Ready or Not?

MISP Readiness Assessment Cross-Regional Analysis

2021-2024

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Acknowledgements

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The Minimum Initial Service Package (MISP) for sexual and reproductive health in crisis situations is developed by the Inter-Agency Working Group on Reproductive Health in Crises (IAWG). This document's publisher, UNFPA, is one of IAWG's member agencies. The discussion of abortion in this document reflects the guidance of the IAWG. In line with the ICPD paragraph 8.25, where abortion is legal, UNFPA states that national health systems should make safe abortion care accessible to the full extent of the national law. Post-abortion care should be available everywhere to save women's lives. UNFPA respects the sovereign right of countries to decide the extent to which safe abortion care is part of a comprehensive approach to sexual and reproductive health and reproductive rights. In all cases and everywhere, UNFPA opposes criminalization of abortion and opposes reproductive violence such as coercive abortion, forced pregnancy or the discriminatory practice of gender-biased sex selection.

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Contents

Abbreviations

APRO	UNFPA Regional Office for Asia and the Pacific
ARV	Antiretroviral
ASRO	UNFPA Regional Office for the Arab States
BEmONC	Basic emergency obstetric and newborn care
CSO	Civil society organization
EECA	UNFPA Regional Office for Eastern Europe and Central Asia
EECARO	UNFPA Regional Office for Eastern Europe and Central Asia
EmONC	Emergency obstetric and newborn care
ESARO	UNFPA Regional Office for East and Southern Africa
GBV	Gender-based violence
HIV	Human immunodeficiency virus
IAFM	Inter-Agency Field Manual
IAWG	Inter-Agency Working Group for SRH in crisis
IARH kits	Inter-Agency Reproductive Health kits
IEC	Information, education and communication
IPPF	International Planned Parenthood Federation
IUD	Intrauterine device
LAC	UNFPA Regional Office for Latin America and the Caribbean
MISP	Minimum Initial Service Package
MRA	MISP Readiness Assessment
NGO	Non-governmental organization
PEP	Post-exposure prophylaxis
SRH	Sexual and reproductive health
SRHiE	SRH in Emergencies
STIs	Sexually transmitted infections
UNFPA	United Nations Population Fund
UNHCR	United Nations Refugee Agency
USAID	United States Agency for International Development
WCARO	UNFPA Regional Office for West and Central Africa

Executive summary

This report, **Ready or Not? MISP Readiness Assessment Cross-Regional Analysis**, focuses on the Minimum Initial Service Package (MISP) for Sexual and Reproductive Health in Crisis Situations. The MISP is a priority set of life-saving activities implemented at the onset of humanitarian crises. It forms the starting point for sexual and reproductive health (SRH) programming in humanitarian emergencies and should be sustained and built upon with comprehensive SRH services throughout protracted crises and recovery.

To ensure governments and other key stakeholders are prepared to implement the MISP for SRH during emergencies, UNFPA periodically supports countries to undertake MISP Readiness Assessments (MRAs). The assessment is a multi-step process that helps governments and stakeholders evaluate their preparedness across five key areas: policy environments, coordination mechanisms, data, resources and service delivery.
This report presents the findings of a cross-regional analysis of the MISP Readiness Assessments supported by UNFPA over five years, 2021 to 2024. It draws information from 77 country-level self-assessments, 64 of which allowed in-depth analysis, and six regional reports. An external consultant supported this analysis in close coordination with UNFPA experts. The report identifies cross-cutting trends, presents key results and provides recommendations to enhance SRH preparedness for emergency response. A specific focus on refugees and displaced populations as part of the MRAs is highlighted.

This cross-regional analysis reveals persistent gaps and challenges, including shortcomings in coordination, data deficiencies, funding shortages, and limited MISP awareness and implementation capacity. Policy for SRH in emergencies was another area with significant gaps. While almost all countries had national health emergency response policies, some 60 per cent of these policies lacked meaningful SRH integration. Furthermore, only one-fifth of the assessed countries had a national SRH policy that incorporated SRH emergency preparedness and response provisions. Across countries' assessments, the specific SRH needs of refugees and displaced populations are often overlooked.

As part of MISP Readiness Assessments, countries assessed their health systems' capacity to provide services related to the MISP. The conclusions of MRAs from the 64 countries that allowed in-depth analysis indicates that the resources available to provide the SRH services of the MISP are largely insufficient or at minimum level. This means that the countries either cannot meet the demand for these services even in stable times, or they can only just meet the minimum under normal circumstances, with no surge capacity available to meet the additional needs of an emergency.

To address identified gaps and challenges, this report recommends that UNFPA invest in strengthening all areas relevant to the MISP service provision objectives. Key areas include: emergency obstetric care and skilled birth attendance, clinical management of rape and intimate partner violence survivors, prevention and treatment of STIs including HIV, contraception and family planning, and safe abortion care in circumstances where

abortion is not against the law (ICPD Programme of Action, para. 63). It will be important to link development programmes to emergency preparedness and humanitarian response. It will also be important to involve women and girls in humanitarian programming to ensure that interventions are targeted, effective and protective.

Audience: This report is for use by governments and other key stakeholders, partners in humanitarian preparedness, and UNFPA globally. Recommendations emerging from this cross-regional analysis are both global and UNFPA-specific.

Purpose: The findings and recommendations are provided as a contribution to efforts to implement the MISP for SRH during emergencies. The recommendations are designed to strengthen SRH preparedness and response and to improve the assessment of refugee needs through the MISP Readiness Assessment process.

Global recommendations for improved SRH preparedness

Prepare

1. Secure high-level policy commitment and institutionalize preparedness efforts
2. Establish multilevel coordination mechanisms
3. Allocate dedicated resources for SRH preparedness and response

Deliver

4. Build and maintain a skilled workforce
5. Strengthen SRH supply chain systems
6. Improve data collection and information management

Sustain

7. Embed SRH preparedness within the humanitarian–development–peace nexus efforts
8. Regularly review and adapt SRH preparedness, both MRAs and the resulting action plans

Recommendations for UNFPA internal practice

A. Implement and review MRA Action Plans and regularly update MRAs

B. Document lessons learned and create cross-regional and cross-country learning opportunities

C. Institutionalize sexual and reproductive health in emergencies (SRHiE) throughout UNFPA: Lead the way by building collaborative emergency preparedness initiatives and coordinate humanitarian response

D. Strategically mainstream SRHiE preparedness into UNFPA Country Programmes

Recommendations regarding displaced population in MRAs

Integrate refugee-specific questions: Incorporating targeted questions about refugees and displaced populations into relevant MRA subsections, such as service delivery, coordination and data collection, to ensure comprehensive assessment.

UNHCR collaboration: Partnering with UNHCR to leverage their expertise and develop optimal strategies for integrating refugee issues into the MRA.

Develop a "refugee lens" guidance: Creating a supplementary guidance document or integrating a "refugee lens" – a framework or approach for addressing issues from the specific perspective of forcibly displaced people – into the existing MRA guidance, to provide contextual information and specific considerations for assessing SRH readiness in refugee settings.

Evaluate a camp-specific assessment: Conducting a feasibility study to assess the benefits of adding a dedicated section to the MRA for evaluating SRH readiness in refugee camps.

These recommendations collectively provide a road map for countries and UNFPA to strengthen and systematize SRH emergency preparedness and humanitarian response. Such a road map will include coordination and support to the availability, quality and effectiveness of life-saving SRH services during emergencies. Ultimately, the implementation of these recommendations saves lives and protects dignity during crises. MRAs have advanced SRH emergency preparedness yet significant gaps remain. In this era of drastically diminished development funding, linking development and humanitarian action and ensuring relevance in preparedness and quality in programming and response are imperative.

Introduction

UNFPA works to keep sexual and reproductive health and gender-based violence protection services at the heart of humanitarian action and to champion the rights of women and girls in every crisis setting.

Crises today have wide-reaching impacts. The drivers of humanitarian needs are multiple and complex, including armed conflict, protracted insecurity, disease outbreaks and climate change.[1] Conflicts, population movements, pandemics, natural hazards and fragility create crisis situations that often call for quick and coordinated responses.

Conflicts, population movements, pandemics, natural hazards and fragility create crisis situations that often call for quick and coordinated responses. It is well-documented that these emergency situations have a disproportionate impact on population groups that already face inequalities during stable times. They exacerbate the vulnerability of women, girls and marginalized groups and reduce their access to health services, including sexual and reproductive health (SRH) services.

Women and newborns in fragile and conflict-affected settings are twice as likely to die in pregnancy and childbirth, and account for over 60 per cent of maternal deaths globally.[2] Increased risk of sexual violence, including sexual assault, can lead to unintended pregnancies and unsafe abortions in contexts where access to care is inadequate. The **Minimum Initial Service Package for Sexual and Reproductive Health in Crisis Situations ("MISP")** was established in the mid-1990s by the Inter-Agency Working Group (IAWG) to address the historical neglect of reproductive health in humanitarian emergencies. It was created to provide a standardized, life-saving set of actions to prevent excess morbidity and mortality, particularly among women and girls, who make up a large percentage of affected populations.

The MISP outlines the most critical SRH services to prevent morbidity and mortality, while protecting the right to live with dignity in humanitarian settings. This essential package is a key component of the Inter-Agency Field Manual (IAFM) on Reproductive Health in Humanitarian Settings, the leading global resource for guiding SRH interventions during emergencies.[3]

1 Under-Secretary-General for Humanitarian Affairs Mark Lowcock at the ODI Humanitarian Policy Group/Institute for Security Studies webinar, 'The climate crisis and humanitarian need: taking action to support the world's most vulnerable communities', 29 April 2021.

2 WHO, UNICEF, UNFPA, World Bank Group and UNDESA/Population Division, 2025. Trends in Maternal Mortality: 2000 to 2023. See: UNFPA, News, Frontline Midwives, May 2025.

3 2018 Inter-Agency Field Manual on Reproductive Health in Humanitarian Settings. https://www.iawgfieldmanual.com/manual

Figure 1 **What is the MISP?**

Minimum Initial Service Package for Sexual and Reproductive Health in Crisis Situations

The MISP for SRH is a set of lifesaving priority activities to be implemented from the onset of a crisis. These services are to be scaled up and sustained to ensure equitable coverage throughout protracted crises and recovery, while planning to integrate comprehensive SRH into primary health care as soon as possible. To support MISP implementation, UNFPA procures commodities to provide Inter-Agency Reproductive Health (IARH) kits containing essential supplies and equipment.

Source: MISP Readiness Assessment, IPPF, 2020.

Current context

The COVID-19 pandemic and the consequences of climate change have highlighted that all countries are prone to crisis situations; hence the need for emergency preparedness and resilience building is vital. In addition to growing emergency situations, the funding landscape for SRH preparedness and response is shrinking. According to the Guttmacher Institute policy analysis, the most recent USAID funding freeze has led and will continue to lead to a denial of contraceptive care for millions of women and girls. This will increase the risk of unintended pregnancies, maternal deaths, and the spread of HIV and other STIs.[4] These challenges call for adequate and smart investments that will ensure continued access to life-saving SRH care during shocks and stressors.

In 2025, World Health Day announcements highlight both progress and persistent challenges in maternal health. While global maternal mortality declined by 40 per cent between 2000 and 2023, the rate of improvement has slowed since 2016, indicating "fragile" progress. Furthermore, significant inequalities persist between high- and low-income countries. Alarmingly, countries experiencing conflict or fragility account for 61 per cent of global maternal deaths, despite representing only 25 per cent of global live births. This stark disparity underscores the urgent need for targeted interventions in these vulnerable settings.

A critical step in addressing urgent needs and ensuring preparedness is assessing systems' readiness to deliver essential SRH care during emergencies. A key tool is the MISP Readiness Assessment (MRA). The MRA's objective is to help governments assess their readiness to implement the MISP during an emergency and improve readiness through the action plan implementation.

MISP: Minimum Initial Service Package
SRH: Sexual and reproductive health
MRA: MISP Readiness Assessment

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4 Guttmacher Institute, Policy Analysis, April 2025.; UNFPA, Statement by UNFPA Executive Director on the United States Government funding cuts, February 2025.

Purpose of the MISP Readiness Assessment (MRA) cross-regional analysis

Over the past five years, UNFPA has dedicated resources to conducting MRAs across various regions and countries. The findings of these assessments support national entities such as the Ministries of Health and Disaster Management Authorities to develop SRH emergency preparedness plans. Use of MRAs helps bolster the availability of SRH services during crises. In 2025, UNFPA carried out a cross-regional analysis that aims to consolidate these efforts. It assesses past actions and pinpoints overarching and recurrent challenges to guide future planning, investments and advocacy. Furthermore, as part of the Global Refugee Forum in November 2023, UNFPA pledged to enhance the focus on addressing the SRH needs of displaced populations, particularly refugees, through the MRA process. This commitment involves ensuring that the SRH needs of displaced populations are understood and addressed.

The objectives of the cross-regional analysis are three-pronged:

- → Take stock of what has been done so far
- → Identify any cross-cutting issues emerging from the regions to best inform future planning, investment and advocacy efforts
- → Understand if and how the needs of refugees are addressed and reflected in the MRA.

This cross-regional analysis establishes a baseline to evaluate the strengths, weaknesses, opportunities and threats identified in different regional and national MRA reports. It informs the work of the UNFPA Humanitarian Response Division and the Maternal and Newborn Health Team. The analysis contributes to understanding how the needs of displaced populations were addressed in past MISP Readiness Assessments coordinated by UNFPA Regional Offices. The analysis also provides recommendations on how to maintain or strengthen this focus during the next MRA cycle.

2025

UNFPA carried out a cross-regional analysis that aims to consolidate these efforts.

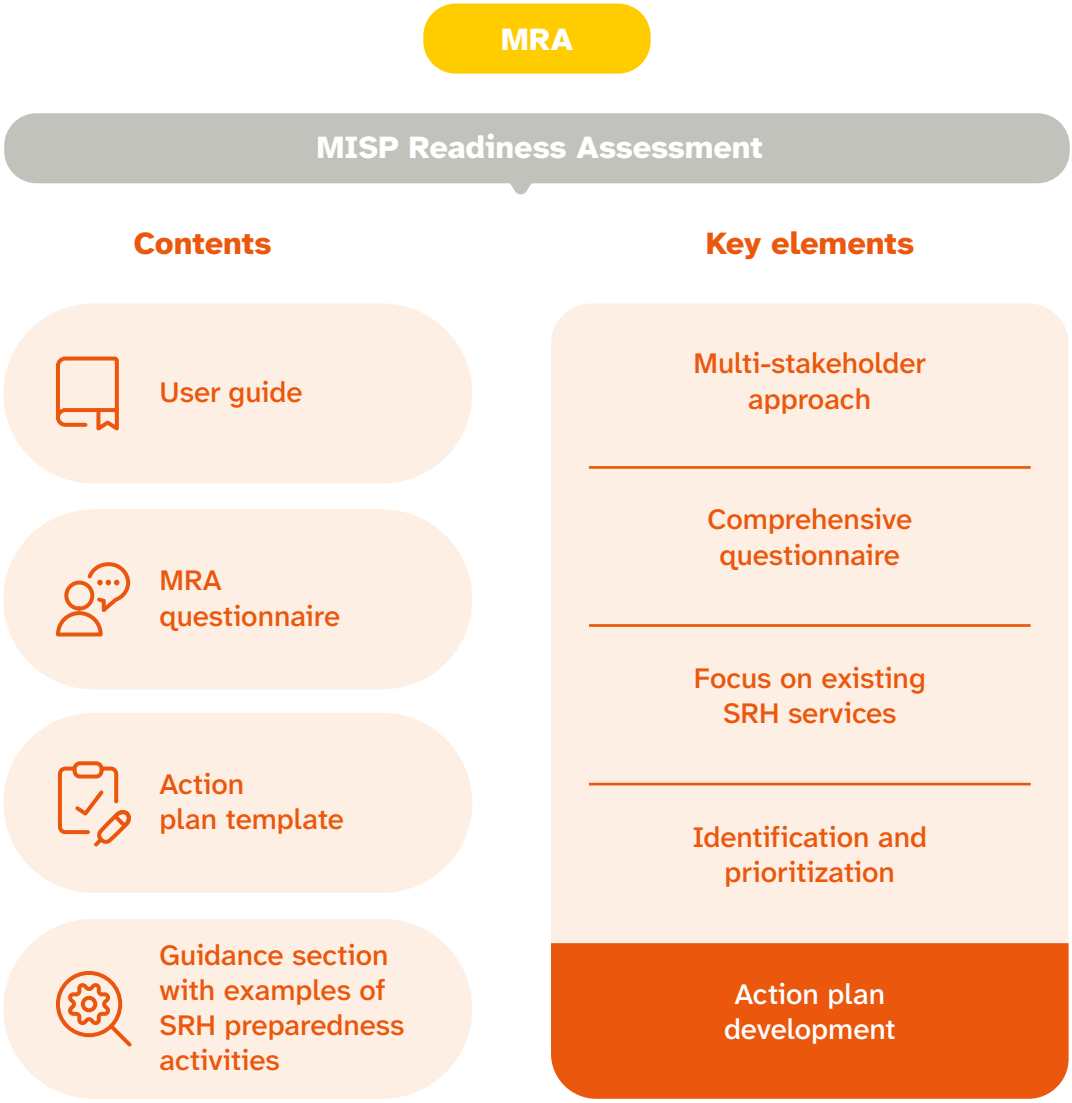
1. MISP Readiness Assessment: Overview of the tool

The MRA is a multi-step process designed to assist governments in evaluating their preparedness to implement the MISP for SRH during an emergency.

It offers a structured approach to identify and address gaps in policy, coordination, data, resources and service delivery related to SRH during crises. The MRA was first developed in 2013 and revised in 2020. Conducting an MRA is a valuable opportunity for countries to assess and understand their current state of readiness to respond to the SRH needs of women and girls in emergencies.

Figure 2 **What is the MRA?**

MRA stands for "MISP Readiness Assessment". The MRA is a tool used by governments, United Nations agencies, and NGOs to evaluate their preparedness to implement the Minimum Initial Service Package for Sexual and Reproductive Health (MISP) during a humanitarian emergency. It provides a snapshot of a country's capacity to deliver essential sexual and reproductive health services immediately after a crisis and helps identify gaps that need to be addressed to strengthen that preparedness.



Source: Content from MISP Readiness Assessment, IPPF, 2020.

1.1 Key elements of the MRA

Multi-stakeholder approach: The MRA involves various stakeholders, including government ministries (e.g. Health, Disaster Management, Social Affairs), United Nations agencies, NGOs, civil society organizations (CSOs), community-based organizations, faith-based organizations, donors and professional organizations.

Comprehensive questionnaire: The assessment is based on a questionnaire that examines readiness related to:

- Policy environment
- Coordination mechanisms
- Data collection
- Available resources
- Service delivery across the MISP objectives at national and subnational levels.

Focus on existing SRH services: The MRA builds upon existing SRH services (during stable times) to understand how these can be leveraged during emergencies.

Identification and prioritization: The assessment details a process on how to identify preparedness gaps and prioritize activities and areas of work. It helps identify and prioritize the MISP and SRH areas that need to be strengthened to be readily available during an emergency, using an all-hazard approach.

Action plan development: The MRA's results assist countries in developing sound and meaningful action plans to strengthen their readiness to provide the MISP at the onset of an emergency and improve SRH responses during crisis recovery.

The MRA tool includes a user guide, the MRA questionnaire, an action plan template and a guidance section with examples of SRH preparedness activities.

Overall, the MRA serves as a valuable tool for countries to identify strengths and weaknesses in their preparedness for providing essential SRH services during emergencies, ultimately contributing to more effective and coordinated responses.

1.2 Background of the MRA and its implementation

UNFPA Regional Offices started undertaking regular MRAs as of 2014. The UNFPA Regional Office for Eastern Europe and Central Asia (EECARO) pioneered this work with the establishment of the Inter-Agency Working Group on Reproductive Health in Crises for Eastern Europe and Central Asia (EECA IAWG).[5] The objective was to regionally build knowledge and raise awareness on the importance of providing life-saving SRH services, from the onset of an emergency as described in the MISP. This includes strengthening the coordination mechanism at national, subnational and regional level.

An initial regional mapping of preparedness capacity was conducted in 2012 in the EECA region that revealed a lack of understanding of the importance of SRH availability during emergencies, especially from the onset of a crisis. Additionally, capacity building needs were highlighted and the need for a better integration of SRH into health emergency preparedness, response and contingency plans and policies. The first MRA tool was developed in 2013 by UNFPA EECARO in collaboration with the International Planned Parenthood Federation (IPPF) European Network. The aim of the tool was to help country teams together with their stakeholders (government, United Nations, NGOs, health care providers) assess their joint SRH in Emergencies (SRHiE) preparedness and implementation capacity. Two assessments took place in EECA using the tool's first version, one in 2014 and one in 2017.[6,7]

In 2020, the MRA tool was revised under the leadership of IPPF, IAWG and UNFPA based on feedback that the tool was at times complicated and too long and lacked sufficient guidance documents to complete the questionnaire. This led to the development of a revised MRA package that reflected an improved assessment tool including stakeholder guidance on concrete action steps to improve MISP preparedness. As the Inter-Agency Field Manual (IAFM) including the MISP was revised in 2018, the MRA also needed amendments to reflect these changes.

In 2022, an "MRA Toolbox" was developed by UNFPA and partners in Asia and the Pacific to complement the existing MRA tools to help guide country offices and partners in preparing for and conducting an MRA. In addition, the UNFPA Regional Office for Asia and the Pacific (APRO) partnered with JSI to digitize the MRA to make it easier to collect and analyse data.

The current MRA has been translated into multiple languages and is currently available in English, French, Arabic, Spanish, Russian and Portuguese.

5 The Working Group was established during the 13th annual meeting of the Global IAWG (Istanbul, Türkiye).

6 UNFPA and IPPF, 2021 to 2024. Assessment of Countries' Readiness to Provide Minimum Initial Service Package for SRH During a Humanitarian Crisis in the Eastern Europe and Central Asia Region.

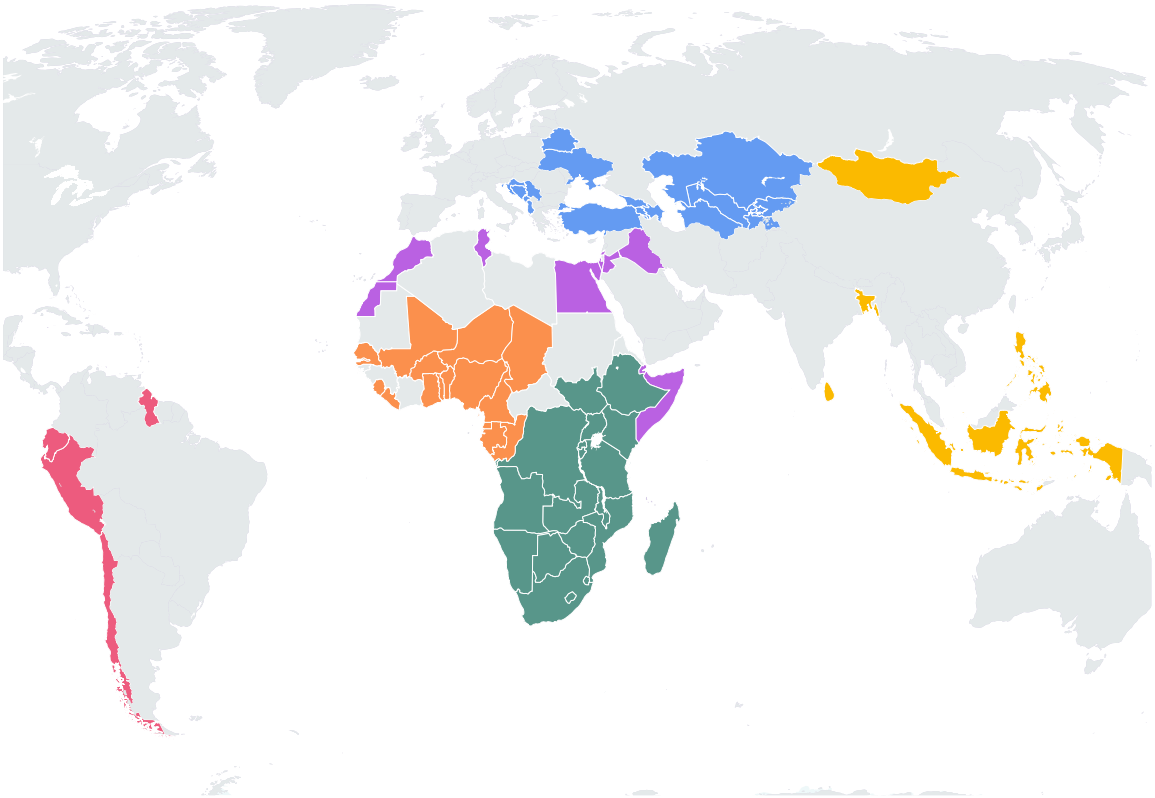
7 Ibid.

1.3 Regional MRA initiatives

Regional MRA activities have been carried out in the Arab States (2023–2024), Asia and the Pacific (2023–2024), East and Southern Africa (2022), Eastern Europe and Central Asia (2021), Latin America and the Caribbean (2022–2024) and West and Central Africa (2023). Over the five years from 2021 to 2024, a total of 77 countries conducted an MRA across all UNFPA regions. (Details about countries are included in Annex 2.) Figure 3 provides an overview of MRA implementation since 2021.

All regions have utilized the MRA to assess their overall readiness; however, the process differed in terms of time frame, scope, challenges faced and specific areas of focus. The Eastern Europe and Central Asia region had the advantage of building on previous MRA rounds, while the other regions were largely undertaking the assessment for the first time. Each region tailored the MRA process to its specific context, considering factors such as political stability, resource availability and existing policy frameworks. Several regions have developed regional reports including a regional analysis and recommendations, specifically the Arab States, Asia and the Pacific, East and Southern Africa and Eastern Europe and Central Asia.

Figure 3 **Global overview of MRA implementation, 2021 to 2024**



Region	Number of countries and territories that conducted MRAs
Arab States (AS)	9
Asia and the Pacific (AP)	10
Eastern Europe and Central Asia (EECA)	15
East and Southern Africa (ESA)	22
Latin America and the Caribbean (LAC)	5
West and Central Africa (WCA)	16

Disclaimer: The designations employed and the presentation of material on the map do not imply the expression of any opinion whatsoever on the part of UNFPA concerning the legal status of any country, territory, city or area or its authorities, or concerning the delimitation of its frontiers or boundaries.

Source: UNFPA, 2026. *Ready or Not? MISP Readiness Assessment Cross-Regional Analysis (2021-2024).*

MRAs have been conducted in six regions over five years, from 2021 to 2024:

Arab States: The MRA was conducted in **9 countries** between April 2023 and December 2024 with support from UNFPA Regional Office (ASRO). The office supports the work of 20 countries and territories in the region. The assessment involved national experts from entities such as the Ministry of Health, Disaster Management Authorities, United Nations agencies and NGOs. Technical assistance included webinars, supporting documents, sharing practices and consultant support.

Asia and the Pacific: The MRA was conducted across **10 countries** between 2022 and 2024. The UNFPA Regional Office (APRO) covers a total of 36 countries, including 14 Pacific island nations. This process involved a structured approach that began with collaborative planning alongside the Ministry of Health and other relevant stakeholders. Data collection was primarily undertaken through participatory MRA workshops, which convened diverse stakeholders who utilized the standardized questionnaire. The digital MRA (dMRA) tool was sometimes employed to streamline data collection and analysis. Data analysis identified strengths and weaknesses, informing the collaborative development of national action plans with prioritized activities. Subnational assessments using Key Informant Interviews sometimes complemented the national evaluation.

East and Southern Africa: The MRA was conducted in **22 countries** between January and December 2022 with support from the UNFPA Regional Office (ESARO), which supports 23 countries in the region. The countries completed the MRA and developed national action plans through a consultative process with various national experts. UNFPA country offices collaborated with national consultants and conducted MRA workshops, followed by validation workshops with partners.

Eastern Europe and Central Asia: The MRA was conducted in **15 countries** between March and December 2021. Fifteen countries completed the MRA questionnaire, and 14 developed an action plan. The UNFPA Regional Office supported 17 countries at the time of the assessment. The assessment involved national experts from entities such as the Ministry of Health, SRH organizations, UNFPA country offices, the Red Cross/Red Crescent, NGOs and other institutions. Over 120 entities participated in the assessment.

Latin America and the Caribbean: The MRA was conducted in **5 countries** between 2022 and 2024. UNFPA often supported these assessments, which involved a consultative approach with various national stakeholders. Typically facilitated through workshops, these processes guided participants in evaluating their country's readiness and in developing national action plans to address identified gaps in emergency preparedness for essential SRH services. The UNFPA Regional Office (LACRO) covers 41 countries and territories in the region, including 22 countries and overseas territories in the English and Dutch Speaking Caribbean.

West and Central Africa: The MRA was conducted in **16 countries** in 2023, with some assessments extending into 2024. The process was supported by the UNFPA Regional Office (WCARO), which covers 23 countries. National consultants were recruited to coordinate the process and facilitate consultative workshops with key stakeholders, including Ministries of Health, disaster management agencies and civil society organizations. The workshops invited participants to analyse the MRA questionnaire, identify gaps and develop prioritized national action plans for emergency preparedness.

1.4 Methodology

This review encompassed a desk-based analysis of regional and national MRA reports. An external consultant supported this analysis in close coordination with UNFPA experts. The following steps were undertaken:

Report collection: National reports from all countries that conducted an MRA were obtained. While 77 countries have conducted an MRA since 2021, data from 64 countries was available for in-depth analysis for the purposes of this report. Regional reports were collected from the Arab States (2023–2024), Asia and the Pacific (2024–2025), East and Southern Africa (2022), Eastern Europe and Central Asia (2021), Latin America and the Caribbean (2022–2024) and West and Central Africa (2023).

Qualitative analysis: A qualitative analysis was conducted to identify common themes, trends, best practices and recommendations across the reports. This involved:

- → Identifying key findings related to MISP preparedness and implementation.
- → Analysing the strengths and weaknesses of MRA processes across regions.
- → Extracting examples of successful strategies and innovative approaches.
- → Documenting challenges and lessons learned.

Comparative analysis: A comparative analysis was performed to examine regional variations in MRA implementation, with a particular focus on comparing the different recommendations presented in each report. This analysis aimed to identify recommendations that were relevant and applicable across multiple regions, highlighting common priorities and strategies for improvement.

1.5 Limitations

While this review provides valuable insights into regional and national MRA implementation, it is important to acknowledge its limitations:

Reliance on available reports: The review relied exclusively on available MRA reports, which may not have captured the full spectrum of implementation activities and contextual nuances. For instance, informal discussions, in-country consultations, and qualitative data that were not formally documented in the reports could have provided a more complete picture of the assessment process and its outcomes. This reliance on written reports might lead to a potential bias towards documented information, neglecting the tacit knowledge and on-the-ground experiences of practitioners.

Variations in reporting formats and detail: Significant variations in reporting formats and levels of detail across regions posed challenges to comparative analysis. Some reports provided comprehensive narratives and detailed data, while others were more concise, lacking specific examples or quantitative measures. This inconsistency hindered the ability to conduct a standardized comparison and identify nuanced differences in implementation strategies.

Data set: A total of 77 countries conducted an MRA between 2021 and 2024. Of these countries, 64 used the standard MRA questionnaire (no modification) and shared a complete report. Analysis is based on these 64 reports. For the other 13 MRAs, some used a modified questionnaire, some reports were incomplete and a few reports could not be retrieved.

77 countries

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Of these countries, 64 used the standard MRA questionnaire (no modification) and shared a complete report. Analysis is based on these 64 reports. For the other 13 MRAs, some used a modified questionnaire, some reports were incomplete and a few reports could not be retrieved.

2. Findings of the MRA cross-regional analysis

The cross-regional analysis shows that many countries demonstrate strengths in national emergency policies, health preparedness plans, general disaster management coordination and ability to store resources.

However, SRH and the MISP are often not sufficiently integrated into relevant policy frameworks, and coordination remains a recurring issue due to inconsistent engagement among stakeholders, particularly during the preparedness phases. Additional key challenges include a lack of SRH-specific data collection tools, inadequate funding, shortages of essential commodities and inconsistent MISP training. While HIV and other sexually transmitted infections (HIV/STI) services are generally more available, significant gaps persist in addressing sexual violence, maternal and newborn health, unintended pregnancies and safe abortion care in circumstances where abortion is not against the law.[8] In particular, gaps exist related to resources, access and integration into emergency response systems.

Section 2 presents the finding as follows:

2.1 **MRA Section I:** Overall readiness: policies, coordination, data and resources

2.2 **MRA Section II:** Readiness to provide services as outlined in the MISP

2.3 **MISP Objective 2:** Prevent sexual violence and respond to the needs of survivors

2.4 **MISP Objective 3:** Prevent the transmission of and reduce morbidity and mortality due to HIV and other STIs

2.5 **MISP Objective 4:** Prevent excess maternal and newborn morbidity and mortality

2.6 **MISP Objective 5:** Prevent unintended pregnancies

2.7 **Additional MISP priority:** Ensure safe abortion care to the full extent of the law

8 In line with the ICPD paragraph 8.25, where abortion is legal, UNFPA states that national health systems should make safe abortion care accessible to the full extent of the national law. Post-abortion care should be available everywhere to save women's lives. UNFPA respects the sovereign right of countries to decide the extent to which safe abortion care is part of a comprehensive approach to sexual and reproductive health and reproductive rights. In all cases and everywhere, UNFPA opposes criminalization of abortion and opposes reproductive violence such as coercive abortion, forced pregnancy or the discriminatory practice of gender-biased sex selection.

2.1 MRA Section I: Overall readiness: policies, coordination, data and resources

Section 1 of the MRA assesses a country's enabling environment for providing SRH and/or the MISP during emergencies. The section is structured into four sub-sections: 1) National and subnational disaster management policies and plans, 2) Coordination mechanisms for SRH disaster management, 3) SRH data at national and subnational level and 4) Resources for MISP implementation.

Strengths

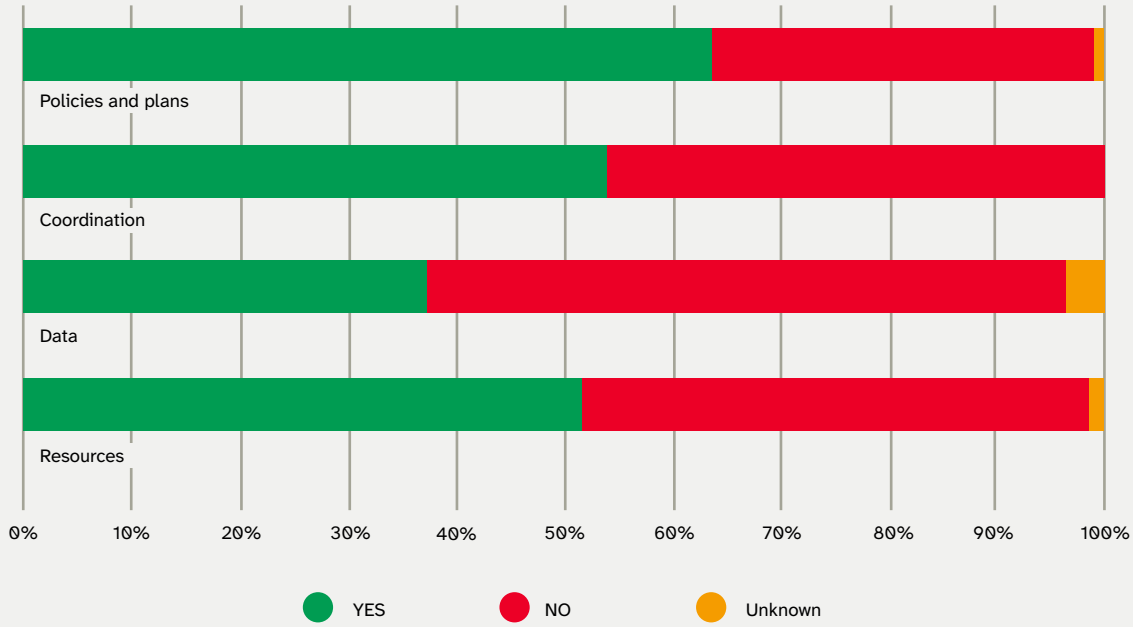
The findings indicate several strengths across regions:

- → **National emergency policies:** A large majority of countries (61 out of 64) have a national emergency policy. This provides a foundational framework for addressing disasters and crises, which is essential for organizing a coordinated response.
- → **Health preparedness plans:** A large majority of countries (56 out of 64) also have National Health Preparedness and/or Response Plans. These plans are critical for outlining the steps and resources needed to address health-related emergencies, ensuring that healthcare systems can effectively respond to crises.
- → **National disaster management coordination mechanisms:** All countries reviewed to date have national coordination mechanisms for disaster management. These mechanisms facilitate communication and collaboration among various stakeholders, ensuring a unified and efficient approach to disaster response.
- → **Warehouses and storage facilities:** Most countries (57 out of 64) have warehouses and storage facilities for prepositioning resources. This allows for the strategic placement of essential supplies, ensuring that they can be quickly distributed to affected areas when a disaster strikes.

Gaps

The findings identify key gaps across regions. While these strengths provide a solid foundation, significant gaps remain in integrating sexual and reproductive health into these established frameworks. As shown in Figure 4, the results across regions indicate the following: **The weakest ratings are found in the availability of existing assessments and collected data that include essential SRH data to shape a meaningful MISP response.**

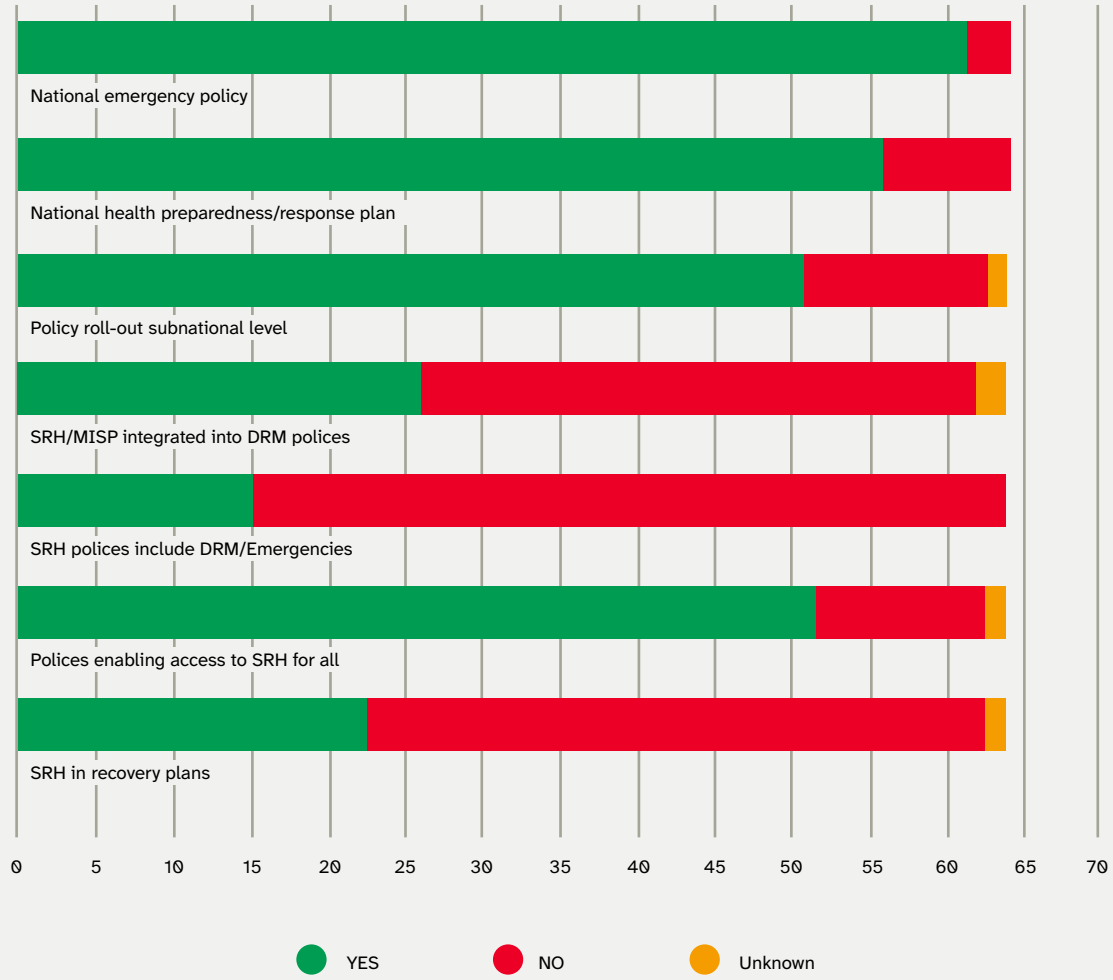
Figure 4 **Results of MRA Section I on overall preparedness**



Source: UNFPA, 2026. *Ready or Not? MISP Readiness Assessment Cross-Regional Analysis (2021-2024).*

Integration is inadequate: SRH or the MISP are not adequately integrated into disaster management policies, SRH/RH policies and/or recovery plans. The compiled data on "Policy" shows that this section rates the highest when considering all questions of that sub-section. While indeed many countries have national emergency policies and health preparedness plans, SRH, including the MISP, is often not sufficiently included in these policy frameworks. (SRH including the MISP only exists in 26 out of 64 countries). Some countries show progress in aligning SRH within broader health emergency strategies. However, the lack of comprehensive inclusion of SRH in emergency response plans or multi-hazard plans undermines preparedness and response efforts. In addition, development policies focusing on SRH or RH rarely cover the MISP or emergency preparedness and response for SRH (only existing in 15 out of 64 countries). This disconnect and lack of risk-informed planning in development policies is especially problematic given that crises exacerbate inequalities for women, girls and marginalized groups, reducing their access to essential health services, including SRH.

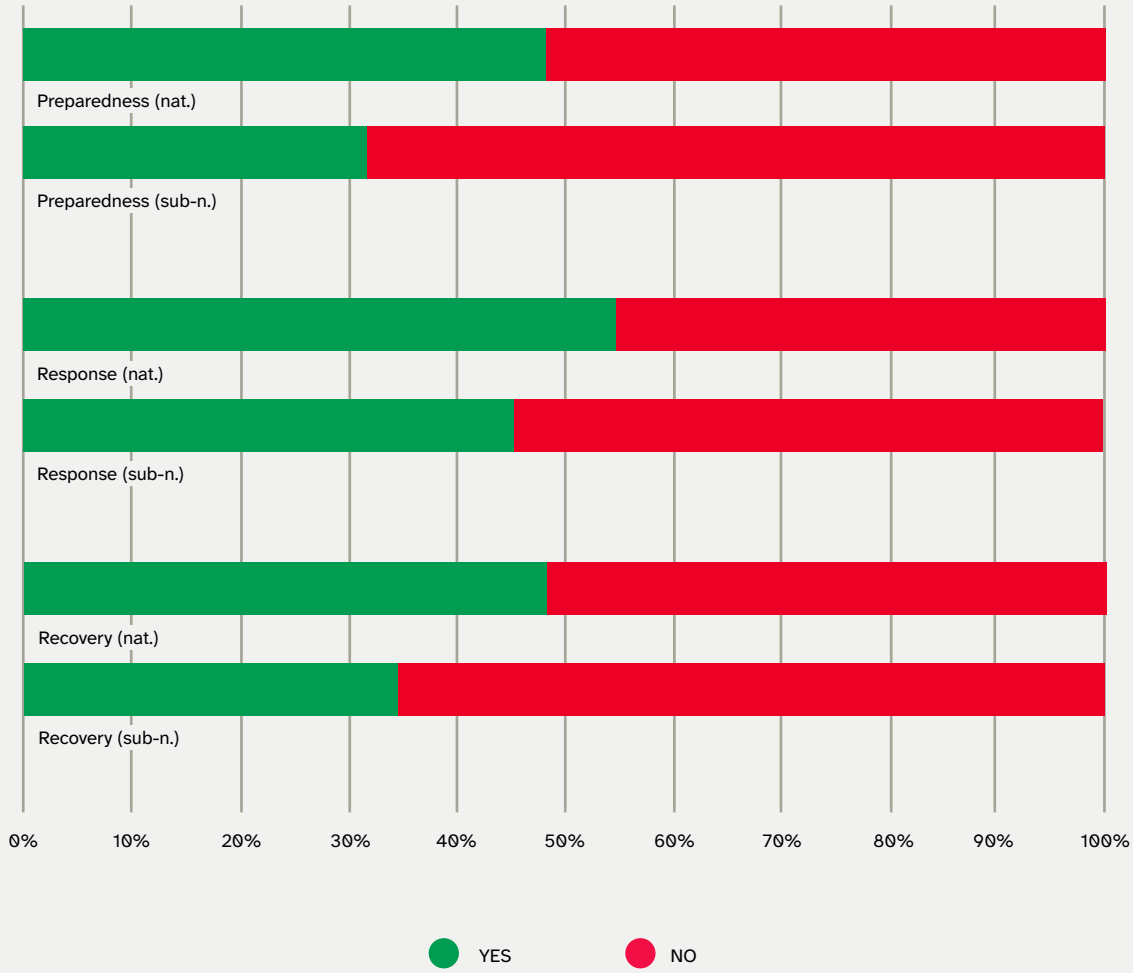
Figure 5 **Availability of policies and plans: National and subnational disaster management policies and plans, number of countries**



Source: UNFPA, 2026. *Ready or Not? MISP Readiness Assessment Cross-Regional Analysis (2021-2024).*

→ **Coordination is a challenge:** Coordination is identified as an issue for many countries, with preparedness rating lower and coordination being rather reactive covering emergencies. Various challenges at the level of coordination have been identified as a recurring issue. (This is similar to the baseline assessment report on SRH coordination conducted under the SRH Task Team of the Global Health Cluster.) Many countries have health entities in charge of disaster management coordination (53 out of 64 countries). However, many countries seem to be lacking SRH-specific working groups focusing on emergency preparedness. In some countries, there have been efforts to embed SRH within reproductive, maternal, newborn, child and adolescent health (RMNCAH) committees or the Sexual and Reproductive Health Technical Working Group (SRH TWG), but the lack of operational coordination groups hampers progress. The analysis also shows that there is inconsistent engagement between SRH stakeholders and disaster management structures, which results in fragmented efforts.

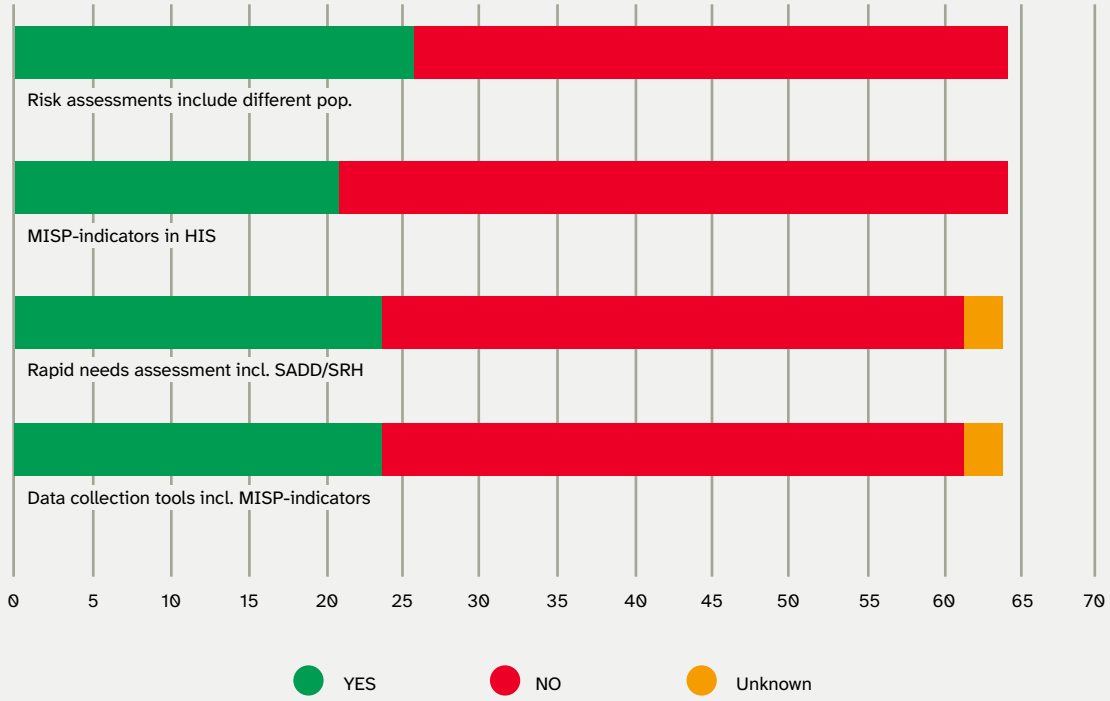
Figure 6 **Availability of SRH coordination mechanisms, national versus subnational level**



Source: UNFPA, 2026. *Ready or Not? MISP Readiness Assessment Cross-Regional Analysis (2021-2024).*

Data collection is weak: The findings indicate a lack of comprehensive SRH-specific data collection tools in emergencies and a lack of integration of MISP indicators into Health Information Management Systems (HIMS). SRH data collection and availability is a recurring weakness across regions. This includes a lack of standardized tools, disaggregated data, and integration of MISP-related indicators into health information systems. There is also a lack of data and evidence on SRH needs in emergency situations, hindering effective planning and response.

Figure 7 **ASRH data availability at national and subnational level, number of countries**



Source: UNFPA, 2026. *Ready or Not? MISP Readiness Assessment Cross-Regional Analysis (2021-2024).*

Figure 8 **Financial resources for MISP preparedness and implementation, number of countries**

Source: UNFPA, 2026. *Ready or Not? MISP Readiness Assessment Cross-Regional Analysis (2021-2024).*

Earmarked financial resources for SRH preparedness are lacking: The availability of financial resources for MISP implementation is a challenge. Many countries lack dedicated funding for SRH emergency preparedness and response and rely on external funding sources. There is overall a lack of dedicated funds for SRH emergency preparedness. In addition, the MRA across countries reveal consistent challenges, including insufficient pre-positioning of SRH supplies, limited stockpiles in emergency reserves, and the absence of clear mechanisms for rapid procurement including emergency waivers.

In summary, the cross-regional analysis of the MRAs highlights that there is a need for stronger integration of SRH into disaster management policies as well as stronger integration of emergency preparedness and response into SRH and reproductive health policies. There is also a need for enhanced coordination among stakeholders particularly during preparedness, improved data collection and monitoring, and increased financial resources for SRH preparedness. These outcomes of the MRAs also reflect a growing recognition of the importance of linking humanitarian responses with long-term development goals to build more resilient and equitable systems.

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2.2 MRA Section II: Readiness to provide services as outlined in the MISP

Section II of the MRA delves into a country's preparedness to deliver essential SRH services during emergencies. By examining existing SRH services in stable times, the assessment aims to determine how these resources can be mobilized and adapted when crisis strikes.

MISP services – General

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

The analysis of the findings shows that while some foundations are in place, significant work remains to ensure a robust and effective capacity to provide adequate emergency responses.

Strengths

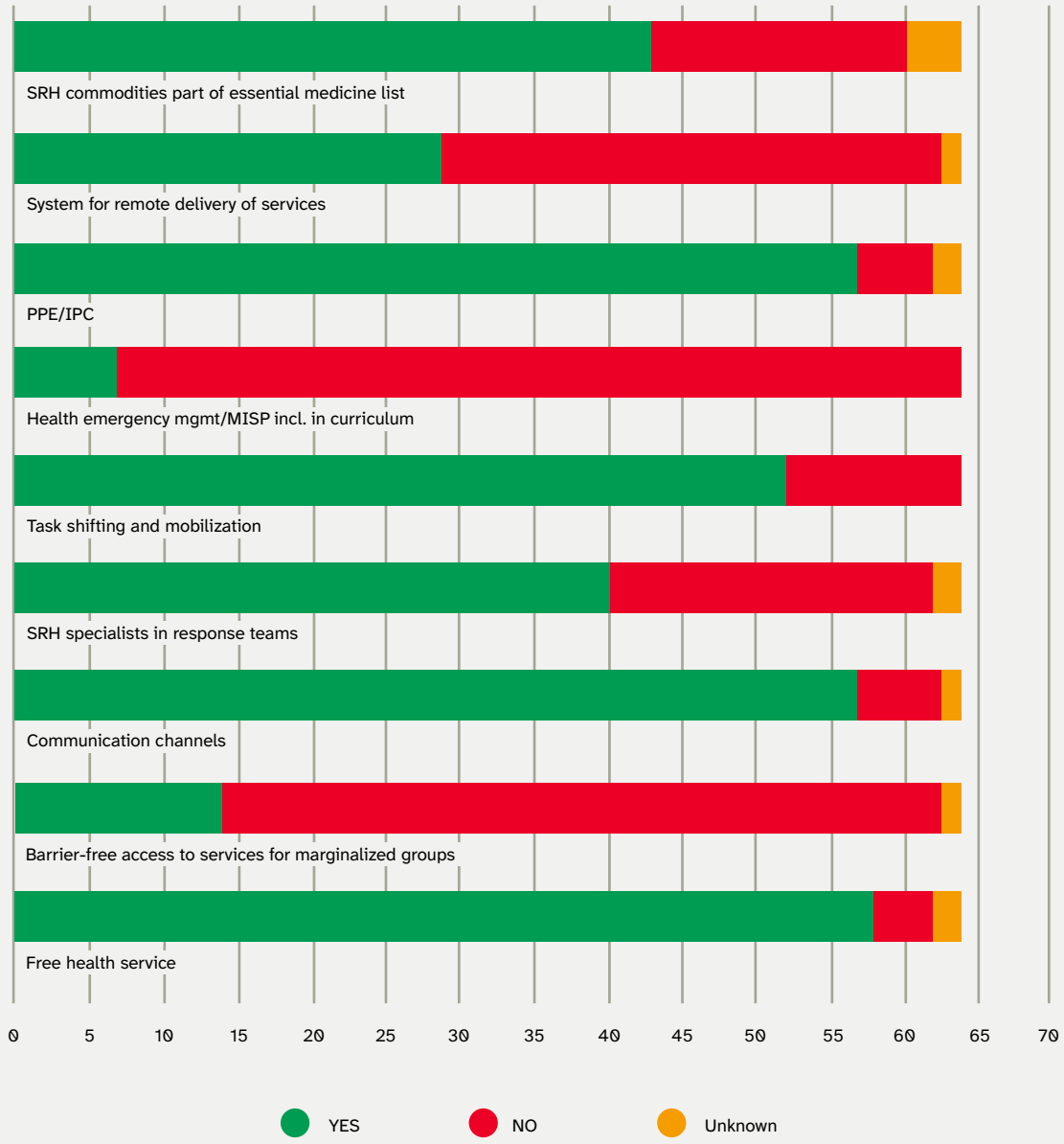
Regarding strengths, provisions for access to free health services for crisis-affected populations seem to be largely available and offer a crucial safety net, ensuring that those in need can receive care without financial barriers. Furthermore, access to diverse communication channels, including radio, text messaging and WhatsApp seem to be largely available, which creates opportunities for rapid information dissemination and community engagement during emergencies.

Gaps

Strengths may be undermined by several critical weaknesses. Essential SRH commodities needed for MISP implementation are often missing from national essential medicines lists. (**Supplies are missing in 21 out of 64 countries.**) This creates potential shortages and hinder the ability to provide life-saving care. Similarly, systems for remote service delivery, such as telemedicine, are often lacking. (**Systems are lacking in 35 out of 64 countries.**) This limits access for those who cannot reach traditional health care facilities.

Across regions, the findings highlight inconsistent integration of MISP training into health care curricula. **(MISP training integrated into health care curricula is missing in 57 out of 64 countries.)** This points to a need to advocate for curriculum reform and increased preparedness. It also leaves national health care providers such as midwives, nurses and doctors ill-prepared to address the unique challenges of SRH in emergency settings. Some countries have begun to address this gap through curriculum reviews and collaborations with organizations such as the World Health Organization. Targeted efforts are needed to ensure that health care providers are adequately equipped to handle SRH challenges in emergency settings.

Figure 9 **Results MRA Section II: MISP – General, number of countries**



Source: UNFPA, 2026. *Ready or Not? MISP Readiness Assessment Cross-Regional Analysis (2021-2024).*

In some countries, challenges are further compounded by the absence of clearly defined task-shifting mechanisms and the lack of trained SRH providers on health response teams. This hinders the ability to deliver comprehensive care when it is needed most.

MISP objectives

Having reviewed the general landscape for the provision of MISP services, the following sections examine specific MISP objectives. Each section of the MRA addresses a critical aspect of SRH in emergency settings:

- → **MISP Objective 2:** Prevent sexual violence and responding to the needs of survivors
- → **MISP Objective 3:** Prevent the transmission of and reducing 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
- → Ensure safe abortion care **(SAC)** to the full extent of the law.

The countries also assessed the capacity of their health systems to provide services related to the MISP. The results indicate that the resources available to provide these services, including qualified personnel, facilities, supplies and equipment, are largely insufficient or only at a level of the minimum services needed. Countries either: (a) cannot meet the demand for these services even in stable times, or (b) can only meet the minimum requirements under normal circumstances, with no surge capacity available for emergencies.

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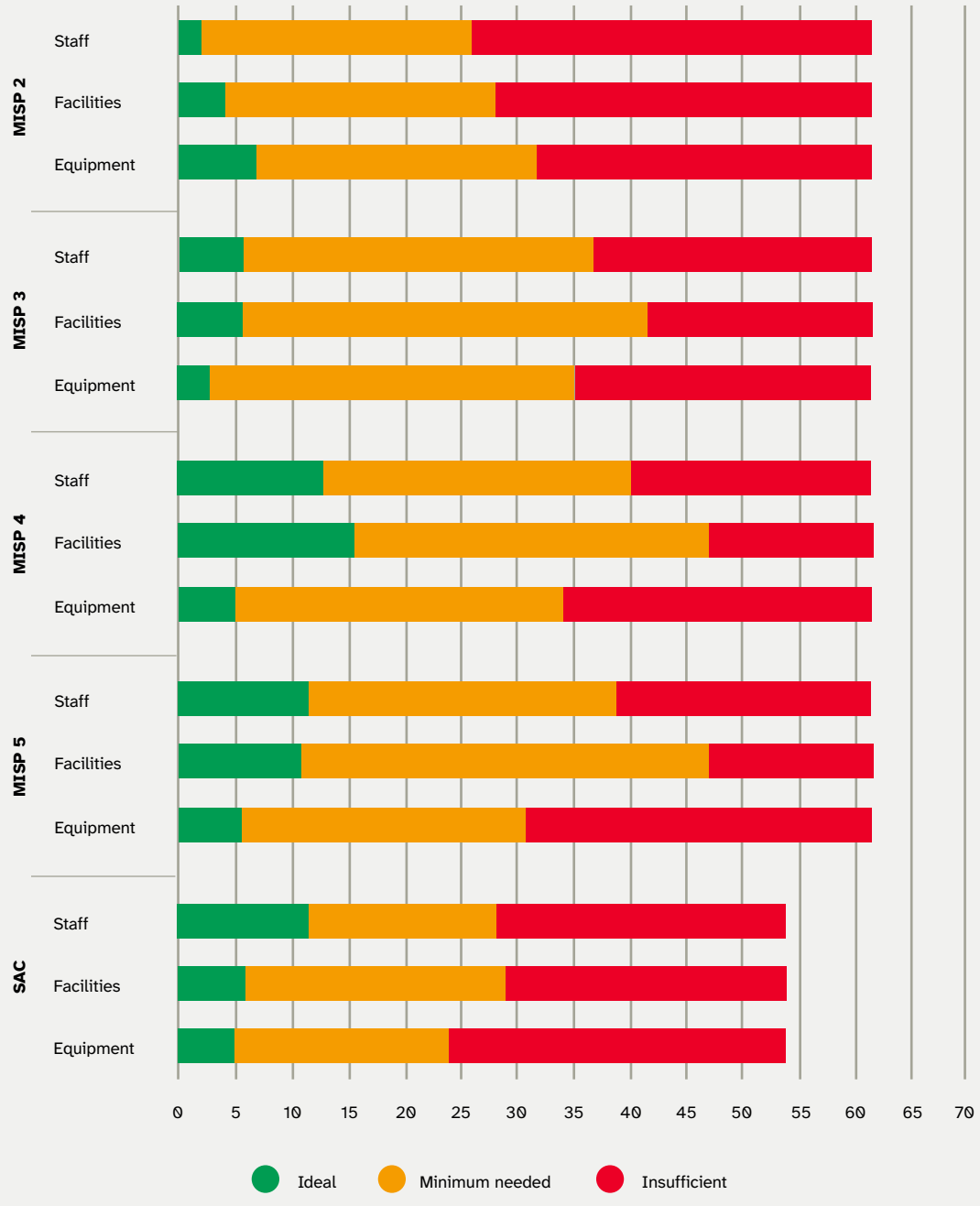
Figure 10 **Health systems' capacity to provide services related to the MISP**

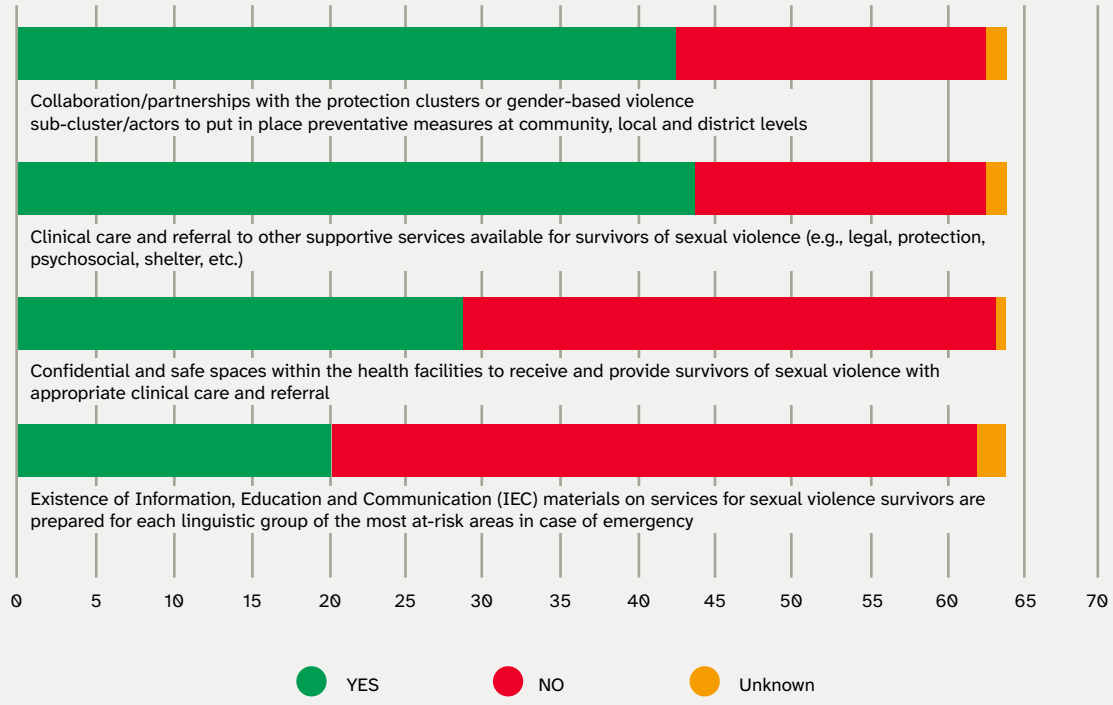


Source: UNFPA, 2026. *Ready or Not? MISP Readiness Assessment Cross-Regional Analysis (2021-2024).*

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

Sexual violence is often a frequent occurrence in all types of humanitarian settings and especially in conflict situations. All actors in humanitarian settings must be aware of the risks of sexual violence and those related to sexual exploitation and abuse. Their role is to coordinate multi-sectoral activities to prevent these and protect the affected population, particularly women, girls and other at-risk populations.[9]

Figure 11 **Availability of elements under MISP Objective 2**



Source: UNFPA, 2026. *Ready or Not? MISP Readiness Assessment Cross-Regional Analysis (2021-2024).*

9 IAWG, 2018. 2018 Inter-Agency Field Manual on Reproductive Health in Humanitarian Settings, Inter-Agency Working Group on Reproductive Health in Crises. Chapter 3, p.23.

Gaps

Low overall readiness: Responses related to MISP Objective 2 consistently receive low ratings, indicating significant gaps in preparedness and service availability.

- **Inadequate service and supplies availability:** A recurring challenge is the limited availability of services for survivors of sexual violence. This includes a shortage of dedicated facilities such as Women's Care Units, as well as inconsistent service delivery and frequent stockouts of essential supplies. The MRAs do not provide a list of specific supplies that are out of stock for the provision of services under MISP Objective 2. They do highlight general supply shortages and specific instances of missing items that impact service delivery.
- **Shortcomings in clinical care and referrals:** Significant gaps exist in providing clinical care and establishing effective referral processes for survivors. This is compounded by a lack of confidential and safe spaces within health facilities, hindering the delivery of timely and appropriate support.
- **Deficiencies in coordination and policy integration:** Coordination among different actors and the integration of SRH services into disaster management frameworks remain limited. Existing policies often lack explicit provisions for addressing sexual violence in emergencies, creating critical gaps in preparedness.
- **Lack of qualified professionals:** There is often an identified need for more qualified health professionals to provide psychological support to survivors of violence and to collect forensic evidence.
- **Need for improved IEC materials:** There is a general lack of updated, context-specific IEC materials in local languages, especially materials that are accessible for persons with disabilities.

Overall, these trends highlight the need for comprehensive improvements in coordination, resource allocation, service delivery and policy integration to ensure an effective response to sexual violence in emergency settings.

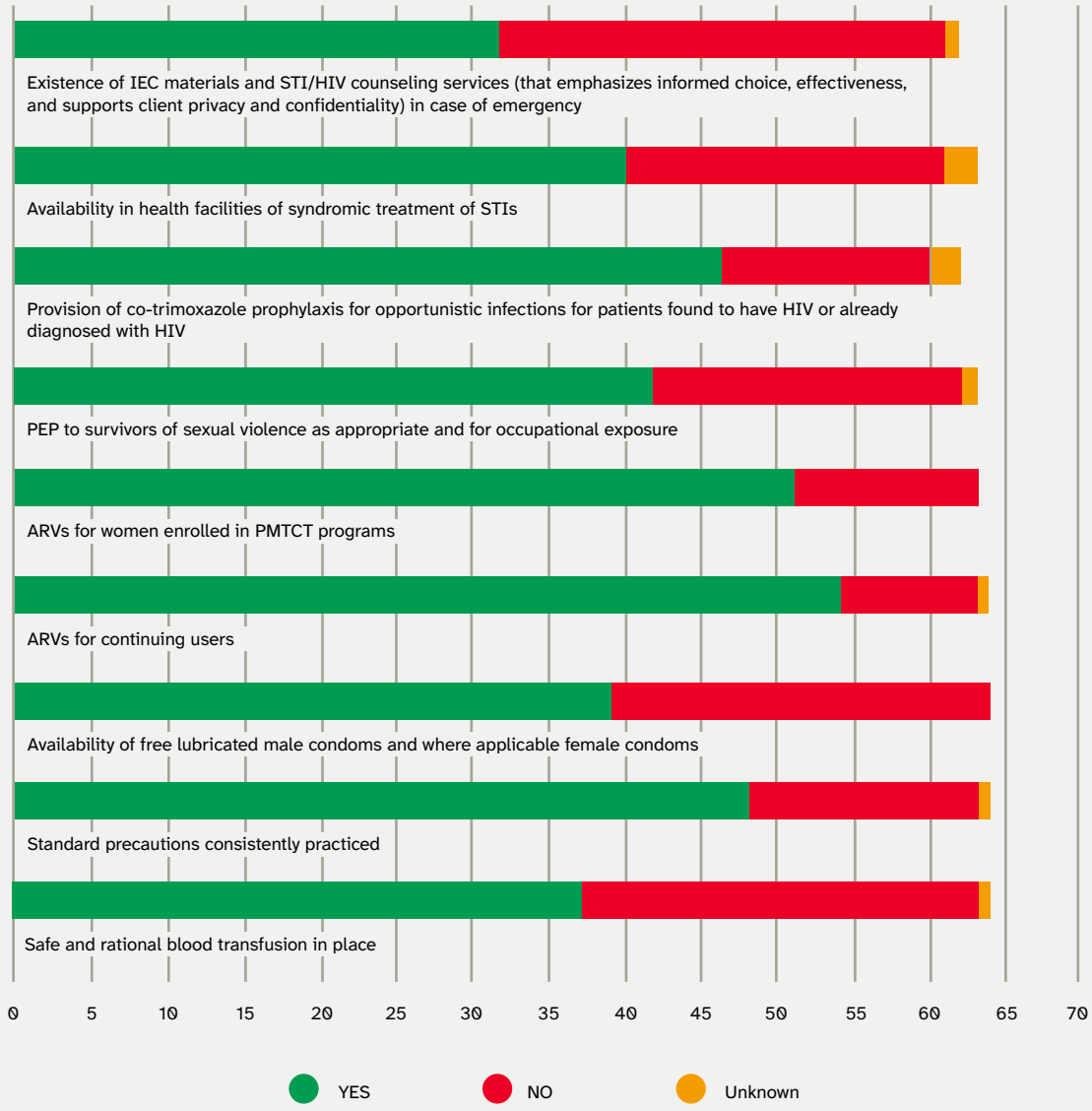
Strengths

The analysis of the MRAs clearly shows challenges and gaps to be addressed. The analysis also shows some strengths. The MRA analysis highlights that partners involved generally know the actors responsible for ensuring service provision, with government entities consistently recognized as key providers of GBV services. These governmental efforts are supported through collaboration with international and local NGOs as well as civil society and community-based organizations. Moreover, some countries have well-established partnerships with protection clusters or GBV actors. Some countries also have minimum requirements for qualified staff and facilities. In some countries, existing referral systems could potentially be scaled in emergencies. Finally, in some countries there is a favourable legal and institutional basis with public listening and guidance centres, support to civil society organizations (CSOs), intersectoral coordination mechanisms, free service provision and training for professionals.

2.4 MISP Objective 3: Prevent the transmission of and reduce morbidity and mortality due to HIV and other STIs

In humanitarian emergencies, women and girls are at heightened risk of sexual violence and exploitation, along with increased vulnerability to HIV infection, yet they are frequently cut off from essential protection services. MISP Objective 3 focuses on preventing the transmission of and reducing morbidity and mortality due to HIV and other STIs during emergencies. Across regions, several strengths emerge from the MRAs.

Figure 12 **Availability of elements under MISP Objective 3**



Source: UNFPA, 2026. *Ready or Not? MISP Readiness Assessment Cross-Regional Analysis (2021-2024).*

Strengths

Across regions, several strengths emerge from the MRAs:

- **Adequate availability of HIV/STI services:** are generally more adequately available compared to services for sexual violence or unintended pregnancies. These services have been reported as having the potential to be scaled up in case of an emergency in many countries.
- **Provisions for prophylaxis:** Most countries report having adequate provisions for co-trimoxazole prophylaxis for opportunistic infections in patients with HIV. Post-exposure prophylaxis (PEP) is also generally available to survivors of sexual violence and for occupational exposure.
- **Consistent practice of standard precautions:** In nearly all countries, standard precautions are consistently practised.
- **Availability of antiretroviral therapy (ART):** ARVs, or antiretrovirals, are individual drugs that, when combined, are highly effective at managing HIV. ART is often a scheduled combination of ARVs. ARVs for continuing users and for women enrolled in prevention of mother-to-child transmission (PMTCT) programmes are generally available.

Gaps

Regarding gaps, the following trends emerge:

- **Challenges in ensuring safe blood transfusions:** A recurring challenge is the ability to provide safe and rational blood transfusions, with many countries reporting this as a significant gap, even during stable times.
- **Potential limitations in condom availability:** The availability of free lubricated male condoms (and female condoms, where applicable) may be limited in some regions.

Overall, while many countries show a reasonable level of preparedness for MISP Objective 3, challenges remain in ensuring the consistent availability of safe blood transfusions and condoms, and in ensuring the existence of adequate IEC material in relevant languages.

2.5 MISP Objective 4: Prevent excess maternal and newborn morbidity and mortality

During labour and the immediate postnatal period is when many maternal and newborn deaths occur. The first day of life is the highest risk period for newborns. This MISP objective addresses the main causes of maternal and newborn mortality and morbidity, and the life-saving interventions that must be available in any humanitarian crisis.[10]

Strengths

MISP Objective 4 focuses on preventing excess maternal and newborn morbidity and mortality during emergencies. The MRA results showed several notable strengths. Government units seem to be consistently engaged in ensuring the provision of maternal and newborn services. Their efforts are often supported by international NGOs in many countries. Additionally, there is provision of information to communities regarding the availability of safe delivery, emergency obstetric and neonatal care services, along with stressing the importance of seeking care at health facilities. Many locations have referral systems for obstetric complications that operate 24/7. In terms of care, there is the availability of post-abortion care in health centres and hospitals. Finally, in some countries, referral hospitals are equipped with skilled staff and supplies for comprehensive EmONC services, while others have adequate provision of basic EmONC at the health facility level.

Gaps

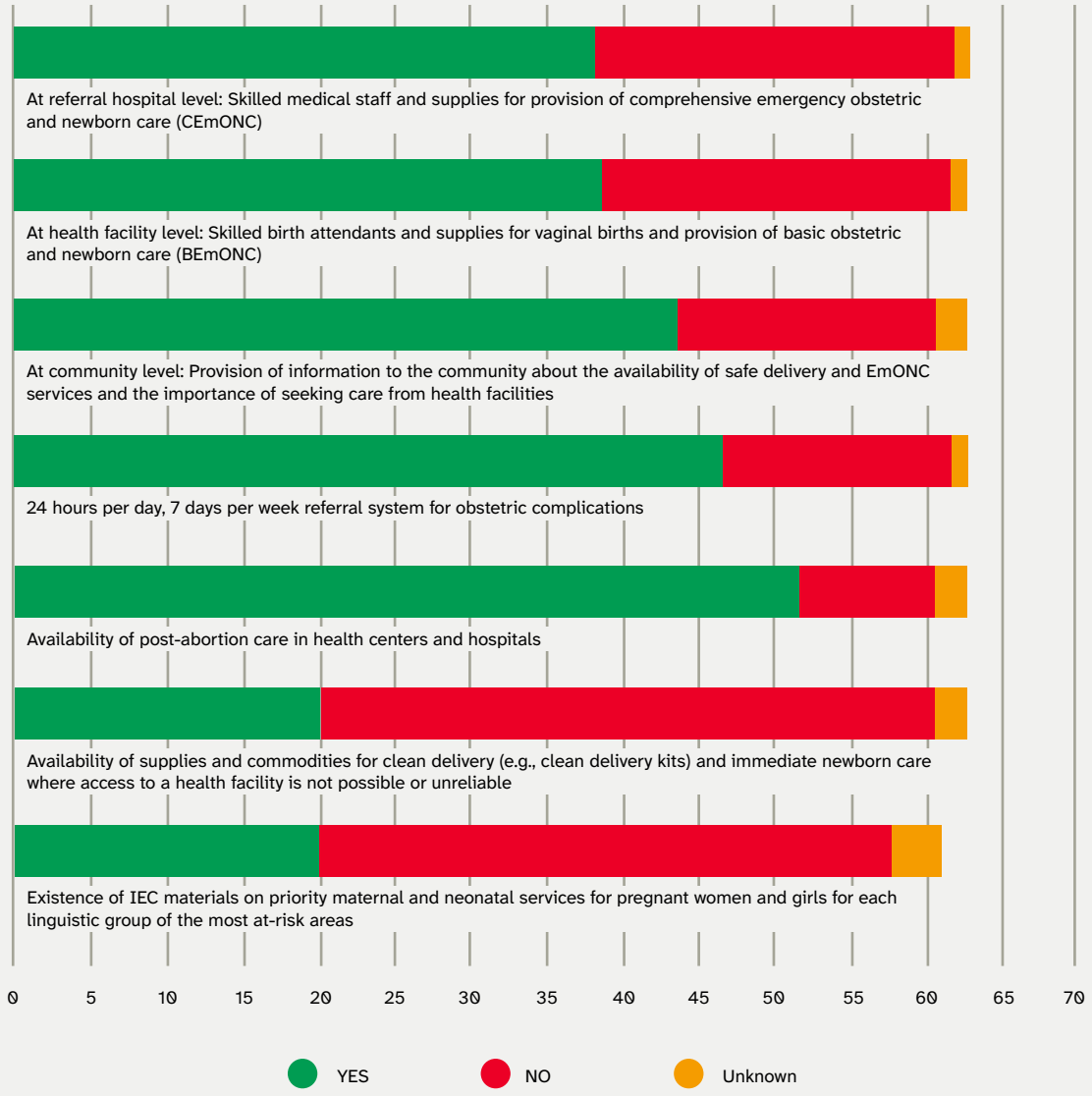
Several weaknesses exist in preventing excess maternal and newborn morbidity and mortality during emergencies:

- **Limited engagement of civil society:** Civil society and community-based organizations (CBOs) have limited engagement in some countries, which reflects missed opportunities for localized support.
- **Private sector collaboration:** The private sector's role is minimal in some areas, suggesting opportunities for expanded collaboration.
- **Lack of skilled staff and supplies:** Referral hospitals lack skilled staff and supplies for comprehensive EmONC services in several countries, which indicates limited readiness.
- **Gaps in basic emergency obstetric and newborn care:** There are inadequacies in providing information to the community about the availability of safe delivery and EmONC services, as well as challenges in offering adequate BEmONC at the health facility level in some countries.

While MISP Objective 4 benefits from strong governmental engagement and some key services and systems, there remain significant gaps. Such gaps are related to community involvement, private sector collaboration, and ensuring that all facilities are appropriately equipped to manage maternal and newborn emergencies.

10 IAWG, 2018. 2018 Inter-Agency Field Manual, Chapter 3, p. 42.

Figure 13 **Availability of elements under MISP Objective 4**

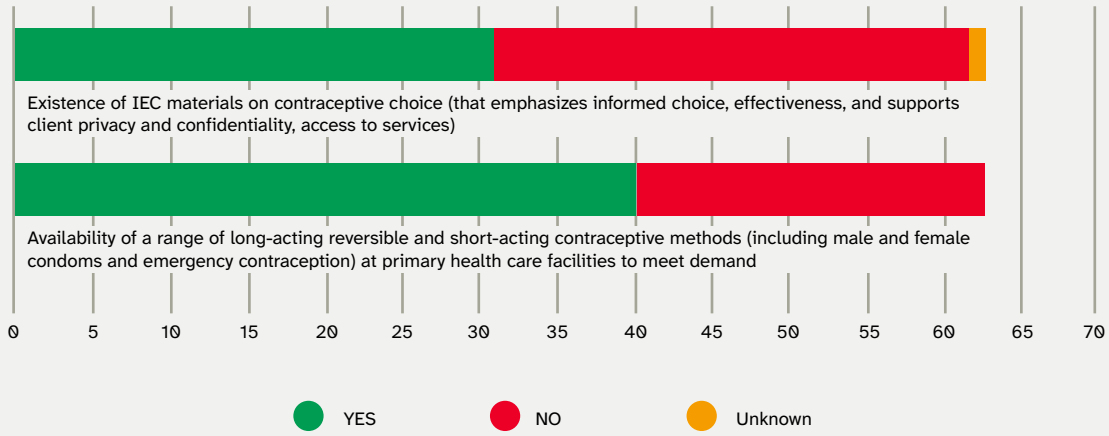


Source: UNFPA, 2026. *Ready or Not? MISP Readiness Assessment Cross-Regional Analysis (2021-2024).*

2.6 MISP Objective 5: Prevent unintended pregnancies

Improving access to contraception within an emergency response is a safe, effective, and cost-effective method of preventing unintended pregnancies and reducing maternal and newborn deaths, unsafe abortions and pregnancy-related morbidities.[11]

Figure 14 **Availability of elements under MISP Objective 5**



Source: UNFPA, 2026. *Ready or Not? MISP Readiness Assessment Cross-Regional Analysis (2021-2024).*

The MRA results can be grouped into two areas – trends in contraceptive availability, and related information, education and communication materials (IEC) around these trends.

Contraceptive availability trends:

- **Range of methods:** A range of contraceptive methods is generally available. This includes male and female condoms, oral contraceptives, IUDs (intrauterine devices), injectables and contraceptive implants.
- **Deficits in meeting demand:** Notable deficits remain in meeting the demand for contraceptives in several countries. Insufficient pre-positioning of SRH supplies, limited stockpiles in emergency reserves, and the absence of clear mechanisms for rapid procurement are key challenges.
- **Supply chain issues:** A critical supply chain challenge is the lack of reliable mechanisms for rapidly sourcing SRH supplies. Although the pre-packaged IARH kits are intended to overcome this lack, they too often face substantial delays, leaving critical gaps in the initial emergency response.

11 IAWG and Women's Refugee Commission, 2019. Minimum Initial Service Package (MISP) for Sexual and Reproductive Health (SRH): Distance Learning Module.

IEC materials on contraceptive trends:

- → **Lack of IEC materials:** There is a general lack of information, education and communication (IEC) materials on contraceptive choices in some countries.
- → **Language and inclusivity:** IEC materials need to be translated into relevant local languages and made accessible for persons with disabilities.

2.7 Additional MISP priority: Ensure safe abortion care to the full extent of the law

Another priority was added to the six objectives of the MISP in 2018. Over 60 per cent of unintended pregnancies end in abortion and an estimated 45 per cent of all abortions are unsafe, causing 8 per cent of all maternal deaths globally.[12] Safe abortion care is available across regions, but legal status and access vary. Key challenges include a lack of IEC materials, which hinder informed decision-making. Some regions have referral systems while others lack them. Resources are often limited, with unqualified staff, equipment and supplies. Additionally, stigma and a lack of knowledge about the legal status of abortion and services create barriers. While countries completed the MRA, this section of the questionnaire was the most difficult to complete, most likely due to stigma and discrimination around abortion.[13] Post-abortion care has no legal restrictions and should always be available.

60%

of unintended pregnancies end in abortion.

45%

of all abortions are unsafe.

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12 Global and regional causes of maternal deaths 2009–20: a WHO systematic analysis Cresswell, Jenny A et al. The Lancet Global Health, Volume 13, Issue 4, e626 - e634

13 In line with the ICPD paragraph 8.25, where abortion is legal, UNFPA states that national health systems should make safe abortion care accessible to the full extent of the national law. Post-abortion care should be available everywhere to save women's lives. UNFPA respects the sovereign right of countries to decide the extent to which safe abortion care is part of a comprehensive approach to sexual and reproductive health and reproductive rights. In all cases and everywhere, UNFPA opposes criminalization of abortion and opposes reproductive violence such as coercive abortion, forced pregnancy or the discriminatory practice of gender-biased sex selection.

3. Recommendations

How can countries ensure that SRH services are available and effective during emergencies? The recommendations proposed below are based on the cross-regional analysis of MISP Readiness Assessments supported by UNFPA from 2021 to 2024. They suggest steps at the national, regional and global levels.

Implementing the recommendations will contribute to strengthening emergency preparedness for SRH and the MISP and inform the role of UNFPA. These targeted strategies will also help to strengthen policy frameworks, data management, resource allocation, capacity building, service delivery, coordination and community engagement.

3.1 Global recommendations for improved SRH preparedness

Prepare 	**1.** Secure high-level policy commitment & institutionalize preparedness efforts **2.** Establish multilevel coordination mechanisms **3.** Allocate dedicated resources for SRH preparedness and response
Deliver 	**4.** Build and maintain a skilled workforce **5.** Strengthen SRH supply chain systems **6.** Improve data collection and information management
Sustain 	**7.** Embed SRH preparedness within the humanitarian–development nexus efforts **8.** Regularly review and adapt SRH preparedness, both MRAs and the resulting action plans

Prepare

1. Secure high-level policy commitment and institutionalize preparedness efforts

Need: Advocate with high-level policymakers (governmental, health authorities, and disaster management agencies) for formal political endorsement and sustained financial commitment to SRH preparedness at both national and subnational levels. Emphasize that SRH is a life-saving component of emergency response.

Policy integration: Actively work to embed comprehensive SRH preparedness plans, protocols, and the MISP into existing national and subnational health emergency preparedness frameworks, disaster risk reduction strategies, and contingency plans. This includes advocating for a legislative environment that supports the provision of the MISP during any emergency, adopting an all-hazards approach.

Institutionalization: Ensure that preparedness elements are integrated into national SRH strategies and development plans, not just emergency plans, to institutionalize its prioritization and ensure alignment with broader health and disaster frameworks for seamless, risk-informed implementation.

2. Establish multilevel coordination mechanisms

Clear structures: When not existing, design and operationalize coordination structures with clear mandates, roles, and responsibilities for SRH in emergencies. These mechanisms span from national to local/community levels.

Multi-sectoral engagement: Ensure these structures facilitate robust communication channels and collaboration across diverse actors, including relevant government ministries (Health, Disaster Management, Gender/Social Affairs), United Nations agencies, national and international non-governmental organizations (NGOs), Civil Society Organizations (CSOs), community-based organizations (including those representing marginalized groups), faith-based organizations, and professional bodies.

Dedicated SRH focus: Establish or empower dedicated SRH-specific working groups (or sub-groups within existing health/disaster clusters/sectors) at national and subnational levels. These groups should focus on preparedness, response and recovery. They serve as hubs to align stakeholders, streamline efforts, avoid duplication, and ensure accountability regarding the delivery of SRH services as part of a humanitarian response. Where SRH working groups are non-existent, concerted efforts are needed to create these robust structures.

3. Allocate dedicated resources for SRH preparedness and response

Predictable funding: Advocate for and secure sufficient, predictable, and dedicated financial allocations specifically for SRH emergency preparedness and humanitarian response. This includes establishing clear budget lines within national and subnational health and emergency budgets.

Contingency funds: Establish accessible contingency funds or mechanisms for the rapid mobilization of funds to support an SRH response during acute emergencies. This helps to ensure that resources are readily available for immediate needs, including the sourcing of SRH supplies and equipment (IARH kits and other).

Diverse funding streams: Explore and secure diverse funding streams, including specific domestic funding to avoid shortages and ensure adequate pre-positioning, alongside strengthening regional partnerships for potential resource-sharing systems. Equip key stakeholders with the knowledge to develop and manage these funding mechanisms effectively.

Deliver

4. Build and maintain a skilled workforce

Comprehensive training: Invest in continuous, comprehensive, and recurring training and capacity building programmes for a wide range of SRH service providers (doctors, nurses, midwives, community health workers) and other relevant personnel.

MISP-focused curriculum: All components of the MISP are covered in training. Topics include critical skills for emergency SRH care such as maternal and newborn health (including EmONC), clinical management of rape (CMR), and provision of contraceptives and family planning. Topics also include syndromic treatment of STIs and continuation of ARVs, and safe abortion care in circumstances where abortion is not against the law.[13]

Institutionalize training: Ensure awareness about the MISP. Advocate for and support the integration of all competencies required for the implementation of the MISP service provision objectives (objectives 2–5). This integration into national pre-service and in-service curricula for midwives, nurses, doctors and other health workers will help to build a sustainable network of trained personnel.

Retention and surge capacity: Develop retention strategies for skilled SRH providers in emergency-prone areas and establish mechanisms for deploying trained personnel (surge capacity) to scale up responses during crises.

5. Strengthen SRH supply chain management

Robust systems development: Develop and implement robust, resilient, and agile supply chain management systems specifically for SRH commodities. This includes accurate forecasting, timely procurement, appropriate storage (including cold chain where necessary), and efficient distribution mechanisms.

Essential Medicines List (EML) integration: Advocate for the integration of all essential SRH commodities needed for MISP implementation into national and subnational essential medicines lists to ensure their prioritization in procurement and supply management. These essential supplies are included in the Inter-Agency Reproductive Health kits.

Contingency planning: Develop and implement contingency plans for the supply chain in emergencies. This includes mechanisms for rapid procurement (e.g. emergency waivers, standing agreements with pre identified suppliers), strategic pre-positioning of essential SRH commodities to ensure they are readily accessible, secure locations, and efficient last-mile distribution and transportation systems. The pre-positioned SRH commodities include Inter-Agency Reproductive Health kits.

Building capacity: Build the necessary capacity among relevant stakeholders in supply chain management specifically for SRH in emergency settings.

6. Improve data collection and information management

Standardized tools and indicators: Establish and promote the use of standardized data collection tools and protocols for SRH in emergencies. This includes advocating for the integration of MISP-related indicators and sex, age and disability-disaggregated data (SADDD) into all relevant health assessments (e.g. rapid needs assessments, health sector assessments) and routine health management information systems (HMIS).

Timely reporting and analysis: Ensure mechanisms are in place for timely, regular reporting and analysis of SRH indicators during preparedness, response, and recovery phases. This data can be used to inform decision-making, resource allocation and programme adjustments.

Information sharing: Facilitate effective information sharing and dissemination of SRH data among all relevant stakeholders, ensuring data is accessible and utilized for coordinated action. Consider digitizing data collection tools where feasible to improve efficiency and accuracy.

Addressing gaps: Actively work to address the common lack of comprehensive SRH data by fostering a unified and coordinated approach to data management, including securing resources for data collection and system revisions.

Sustain

7. Embed SRH preparedness within the humanitarian–development–peace nexus

Strategic investment: Position SRH preparedness not merely as a humanitarian add-on but as a strategic and necessary investment within long-term development programmes and national health system strengthening efforts.

Collaborative programming: Foster collaborative programming and partnerships that bridge immediate humanitarian SRH needs with long-term development goals. This involves embracing the humanitarian–development–peace nexus approach, particularly in fragile states and crisis-prone regions that frequently transition between emergency, recovery, and development phases.

Policy coherence: Advocate for the integration of disaster management and emergency response considerations into SRH development policies and, conversely, ensure development perspectives inform preparedness to build community and institutional resilience. This approach ensures preparedness is a core component of development work, with dedicated funding and focus.

8. Regularly review and adapt SRH preparedness

Monitoring and evaluation (M&E): Implement robust M&E mechanisms for routine monitoring of SRH preparedness levels and the effectiveness of response efforts. This includes tracking the implementation of MRA recommendations and action plans.

Learning and adaptation: Establish processes for regular review, learning from past experiences (both successes and failures), and adapting SRH preparedness strategies, plans, and interventions based on M&E findings, emerging evidence, and evolving contexts.

Cross-learning: Facilitate and participate in cross-country and cross-regional learning opportunities to share best practices, lessons learned, and innovative approaches in SRH emergency preparedness and response.

Iterative improvement: Treat SRH preparedness as an iterative process, ensuring that MRA findings and action plans are regularly reviewed and updated to maintain relevance and drive continuous improvement in the capacity to deliver essential SRH services during emergencies.

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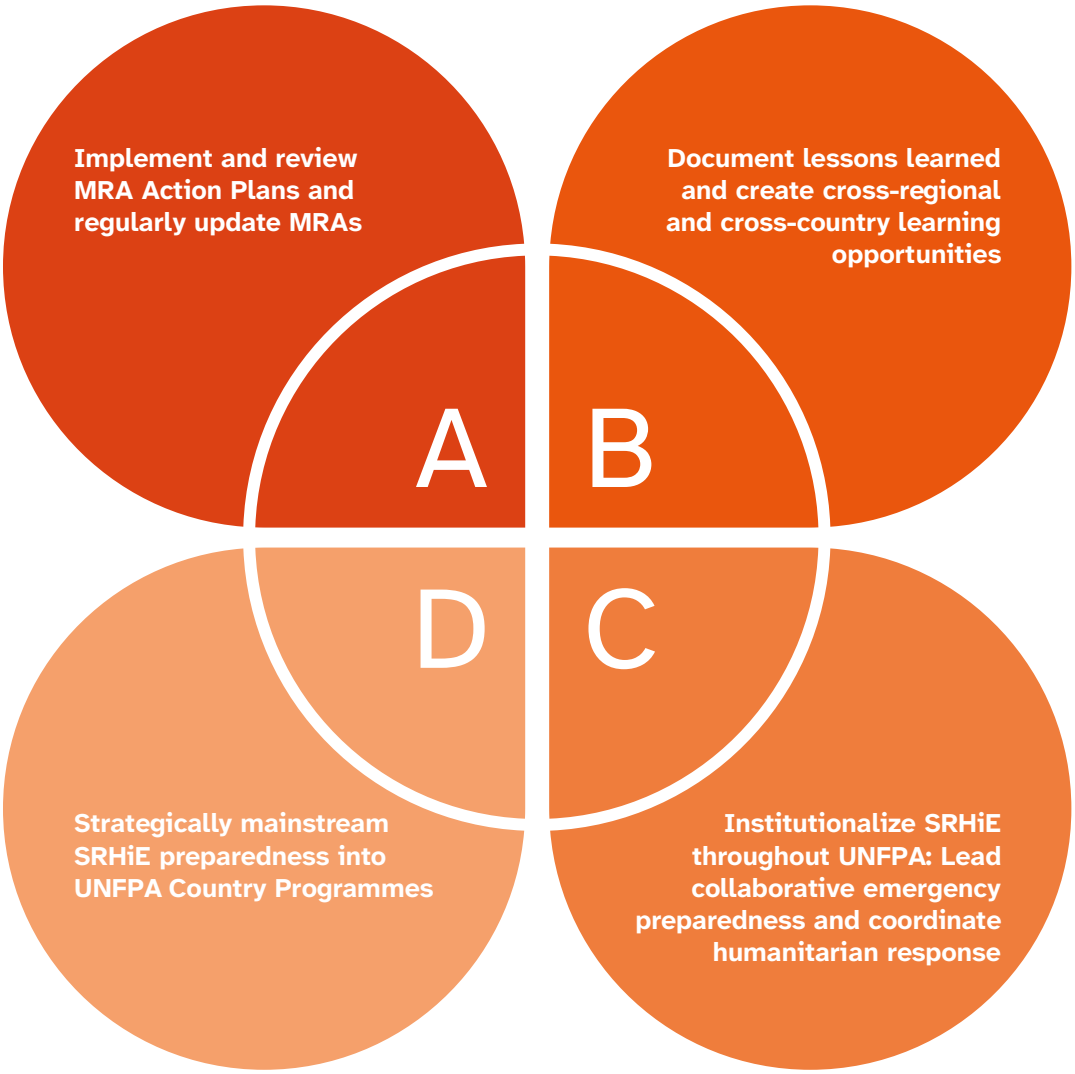
3.2 Strategic recommendations for UNFPA internal practice



A

Implement and review MRA Action Plans and regularly update MRAs

Following the completion of the MRA, it is essential that UNFPA country offices prioritize the development and implementation of action plans to address identified gaps in SRH preparedness. Furthermore, to ensure the continued relevance and effectiveness of preparedness efforts, it is strongly recommended to establish mechanisms for regular review and updating of the MRA findings and action plans. This iterative process allows for the incorporation of lessons learned, adaptation to evolving contexts, and sustained improvement in the capacity to deliver essential SRH services during emergencies. The MRA serves as a starting point, necessitating ongoing efforts and investment to build more resilient health systems.

B

Document lessons learned and create cross-regional and cross-country learning opportunities

Establish mechanisms for regularly assessing the impact and adaptability of SRH programmes to ensure alignment with evolving needs and priorities. This includes creating systems to track the implementation of MRA recommendations and the integration of the MISP into national policies and response plans. It is also important to document and widely share best practices and lessons learned to enable other countries and regions to learn from expertise. Furthermore, fostering community buy-in and empowering local populations to advocate for and access preventive care and life-saving services is key.

→ Establish mechanisms to regularly assess the impact and adaptability of SRH programmes to ensure alignment with evolving needs and priorities.

→ Advocate for establishment of a regional monitoring system to track the implementation of MRA recommendations and the integration of the MISP into national policies and response plans.

C

Institutionalize SRHiE throughout UNFPA: Lead collaborative SRH emergencies preparedness and coordinate humanitarian response

Build and maintain robust partnerships across countries to share knowledge, resources, and best practices for **SRH in Emergencies (SRHiE)**, emergency preparedness and humanitarian response. This includes developing regional frameworks for coordinated SRHiE preparedness and responses, establishing mechanisms for mutual aid and technical support during crises and supporting and participating in high-level events on SRHiE in coordination with UNFPA and other regional offices. By engaging with other United Nations agencies and strengthening collaboration with the World Health Organization, countries can advocate for the integration of MISP readiness into national action plans. Furthermore, establishing regional SRHiE/preparedness initiatives and working groups can provide countries with opportunities to learn from each other and create synergies.

→ Support and participate in high-level events on SRHiE preparedness in coordination with UNFPA and other regional offices.

→ Build and maintain robust partnerships across countries to share knowledge, resources, and best practices for SRHiE preparedness and response.

→ Publish national MRA reports for partners and stakeholders to use for improved planning and implementation of SRH preparedness activities.

D

Strategically mainstream SRH preparedness into UNFPA country programmes

Emergency preparedness involves systematically investing in capacities, enablers and competencies required to implement the MISP. SRH risks and needs must be considered as part of all disaster management initiatives, emergency preparedness, anticipatory action, and events related to disease outbreaks, conflict, displacement, extreme weather and food shortages, for example.

Embed commitment to the MISP across relevant SRH plans, country programmes and documents.

Towards SRH emergency preparedness, reflect the dynamic realities, especially in fragile states, where the humanitarian–development–peace nexus work is crucial to resilience building.

SRH emergency preparedness is a strategic investment within country programmes. It can be included in all relevant initiatives and country programme documents. Emergency preparedness is a development responsibility requiring humanitarian know how.

It involves systematically investing in capacities, enablers and competencies required to implement the MISP. SRH risks and needs have to be considered as part of all disaster management initiatives, emergency preparedness, anticipatory action, etc., and for all types of events, be they related to disease outbreak, conflict, displacement, extreme weather or food shortage.

Commitment to the MISP needs to be embedded across relevant plans, to ensure all SRH initiatives reflect the dynamic realities, especially in fragile states where the humanitarian–development–peace nexus work is crucial to resilience building.

This integrated approach will not only enhance reactive emergency response but also strengthen SRH care during stable times by building resilient systems able to withstand stressors and shocks – ultimately helping to preserve development gains in the event of a crisis.

UNFPA links the development and humanitarian perspectives and know-how on SRH. This helps ensure that preparedness is adequately funded and embedded within all nexus-focused work, contributing to more effective emergency responses. It also fosters long-term community resilience in stable settings where maternal mortality is unacceptably high and where the system is unable to cope with current SRH needs.

3.3 Conclusions of the MRA cross-regional analysis

Integrating the commitment to the MISP for SRH into national disaster frameworks is a vital investment in saving lives, protecting dignity, and preventing needless harm during emergencies.

While progress has been made, substantial gaps persist in policy integration, coordination, data collection, resource mobilization, and capacity building, disproportionately impacting women, girls, and marginalized communities. To close these gaps, urgent action is imperative. This includes linking disaster management and emergency response to SRH development policies, thus strengthening the humanitarian–development–peace nexus. Leveraging opportunities like cross-country learning, building existing structures, and bolstering data collection and analysis, alongside capacity building and community engagement, will pave the way for more resilient health systems. By prioritizing these actions, nations can dramatically improve their capacity to deliver timely, life-saving sexual and reproductive health services during crises, safeguarding the rights and dignity of the most vulnerable.

In an era of shrinking humanitarian funding, bridging the gap between development and humanitarian action is no longer optional; it is a necessity.

The latest maternal mortality trends are concerning in many ways and symbolic of the unequal access to quality SRH services across the world.

Humanitarian and fragile settings carry the large burden of the world's maternal mortality. MISP awareness is still low, and countries state their limited capacity to provide minimal SRH services even in stable situations and less in an emergency. One priority is to strengthen investment by UNFPA and other relevant stakeholders in raising awareness about the MISP. Another priority is to coordinate and support SRH in emergency preparedness and as part of humanitarian response.

4. Overview of references to refugees in MRA findings

This section of the report analyses the inclusion of refugee considerations within MRAs conducted from 2021–2024.

In recent years, the plight of refugees has become a critical issue demanding global attention. This section of the report provides an overview of reference to refugees in the MRAs conducted between 2021 and 2024. Through these assessments, the aim is to understand how and if the MRAs help assess the preparedness and responsiveness of various health systems in addressing the needs and challenges faced by refugees. This will also help assess whether the tool needs revision to better address these critical issues.

4.1 MRA references to refugees

Overall, analysis of the MRAs shows that there is little specific attention towards refugees and displaced populations in the MRA findings. This lack is likely because the MRA does not include specific questions about refugees.

For the purpose of this analysis, only MRA reports from countries hosting more than 50,000 refugees according to UNHCR database were analysed.

Table 1 **References to refugees in MRA questionnaires, reports and action plans in countries hosting over 50,000 refugees**

MRA	Reference to refugees
Arab States	
Egypt	The report references the significant number of refugees and asylum-seekers with refugees from South Sudan, Eritrea, Ethiopia, Yemen, Somalia and Iraq facing many challenges. They struggle with unstable income, high inflation, limited job opportunities, language barriers, and lack of access to education. Many depend on humanitarian aid for basic needs and support. Egypt's National Health Strategic Plan aims to strengthen health care systems for all, including refugees and migrants. It prioritizes emergency preparedness, response, and disaster recovery while maintaining essential services. The plan aligns with global health security initiatives and seeks to make health care facilities sustainable amid climate change, ensuring care for vulnerable populations.
Iraq	No reference
Jordan	The report references the significant number of refugees in Jordan. Refugees have access to SRH services within and outside refugee camps. The national reproductive health sub-working group in Jordan is dedicated to addressing the reproductive health needs of both women and men. Its mission is to provide accessible and high-quality services to Syrian refugees, alongside the host community and other groups. By focusing on these efforts, the group aims to enhance the long-term response capabilities and resilience of the communities it serves.
Asia and the Pacific	
Bangladesh	Information on the Rohingya refugee situation.

Lebanon	The outcomes and analysis results indicated that access to SRH services is available and utilized across different regions in Jordan, including refugee camps, when compared to other health care services. Delivery services are provided in Syrian refugee camps by doctors and midwives. This is supported by a referral system and access to ambulances for transfers to other healthcare facilities when necessary.
East and Southern Africa	
Burundi	In the context of disaster management, the MRA mentions that there is a national SRHiE coordination mechanism responsible for disaster management during crises. For the coordination on response in case of emergencies such as natural disasters, there is a mention of the repatriation of refugees. (Q10) The findings highlight that CERF funds are mobilized for the acquisition of reproductive health kits intended for areas affected by floods, areas of repatriation of former Burundian refugees in neighbouring countries, and areas around refugee camps. (Q21)
Democratic Republic of the Congo	The DRC's national reproductive health policy mentions sexual and reproductive health for refugees and special groups (adolescents, single individuals, displaced persons, disaster survivors, etc.) but lacks detailed strategies and specific actions. (Q6)
Ethiopia	The assessment reveals that while MISP indicators are largely integrated into the Ethiopian health information system (HIS), it is important to note that data from refugee camps and internally displaced persons (IDPs) are often excluded from HIS, EDHS, and many national surveys. (Q14) The MRA results highlight barriers that refugees face in accessing special services include inconvenient health facilities, lack of policies on SRH services, safety and security concerns, and language barriers. (Q29) The MRA findings suggest that the Ministry of Health draw insights from the Ministry of Education's National Refugee Education Strategy to integrate services, gather health data, and formulate a National Refugee Health Strategy. (Recommendation)
Kenya	The MRA report clearly mentions the refugee situation. Kenya hosts around 468,910 refugees in Dadaab, Kakuma, and Kalobeyei camps. Numbers are rising due to conflicts and natural disasters in the Democratic Republic of Congo, Somalia, and South Sudan. The subnational coordination mechanisms mention the Refugee Affairs Secretariat but lack details. (Q11) Note: Kenya's Refugee Affairs Secretariat (RAS) manages refugee issues under the Ministry of Interior. RAS registers, documents, and coordinates services for refugees and asylum seekers, working with UNHCR and NGOs to protect and assist them. It oversees refugee camps, ensuring rights and welfare according to laws. The focus on SRH within RAS is unclear.

Rwanda	During a crisis, affected populations can access free health services funded by organizations like UNHCR. The 2021-2024 Joint Strategy on Economic Inclusion of Refugees and Host Communities in Rwanda focuses on integrating refugees into socioeconomic transformation, aligning with UNDAP II's commitment to include everyone. By 2023, UNDAP II aims to integrate refugees into social protection schemes, support their health insurance needs, and provide essential services like health and education to refugees, returnees, and host communities. (Q30)
South Africa	No reference
South Sudan	No reference
Tanzania	Regarding data collection, the findings show that in refugee settings, various surveys such as the Standardized Expanded Nutritional Survey (SENS) are conducted, which include data on age and sex. However, disability status is not captured. In refugee camps, there are also Joint Assessment and Monitoring (JAM) exercises that include data on age and sex. (Q16) The findings indicate that, in refugee settings, UNHCR conducts balanced scorecard exercises that include MISP priority indicators addressing SRH-related issues. (Q17) Rapid sourcing of supplies is handled by the National Medical Stores Department (MSD). However, the findings highlight that refugees are not fully integrated into the SRH commodities and national supply chain. (Q19) In refugee camps, IEC materials are produced in Kirundi for Burundian refugees and Kiswahili for Congolese refugees. (Q35)
Uganda	There is no comprehensive National Health Preparedness or Emergency Response Plan, but a policy for the refugee crisis response exists: the Health Sector Integrated Refugee Response Plan (2019). (Q2) The Health Sector Integrated Refugee Response Plan does not capture or refer to the MISP. (Q5) SRH is part of the Refugee Response Plan (RRP) and the Health Sector Integrated Refugee Response Plan. (Q7) Access to PEP is influenced by its availability at accredited facilities. Facilities in refugee settlements that are not yet accredited by the national health system cannot provide this service. (Q41)
Zambia	No reference

Eastern Europe and Central Asia	
Armenia	No reference
Kazakhstan	No reference
Moldova (Republic of)	In 2020, the MHLSP issued a new regulation providing free modern contraceptives to 12 vulnerable groups. These groups include survivors of crises, refugees, asylum-seekers, stateless individuals, and migrants. The regulation applies in any context, including humanitarian crises or public health emergencies. In Moldova, national studies supported by international development partners examined COVID-19 risks and impacts on various groups, including Roma people, refugees, asylum seekers, stateless persons, young people, and older people. (Note: not SRH-specific) (Q14)
Türkiye	NGOs providing emergency SRH counselling to refugees report having adequate personal protective equipment (PPE) and Infection Prevention and Control (IPC), despite lacking plans. (Q24) NGOs state that they can provide mental health support to refugees through private psychiatrists'offices and psychologists. (Q34)
West and Central Africa	
Cameroon	The report references the significant number of refugees in Cameroon, but it does not include specific details in the assessment results concerning the refugees.
Chad	No reference
Congo (Brazzaville)	No reference
Mali	The report references the significant number of refugees in Mali, but it does not include specific details in the assessment results concerning the refugees.
Nigeria	No reference

4.2 Recommendations regarding specific attention to displaced population in MRAs

To improve the MRA so that it gives specific attention to understanding the SRH needs of displaced populations, the following revisions to the current MRA can be considered:

4.2.1 Integrate refugee-specific questions

→ Incorporate specific questions about refugees and displaced populations within the relevant subsections of the MISP Readiness Assessment.

→ Revise the existing MRA questionnaire to include targeted questions that specifically address the SRH needs of refugee populations.

These questions could be integrated into relevant subsections, such as service delivery, coordination, and data collection, rather than creating a separate, isolated section. For example, within the service delivery section, include questions about the availability of SRH services within refugee camps or settlements, the accessibility of these services to refugee women and girls, and any specific barriers they face. Within the data collection section, add questions about the collection of disaggregated data on SRH needs among refugees. This ensures that refugee-specific considerations are embedded throughout the assessment and not treated as a separate, secondary issue.

4.2.2 UNHCR collaboration

→ Collaborate with the UNHCR to determine the optimal way to integrate refugee issues into the MRA.

→ Establish a formal partnership with UNHCR to leverage their expertise and experience in refugee protection and SRH programming.

→ Conduct joint consultations to identify the most effective strategies for integrating refugee-specific questions and indicators into the MRA.

This collaboration could include:

→ Sharing existing data and best practices on SRH in refugee settings.

→ Developing standardized language and definitions for refugee-related terms within the MRA.

→ Ensuring the MRA aligns with UNHCR's existing frameworks and guidelines for refugee protection.

4.2.3 Develop a “refugee lens” guidance

→ When conducting assessments in countries with significant refugee populations, ensure the guidance document includes a “refugee lens” for each question.

→ Develop a supplementary guidance document, or integrate into the existing one, that provides a refugee lens for each question in the MRA.

The refugee lens offers contextual information and specific considerations for assessing SRH readiness in refugee settings. For example, when assessing coordination mechanisms, the guidance could prompt assessors to consider the involvement of refugee-led organizations and the coordination between humanitarian actors and host governments in refugee camps. Additionally, the guidance could include case studies and examples of best practices for addressing SRH needs in refugee populations. This ensures that assessors are equipped to apply a nuanced and informed approach when conducting an MRA in countries with significant refugee populations.

4.2.4 Evaluate a camp-specific assessment

→ Evaluate the possibility of adding a section that specifically assesses refugee camps.

→ Conduct a feasibility study to evaluate the potential benefits and challenges of adding a dedicated section to the MRA that specifically assesses SRH readiness in refugee camps.

This evaluation could consider:

→ The prevalence and size of refugee camps within the region.

→ The unique SRH challenges facing refugees living in camp settings.

→ The availability of data and resources for conducting camp-specific assessments.

→ The potential for this section to provide valuable insights that are not captured by the general MRA.

If the study determines that a camp-specific section is feasible and beneficial, develop standardized indicators and assessment tools that are tailored to the unique context of refugee camps.

Annex 1
Structure and questions of the MRA

The detailed questionnaire can be accessed here:

https://wordpress.fp2030.org/wp-content/uploads/2023/07/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 level	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

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 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, 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 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:
	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 sub national level to assist with emergency preparedness and response?
13	Are civil society organizations and community-based organizations working/ representing marginalized 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, persons 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 (HIS)?
16	Do rapid needs assessment forms for emergency response (rapid assessments and health sector assessments) include sex, age and disability (SADD) 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 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 a 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 sub national 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 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	Does the health care training curriculum 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 on the availability of MISP-related services in case of an emergency?
29	Are there any barriers for marginalized groups (e.g. women with disabilities, adolescents, sex workers, people of diverse SOGIESC, PLHIV, 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[10] identified and available that are accessible for survivors of GBV?
33	Is there a clear up-to-date referral system that 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 sub cluster/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 are 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 regards 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/ARV 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 precautions11 consistently practised
41.3	Availability of free lubricated male condoms and where applicable female condoms
41.4	ARVs for continuing users
41.5	ARVs for women enrolled in PMTCT 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 emphasizes informed choice, effectiveness, and supports 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 regards 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 (EmONC) 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 referral hospital level: Skilled medical staff and supplies for provision of comprehensive emergency obstetric and newborn care (CEmONC)
46.2	At health facility level: Skilled birth attendants and supplies for vaginal births and provision of basic obstetric and newborn care (BEmONC)
46.3	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
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 regards 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 emphasizes informed choice, effectiveness, and supports client privacy and confidentiality, access to services)
52	Based on the above services, how would you rate the existing health system's ability to provide contraceptive services in your location with regards 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 where, 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 regards 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 2 Overview of MRA implementation and data analysis for the cross-regional analysis

Regions are listed by the number of MRAs conducted from 2021 to 2024.

Region	Country	Year (latest)	MRA Questionnaire available and used for the cross-regional analysis	MRA reviewed to analyse special attention for refugees
East and Southern Africa (ESA) 22 MRAs	Angola	2022	x	
	Botswana	2022	x	
	Burundi	2022	x	x
	Comoros	2022	x	
	Democratic Republic of the Congo	2022	x	x
	Eswatini	2022	x	
	Ethiopia	2022	x	x
	Kenya	2022	x	x
	Lesotho	2022	x	
	Madagascar	2022	x	
	Malawi	2022	x	
	Mauritius	2022	x	
	Mozambique	2022	x	
	Namibia	2022	x	

	Rwanda	2022	x	x
	Seychelles	2022	x	
	South Africa	2022	x	x
	South Sudan	2022	x	x
	Tanzania	2022	x	x
	Uganda	2022	x	x
	Zambia	2022	x	x
	Zimbabwe	2022	x	
West and Central Africa (WCA) 16 MRAs	Benin	2023	x	
	Burkina Faso	2023	x	
	Cameroon	2023	x	x
	Chad	2024		x
	Congo (Brazzaville)	2024		x
	Equatorial Guinea	2023	x	
	Gabon	2023	x	
	Gambia	2023	x	
	Ghana	2023	x	
	Liberia	2023	x	
	Mali	2023	x	x
	Niger	2024	x	
	Nigeria	2023	x	x
	Senegal	2023	x	
	Sierra Leone	2023	x	
	Togo	2023	x	

Eastern Europe and Central Asia **15 MRAs**	**Albania**	2021	x	
	Armenia	2021	x	x
	Azerbaijan	2021	x	
	Georgia	2021	x	
	Kazakhstan	2021	x	x
	Kosovo*	2021	x	
	Kyrgyzstan	2021	x	
	Moldova	2021	x	x
	North Macedonia	2020	x	
	Serbia	2021	x	
	Tajikistan	2021	x	
	Türkiye	2021	x	x
	Turkmenistan	2021	x	
	Ukraine	2021	x	
	Uzbekistan	2021	x	
Asia and the Pacific **10 MRAs**	**Bangladesh**	2023		x
	Indonesia	2022		
	Mongolia	2024	x	
	Nepal	in progress		
	Pakistan	in progress		
	Philippines	2024		
	Sri Lanka	2024	x	
	Fiji	2022	x	
	Micronesia (Federated States of)	2023	x	

* See UN Security Council Resolution 1244

	Marshall Islands (Republic of the)	2023		
	Solomon Islands	2023		
	Tonga	2022		
Arab States 9 MRAs	Egypt	2024	x	x
	Iraq	2024	x	x
	Jordan	2023	x	x
	Lebanon	2023	x	x
	Morocco	2024		
	Palestine (State of)	2023	x	
	Somalia	2023	x	
	Tunisia	2023	x	
	Yemen	2023	x	
Latin America and the Caribbean 5 MRAs	Chile	2024		
	Dominican Republic	2022	x	
	Ecuador	2022	x	
	Guyana	2024		
	Peru	2024		

United Nations Population Fund

730 Third Avenue, New York, NY 10017, USA

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