2020
VERSION FOR FIELD TESTING

MRA

MISP Readiness Assessment

Assessing Readiness to Provide the Minimum Initial Service Package (MISP) for Sexual and Reproductive Health in Emergencies

PRODUCED BY

International Planned Parenthood Federation

IN COLLABORATION WITH

Inter-Agency Working Group on Reproductive Health in Crises and United Nations Population Fund

Table of contents

Acknowledgements

The idea of an assessment to support country actors evaluate the readiness of their system to provide lifesaving Sexual and Reproductive Health (SRH) services (as outlined in the Minimum Initial Service Package for SRH, or MISP) during an emergency was initiated by actors in the Eastern Europe and Central Asia (EECA) Region. They pioneered comprehensive SRH Preparedness work at the national level with support of UNFPA and International Planned Parenthood Federation (IPPF), through the development and implementation of a MISP readiness assessment tool in 18 countries.[1]

This update of the MISP Readiness Assessment (MRA), led by IPPF, is inspired by the 2018 update to the MISP for SRH outlined in the Inter-Agency Field Manual on Reproductive Health in Humanitarian Settings, related resources, and subsequent experiences. These experiences have highlighted the need for more supportive guidance, and formats that can be used by a range of national and subnational stakeholders to help them better prepare and plan for SRH in emergencies.

The MRA development has been made possible with support from Family Planning 2020. Nesrine Talbi, an IPPF consultant, was the lead author. Input and coordination for the overall process was overseen by Keya Saha-Chaudhury of IPPF.

A special thanks goes to colleagues who have reviewed the MRA, provided their insights, expertise, and thoughtful comments. These include members of the Inter-Agency Working Group for Reproductive Health in Crises sub-working groups on the MISP, the Training Partnership Initiative (TPI) and the Emergency Preparedness and Resilience Working Group (EPRWG), as well as colleagues from UNFPA, Women's Refugee Commission (WRC), FP2020, Ipas and IPPF Member Associations.

The document is addressing a relatively new area of work for SRH stakeholders and we encourage partners to test the process outlined in the MRA so that learnings can be drawn and improvements made where needed.

This assessment is dedicated to the memory of our beloved colleague Jennifer Schlecht, who worked tirelessly to support the development of resources to equip national stakeholders with the tools needed to better prepare for delivery of SRH services in emergencies.

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Acronyms

ARV	Anti-retro viral
BEmONC	Basic emergency obstetric and newborn care
CEmONC	Comprehensive emergency obstetric and newborn care
DHS	Demographic and health survey
EC	Emergency Contraception
EmONC	Emergency obstetric and newborn care
GBV	Gender-based violence
Health-EDRM	Health Emergency Disaster Risk Management
HIS	Health Information System
HIV	Human Immunodeficiency Virus
IAFM	Inter-Agency Field Manual on Reproductive Health in Humanitarian Settings
IEC	Information, Education, Communication
IAWG	Inter-Agency Working Group on Reproductive Health in Crisis
IUD	Intra-uterine device
MISP	Minimum Initial Service Package for SRH
MRA	MISP Readiness Assessment
PLHIV	People living with HIV
PMTCT	Prevention of mother-to-child transmission
PWD	People with disabilities
RH	Reproductive Health
SOGIESC	Sexual orientation, gender identities and expressions and sex characteristics
SRH	Sexual and Reproductive Health
SRHiE	Sexual and Reproductive Health in Emergencies
STI	Sexually transmitted infections

Terminology

The following terms are adopted directly from the WHO Glossary of Health Emergency and Disaster Risk Management terminology (2020):[2]

Emergency response plan: A document that describes how an agency or organization will manage its responses to emergencies various types. Note: It provides a description of the objectives, policy and concept of operations for a response to an emergency. It also offers the structure, authorities and responsibilities for a systematic, coordinated and effective response. In this context, emergency plans are agency- or jurisdiction-specific, and they detail the resources, capacities and capabilities that the jurisdiction, agency or organization will employ in its response (WHO 2017a).[3]

Disaster risk reduction: Activities aimed at preventing new disaster risk, reducing existing disaster risk, and managing residual risk—all of which contribute to strengthening resilience and therefore to the achievement of sustainable development.

Disaster risk reduction strategies and policies: Strategies and policies that define goals and objectives across different timescales, with concrete targets, indicators and time frames. ***Note:*** *In line with the Sendai Framework for Disaster Risk Reduction 2015-2030, these should be aimed at preventing the creation of disaster risk, the reduction of existing risk and the strengthening of economic, social, health and environmental resilience (UNGA 2016).*

Disaster risk management: The application of disaster risk reduction policies and strategies to prevent new disaster risk, reduce existing disaster risk and manage residual risk, contributing to the strengthening of resilience and reduction of disaster losses.

Preparedness (emergency): The knowledge and capacities developed by governments, response and recovery organizations, communities and individuals to effectively anticipate, respond to and recover from the impacts of likely, imminent or current disasters. Preparedness action is carried out within the context of disaster risk management and aims to build the capacities needed to efficiently manage all types of emergencies and achieve orderly transitions from response to sustained recovery. Preparedness is based on a sound analysis of disaster risks and good links with early warning systems, and includes such activities as contingency planning, the stockpiling of equipment and supplies, the development of arrangements for coordination, evacuation and public information, and associated training and field exercises. These must be supported by formal institutional, legal and budgetary capacities. The related term "readiness" describes the ability to quickly and appropriately respond when required. ***Note:*** *The WHO terminology uses preparedness and readiness interchangeably and this has been adopted in this document.*

Preparedness plan (emergency): [A plan that] establishes arrangements in advance to enable timely, effective and appropriate responses to specific potential hazardous events or emerging disaster situations that might threaten society or the environment (UNGA 2016).

Risk assessment: 1. The process of determining risks to be prioritized for risk management, by the combination of risk identification, risk analysis, and evaluation of the level of risk against predetermined standards, targets, or other criteria. Note: Risk assessments include a review of the technical characteristics of hazards, an analysis of exposures and vulnerability, and an evaluation of the effectiveness or prevailing coping capacities in respect to likely risk scenarios (WHO 2015b).

2. The identification of environmental health hazards, their adverse effects, target populations and conditions of exposure. A combination of hazard identification, dose–response assessment, exposure assessment and risk characterization (WHO 2009).

3. A three-part process of identifying, recognizing and describing risks; analyzing identified risks to understand the nature, sources and causes to estimate the level of risk; and evaluating each level of risk to determine whether or not it is tolerable or acceptable.

The following term is adopted directly from the ICPD Programme of Action (1994):[4]

Sexual and reproductive health: sexual and reproductive health (SRH) is a state of complete physical, mental, and social well-being (not merely the absence of disease and infirmity) in all matters relating to the reproductive system and its functions and processes. SRH therefore implies that people are able to have a satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide if, when, and how often to do so. Implicit in this last condition are people's rights to be informed and have access to safe, effective, affordable, and acceptable contraceptive methods of their choice, as well as other interventions and strategies for fertility regulation that are not against the law. People should also have the right to access appropriate health care services that will enable women to go safely through pregnancy and childbirth and provide individuals and couples with the best chance of having a healthy infant.

Introduction

Sexual and reproductive health (SRH) needs are not put on pause during emergencies—and often increase due to disruptions to health systems, displacement and breakdowns in societal protection and social structures. Pregnancies, complications, risk of STI and HIV transmission and the wish to access contraceptives do not stop when an emergency strikes. In addition, the risks of unsafe abortions, unsafe deliveries and sexual- and gender-based violence can worsen during times of crisis and exacerbate the existing vulnerability of women, girls, marginalized and underserved groups. To mitigate these risks, access to quality SRH care in emergencies is essential.

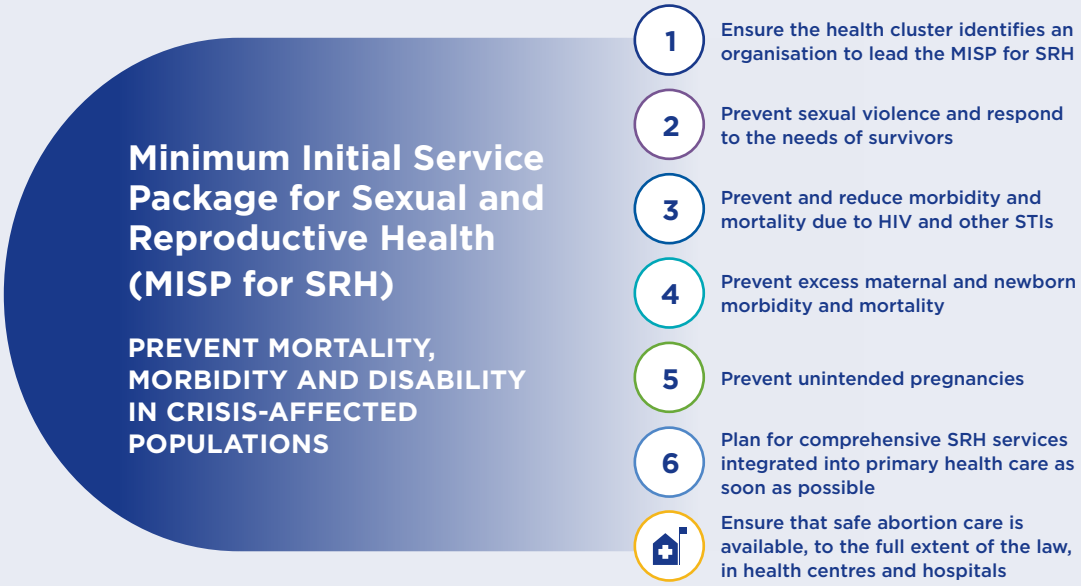
The International Conference on Population and Development (ICPD) in Cairo in 1994 clearly recognized that reproductive health is a basic human right. In 1995, members of the international humanitarian community formed the Inter-Agency Working Group (IAWG) on Reproductive Health in Crises and developed a set of minimum reproductive health interventions to be put in place at the outset of a humanitarian crisis known as the Minimum Initial Service Package (MISP) for SRH. The MISP includes the SRH services that are most important in preventing morbidity and mortality while protecting the right to life with dignity in humanitarian settings. It is one of the chapters of the *Inter-Agency Field Manual (IAFM) on Reproductive Health in Humanitarian Settings*, the authoritative source for global guidance on addressing SRH in emergencies.

Despite recognizing the importance to provide lifesaving SRH care during emergencies and it being acknowledged in international standard documents such as the *Sphere Minimum Standards in Disaster Response*, several evaluations on MISP implementation showed that essential SRH services are still not consistently implemented. Greater efforts are needed to ensure availability of SRH care for all during emergencies and this includes strengthening preparedness efforts.

What is the MISP?

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

For more information, see **IAFM MISP Chapter 3**



Why Assess MISP Readiness?

The momentum for investing in preparedness has grown over the last few years. In 2019, 168 million people were in need of humanitarian assistance—the highest figure recorded in decades.[5] More people are being displaced by conflict as humanitarian crises last longer, climate-related hazards are emerging more frequently, and infectious disease outbreaks and epidemics—which disproportionately hit society's most marginalized and underserved groups—are becoming ever more common.

The importance of crisis preparedness has been acknowledged during the World Humanitarian Summit (2016), notably through the initiative *Global Partnership for Preparedness*.[6] The objectives of the Partnership are to reach an essential level of readiness in order to reduce the suffering and loss of life and dignity from disasters.

Other global frameworks and commitments, such as the *Sendai Framework for Disaster Risk Reduction 2015-2030*, demand for the design of inclusive policies which provide access to basic health care including SRH care. The framework calls for increased attention to resilience, and it identifies health—including SRH—as a critical aspect of strengthening individual and community resilience.[7] SRH preparedness also supports the Sustainable Development Goals (SDGs) and in particular Goal 3 (Ensure healthy lives and promote well-being for all at all ages) and Goal 5 (Achieve gender equality and empower all women and girls). More recently, the World Health Organization's (WHO) operational guidance on COVID-19[8] reiterated that SRH services should be prioritized, and service delivery should be secured.

The WHO Health Emergency Disaster Risk Management (Health-EDRM) Framework (2019) calls for a systematic approach in establishing coordinated preparedness planning and the need to analyze the context, the risks and the capacities in place. The "key steps in developing Health-EDRM strategies and implementing priority actions" (6.1.) of the framework can be adapted to the SRH sector and would include the following components:

- Conduct a risk assessment at all levels (national, sub-national and local) to identify the risks of hazardous events in the country detailed by region
- Assess current SRH readiness and capacity to implement the MISP, which will help to identify strength and areas in need of development for MISP service provision
- Prioritize needed actions by developing and implementing multi-sectoral strategies and action plans with priority actions to improve readiness to implement the MISP

Thus, governments and other national stakeholders need clear plans, trained personnel, supplies and assigned responsibilities on how to continue providing care to the people most at risk. This MISP Readiness Assessment is intended to support this process of preparedness.

PART 1

User Guide

The **MISP Readiness Assessment (MRA)** is for governments, the United Nations, civil society organizations, community-based organizations and private sector actors—particularly those working in the area of SRH and disaster management—to come together and assess the readiness to implement the MISP during an emergency.

What is the MISP Readiness Assessment (MRA)?

The aim of the Minimum Initial Service Package (MISP) Readiness Assessment is to provide a **snapshot of national and/or sub-national readiness and capacity to ensure access to essential SRH services as outlined in the MISP**. It helps to identify key areas that need further investment, and can help as a starting point for structured and targeted SRH preparedness work.

The assessment details a process on how to identify and prioritize areas that need work. It is based on a questionnaire which looks at readiness regarding policy, coordination, data, resources and service delivery across the MISP objectives at national or sub-national level. The MRA Questionnaire builds on all MISP Objectives.

The process calls for a multi-stakeholder effort and strong ownership of national and sub-national government entities. The assessment is relevant for any country, and has been inspired by and adapted from the *MISP readiness assessment tool* (2013, IPPF EN and UNFPA EECARO) and *The Country Assessment and Monitoring Tool for the integration of Sexual and Reproductive Health into Emergency and Disaster Risk Management for Health* (2016, RH working group of the Thematic Platform on Emergency and Disaster Risk Management for Health of the International Strategy for Disaster Reduction).

The MRA includes:

Part 1: User Guide
A detailed User Guide for the lead facilitators outlining a step-by-step approach to the MRA process, which includes the completion of the MRA questionnaire, the prioritization of actions to undertake and the follow-up plans.

Part 2: MRA Questionnaire
A set of questions looking at the following elements:

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

Part 3: Action Plan template
A template to identify prioritized activities which partners will work on in the next 18 months.

Part 4: Guidance for SRH preparedness activities
A list of suggested activities and resources, based on existing literature, which can be reviewed to develop/inspire activities for the action process. The activities should be selected based on responses to the questionnaire and context.

When should the MRA be conducted?

The assessment should be done during stable times when there is the opportunity to complete preparedness activities and integrate them into ongoing activities. It is not intended for use in a response phase of an emergency.

For rapid assessments during the response period, please refer to national tools and the MISP checklist in the IAFM for guidance.

The MRA is intended to complement other preparedness tools such as the *Community Capacity Needs Assessment tools* (ACCESS consortium)[9] designed for working at community level and the toolkit '*Ready to Save Lives: A Preparedness Toolkit for Sexual and Reproductive Health Care in Emergencies*' (FP2020, IPPF, JSI, WRC, UNFPA) which brings together existing learnings, guidance and recommendations for national stakeholders to start working on SRH preparedness. For the transition to comprehensive SRH services in a recovery phase, it is recommended to use the workshop designed by the IAWG on transitioning from the MISP to comprehensive SRH services (currently being finalized).

The following factors are to be considered:

- The assessment focuses on the different objectives of the MISP. That means **good awareness and buy-in from key stakeholders (including the government) for the MISP should ideally exist first.**

- Consider using the assessment as a **follow-up to MISP orientations/trainings**, or where there has been **policy integration**, to ensure improved knowledge is translated into concrete actions.
- The assessment can also be useful to develop **Terms of Reference (ToR) and action plans for SRH coordination groups where they exist.**
- The results of the MRA should **inform countries' disaster risk reduction plan** or also act as a call to **strengthen emergency preparedness and response plans**
- The assessment can form **part of an after-action review process** for emergencies to see how to strengthen preparedness work for future responses.
- The assessment can identify activities relevant to **development and humanitarian plans and agenda**, as part of the humanitarian-peace-development nexus

Who is the MRA User Guide for?

The details in the user guide and accompanying sections are specifically designed for the representatives who will be leading and facilitating the MRA process, but can be relevant for all participants.

MISP Readiness Assessment

Broadly speaking, there are six proposed steps to the process:

1. Identify the lead agency or agencies and the key partners to be involved
2. Prepare the MRA supporting documents
3. Complete the MRA Questionnaire
4. Analyze MRA Questionnaire results and prioritize the gaps to address
5. Develop the action plan
6. Plan the follow-up

The details on each step are outlined here as well as a quick memo checklist for each step.

Conducting the MRA is a **process** in itself and it is very important to go through the different steps which will allow stakeholders to identify the needed preparedness activities and develop a meaningful action plan.

Note: an indicative timeline for planning for the MRA is available in the Annex

Step 1—Identify the lead agency(-ies) and the key partners to be involved

- ☐ **Lead agency/organization identified**
- ☐ **Co-lead agency/organization identified**
- ☐ **Key stakeholders to take part in the MRA are identified**

IDENTIFYING LEAD AGENCY(-IES) AND FACILITATORS

While a successful outcome relies on teamwork, there is a need to have specific organizations to take the lead to ensure an efficient process. The lead is responsible for facilitating the whole process including collecting and inputting the required information. Where possible, it is recommended to have the **Government co-lead the process with UNFPA, IPPF Member Associations or a lead SRH agency available in the area**.

If there is already an SRH coordination group with knowledge of emergencies functioning, it is recommended this group leads the assessment. Where there is no group, a lead agency which has the capacity to convene the different actors required should be chosen.

The lead agency/organization should identify a facilitator who will coordinate and lead the MRA process together with the co-lead. The following expertise is needed:

- Good knowledge of the national and sub-national disaster management systems
- Strong knowledge of the SRH (including MISP) and health systems
- Excellent coordination and collaboration with other national and international stakeholders

Note: *If buy-in and commitment from the government is challenging to get for this process, consider conducting induction trainings or advocacy sessions on the MISP in advance, to ensure key government counterparts have a good understanding of the lifesaving benefits of SRH in emergencies and the need to work on SRH preparedness.*

IDENTIFY KEY PARTNERS TO PARTICIPATE IN THE MRA PROCESS

The lead organizations should identify the key partners to be involved in completing the MRA Questionnaire and developing the action plan.

Partners/participants should be alerted at least **one to two months in advance** of the assessment process to ensure the right focal points are nominated from each agency and they receive the required documents in a timely manner.

Experience has demonstrated that diversity of expertise is key to the success of this process. Partners should include those who are involved in SRH, Health, Protection and Disaster Management, at national or sub-national levels. Ideally, they should be the representatives who would most likely be responsible for the continuation of SRH care and MISP implementation, and as such are interested to invest resources in advance for better preparedness.

Therefore, it is highly recommended to include representatives from:

- Government (including reproductive health experts and emergency disaster risk management experts)—ideally in a leading role
- United Nations agencies
- NGOs
- Community-based organizations and community representatives (e.g., youth leaders, women with disabilities, people with diverse SOGIESC, religious leaders, refugees, people living with HIV, etc.)
- Red Cross/Red Crescent movements
- National professional organization (e.g., midwives associations, Ob-gyns, etc.)
- Academic and training institutes
- Representatives of the private health sector.

Individuals participating should be a mix of policy, administrative/management, medical, and field staff related to the different components of the MISP. Examples could be the Ministry of Social Welfare, which is typically responsible for protection against gender-based violence (GBV) and management of non-clinical aspects of GBV, or national HIV authorities.

The MRA process is also the opportunity to bring together humanitarian and development actors. This contributes to a well-rounded understanding of the local situation and helps leverage each other's knowledge and resources effectively. Bridging humanitarian and development actors also aligns with the humanitarian-peace-development nexus.

Note: *If partners are not familiar with the MISP, consider recommending they complete the MISP Distance Learning Module first or attend a MISP orientation/training*

Step 2—Prepare MRA supporting documents

- ☐ **MRA translation is available (if needed)**
- ☐ **MRA supporting documents are prepared and shared with participants**
- ☐ **Supporting documents for completing the MRA Questionnaire are collected**

CONTEXTUALIZE/TRANSLATE THE MRA

The lead agency/organization, together with the co-lead, should check that the **terminology** used in the MRA is coherent with the national context and that the MRA Questionnaire and guidance documents **are translated** as needed.

PREPARE SUPPORTING DOCUMENTS FOR PARTICIPANTS AND FACILITATORS

Preparing supporting documents in advance will be essential to completing the questions included in the MRA Questionnaire and facilitating a rich discussion during the workshop.

Supporting documents for participants/partners—some general documents

As everyone will have varying degrees of knowledge of the MISP, the following documents can be very helpful to share with the partners in advance:

- The MRA Questionnaire (see page 16)
- MISP Cheat Sheet: provides an overview of the objectives and activities included in the MISP for SRH
- The Interagency Field Manual for Reproductive Health Guide (Chapter 2 and 3): The guidelines for all field practitioners working on SRH in emergencies
- Inter-agency Emergency Reproductive Health Kits (IARH Kits): a manual providing information on use, contents and ordering procedures for a set of reproductive health kits.

Note: *If accessing certain documents is challenging, you may seek out the support of other organizations or experts who could provide this input prior to the workshop or during the time of the workshop*

Note: *A good understanding of the legal context and the cultural and religious habits will be needed to assess whether there are any specific barriers for certain populations like youth, unmarried women, refugees, ethnic minorities etc. to access essential SRH services. Knowledge on barriers and/or restrictive legislations/policies will be useful when conducting the assessment.*

Supporting policy documents for the facilitator(s)

Collecting—and sharing, if needed—relevant country-level policy documents in advance can help ensure a better understanding of the readiness environment amongst participants and facilitate the discussion.

It is suggested that the lead organizations are responsible for collecting the following national and sub-national level documents in advance:

- Any existing national and/or sub-national disaster/emergency policy and plans, Health Emergency plans, Risk Assessment documents, etc.
- Health Information System indicators
- Disaster management system indicators (if available)
- Essential medicines list
- Overall SRH policies/guidelines (including family planning, contraception, adolescents SRH)
- National HIV and STI legislation/policies/operating procedures
- National GBV legislation/ policies/operating procedures
- National abortion legislation/policies/operating procedures
- Existing action plans on SRH preparedness or health/SRH assessments

Step 3—Complete the MRA Questionnaire

- ☐ **An option for completing the MRA Questionnaire has been chosen (Option 1, 2 or 3)**
- ☐ **MRA Questionnaire completed using a multi-stakeholder approach**

The MRA Questionnaire (see page 16) is to be completed as a team composed of the lead agency, co-lead and the key national stakeholders identified under Step 1. The questionnaire is composed of a set of 58 questions that will help assess a country's/region's readiness to implement the MISP for SRH in case of an emergency. The questionnaire can be completed for national level and/or specifically for a sub-national level such as province, region, district, etc.

The completion of the questionnaire and action plan can be done in different ways but will require **bringing partners together at some point in time**. The different options for conducting the exercise include:

Option 1: During a one-off workshop—Conduct a 1.5-day workshop (ideally) that convenes the key partners to fill out the questionnaire, analyze gaps and prioritization, and conclude with a clear follow-up action plan and monitoring plan *(the Annex provides a planning outline for the MRA process)*

Option 2: Over an agreed timeline—Complete each section/s over a period of time. This option would require several shorter meetings over an agreed timeline and may work best where existing SRH coordination groups are in place. The group can discuss the process.

Option 3: Complete first the assessment and then meet to discuss—Another option is to circulate the questionnaire in advance and ask partners to complete sections which are relevant to them. Once this is done, convene a meeting to review and discuss the findings, address gaps and complete the prioritization and action planning.

Note: *It is suggested to share the questionnaire in advance with key stakeholders so they can identify the best process for them.*

STRUCTURE OF THE MRA QUESTIONNAIRE

The questionnaire has three main sections:

Section 0 **General Information—**This section provides information on who completed the questionnaire, the partners involved and the specific geographical area (national or sub-national) the answers of the questionnaire relate to.

- Note: Answers to some of the questions might be very different depending on the location. Therefore, it is very important to highlight if the answers reflect a national or a sub-national reality.

Section I **National-level overall readiness: policies, coordination and resources—**A set of questions focusing on the policy environment, coordination mechanisms, SRH data and financial resources. It includes four sub-sections:

1. National and sub-national Disaster Management policies and plans
2. Coordination Mechanisms for SRH Disaster Management
3. SRH data at national and sub-national level
4. Resources for MISP implementation

- Note: MRA participants with a good understanding and knowledge on policies, disaster risk management, coordination mechanisms and data will be essential

Section II **Readiness to provide services as outlined in the MISP—**A set of questions focusing on the readiness to provide the MISP-related services. Most questions look at existing SRH services (during stable times) to understand how these can be leveraged. It includes six sub-sections:

1. MISP Services—General
2. MISP Objective 2—Prevent sexual violence and respond to the needs of survivors
3. MISP Objective 3—Prevent the transmission of and reduce morbidity and mortality due to HIV and other STIs
4. MISP Objective 4—Prevent excess maternal and newborn morbidity and mortality
5. MISP Objective 5—Prevent unintended pregnancies
6. Other priority activity: Safe abortion care to the full extent of the law
    - Note: MRA participants with medical background (e.g., doctors, nurses, midwives) and technical knowledge on HIV, STI, GBV, maternal and newborn health, contraception and safe abortion care will be essential

FILLING IN THE MRA QUESTIONNAIRE

Most of the questions can be answered by '*yes*', '*no*' or '*don't know*'.

Example:

	Yes	No	Don't know	Comment/Reference/Details
Does your country have a **National Health Preparedness and/or Emergency Response Plan**? *If yes, please specify*				

If you tick '**Don't know**', this highlights a gap of information to be filled in the future. The partners involved in the assessment should agree on how to proceed with these questions and agree on a strategy to gather the missing information.

For most questions a 'Comment/Reference/Details' box is included. It is for participants to elaborate on why a rating was selected.

The **'comment/reference' box** is meant to add important details regarding the national context—for example, the name and details of a policy or explanation of why something is not in place or its current status. The information to be provided in the comment box is crucial and should not be missed.

Some questions require assessing the level to which something is in place. These can be considered as **self-reflection** questions where the team will need to find an agreement on the rating (ideal, minimum needed or insufficient—see example below) based on the information and the contextual knowledge they have. A specific space—like a comment box—is provided to explain the rationale for the rating.

Based on the above, how would you rate the existing health systems ability to provide **HIV and STI Management as outlined in the MISP for SRH** in your area with regards to the following elements:	Ideal	Minimum needed	Insufficient	Comment/Reference *Provide here a rationale for the rating*
Qualified Medical Personnel				
Facilities (e.g., Clinics, safe spaces, etc.)				
Supplies/equipment				

The rating corresponds to the following definitions:

Insufficient = Cannot meet current demand

Minimum needed = Able to manage current demand

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

SPHERE sets out some standards that can be useful and helpful to consider when making these assessments. In the absence of national standards, stakeholders can use these standard indicators as a basis for ratings:

- Minimum one to two community health workers per 1,000 people
- Minimum 23 skilled birth attendant personnel (doctors, nurses, midwives) per 10,000 people
- 80% of health facilities with essential medicines
- All primary health centers report availability of at least four methods of contraception between three and six months after the onset of the crisis
- Basic emergency obstetric and newborn care: minimum five facilities per 500,000 people
- Comprehensive emergency obstetric and newborn care: minimum one facility per 500,000 people

For additional indicators and information, refer to the SPHERE Handbook chapter on **Sexual and Reproductive Health p.327**

Step 4—Analyze MRA Questionnaire results and prioritize the gaps to address

- ☐ **Answers to the MRA Questionnaire are analyzed with key stakeholders**
- ☐ **Capacities, needs and gaps are identified**
- ☐ **Gaps are prioritized using a prioritization methodology**

Once the MRA Questionnaire is completed, the responses need to be translated into actionable preparedness activities. To do so, participants will have to:

- Analyze and reflect on the responses provided in each section and sub-section of the MRA Questionnaire
- Identify existing capacities and assets (mostly questions answered with 'yes' or 'ideal'), as well as the needs and gaps (questions answered with 'no' or 'don't know').
- Identify which areas to focus resources and preparedness efforts on

As it may not be possible to work on all the areas identified as needing support immediately, going through a prioritization exercise will be crucial.

Note: *The services listed under the MISP Objectives are to be considered as the absolute minimum requirements needed to be put in place at the onset of an emergency.*

The success of the prioritization step calls for **structured and well-facilitated discussions**. The role of the facilitator on this step is essential as well as the knowledge on the local context of stakeholders involved.

There are many different ways to work on prioritization and different methodologies can be used and adapted to the context. It is up to the lead agency and co-lead to decide on what method to use to come up with prioritized actions for their action plan.

One suggested approach is to use a methodology inspired from the **MoSCoW methodology**, a technique often used in business and project management to reach common understanding with stakeholders for managing requirements:

Mo MUST HAVE
The most vital things you can't live without

S SHOULD HAVE
Things you consider as important, but not vital

Co COULD HAVE
Things that are nice to have

W WON'T HAVE
Things that provide little to no value you can give up on

The following process is suggested to help develop your action plans:

- Break the questionnaire down by sections (Section I and Section II) and then by sub-sections (see 'Structure of the Questionnaire') and look at the answers focusing on questions where you answered 'no' or 'don't know' to identify gaps and needs. Take the time to look at the questions where you answered 'yes' to identify strengths and existing capacity. The comment box will also provide valuable information and details on the current situation that will help get a better understanding of what is already existing and what is missing (e.g., the type of emergencies covered by the national emergency response plan, information on coordination mechanisms, list of actors responsible for the provision of Maternal and Newborn health, etc.)
- Based on this, write on post-it notes the capacities/assets (based on positive responses, one idea per post-it) and the gaps the assessment revealed (one gap per post-it using a different color)
- Group the post-its by sub-section (e.g., Section I: National and sub-national Disaster Management Policies and Plans, Section I: Coordination Mechanisms for SRH disaster management, Section II: MISP Services General, etc.)
- Break into smaller groups to discuss the gaps identified and decide on the level of importance of each gap by sub-section to be addressed. Decide if the gap should be rated P1, P2, P3 or P4 according to the guidance below:
  - **Priority 1 (P1)—Must have (Mo):** These issues are essential to address to ensure MISP readiness. If these are not available, provision of the MISP during an emergency will not happen.
  - **Priority 2 (P2)—Should Have (S):** Group here the issues that are important, but not essential, and could be done later
  - **Priority 3 (P3)—Could Have (Co):** Group here the issues that would be nice to have but are not absolutely necessary given your context.
  - **Priority 4 (P4)—Won't have (W):** Group here the issues that provide little to no additional value and that do not require action at this point.
- Discuss the results of the rating and the rationale for it in the larger group.
- Get common agreement.
- Then review all the post-its rated P1 and P2. Select the ones that can be addressed/initiated within 12 to 18 months considering availability of opportunities, finances and human resources.
- For the P1 and P2 priorities that cannot be addressed because of lack of resources or other constraints, park them separately and discuss resource mobilization options and other strategies to address these.

Note: *Keep notes of gap areas identified as P3 and P4 and review these when you meet again six months later (see Step 6 on Follow-up)*

Step 5—Develop the action plan

- ☐ **Guidance for SRH preparedness activities reviewed**
- ☐ **Action plan developed and agreed upon as a group**

Developing an action plan is the last step of the assessment process and is a crucial part of the MRA.

The action plan should be developed with the team that completed the MRA Questionnaire. If you decided to complete the MRA Questionnaire during a workshop, the action plan exercise would take place on Day 2.

Note: *In contexts where the active involvement of Ministry of Health and/or Disaster Management authorities are challenging, assessment findings can help inform advocacy strategies towards the government.*

Based on the priority gaps identified in Step 4 (prioritization), partners will have to decide on actions/activities to be undertaken. The '**Guidance for SRH preparedness activities' section** is a compilation of recommended activities based on guidance from key resources and past experiences that will help to inform the next steps and provide ideas on the type of activities that could be proposed in the action plan.

The **action plan** should clearly outline who is responsible for each action item, timelines and resources required. If additional resources need to be mobilized, this should be clearly marked.

See page page 33 for the Action Plan template

Note: *If SRH preparedness Action Plans already exist and are being used, it is suggested to compare and integrate wherever possible to avoid duplication and maximize resources.*

Step 6—Plan the follow-up

- ☐ **Follow-up activities agreed upon**
- ☐ **Responsibilities for monitoring the action plan attributed**
- ☐ **Time frame to reconvene again agreed upon**

To ensure the action plan is progressing, the lead organization, co-lead and partners should put in place a clear process for monitoring and resource mobilization strategies where needed. In contexts where an SRH coordination group exists, updates on the action plan can serve as a standing agenda item.

Once the action plan is finalized, the lead organization and co-lead must ensure that participants agree on:

- who will **monitor** the action plan's implementation
- at what **frequency**
- when the group will **reconvene** to collectively look at the progress made

At minimum, it is advised to schedule a follow-up within **six months** of the action planning process. Also, consider an **annual review process** in line with organizational work planning and budgeting so that necessary key activities are also included.

PART 2

MRA Questionnaire

The following pages in this section of the booklet are presented in landscape orientation so that the Questionnaire can be easily read.

The Questionnaire is also available for download as a Microsoft Word document for interactive use.

General Notes

See "Step 3—Complete the MRA Questionnaire" for guidance.

The purpose of the questionnaire is to assist national and/or local-level stakeholders to assess the readiness to provide the MISP for SRH in emergencies. More specifically, it is to identify areas that need further investment and target the SRH preparedness actions that need strengthening in order to implement a comprehensive MISP during emergencies.

If you are unclear on any questions, please refer to the MISP cheat sheet for further details

MISP Objective 1 (Coordination) and 6 (comprehensive SRH services) are integrated in different sections of the MRA Questionnaire. The other MISP objectives are covered in specific sub-sections.

Overall Structure of the MRA Questionnaire

SECTION 0—GENERAL INFORMATION	

SECTION I—NATIONAL-LEVEL OVERALL READINESS: POLICIES, COORDINATION AND RESOURCES *(related to MISP Objective 1)*	
National and sub-national Disaster Management Policies and Plans	Question 1–7
Coordination Mechanisms for SRH disaster management	Question 8–13
SRH Data at national and sub-national 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, 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 53–57

Section 0—General Information

WHO LED THE ASSESSMENT?	DATE OF THE ASSESSMENT	AT WHAT LEVEL WAS THE ASSESSMENT CONDUCTED? *Hereafter referred to as 'selected area' or 'your location'*	IF SUB-NATIONAL LEVEL, SPECIFY THE PROVINCE, DISTRICT, REGION, ETC:	PARTICIPANTS INVOLVED IN THE ASSESSMENT *(You can attach participants' list)*
		☐ National level ☐ Sub-national level		

Section I—National-Level Overall Readiness: Policies, Coordination And Resources

(related to MISP Objective 1)

#		Yes	No	Don't know	Comment/Reference/Details
NATIONAL AND SUB-NATIONAL DISASTER MANAGEMENT POLICIES AND PLANS					
1	Does your country have a **National Emergency Preparedness and/or Response Policy and/or Plan**? *If yes, please specify and mention in the comment box the type of emergencies it covers (e.g., natural hazard, conflict, public health emergencies, etc.)*				
2	Does your country have a **National Health Preparedness and/or Emergency Response Plan**? *If yes, please specify*				
3	Are these plans rolled out at **sub-national level**? *If yes, please specify*				

4	Is **SRH and/or the MISP** integrated into any **national** or **sub-national emergency health response policy and/or plan**? *If yes, please specify if all MISP components are integrated as well as the title, the region and year or the policy/plan.*				
5	Are there any SRH policies or plans that include provisions for **disaster management and/or emergency response**? *If yes, please specify*				
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.)? *If yes, please list which populations*				
7	To your knowledge, is **SRH included in recovery plans** when response moves from acute to more comprehensive services?				

COORDINATION MECHANISMS FOR SRH DISASTER MANAGEMENT					
8	Is there a **coordination mechanism** responsible for **disaster management** during crisis? *If yes, which one and mention in the comment box the type of emergencies it covers (e.g., natural hazard, conflict, pandemics, etc.)*				
9	In this disaster management mechanism, is there an entity responsible for **health, including SRH and GBV**, during response? *If yes, please specify*				

10	Is there a coordination mechanism (e.g., SRH working group) to discuss SRH in Emergencies at the **national level** when it comes to: *If yes, please specify which one(s) in the comment box, mention the frequency of the meetings, and the type of emergencies covered by the group*				
	Preparedness				
	Response				
	Recovery				
11	Is there a structure/coordination mechanism (e.g., SRH working group/ disaster committee) to discuss SRH in Emergencies at the **sub-national level** when it comes to: *If yes, please specify which one(s) in the comment box, mention the frequency of the meetings, and the type of emergencies covered by the group*				
	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? *If yes, please specify in the comment box*				
13	Are civil society organizations and community-based organizations working/ representing marginalized and underserved groups (e.g., women and men with disabilities, people living with HIV, people of diverse SOGIESC, youth groups, religious leaders, sex workers, ethnic minorities, etc.) included in the coordination mechanisms? *If yes, please specify and list participants*				

SRH DATA AT NATIONAL AND SUB-NATIONAL LEVEL					
14	Do current risk assessments address impacts on different populations (e.g., women, people with disabilities, People living with HIV, people of diverse SOGIESC, youth, sex workers, ethnic minorities, etc.) *If yes, please specify in the comment section.*				
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? *If yes, please specify the type of questions in the comment section*				
17	Do data collection tools (e.g., Health forms) for emergency response include MISP-related indicators (see MISP Checklist)?				
RESOURCES FOR MISP PREPAREDNESS AND IMPLEMENTATION					
18	Do mechanisms for **rapid mobilization of funds** exist to support an SRH response? (e.g., contingency funds, country-based pooled funds, etc.) *If yes, please specify in the comment box*				
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.)? *If yes, please specify*				
20	Do you have **warehouses or storage facilities** where medical supplies for SRH are prepositioned or could be stored? *If yes, please specify*				
21	Are there any **funds** to support health and/or SRH **emergency preparedness** at the national or sub-national level? *If yes, please specify*				

Section II—Readiness to Provide Services as Outlined in the MISP

Note: *The questions in this section are assessing the situation during stable times to better understand what can be leveraged during emergencies.*

MISP SERVICES—GENERAL					
#		Yes	No	Don't know	Comment/Reference/Details
22	Are all the SRH commodities needed for MISP implementation (see IARH kit booklet) part of the national **essential medicines list**? *If no, please specify the ones where there are no equivalent available and may affect MISP implementation*				
23	Do you have the systems in place to support **remote delivery of services** (e.g., 21digital health, telemedicine, online consultation, etc.)? *If yes, please specify which in the comment box*				
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? *If yes, please specify in the comment box*				
25	Do the **health care training curriculum or other relevant trainings**, including on online platforms, for health staff integrate health emergency management and/or the MISP? *If yes, specify which one: nursing, doctors, midwives, etc.*				
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) *If yes, please specify in the comment box*				
27	Do **health response teams** contain specialist SRH providers?				
28	Are there **diverse communication channels** (e.g., radio, text messaging, WhatsApp, etc.) available which can be leveraged to inform the community on the availability of MISP-related services in case of an emergency? *If yes, specify what these are and how hard-to-reach populations are being considered.*				

29	Are there any barriers for marginalized and underserved 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? *Please clarify which in the comment box*				
30	Are there provisions for **free access** to health services (consider the MISP) for crisis-affected populations? *Please specify in the comment box*				

MISP OBJECTIVE 2—PREVENT SEXUAL VIOLENCE AND RESPOND TO THE NEEDS OF SURVIVORS			
		Answer	Comment
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? *Please list all agencies (e.g., name of the government unit, INGOs, civil society, community-based organization, private sector, etc.)*		
32	Are **safe, private, and confidential spaces**[10] identified and available which are accessible for survivors of GBV? *If yes, please specify*		
33	Is there a clear up-to date **referral system**, which links the various GBV service poviders (e.g., health, GBV case management, legal, potection etc) that can be leveraged during emergencies? *If yes, please specify*		
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)	*Please specify the type of health facility—e.g., Health post, Primary health center, Referral hospital—district, Referral hospital—province, Referral hospital—national, Private clinics, other*	
	Emergency Contraception (EC)		
	Pregnancy testing, pregnancy options information		

	Antibiotics to prevent and treat STIs				
	Post-exposure prophylaxis (PEP)				
	HepB vaccine				
	Care of wounds and prevention of tetanus (Tetanus toxoid/Tetanus immunoglobulin)				
	Psychosocial support				
	Safe abortion care/referral to safe abortion care (to the full extent of the law)				
	Forensic evidence collection				
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**?	Yes	No	Don't know	Comment/Reference
	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				
	Clinical care and referral to other supportive services available for survivors of sexual violence (e.g., legal, protection, psychosocial, shelter, etc.)				
	Confidential and safe spaces within the health facilities to receive and provide survivors of sexual violence with appropriate clinical care and referral				
	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:	Ideal	Minimum needed	Insufficient	Comment/Reference *Provide here a rationale for the rating*
	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)				

MISP OBJECTIVE 3—PREVENT THE TRANSMISSION OF AND REDUCE MORBIDITY AND MORTALITY DUE TO HIV AND OTHER STIS			
		Answer	Comment
37	Which actors are **responsible** for ensuring the provision of **HIV services** in the selected area? *Please list all agencies (e.g., name of the government unit, INGOs, civil society, community-based organization, private sector, etc.)*		
38	Which actors are **responsible** for ensuring the provision of **STI services** in the selected area? *Please list all agencies (e.g., name of the government unit, INGOs, civil society, community-based organization, private sector, etc.)*		
39	Is there a clear, up-to-date **referral system** for **HIV/ARV** services that can be leveraged during emergencies? *If yes, please specify.*		
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)	*Please specify the type of health facility, e.g., Health post, Primary health center, Referral hospital—district, Referral hospital—province, Referral hospital—national, Private clinics, other*	
	ARV		
	Syndromic management of STI		

	Prevention of mother-to-child transmission (PMTCT)				
	Condom Distribution				
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**?	Yes	No	Don't know	Comment/Reference
	Safe and rational blood transfusion in place				
	Standard precautions[11] consistently practiced				
	Availability of free lubricated male condoms and where applicable female condoms				
	ARVs for continuing users				
	ARVs for women enrolled in PMTCT programs				
	PEP to survivors of sexual violence as appropriate and for occupational exposure				
	Provision of co-trimoxazole prophylaxis for opportunistic infections for patients found to have HIV or already diagnosed with HIV				
	Availability in health facilities of syndromic treatment of STIs				
	Existence of IEC materials and STI/HIV counseling 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:	Ideal	Minimum needed	Insufficient	Comment/Reference *Provide here a rationale for the rating*
	Qualified Medical Personnel				
	Facilities (e.g., Clinics, hotlines, etc.)				
	Supplies/equipment				

MISP OBJECTIVE 4—PREVENT EXCESS MATERNAL AND NEWBORN MORBIDITY AND MORTALITY					
		Answer			Comment
43	Which actors are **responsible** for ensuring **the provision of Maternal and Newborn services** in the selected area? *Please list all agencies (e.g., name of the government unit, INGOs, civil society, community-based organization, private sector, etc.)*				
44	Is there a clear up-to-date Emergency Obstetric and Neonatal Care (EmONC) **referral system** that can be leveraged during emergencies ? *If yes, please specify (e.g., MoUs with hospitals, ambulance available, phone numbers shared, back-referral structure, etc.)*				
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)	*Please specify the type of health facility, e.g., Health post, Primary health center, Referral hospital—district, Referral hospital—province, Referral hospital—national, Private clinics, other*			
	Skilled birth attendance				
	Basic EmONC[12]				
	Comprehensive EmONC[13]				
	Post-abortion care				
	24/7 Ambulance/transport service				
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**?	Yes	No	Don't know	Comment/Reference
	At referral hospital level: Skilled medical staff and supplies for provision of comprehensive emergency obstetric and newborn care (CEmONC)				

	At health facility level: Skilled birth attendants and supplies for vaginal births and provision of basic obstetric and newborn care (BEmONC)				
	At community level: Provision of information to the community about the availability of safe delivery and EmONC services and the importance of seeking care from health facilities.				
	24 hours per day, 7 days per week referral system for obstetric complications				
	Availability of post-abortion care in health centers and hospitals				
	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				
	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:	Ideal	Minimum needed	Insufficient	Comment/Reference *Provide here a rationale for the rating*
	Qualified Medical Personnel (e.g., Skilled Birth Attendance, BEmONC, CEmONC)				
	Facilities (e.g., Clinics,hospitals, etc.)				
	Supplies/equipment				

MISP OBJECTIVE 5—PREVENT UNINTENDED PREGNANCIES					
		Answer			Comment
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? *Please list all agencies (e.g., name of the government unit, INGOs, civil society, community-based organization, private sector, etc.)*				
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? *If yes, please specify*				
50	Which **level of health facilities** can provide the following **contraceptives to prevent unintended pregnancies** in the selected area? (consider the lowest level)	*Please specify the type of health facility, e.g., Health post, Primary health center, Referral hospital—district, Referral hospital—province, Referral hospital—national, Private clinics, other*			
	Male and Female (where already used) Condoms				
	Oral Contraceptive Pills				
	Intra-uterine device (IUD)				
	Injectables				
	Implants				
	Emergency Contraception (EC)				
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**?	Yes	No	Don't know	Comment/Reference
	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				

	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:	Ideal	Minimum needed	Insufficient	Comment/Reference *Provide here a rationale for the rating*
	Qualified Medical Personnel				
	Facilities (e.g., Clinics, pharmacies, hotlines, etc.)				
	Supplies/equipment				

OTHER PRIORITY ACTIVITY: SAFE ABORTION CARE TO THE FULL EXTENT OF THE LAW

#		Yes	No	Don't know	Comment/Reference
53	Are there any situations in your context in which safe abortion care can be provided? *If yes, specify the provisions stated in the national law and policies* *If no, please include the legal language in the policy/legal documents (you can then skip questions 54-58)*				
		Answer			Comment
54	Which actors are **responsible** for ensuring the provision of safe abortion care in the selected area? *Please list all agencies (e.g., name of the government unit, INGOs, civil society, community-based organization, private sector, etc.)*				
55	Is there a clear **referral system** that can be leveraged during emergencies? *If yes, please specify*				
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)	*Please specify the type of health facility, e.g., Health post, Primary health center, Referral hospital—district, Referral hospital—province, Referral hospital—national, Private clinics, other*			
	Medication abortion				
	Vacuum aspiration, dilatation and evacuation				
	Induction procedures as recommended by WHO				
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:	Ideal	Minimum needed	Insufficient	Comment/Reference *Provide here a rationale for the rating*
	Qualified Medical Personnel (e.g., trained on medical procedures, abortion values clarification *and attitude transformation*)				
	Facilities (e.g., Clinics, hotlines, etc.)				
	Supplies/equipment				

PART 3

Prioritized Action Plan

(See "Step 4—Analyze MRA Questionnaire results and prioritize the gaps to address" and "Step 5—Develop the action plan" for further guidance)

- The action plan focuses on the gaps identified as P1 and P2 in the 'prioritization' exercise (see Step 4 in the User Guide).
- Activities should be developed for each P1 and P2 selected. Focus on activities which can be done in the next 12 to 18 months.
- List activities where budget is available and partners will be part of the contribution. For the ones where budget is not yet available, develop resource mobilization activities.
- Refer to the 'Guidance & Suggested Activities' section when developing the proposed activities.
- The workplan should be reviewed every 6 months.

The Prioritized Action Plan is also available for download as a Microsoft Word document for interactive use.

PRIORITY LEVEL	IDENTIFIED GAP AND SECTION	PROPOSED ACTIVITIES	LEAD AGENCY/ PARTNERS	TIMEFRAME	RESOURCES	EXPECTED RESULTS
P1	*Specify the gap and the section from the MISP readiness assessment your activities will address*	*You can list here as many activities as needed*	*Include the partners in charge of each action*		*Specify budget source (e.g., partners contribution)*	
P1	Insufficient number of nurses/ midwives trained to provide Basic Emergency Obstetric and Newborn Care (BEmONC) services	Refresher training for nurses/ midwives from tertiary institutions and primary health care centers on BEmONC	Nurses association	Dec 2020	Training materials/ facilitators (UNFPA)	More qualified staff available to provide BEmONC services during emergencies

PART 4

Guidance for SRH preparedness activities

(See "*Step 5—Develop the action plan*" for further guidance on how to use this section)

The MRA Questionnaire provides an overview of the potential readiness to implement the MISP based on current availability of services at the time of the assessment. It allows stakeholders to identify strengths with regards to SRH preparedness and the areas that need to be reinforced. While every context is different and specific, there are some key elements to consider when working on SRH preparedness.

The Guidance is also available for download as a Microsoft Word document for interactive use.

General Notes

The section below outlines activities and resources which can be used to develop the action plan activities based on responses to the MRA Questionnaire rated as 'insufficient', 'no', or 'don't know'. The are based on guidance and learnings from existing resources. More comprehensive information and tools can be found in the supporting list of resources. This section is not intended as an exhaustive list but it can be used for inspiration and adaptation to your context.

The guidance is structured around the different sections of the questionnaire (Section I and Section II).

In addition, the following overarching resources are useful to learn more from various country examples that implemented SRH preparedness activities:

- **Improving readiness to provide the MISP of SRH care during a humanitarian crisis in EECA—Results of the 2nd MISP Readiness Assessment 2014-2017** (IPPF EN/UNFPA, 2018)
- **Ready to Save Lives—A preparedness toolkit for Sexual and Reproductive Health Care in Emergency** (FP2020, IPPF, JSI, WRC, UNFPA, 2020)

The **MRA Questionnaire** can be considered as a **starting point** to work on SRH preparedness and helps to get a better understanding of the situation. More in-depth follow-up might be needed on specific areas (e.g., GBV, logistics, HIV, etc.) to address some of the identified gaps. Additional useful resources and tools are listed in this section.

Section I—National-Level Overall Readiness: Policies, Coordination and Resources

Specific activities and resources are outlined per sub-section of Section I of the MRA Questionnaire.

National and Sub-National Disaster Management Policies and Plans

Ensuring the **National and sub-national disaster management policies and plans include** the needed provisions to provide SRH care as outlined in the MISP for SRH during an emergency.

If in the questionnaire you answered mostly 'no' or 'don't know' to the questions from the section '***National and sub-national Disaster Management Policies and Plans'*** (Q1-7), it identifies that SRH is not part of your current disaster management plans.

Consider integrating SRH into key policies and plans to help ensure MISP is part of emergency response planning. To improve national and sub-national policies, strong advocacy strategies with robust partnerships will be needed.

» Suggested activities to support SRH integration into national disaster management systems:

- Map which policies and plans to target for MISP for SRH integration
- Identify restrictive policies and advocate for improvements
- Explore opportunities and track when policies are being revised to advocate for MISP/SRH integration
- Advocate for the inclusion of SRH into existing contingency plans
- Build relationships with key national government counterparts
- Build the knowledge on the importance of having lifesaving SRH care during emergencies—consider using the MISP policy makers workshop manual
- Involve government representatives from relevant ministries in trainings on Sexual and Reproductive Health in Emergencies and events to create policy champions

Key Resources:

- Integrating sexual and reproductive health into emergency and disaster risk management for health: Policy Brief (IAWG, 2020) (currently in draft format)
- Disaster Risk Management for Health: Sexual and Reproductive Health: Fact Sheet (IAWG, 2020) (currently in draft format)

- 'Learning Brief on Integration' from the *Ready to Save Lives—A preparedness toolkit for Sexual and Reproductive Health care in Emergencies* (FP2020, IPPF, JSI, WRC, UNFPA, 2020)

Coordination Mechanisms for SRH Disaster Management

The **coordination mechanisms for SRH emergency preparedness** are existing and functional.

» Suggested Activities to establish and/or strengthen effective SRH coordination bodies:

- Consider integrating preparedness and response into existing SRH coordination mechanisms/ technical working groups or establish a specific coordination groups for supporting emergencies
- Establish relationship and cooperation with other relevant sectors (e.g., HIV, protection, GBV, health professional groups—like midwife associations and Ob-gyn associations.)
- Collaborate and meaningfully include community-based organizations working with marginalized and underserved groups (e.g., women and girls, youth networks, people with disabilities, people of diverse SOGIESC, PLHIV, ethnic minorities, religious leaders, etc.)
- Ensure the SRH working group works effectively by:
  - Having clear ToR with defined roles and responsibilities for the working group
  - Meeting on a regular basis
  - Having a joint yearly action plan with lines of accountability and regular monitoring
  - Having key partners (including government, community-based organizations, NGOs, UN and first responders)—employing a multi-sector approach—on board
  - Having a dedicated budget
  - Including members from marginalized groups to ensure inclusiveness
  - Having a clear activation system in place in case of an emergency
- Use existing SRH Focal Points to leverage work on SRH emergency preparedness

If you answered mostly 'no' or 'don't know' in the questionnaire to the section '***Coordination Mechanisms for SRH emergency preparedness'*** (Q8-13), it identifies a lack of SRH coordination.

Coordination during any emergency is instrumental and will contribute to better responses and more efficient use of resources. In order for coordination mechanisms to be efficient, it is best if they are set up prior to any emergency to ensure effective collaboration on preparedness and response.

Key Resources

- 'Learning Brief on Coordination' from the Ready to Save Lives—A preparedness toolkit for Sexual and Reproductive Health care in Emergencies (FP2020, IPPF, JSI, WRC, UNFPA, 2020)

SRH Data at National and Sub-National Level

SRH-related information and data are available and monitored closely.

If you answered mostly 'no' or 'don't know' in the questionnaire to the section ***'SRH data at national and sub-national level'*** (Q14-17), it identifies that existing assessments and data do not collect essential SRH data which would be needed to shape MISP responses.

Consider working during preparedness to integrate key questions and indicators into relevant forms to ensure essential data on SRH is not lost during response. It will help lead to more effective programming and evidence.

» Suggested Activities to improve availability of SRH-related data:

- Include essential SRH questions into risk assessment and rapid assessment forms
- Ensure health data collection tools used during the response to capture key MISP data and indicators
- Ensure sex-, age- and disability-disaggregated data is collected to ensure marginalized and underserved groups can be identified
- Advocate for the integration of SRH indicators in the existing health information systems (HIS)

Key Resources:

- MISP Checklist (IAWG, 2020)
- Inter-Agency Field Manual on Reproductive Health in Emergencies (IAWG, 2018)

- Demographic and Health Survey (DHS), if available, to inform preparedness activities to meet response needs
- National or district HIS, if available, or other routine surveillance or health facility data
- Any rapid assessment tools including MICS (Multiple Indicator Cluster Survey), or vulnerability or health assessments

Resources for MISP Preparedness and Implementation

The cross-cutting resources for the implementation of the MISP are in place.

If you answered mostly 'no' or 'don't know' in the questionnaire to the section '***Resources for MISP preparedness and implementation***' (Q18-21), this identifies the gaps in the capacity to shift in a timely manner from stable times to emergencies regarding availability of commodities, equipment, human resources and/or funding.

While it is impossible to know precisely what is needed in advance for response, this is a chance to reflect on how existing disaster management systems may be leveraged or adapted specifically for health and SRH service delivery (e.g., surge rosters, procurement agreements, etc.)

» Suggested activities to strengthen availability of resources:

- Map existing rapid mobilization of funds at country level, like country-based pooled funds, government contingency funds or national emergency funds
- If UN humanitarian systems are functioning, create links with key agencies such as UNFPA, WHO, UNHCR, UNICEF to raise awareness on SRH needs and ensure inclusion in Humanitarian Response Plans (HRPs) and contingency plans
- Coordinate with the private sector and business industry to identify opportunities for response support, such as in logistics and getting additional staff
- Map opportunities for both local and international rapid sourcing of supplies and equipment (including warehousing) needed for MISP implementation
- Test coordination and existing response mechanisms through regular simulations
- Advocate towards the government and donors to secure funding for SRH preparedness activities

Section II—Readiness to Provide Services as Outlined in the MISP

This section of the questionnaire starts with some general questions (Q22-30) and then goes through each component of the MISP individually (Q31-58). It allows stakeholder to have an overview of the readiness to provide MISP-related services. It also helps identify which components of service provision need to be strengthened during preparedness. As there are many common elements to ensuring adequate service provision, this section will focus on providing an overall guidance.

When reviewing the questions, focus on the ones you rated as 'no' and 'insufficient'. The questions on availability of services for each MISP objective and at different facility levels will help you develop more targeted activities.

Some suggested activities to ensure availability of MISP-related services during an emergency are outlined below:

» Suggested activities to secure MISP-related services: POLICIES & LEGISLATION

Check if national legislation and policy include specific guidance on SRH during emergencies and cover the following topics as outlined in the MISP:

- prevention and response to sexual violence
- reducing HIV transmission and meeting STI needs
- providing priority maternal and newborn health services in crises
- 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
- Access to safe abortion care to the full extent of the law

- Disability-inclusive, youth-friendly and non-discriminatory SRH services, including for refugees, undocumented migrants and internally displaced people.

» Suggested activities to secure MISP-related services: LOGISTICS & SUPPLIES

- Assess the range and quality of SRH products available locally
- Pre-position IARH kits, if feasible, or relevant supplies, medicines and equipment as adequate given the context
- Develop standby agreements for vendors and transporters
- Identify warehouse and storage space
- Ensure staff are aware and trained on IARH kit content, relevant supplies and equipment

» Suggested activities to secure MISP-related services: WORKFORCE

- Advocate for an agreement with the Ministry of Health for rapid mobilization of staff and review or organize shifting policies for emergencies
- Develop job descriptions and ToR of key positions ready for dissemination at the onset of an emergency
- Establish a surge roster tailored to the context
- Map skilled medical staff to provide MISP-related services
- Ensure that knowledge on different MISP components is up-to-date and provide refresher trainings where needed
- Collaborate with relevant ministries and identify medical training curriculums where MISP-specific components can be integrated, such as in the curriculums for midwives, nurses, doctors, etc.
- Consider opportunities for the accreditation of trained health providers on the MISP
- Suggest that all emergency response staff, especially surge staff, become certified in the MISP Distance Learning Module
- Organize refresher trainings for service providers—ideally at least every two years –using the training courses developed by the IAWG Training Partnership Initiative 'SRH Clinical Outreach Refresher Trainings (S-CORTs)', which was designed for humanitarian contexts.

» Suggested activities to secure MISP-related services: PUBLIC AND PRIVATE MEDICAL FACILITIES

- Map the number, type, location of medical facilities that offer MISP-related services
- Map accessibility of existing medical facilities for people with disabilities, people living in remote areas, young people, community groups, etc.
- Map functionality of existing health facilities, particularly in high-risk areas (e.g., refer to IAWG Health facility checklist)

» Suggested activities to secure MISP-related services: SERVICE PROVISION

- Develop and adapt medical protocols for emergency contexts
- Develop/pilot community-based and self-care approaches (e.g., Self-care interventions for SRHR)
- Consider preparing for remote service delivery, such as telemedicine, online consultation, mobile outreach delivery, community health workers and task shifting
- Map referral pathways and providers for MISP-related care
- Invest during the preparedness process in supportive supervision, mentoring values clarification exercises for program staff and health professionals—particularly to address stigmatized SRH service areas such as safe abortion, contraception, GBV, etc.) and refresher trainings to equip health providers to confidently provide quality care that is stigma-free and inclusive during response

» Suggested activities to secure MISP-related services: COMMUNITY ENGAGEMENT

- Develop a relationship with community-based organizations (focusing on women-led groups), marginalized and underserved groups (e.g., disabled people organizations, SOGIESC organizations, PLHIV networks, etc.) during the design of response plans, communication systems, establishment of response teams and work out innovative approaches for service delivery models
- Focus on women-led groups and community-based organizations to ensure they are included in reviewing referral pathways, design and delivery of health programming
- Keep in mind the 'do no harm' and 'leave no one behind' principles every step of the process

» Suggested activities to secure MISP-related services: COMMUNICATION

- Work with communities to identify appropriate communication channels for use during emergencies to inform the community on:
  - services for the survivors of sexual violence
  - STI treatment services
  - Access to ARV
  - availability of safe delivery and EmONC services
  - voluntary contraceptives and family-planning services in the case of an emergency
- Develop information material accessible for people with learning disabilities, visual impairment, hearing impairment, etc. and in other languages or dialects

» Suggested activities to secure MISP-related services: IEC MATERIAL

- Prepare culturally appropriate messages in local language and accessible for all, including for people with disabilities
- IEC materials on contraceptive counseling services which emphasizes informed choice, effectiveness, and supports client privacy and confidentiality in case of emergency
- IEC materials on safe abortion care available to the full extent of the law

Key Resources

LOGISTICS AND SUPPLIES:

- Inter-Agency Emergency Reproductive Health Kits Manual (IAWG, 2011)
- Reproductive Health Kits Management Guidelines for Field Offices (UNFPA)
- Inter-Agency Reproductive Health (IARH) Kits Country Forecasting Tool (JSI/UNFPA, 2020)
- Supply Chain Manager's Handbook (JSI, 2019)
- Continuity of Operations Guide for SRH in Emergencies (JSI, forthcoming)

WORKFORCE:

- MISP Distance Learning Module (IAWG/WRC, 2019)
- IPPF face-to-face training manuals on the MISP (2020)
- IAFM (IAWG, 2018)
- IAWG Training Partnership Initiative (TPI) Refresher Modules: TPI Modules

SERVICE PROVISION

- Interagency Field Manual for Reprodtive Health in Crisis (IAFM) (IAWG, 2018)
- WHO Guidelines on Task Shifting (WHO, 2008)
- WHO consolidated guideline on self-care interventions for health: sexual and reproductive health and rights (WHO, 2019)
- GBV Area of Responsibility website (GBV AoR) with latest resources on GBV in Humanitarian Settings—including for preparedness and response of health services[14]

PUBLIC PRIVATE FACILITIES

- IAWG Health Facility Checklist (IAWG, 2017)

COMMUNITY ENGAGEMENT

- Adolescent Sexual and Reproductive Health Toolkit for Humanitarian Settings (IAWG Adolescent Sexual and Reproductive Health Sub-Working Group, Save the Children, UNFPA, 2016)

IEC MATERIAL

- IAWG Universal IEC templates (IAWG, Women's Refugee Commission, 2016)

ANNEX

Planning the MRA

It is recommended to plan the MRA workshop well in advance and keep track of the necessary logistics needed for the workshop—such as participant selection, translation and venue organization.

The table below outlines the type of activities to consider prior to, during and after the workshop. It can be adapted to best fit each context:

Step 1
Identify the lead agency(-ies) and the key partners to be involved

Step 2
Prepare the MRA supporting documents

Step 3
Complete the MRA Questionnaire

Step 4
Analyze MRA Questionnaire results and prioritize the gaps to address

Step 5
Develop the action plan

Step 6
Plan the follow-up

TIMING	WHAT? (ACTIVITY)
1 to 2 months before the workshop Check: ☐ STEP 1 ☐ STEP 2	• Identify a lead agency/organization as well as a facilitator who will lead the MRA process (see Step 1) • Identify co-facilitators (see Step 1) • Identify key partners to be involved (see Step 1) • Based on partner profiles, consider whether an MISP orientation/training will be needed in advance. Ascertain if a site visit will be beneficial and plan accordingly. • Decide process for questionnaire completion and action planning (see Step 3) • Develop and send out invitation letters, including a brief description of the process as well as the key objectives of the workshop • Select workshop participants, ensuring that come from different groups, including the underserved (e.g., youth leaders, women with disabilities, people with diverse SOGIESC, religious leaders, refugees, people living with HIV, etc.) • Ensure terminology used in the MRA is adequate with the context and organize translation where needed (see Step 2) • Prepare supporting documents for facilitators such as policies, guidelines, etc. (see Step 2) • Prepare an agenda/facilitation plan with the co-facilitators • Identify and confirm the training venue and, if required, any administrative and logistical arrangements such as travel, accommodation, per diems and catering
2 weeks before the workshop Check: ☐ STEP 2	• Review and confirm final list of participants • Review and confirm final list of facilitators • Send participants the MRA general supporting documents (see Step 2) to read and familiarize themselves with before the workshop (e.g., MISP cheat sheet, sheet, MRA Questionnaire, etc.) • Prepare workshop materials and equipment as required • Finalize all administrative and logistical arrangements
One or two days before the workshop	• Meet with the co-facilitator to go through the schedule, make final arrangements, prepare copies of the MRA, etc.

MRA Workshop (1.5 to 2 days) Check: ☐ STEP 3 ☐ STEP 4 ☐ STEP 5 ☐ STEP 6	**Day 1:** • Complete the MRA Questionnaire (Step 3) • Discuss the answers in small groups or in plenary depending on the number of participants (Step 4) • Facilitators to analyze group responses to the questions **Day 2:** • Facilitators to share/confirm analysis from questionnaire • Conduct prioritization exercise (STEP 4) • Review activity guide and develop joint Action Plan (STEP 5 and Guidance for SRH Preparedness Activities) • Agree on follow-up actions (STEP 6) **Optional (may affect length of workshop):** • Consider a MISP Orientation before starting the questionnaire depending on participant knowledge • Consider site visits for participants to aid in understanding of readiness
Within 6 Months after the Workshop Check: ☐ STEP 6	• Conduct survey/workshop to follow up on action plan • Discuss with the team/participants/stakeholders progress made • Revise Action Plan as needed • Agree on next review of the Action Plan, which should be within the next 6 months

Endnotes

1. IPPF EN and UNFPA EECA, *Improving Readiness to Provide the Minimum Initial Service Package of Sexual and Reproductive Health Care During a Humanitarian Crisis in Eastern Europe and Central Asia: Results of the 2nd MISP Readiness Assessment 2014–2017* (IPPF EN and UNFPA EECA, 2018).
2. WHO Glossary of Health Emergency and Disaster Risk Management Terminology. Geneva: World Health Organization; 2020.
3. WHO Glossary of Health Emergency and Disaster Risk Management Terminology. Geneva: World Health Organization; 2020.
4. United Nations Population Fund (UNFPA), Programme of Action adopted at the International Conference on Population and Development, Cairo, 5–13 September 1994, 20th Anniversary Edition (New York: UNFPA, 2014).
5. Global Humanitarian Overview 2020, OCHA 2019
6. https://www.agendaforhumanity.org/initiatives/3840
7. United Nations Office for Disaster Risk Reduction, Sendai Framework for Disaster Risk Reduction 2015-2030 (Geneva. 2015). http://www.unisdr.org/we/coordinate/sendai-framework
8. COVID-19: Operational guidance for maintaining essential health services during an outbreak Interim guidance 25 March 2020, WHO 2020, https://apps.who.int/iris/bitstream/handle/10665/331561/WHO-2019-nCoV-essential_health_services-2020.1-eng.pdf?sequence=1&isAllowed=y
9. Approaches in Complex and Challenging Environments for Sustainable Sexual and Reproductive Health and Rights (ACCESS), Capacity Assessment Tools to Build Community Resilience, Draft for pilot-testing, May 2020.
10. A safe space is a formal or informal place where women, girls and marginalized populations feel physically and emotionally safe
11. Infection control measures that reduce the risk of transmission of blood-borne and other pathogens through exposure of blood or body fluids among patients and health workers
12. See 7 signal functions outlines in MISP Chapter of the IAFM table 9.1
13. See 9 signal functions outlines in MISP Chapter of the IAFM table 9.1
14. The GBV AoR brings together non-governmental organizations, UN agencies, academics and others under the shared objective of ensuring lifesaving, predictable, accountable and effective GBV prevention, risk mitigation and response in emergencies, both natural disaster and conflict-related humanitarian contexts.