
	Ministry of Health and Social Services Primary Health Care
	Ministry of Sport, Youth and National Service (MSYNS)
	Namibia Planned Parenthood Association (NAPPA)
	Society for Family Health (SFH)
	UNDP
	UNESCO
	UNFPA

	UNAIDS
	University of Namibia School of Medicine
	WHO
Rwanda (6)	Africa Humanitarian Action
	Alight Rwanda
	Save the Children
	UNFPA
	UNHCR
Seychelles (4)	Disaster Risk Management Division
	Ministry of Health
	HASO (HIV/Aids Support Organization)
	National Aids Council
South Africa (14)	Catholic Health Care Association of Southern Africa (CATHCA)
	Centre for Positive Care
	HIVSA
	Johannesburg District Health Services
	KwaZulu Natal Provincial Department of Health
	National Department of Health
	Prevention of Mother-to-Child Transmission, HIV Prevention, Obstetrics and Gynecology Clusters
	Right to Care
	Save The Children
	Sr B Women's Wellness Clinic
	Thohoyandou Victim Empowerment Programme
	UNFPA
	Wits Reproductive Health and HIV Institute
	Witkoppen Clinic
South Sudan (20)	Community Initiative for Development Organization
	Catholic Organization for Relief and Development Aid (Cordaid)
	Doctors with Africa CUAMM
	Healthcare Foundation Organization
	Health Link South Sudan
	Health Pooled Fund
	Inter-church Medical Assistance World Health (IMA World Health)
	International Medical Corps
	International Organization for Migration (IOM)
	International Rescue Committee
	Medicair
	Ministry of Health
	The Rescue Initiative South Sudan
	UNFPA
	United Networks for Health
	Universal Intervention and Development Organization
	Women and Child Health Organization
	WHO
	World Vision International

Tanzania (25)	Kidondo DH
	African Youth and Adolescents Network (AfriYAN)
	Ministry of Home Affairs Nyarugusu
	Prime Minister's Office
	Council Health Management Team Kakonko
	Tanzania Red Cross Society Nyarugusu
	Medical Teams International Kigoma
	Ministry of Home Affairs Nduta
	Kakonko HC
	Buhigwe District
	UNHCR
	UNICEF
	RSD Kigoma
	Kigoma District Council
	Kigoma Municipal Council
	Kasulu District Council
	Uvinza District Council
	Kasulu Town Council
	Chama cha Uzazi na Malezi Bora Tanzania (UMATI)
	Regional Health Management Teams
	Regional Administrative Secretary Kigoma
	Tanzania Red Cross Society Nduta
	UNFPA Dodoma
Uganda (32)	ACORD Uganda
	Adjumani District
	Bududa District
	Bulambuli District
	Bundibugyo District
	CAFOMI (Care and Assistance for Forced Migrants)
	IOM
	Kasese District
	Kisoro District
	Koboko District
	Lamwo District
	Madi-Okollo District
	Ministry of Gender, Labour and Social Development (MGLSD)
	Midwives Association of Uganda
	Ministry of Health
	Moyo District
	Medical Teams International (MTI)
	National Union of Women with Disabilities of Uganda (NUWODU)
	Obongi District
	Reproductive Health Uganda (RHU)
	SCI
	Sexual Minorities Uganda (SMUG)
	Sironko District
	Terego District
	Uganda Red Cross Society
	UNAIDS

	UN Women
	UNFPA
	UNHCR
	UNICEF
	Youth Country Coordinator
	Yumbe District
Zambia (16)	Clinton Health Access Initiative
	Churches Health Association of Zambia
	Disaster Management and Mitigation Unit
	International Labour Organization (ILO)
	IOM
	Midwives Association of Zambia
	MoH
	Plan International
	Planned Parenthood Association of Zambia
	UNDP
	UNFPA
	UNHCR
	WHO
	World Vision Zambia
	Young Women's Christian Association (YWCA)
	Zambia Red Cross Society
Zimbabwe	Ministry of Health and Child Care – headquarters and subnational departments
	Headquarters – Reproductive Health, AIDS & TB, Nutrition, Midwifery School, Nursing, Policy and Planning, Legal, Finance, Pharmacy, Monitoring and Evaluation departments
	Provincial Medical Directorate, Mashonaland East
	Provincial Medical Directorate, Mashonaland Central
	Provincial Medical Directorate, Midlands
	Provincial Medical Directorate, Masvingo
	Provincial Medical Directorate, Matabeleland North
	Other government ministries
	• Ministry of Local Government and Public Works Civil Protection Unit
	• Ministry of Women's Affairs, Community, Small and Medium Enterprises Development
	Government parastatals
	• Zimbabwe National Family Planning Council
	NGOs
	• Cordaid
	• FHI 360
	• Population Services Zimbabwe (PSZ)
	United Nations agencies
	• UNFPA

Annex 2 – Structure and questions of the MRA

The detailed questionnaire can be accessed here:
https://fp2030.org/sites/default/files/ready_to_save_lives/MISP_readiness_assessment.pdf.

MRA Questionnaire	
Section I – NATIONAL-LEVEL OVERALL READINESS: POLICIES, COORDINATION AND RESOURCES (related to MISP Objective 1)	
National and subnational Disaster management policies and plans	***Question 1–7***
Coordination mechanisms for SRH disaster management	***Question 8–13***
SRH data at national and subnational levels	***Question 14–17***
Resources for MISP implementation	***Question 18–21***
Section II – READINESS TO PROVIDE SERVICES AS OUTLINED IN THE MISP	
MISP Services – General	***Question 22–30***
MISP Objective 2 – Prevent sexual violence and respond to the needs of survivors	***Question 31–36***
MISP Objective 3 – Prevent the transmission of and reduce morbidity and mortality due to HIV and other STIs	***Question 37–42***
MISP Objective 4 – Prevent excess maternal and newborn morbidity and mortality	***Question 43–47***
MISP Objective 5 – Prevent unintended pregnancies	***Question 48–52***
Other priority activity: Safe abortion care to the full extent of the law	***Question 53–58***

Question Number	Questions
1	Does your country have a national emergency preparedness and/or response policy and/or plan?
2	Does your country have a national health preparedness and/or emergency response plan?
3	Are these plans rolled out at the subnational level?
4	Is SRH and/or the MISP integrated into any national or subnational emergency health response policy and/or plan?
5	Are there any SRH policies or plans that include provisions for disaster management and/or emergency response?
6	To your knowledge, are there national legislation and/or policies with provisions limiting access to SRH care for certain groups (e.g. migrants, undocumented migrants, refugees, youth, unmarried persons, people of diverse sexual orientation, gender identity and expression and sex characteristics (SOGIESC), people living with HIV, sex workers, etc.)?
7	To your knowledge, is SRH included in recovery plans when response moves from acute to more comprehensive services?
8	Is there a coordination mechanism responsible for disaster management during crisis?
9	In this disaster management mechanism, is there an entity responsible for health, including SRH and GBV, during response?
10	Is there a coordination mechanism (e.g. SRH working group) to discuss SRH in emergencies at the national level when it comes to:
	Preparedness
	Response
	Recovery

11	Is there a structure/coordination mechanism (e.g. SRH working group/disaster committee) to discuss SRH in emergencies at the subnational level when it comes to:
	Preparedness
	Response
	Recovery
12	If there are no coordination mechanisms, are SRH focal points appointed at national and/or subnational level to assist with emergency preparedness and response?
13	Are civil society organizations and community-based organizations working with/representing marginalized and underserved groups (e.g. women and men with disabilities, people living with HIV, people of diverse SOGIESC, youth groups, religious leaders, sex workers, ethnic minorities, etc.) included in the coordination mechanisms?
14	Do current risk assessments address impacts on different populations (e.g. women, people with disabilities, people living with HIV, people of diverse SOGIESC, youth, sex workers, ethnic minorities, etc.)?
15	Are MISP-related indicators (see MISP checklist) integrated within the existing health information systems?
16	Do rapid needs assessment forms for emergency response (rapid assessments and health sector assessments) include sex-, age- and disability-disaggregated data and key SRH questions?
17	Do data collection tools (e.g. health forms) for emergency response include MISP-related indicators (see MISP checklist)?
18	Do mechanisms for the rapid mobilization of funds exist to support an SRH response (e.g. contingency funds, country-based pooled funds, etc.)?
19	Do you have a mechanism in place for rapid sourcing – at the national or international level – of SRH supplies and equipment and/or IARH kits (e.g. pre-positioning, buffer stocks, standing agreements, pre-identified suppliers, etc.)?
20	Do you have warehouses or storage facilities where medical supplies for SRH are prepositioned or could be stored?
21	Are there any funds to support health and/or SRH emergency preparedness at the national or subnational level?
22	Are all the SRH commodities needed for MISP implementation (see IARH kit booklet) part of the national essential medicines list?
23	Do you have the systems in place to support the remote delivery of services (e.g. digital health, telemedicine, online consultation, etc.)?
24	In the event of epidemics/pandemics, are there opportunities and plans for scaling up personal protective equipment and infection prevention and control materials for SRH facilities?
25	Does the health-care training curriculum or other relevant training, including on online platforms, for health staff integrate health emergency management and/or the MISP?
26	Does a mechanism exist for health staff to be moved or take on new roles in times of emergencies to better support affected areas (e.g. surge or task shifting)?
27	Do health response teams contain specialist SRH providers?
28	Are there diverse communication channels (e.g. radio, text messaging, WhatsApp, etc.) available that can be leveraged to inform the community on the availability of MISP-related services in case of an emergency?
29	Are there any barriers for marginalized and underserved groups (e.g. women with disabilities, adolescents, sex workers, people of diverse SOGIESC, people living with HIV, refugees, migrants, undocumented migrants, ethnic minorities, etc.) to access SRH services?
30	Are there provisions for free access to health services (consider the MISP) for crisis-affected populations?
31	Which actors are responsible for ensuring the provision of GBV services (e.g. clinical management of rape, protection, legal services, etc.) in the selected area?
32	Are safe, private and confidential spaces that are accessible for survivors of GBV identified and available?
33	Is there a clear up-to-date referral system which links the various GBV service providers (e.g. health, GBV case management, legal, protection, etc.) that can be leveraged during emergencies?
34	Which level of health facilities can provide the following health services (see clinical management of rape) to respond to the needs of survivors in the selected area? (Consider the lowest level of providers.)
35	Given the current state of services in your setting, do you think the following MISP elements are adequate and readily available in case of an emergency?

35.1	Collaboration/partnerships with the protection clusters or gender-based violence subcluster/actors to put in place preventative measures at community, local and district levels
35.2	Clinical care and referral to other supportive services available for survivors of sexual violence (e.g. legal, protection, psychosocial, shelter, etc.)
35.3	Confidential and safe spaces within the health facilities to receive and provide survivors of sexual violence with appropriate clinical care and referral
35.4	Existence of information, education and communication (IEC) materials on services for sexual violence survivors prepared for each linguistic group of the most at-risk areas in case of emergency
36	Based on the above services, how would you rate the existing medical and non-medical structures' (e.g. safe homes, women's associations, etc.) ability to provide services to prevent and respond to sexual and gender-based violence in your location with regard to the following elements:
	Qualified staff (e.g. clinical care of rape, GBV case management, etc.)
	Facilities (e.g. clinics, safe spaces, hotlines, etc.)
	Supplies/equipment (e.g. for clinical care)
37	Which actors are responsible for ensuring the provision of HIV services in the selected area?
38	Which actors are responsible for ensuring the provision of STI services in the selected area?
39	Is there a clear, up-to-date referral system for HIV/antiretroviral services that can be leveraged during emergencies?
40	Which level of health facilities can provide the following services to prevent the transmission of and reduce morbidity and mortality due to HIV and other STIs in the selected area? (Consider the lowest level.)
41	Given the current state of health services in your location, do you think the following MISP elements are adequate and readily available in case of an emergency?
41.1	Safe and rational blood transfusion in place
41.2	Standard precautions consistently practiced
41.3	Availability of free lubricated male condoms and, where applicable, female condoms
41.4	Antiretrovirals for continuing users
41.5	Antiretrovirals for women enrolled in prevention of mother-to-child transmission programmes
41.6	PEP to survivors of sexual violence as appropriate and for occupational exposure
41.7	Provision of co-trimoxazole prophylaxis for opportunistic infections for patients found to have HIV or already diagnosed with HIV
41.8	Availability in health facilities of syndromic treatment of STIs
41.9	Existence of IEC materials and STI/HIV counselling services (that emphasize informed choice and effectiveness and support client privacy and confidentiality) in case of emergency
42	Based on the above services, how would you rate the existing health systems' ability to provide HIV and STI management as outlined in the MISP for SRH in your location with regard to the following elements:
	Qualified medical personnel
	Facilities (e.g. clinics, hotlines, etc.)
	Supplies/equipment
43	Which actors are responsible for ensuring the provision of maternal and newborn services in the selected area?
44	Is there a clear up-to-date emergency obstetric and neonatal care referral system that can be leveraged during emergencies?
45	Which level of health facilities can provide the following services to prevent excess maternal and newborn morbidity and mortality in the selected area? (Consider the lowest level.)
46	Given the current state of health services in your location, do you think the following MISP elements are adequate and readily available in case of an emergency?
46.1	At the referral hospital level: Skilled medical staff and supplies for the provision of comprehensive emergency obstetric and newborn care (CEmONC)
46.2	At the health facility level: Skilled birth attendants and supplies for vaginal births and provision of basic emergency obstetric and newborn care (BEmONC)
46.3	At the community level: Provision of information to the community about the availability of safe delivery and emergency obstetric and neonatal care services and the importance of seeking care from health facilities
46.4	24 hours per day, 7 days per week referral system for obstetric complications

46.5	Availability of post-abortion care in health centres and hospitals
46.6	Availability of supplies and commodities for clean delivery (e.g. clean delivery kits) and immediate newborn care where access to a health facility is not possible or unreliable
46.7	Existence of IEC materials on priority maternal and neonatal services for pregnant women and girls for each linguistic group of the most at-risk areas
47	Based on the above services, how would you rate the existing health systems' ability to provide maternal and newborn care services as outlined in the MISP for SRH in your location with regard to the following elements:
	Qualified medical personnel (e.g. skilled birth attendance, BEmONC, CEmONC)
	Facilities (e.g. clinics, hospitals, etc.)
	Supplies/equipment
48	Which actors are responsible for ensuring the provision and removal of long-acting reversible and short-acting contraceptive methods and services in the selected area?
49	Is there a clear up-to-date referral system for access to short- and long-term contraceptive methods that can be leveraged during emergencies?
50	Which level of health facilities can provide the following contraceptives to prevent unintended pregnancies in the selected area? (Consider the lowest level.)
51	Given the current state of health services in your location, do you think the following MISP elements are adequate and readily available in case of an emergency?
51.1	Availability of a range of long-acting reversible and short-acting contraceptive methods (including male and female condoms and emergency contraception) at primary health care facilities to meet demand
51.2	Existence of IEC materials on contraceptive choice (that emphasize informed choice and effectiveness and support client privacy and confidentiality and access to services)
52	Based on the above services, how would you rate the existing health systems' ability to provide contraceptive services in your location with regard to the following elements:
	Qualified medical personnel
	Facilities (e.g. clinics, pharmacies, hotlines, etc.)
	Supplies/equipment
53	Are there any situations in your context in which safe abortion care can be provided?
54	Which actors are responsible for ensuring the provision of safe abortion care in the selected area?
55	Is there a clear referral system that can be leveraged during emergencies?
56	Are there IEC materials outlining types of services available, and their location, that can be leveraged during emergencies?
57	Which level of health facilities can provide the following abortion services in the selected area? (Consider the lowest level.)
58	Based on the above services, how would you rate the existing medical structures and services that provide safe abortion care in your location with regard to the following elements:
	Qualified medical personnel (e.g. trained on medical procedures, abortion values clarification and attitude transformation)
	Facilities (e.g. clinics, hotlines, etc.)
	Supplies/equipment

Annex 3 – MRA questionnaire results per country

Q	AGO	BDI	BWA	COD	COM	ETH	KEN	LSO	MDG	MOZ	MUS	MWI	NAM	RWA	SSD	SWZ	SYC	TZA	UGA	ZAF	ZMB	ZWE
Section I – NATIONAL-LEVEL OVERALL READINESS: POLICIES, COORDINATION AND RESOURCES (related to MISP Objective 1)																						
1	yes	yes	yes	no	yes	yes	yes	yes	yes	yes	yes	yes	yes	yes	yes	yes	yes	yes	yes	yes	yes	yes
2	yes	yes	yes	no	yes	yes	yes	yes	no	yes	yes	yes	yes	yes	yes	yes	no	yes	no	yes	yes	yes
3	yes	yes	yes	no	no	yes	yes	yes	no	yes	yes	yes	yes	yes	no	yes	no	yes	no	yes	yes	yes
4	yes	yes	no	yes	no	yes	yes	no	yes	no	no	no	no	yes	no	no	no	no	no	no	no	yes
5	no	no	no	no	no	yes	yes	no	no	no	no	no	no	no	no	no	no	no	no	no	no	no
6	no	no	no	no	no	no	no	no	no	no	no	no	no	yes	no	no	no	no	no	no	no	yes
7	no	yes	no	no	no	yes	yes	no	no	yes	no	no	no	yes	no	no	no	no	no	no	yes	no
8	yes	yes	yes	yes	yes	yes	yes	yes	yes	yes	yes	yes	yes	yes	yes	yes	yes	yes	yes	yes	yes	yes
9	yes	yes	no	yes	no	yes	yes	yes	yes	yes	no	yes	yes	yes	yes	yes	yes	yes	yes	no	yes	yes
10	no	yes	no	yes	no	yes	yes	yes	yes	no	no	yes	no	yes	yes	yes	no	no	yes	yes	yes	yes
Preparedness	no	no	no	no	no	yes	yes	no	yes	no	no	yes	no	yes	yes	yes	no	no	yes	yes	yes	yes
Response	no	yes	no	yes	no	yes	yes	yes	yes	no	no	yes	no	yes	yes	yes	no	no	yes	yes	yes	yes
Recovery	no	yes	no	no	no	yes	yes	yes	yes	no	no	yes	no	yes	yes	yes	no	no	no	yes	yes	yes
11	no	no	no	yes	no	yes	yes	yes	yes	yes	no	yes	no	yes	yes	yes	no	yes	no	no	yes	yes
Preparedness	no	no	no	no	no	yes	yes	yes	no	no	no	yes	no	yes	yes	yes	no	no	no	no	yes	yes
Response	no	no	no	yes	no	yes	yes	yes	yes	yes	no	yes	no	yes	yes	yes	no	yes	no	no	yes	yes
Recovery	no	no	no	no	no	yes	yes	yes	no	yes	no	yes	no	yes	yes	yes	no	no	no	no	yes	yes
12	yes	yes	no	yes	no	N/A	yes	yes	yes	N/A	no	N/A	yes	N/A	yes	N/A	no	N/A	no	yes	yes	N/A
13	yes	yes	no	no	no	no	yes	no	no	yes	no	yes	yes	yes	no	yes	no	no	yes	yes	yes	yes
14	no	yes	no	no	no	yes	yes	yes	yes	no	no	yes	yes	yes	yes	no	no	yes	no	yes	yes	yes
15	yes	yes	no	no	yes	no	yes	yes	yes	yes	no	yes	no	yes	yes	no	no	yes	yes	no	no	yes
16	no	yes	no	yes	yes	no	yes	no	no	no	no	yes	yes	yes	yes	yes	no	yes	no	no	no	no
17	no	yes	no	yes	yes	yes	yes	yes	no	no	no	no	no	yes	yes	yes	no	yes	no	no	no	no
18	no	no	no	yes	no	no	yes	yes	no	no	no	no	yes	yes	yes	yes	no	no	no	no	no	yes
19	yes	no	yes	yes	no	no	yes	yes	no	no	no	yes	no	yes	yes	yes	no	yes	no	yes	yes	yes
20	yes	yes	yes	yes	yes	yes	yes	yes	no	yes	yes	yes	yes	yes	yes	yes	yes	yes	yes	yes	yes	yes
21	no	yes	no	no	no	yes	yes	no	no	no	no	no	no	yes	yes	yes	yes	no	no	yes	no	yes

Q	AGO	BDI	BWA	COD	COM	ETH	KEN	LSO	MDG	MOZ	MUS	MWI	NAM	RWA	SSD	SWZ	SYC	TZA	UGA	ZAF	ZMB	ZWE
Section II – READINESS TO PROVIDE SERVICES AS OUTLINED IN THE MISP																						
22	no	yes	yes	yes	yes	yes	no	yes	yes	no	no	yes	yes	yes	yes	yes	yes	yes	yes	yes	yes	yes
23	no	no	no	no	no	no	yes	no	no	no	no	no	no	yes	no	no	no	yes	no	no	no	no
24	no	yes	yes	yes	yes	yes	yes	yes	yes	yes	yes	yes	yes	yes	yes	yes	yes	yes	yes	yes	yes	yes
25	no	no	no	yes	no	no	no	no	no	no	no	no	no	yes	no	no	no	no	no	no	no	no
26	no	yes	yes	no	yes	no	yes	yes	yes	yes	no	yes	yes	yes	yes	yes	yes	no	yes	no	yes	yes
27	no	yes	no	yes	no	no	no	yes	yes	yes	no	no	yes	yes	yes	yes	no	yes	yes	yes	yes	yes
28	yes	yes	no	yes	yes	no	yes	no	yes	yes	yes	yes	yes	yes	yes	yes	yes	yes	yes	yes	yes	yes
29	yes	no	yes	yes	no	yes	yes	yes	no	no	yes	yes	yes	yes	no	yes	yes	yes	yes	no	yes	yes
30	yes	yes	yes	yes	no	yes	yes	yes	yes	yes	yes	yes	yes	yes	yes	yes	yes	yes	yes	yes	yes	yes
31																						
32	yes	yes	no	yes	yes	yes	yes	yes	yes	no	no	no	yes	yes	yes	yes	no	yes	no	yes	yes	yes
33	yes	yes	no	yes	no	yes	yes	yes	yes	yes	yes	yes	yes	yes	yes	yes	yes	yes	yes	yes	yes	yes
34																						
35.1	no	yes	no	yes	no	yes	no	no	no	no	yes	yes	yes	yes	yes	yes	yes	yes	yes	yes	yes	yes
35.2	yes	yes	no	yes	yes	no	yes	yes	no	no	yes	yes	no	yes	yes	yes	yes	yes	no	yes	no	yes
35.3	no	yes	no	yes	yes	no	no	yes	no	no	no	no	no	yes	yes	no	yes	no	no	yes	no	no
35.4	yes	yes	no	yes	no	no	no	no	no	no	no	no	yes	yes	no	no	yes	no	no	yes	no	no
36 Staff	MN	MN	INS	MN	INS	INS	INS	MN	INS	INS	INS	INS	MN	MN	INS	INS	INS	INS	INS	MN	MN	INS
36 Facilities	MN	MN	INS	MN	INS	INS	INS	MN	INS	INS	MN	INS	MN	MN	INS	MN	MN	INS	INS	MN	INS	INS
36 Equipment	INS	INS	MN	MN	INS	INS	MN	I	INS	INS	I	INS	MN	MN	MN	MN	MN	INS	MN	MN	INS	INS

Q	AGO	BDI	BWA	COD	COM	ETH	KEN	LSO	MDG	MOZ	MUS	MWI	NAM	RWA	SSD	SWZ	SYC	TZA	UGA	ZAF	ZMB	ZWE
37																						
38																						
39	yes	no	yes	yes	yes	yes	yes	yes	yes	yes	yes	yes	yes	yes	yes	yes	yes	yes	yes	yes	yes	yes
40																						
41.1	yes	yes	no	yes	yes	no	no	no	no	no	yes	yes	yes	yes	no	no	yes	no	no	yes	no	no
41.2	yes	yes	yes	yes	no	no	yes	yes	no	no	yes	yes	yes	yes	yes	yes	yes	yes	no	yes	yes	no
41.3	yes	yes	no	yes	yes	no	no	yes	no	yes	yes	yes	yes	yes	yes	yes	yes	yes	no	yes	yes	yes
41.4	yes	yes	yes	yes	yes	no	yes	yes	yes	yes	yes	yes	yes	yes	yes	yes	yes	yes	yes	yes	yes	no
41.5	yes	yes	yes	yes	yes	no	no	yes	yes	yes	yes	yes	yes	yes	yes	yes	yes	yes	yes	yes	yes	yes
41.6	yes	yes	yes	yes	yes	no	no	yes	yes	yes	yes	yes	yes	yes	yes	yes	yes	yes	no	yes	yes	yes
41.7	yes	yes	yes	yes	yes	no	yes	yes	yes	yes	yes	yes	yes	yes	yes	yes	yes	yes	N/A	yes	yes	no
41.8	yes	yes	yes	yes	yes	no	no	yes	no	yes	yes	no	yes	yes	yes	yes	yes	no	yes	yes	yes	yes
41.9	yes	yes	no	yes	yes	no	no	yes	no	no	no	no	yes	yes	yes	yes	yes	no	no	no	yes	no
42 Staff	MN	I	INS	MN	INS	INS	MN	MN	INS	INS	MN	INS	MN	I	MN	I	INS	INS	INS	MN	MN	INS
42 Facilities	MN	MN	MN	MN	INS	INS	MN	MN	INS	INS	MN	INS	MN	I	MN	I	MN	MN	MN	MN	MN	INS
42 Equipment	MN	I	INS	MN	INS	INS	INS	MN	INS	INS	MN	INS	MN	I	MN	MN	MN	MN	INS	MN	INS	INS
43																						
44	yes	yes	yes	yes	no	no	yes	yes	no	yes	yes	yes	yes	yes	yes	no	yes	yes	yes	yes	yes	yes
45																						
46.1	no	no	no	yes	yes	no	no	yes	no	no	yes	no	no	yes	no	yes	yes	no	no	yes	yes	no
46.2	no	yes	no	yes	yes	no	no	yes	no	no	yes	no	no	yes	yes	yes	no	no	no	yes	yes	no
46.3	no	yes	no	yes	yes	no	yes	yes	no	yes	yes	yes	yes	yes	yes	no	yes	no	yes	yes	yes	yes
46.4	no	yes	yes	yes	yes	no	no	yes	no	yes	yes	yes	yes	yes	yes	no	yes	no	no	yes	yes	no
46.5	yes	yes	yes	yes	yes	yes	no	yes	yes	yes	yes	yes	yes	yes	no	yes	yes	no	no	yes	yes	no
46.6	no	no	no	yes	yes	yes	no	no	no	no	no	no	no	yes	yes	no	yes	no	no	yes	no	no
46.7	no	yes	no	yes	no	no	no	no	no	no	yes	no	no	yes	yes	no	yes	no	no	no	no	no
47 Staff	INS	MN	MN	MN	MN	MN	INS	I	INS	MN	I	INS	MN	I	MN	MN	MN	INS	INS	MN	MN	INS
47 Facilities	INS	MN	I	MN	MN	INS	MN	MN	INS	INS	I	INS	MN	I	MN	MN	MN	MN	MN	MN	MN	INS
47 Equipment	INS	MN	MN	MN	MN	INS	MN	MN	INS	INS	I	INS	MN	I	MN	INS	MN	INS	INS	MN	INS	INS

Q	AGO	BDI	BWA	COD	COM	ETH	KEN	LSO	MDG	MOZ	MUS	MWI	NAM	RWA	SSD	SWZ	SYC	TZA	UGA	ZAF	ZMB	ZWE
48																						
49	yes	yes	yes	yes	no	no	yes	yes	yes	no	yes	yes	no	yes	yes	yes	yes	yes	yes	yes	yes	no
50																						
51.1	no	yes	yes	yes	no	no	yes	yes	yes	yes	yes	yes	no	yes	yes	no	yes	yes	no	yes	yes	yes
51.2	no	yes	no	yes	no	no	yes	no	no	yes	no	no	no	yes	yes	yes	no	yes	no	no	no	no
52 Staff	INS	I	I	MN	MN	INS	INS	MN	INS	MN	I	MN	INS	I	MN	MN	INS	INS	INS	MN	MN	INS
52 Facilities	INS	MN	MN	MN	MN	INS	MN	MN	INS	MN	I	INS	MN	I	MN	I	INS	MN	INS	MN	MN	INS
52 Equipment	INS	MN	INS	INS	MN	MN	INS	MN	INS	MN	MN	INS	MN	I	MN	INS	INS	INS	INS	INS	MN	INS
53	yes	yes	yes	yes	yes	yes	yes	yes	no	yes	yes	yes	yes	yes	yes	yes	yes	yes	yes	yes	yes	yes
54																						
55	yes	yes	yes	no	no	no	no	no	N/A	yes	yes	no	yes	yes	yes	yes	yes	yes	no	yes	yes	no
56	no	yes	yes	no	no	no	no	no	N/A	yes	no	no	no	no	yes	no	yes	no	no	no	no	no
57																						
58 Staff	MN	MN	MN	MN	INS	INS	INS	INS	N/A	INS	INS	N/A	MN	I	INS	INS	I	INS	INS	INS	INS	INS
58 Facilities	MN	INS	INS	MN	INS	INS	INS	INS	N/A	INS	INS	N/A	MN	I	INS	MN	INS	MN	INS	INS	INS	MN
58 Equipment	MN	INS	INS	MN	INS	INS	INS	INS	N/A	INS	INS	N/A	MN	I	INS	MN	INS	INS	INS	INS	INS	INS

I = Ideal	MN = Minimum needed	INS = Insufficient	? = Don't know	Qualitative data

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