HEALTH CLUSTER

AMHARA AND TIGRAY, ETHIOPIA

The Minimum Initial Service Package for Sexual and Reproductive Health

IMPLEMENTATION EVALUATION

JUNE 2025

Summary

The implementation of the Minimum Initial Service Package (MISP) for Sexual and Reproductive Health in Ethiopia's conflict-affected Amhara and Tigray regions has been uneven, constrained by insecurity, damaged infrastructure, and limited funding.

While Tigray has shown stronger coordination, both regions face critical service gaps in maternal care, human immunodeficiency virus (HIV) prevention, and gender-based violence (GBV) response. Stigma, weak referral systems, and insufficient provider training continue to hinder access. A more integrated, inclusive, and well-resourced approach is urgently needed to ensure sustainable, effective sexual and reproductive health (SRH) services.

What is the MISP?

The **Minimum Initial Service Package (MISP) for SRH in Crisis Situations**, developed by the Inter-Agency Working Group on Reproductive Health in Crisis (IAWG), comprises the *minimum*, lifesaving sexual and reproductive health needs that humanitarians must address at the onset of an emergency (within 48 hours wherever possible). It includes six key objectives: 1) coordination, 2) preventing sexual violence, 3) reducing HIV/STI transmission, 4) preventing unintended pregnancies, 5) ensuring safe childbirth, and 6) planning for comprehensive SRH services. The MISP provides a roadmap for communities to deliver critical care in crisis while laying a foundation to transition to a more comprehensive suite of SRH services (ideally within 3 to 6 months) as communities recover.

Priority Actions

- Establish strong, decentralized SRH coordination structures with emergency plans, dedicated coordinators, and rapid response teams to ensure effective leadership and service continuity.
- Expand survivor-centered services (like One-Stop Centers, safe houses, or cash assistance), ensure confidentiality, and increase community awareness of sexual violence solutions through local engagement.
- Strengthen provider training, reduce stigma, improve data systems, and expand outreach and education to prevent HIV and sexually transmitted infection (STI) transmission, especially in settings hosting internally displaced people (IDPs).
- Improve emergency obstetric care, referral systems, and provider training while promoting community education to prevent maternal and newborn morbidity and mortality.
- Ensure consistent access to a full range of contraceptive options to prevent unintended pregnancies, including through mobile teams and weekend services, with targeted outreach to IDPs and youth.
- Integrate MISP into health worker trainings, secure sustainable funding, improve supply chains, and expand inclusive, community-driven services to develop a comprehensive SRH plan.

This work was conducted on behalf of the Global Health Cluster Sexual and Reproductive Health Task Team (GHC SRH TT). The authors extend their gratitude to the task team members, national SRH Working Group members, and additional reviewers for their valuable contributions.

Background

Humanitarian and fragile settings pose significant risks to the SRH of women and girls, with gender-based violence, unsafe abortion, and inadequate obstetric care being major causes of morbidity and mortality.

Despite this, gaps in SRH services remain, worsened by limited resources and disrupted health systems. The Minimum Initial Service Package (MISP) for SRH provides a framework to address these challenges and has become a standard in humanitarian response. This MISP process evaluation in Ethiopia's Amhara and Tigray regions aims to assess MISP implementation, focusing on its reach, quality, barriers, enablers, and the involvement of key players while also evaluating funding and the impacts of COVID-19.

Context

Ethiopia's key national documents—including the Health Policy, HSTP II, National Youth and SRH Strategies, and the Reproductive Health Strategic Plan—highlight the importance of MISP by emphasizing preparedness, integration of clinical and public health responses, and access to SRH services in emergencies.[1]

They call for expanding services to vulnerable groups, prioritizing youth access, strengthening referral systems, building humanitarian workers' capacity in youth-centered care, promoting self-care in underserved areas, and preventing sexual violence and unintended pregnancies through coordinated, multi-sectoral efforts.

Despite supportive policies, evidence reveals significant GBV and SRH risks in Ethiopia, including limited protection services for survivors, underreporting of GBV, weak emergency SRH coordination and funding, high rates of unplanned and adolescent pregnancies (particularly in rural areas), unsafe abortions due to lack of safe services, high STI and HIV prevalence, and widespread intimate partner violence, all of which negatively impact SRH outcomes.

As of June 2024, Ethiopia hosts 4.5 million internally displaced persons and 933,035 refugees, largely due to conflict, drought, intercommunal violence, and extreme weather events.[2] In the Amhara Region alone, an estimated 388,715 individuals were displaced, while approximately 1,386,272 people have returned to their places of origin.[3] In the Tigray Region, there were an estimated 950,000 IDPs and 989,704 returning IDPs.[4] Recent floods and ongoing conflicts, particularly in Tigray and Amhara, have intensified displacement and humanitarian needs.[5,6] Humanitarian response efforts, including the implementation of the MISP, face significant funding challenges. The 2024 Humanitarian Response Plan seeks $3.237 billion in funding but faces a critical shortfall, including a $47.2 million gap for health services.[7]

SRH needs are consistently noted in Ethiopia's Health Cluster reports, particularly as a study found that 10-40% of women in Tigray experienced some form of GBV between 2020 and 2021, and the situation worsened in 2024, with increased GBV incidents in Amhara and a shortage of safe houses and one-stop centers for survivors.[8,9] Despite high fertility rates, family planning services remain underutilized, especially in Tigray, where unmet needs are particularly high.

Methodology

This mixed-methods study was conducted in Ethiopia's Amhara and Tigray regions to evaluate the implementation of the MISP in response to recent conflicts.

Data was collected between December 2024 and January 2025. Quantitative data was gathered through a health facility assessment (HFA) tool, while qualitative data came from key informant interviews (KIIs) and focus group discussions (FGDs) with community members and internally displaced persons (IDPs). The study included a total of six health facilities, 12 healthcare providers, eight key informants, and 77 community members, assessing the implementation of MISP, service quality, and the challenges encountered. Data analysis employed descriptive statistics using SPSS and Excel for quantitative data and thematic analysis using Dedoose for qualitative data. Ethical approval was obtained from the Institutional Research Ethics Review Committee (IRERC) of the Ethiopian Public Health Association (EPHA) and the International Rescue Committee's (IRC) internal ethics review board.

Findings

Infrastructure and Awareness of MISP Implementation

Desk review findings indicate that **infrastructure challenges**, such as widespread damage to health facilities and the displacement of healthcare workers, impact health service delivery in Tigray and Amhara. In Tigray, many facilities have been looted or damaged, leaving only 13% of facilities operational.[10] In Amhara, more than 50% of health facilities have been damaged, resulting in overwhelming numbers of patients in the facilities that remain operational.[11] The ongoing violence has further strained the healthcare system, with reports of health workers being targeted and facilities looted.

According to the health facility assessment findings, the district hospital in Tigray serves a population of approximately 2 million, while each health center serves around 32,540 people. **Basic utilities are a major concern.** Based on our findings from the HFAs, only 40% of health centers had reliable electricity, and just 60% had access to a functioning water supply. Suhul Shire Hospital, a key referral facility, lacked 24/7 electricity and water; nevertheless, all facilities maintained gender-diverse staffing, with at least one qualified provider available around the clock.

Qualitative data findings show that **awareness of the MISP varied**. At the national level, key informants, particularly within the SRH Working Group, demonstrated a strong understanding of MISP's six core objectives gained through participation in emergency response efforts, online training, and in-person workshops. In contrast, regional stakeholders reported limited MISP training. While many had basic awareness, few could articulate all six objectives, and training gaps were particularly evident in areas such as family planning and basic emergency obstetric and newborn care. Constraints related to insecurity from ongoing conflict and a lack of funding were key barriers to formal capacity-building efforts at the sub-national level.

MISP OBJECTIVE 1

Coordination and Leadership

MISP implementation requires a designated lead agency to coordinate SRH responses. In Ethiopia, according to the desk review and findings from key informant interviews, national-level leadership is led by the Ministry of Health (MoH) through the Ethiopian Public Health Institute (EPHI), with UNFPA serving as a co-chair. At the regional level, coordination has adapted to the political and security realities on the ground.

66.7%
of health facilities have sex-segregated latrines with adequate external lighting.

83.3%
of facilities have latrines that lock from the inside-safety measure for reducing the risk of GBV.

50
healthcare professionals comprehensive training on CMR at national level especially intimate partner violence.

184
incidents of sexual violence have been reported across four surveyed health facilities (1 in Tigray and 3 in Amhara)—in 3 months.

<50%
of the survivors presented at a health facility within the critical 72-hour window to receive post-exposure prophylaxis (PEP) and other time-sensitive services.

Despite continued violence between Amhara armed groups and the federal government, government-led coordination mechanisms have largely dissolved. Current SRH **coordination efforts in Amhara are disjointed and rely heavily on partner-based forums**, such as the USAID Partners Forum and the Implementing Partners Coordination Task Force, with minimal direct involvement from government entities (based on data collection that concluded in January 2025). Coordination among the SRH, GBV, and HIV sub-working groups in Amhara was found to be weak, with limited structured collaboration. Sub-cluster meetings were irregular and inconsistent, which hindered effective service integration and the efficient use of resources.

Coordination efforts in Tigray are perceived to be more robust, with active engagement by the regional government and humanitarian partners. In Tigray, UNFPA took the lead during the height of the conflict due to the absence of a functioning regional government. Post-conflict coordination structures were re-established under the regional health bureau. According to a key informant, the current focus is on supportive supervision and improving the quality of SRH services at static facilities, with the intention of transitioning from the implementation of the MISP to a more comprehensive SRH response. The regional response in Tigray has demonstrated stronger leadership and coordination compared to the national-level efforts by the Ministry of Health (MoH). Evaluative research also suggests that Tigray received more sustained attention and resources than the Afar and Amhara regions, highlighting disparities in the humanitarian response across regions. **Stronger leadership engagement and additional resources have not led to fully effective coordination in Tigray**. Our findings also uncovered weak and fragmented coordination across SRH, GBV, and HIV sub-working groups. Coordination across these working groups and the sub-clusters was infrequent and inconsistent, which impacted service integration and resource optimization.

MISP OBJECTIVE 2

Prevent and Manage the Consequences of Sexual Violence

GBV remains pervasive across crisis-affected communities in the Amhara and Tigray regions of Ethiopia. **Coordination of GBV prevention and response efforts varies** by region. According to key informants, GBV prevention and response in the Amhara region are not well-coordinated, with limited availability of resources, whereas such efforts are relatively stronger in Tigray. For the Tigray region, compared to other sexual and reproductive health (SRH) issues, GBV prevention and response efforts are relatively stronger. Such efforts are characterized by measures taken by the regional government to train at least two healthcare providers per facility in the clinical management of rape (CMR), as well as the translation and distribution of the national GBV management guidelines into Tigrigna, with support from WHO, UNFPA, and CST.

Concerns of Women on Gender-Based Violence

- Long travel distances to reach health facilities, often through unsafe areas.
- Insecure shelter conditions in IDP camps, often made of flimsy plastic sheets that provide no real protection or privacy.
- Neglect of intimate partner violence (IPV) by both communities and humanitarian responders.
- Unsafe school commutes and lack of transportation, particularly affect adolescent girls.
- Overcrowded living conditions increase the risk of harassment, especially near communal facilities like latrines.

In all surveyed facilities, **clinical care for survivors of sexual violence with varying levels of risk was provided**, including post-exposure prophylaxis (PEP), emergency contraception, antibiotics for STIs, pregnancy testing, safe abortion care/referral for safe abortion care to the full extent of the law, and referrals for psychosocial and legal support. However, facilities often lacked privacy, while IDP camps presented unsafe conditions, flimsy shelters and unsafe latrines, contributing to risk.

The **delivery of other services is inconsistent**. Both desk review and qualitative findings show that safe houses have been established in several towns of the two regions to support survivors of gender-based violence (GBV). However, emergency cash assistance is frequently interrupted due to project phase-outs and an ongoing challenge in the recovery process is maintaining survivors' confidentiality while securing stakeholder support.

Efforts were made to improve **ineffective community awareness about GBV and GBV services** through midwife-led community dialogues, public conversations with influential figures (e.g., religious leaders, health extension workers, woreda officials), and conferences for pregnant women. However, community awareness of available services was low, and the stigma significantly deterred survivors from seeking care. Fear of rejection, social isolation, and marriage prospects discouraged disclosure, particularly among adolescent girls.

There is also **limited community-level mobilization around GBV**, especially intimate partner violence (IPV). As per the key informant from the Tigray region, GBV associated with conflict is perceived as more traumatic and, therefore, more deserving of attention, overshadowing IPV and domestic violence, which continue to be normalized or neglected. Key informants stress that rape remains highly underreported in both regions.

MISP OBJECTIVE 3

Prevent HIV and STI Transmission

While surveyed health facilities generally provide key HIV-related services and protocols, **gaps remain in staff training and attitudes**. All surveyed facilities offered syndromic management of sexually transmitted infections (STIs), prevention of mother-to-child transmission of HIV (PMTCT) services, and antiretroviral therapy (ART) for continuing users. Protocols for infection prevention and condom distribution were also in place. According to SRH survey data, six out of the twelve health workers surveyed had received training or instructions on Post-Exposure Prophylaxis (PEP), and the same proportion had provided PEP services in the past three months to prevent HIV following sexual violence or occupational exposure. However, some health workers expressed stigmatizing beliefs, including opposition to PrEP access for sex workers and people in same-sex relationships.

27.3%

of SRH providers believe "PrEP (pre-exposure prophylaxis) should be withheld from people in same-sex relationships and sex workers," citing moral judgments.

33.3%

of SRH providers believe "HIV-positive mothers should not breastfeed their newborns, even if they are on ART," contrary to WHO guidelines.

More gaps in HIV/STIs prevention and services

- Only one of the three health facilities in the Amhara region has ARV treatment protocols for continuing users
- Only one out of the six health facilities provide Hepatitis B vaccines and Hepatitis B immunoglobulin.
- Lack of HIV kits, STI screening tests, ART is not integrated with other SRH services
- Adequate data on the prevalence of STIs is not available.
- Lack of skilled health service providers at IDP clinics and community stigma towards PLHIV.

Qualitative interviews show that community awareness of HIV/STIs appeared relatively strong, especially in Tigray, where prevention strategies like condom use and safe sex practices were known. Nonetheless, **outreach to key populations was almost nonexistent**—such as sex workers or drug users. Community members highlighted the decline in HIV/AIDS awareness campaigns, and women with multiple sexual partners and sex workers lack targeted education or prevention resources. Community stigma towards people living with HIV (PLHIV) is also very common, underscoring the need for more community understanding.

HIV response efforts were also constrained. Key informants and community members mentioned that stockouts and inadequate lab diagnostics further hampered effective HIV response, particularly in IDP settings where testing kits and qualified staff were lacking. ART services were not always integrated with broader SRH services, and clients often had to travel or be referred externally for treatment.

MISP OBJECTIVE 4

Prevent Maternal and Newborn Morbidity and Mortality

Maternal and neonatal health outcomes remain critical in the study regions. Neonatal deaths were reported to have increased during conflict periods. In Tigray, neonatal mortality significantly increased between 2020 and 2022 compared to the pre-crisis period (2019).[12] Similarly, the Amhara region had very high levels of preventable neonatal deaths.[13]

Facility assessments found that while normal deliveries were supported in all surveyed sites, **emergency care and socialization were insufficient**. *Only* Suhul Shire Hospital provides full Comprehensive Emergency Obstetric and Newborn Care (CEmONC) services as it is designated as a CEmONC service delivery point.

Facility assessments found that while normal deliveries were supported in all surveyed sites, **emergency care and socialization were insufficient**. *Only* Suhul Shire Hospital provides full Comprehensive Emergency Obstetric and Newborn Care (CEmONC) services as it is designated as a CEmONC service delivery point. The remaining facilities are designated to provide only Basic Emergency and Trauma Care (BEmONC) services. Findings from the health facility assessment indicate that communities were informed about the availability of skilled attendance at health facilities for normal deliveries and the warning signs of pregnancy complications. However, health facilities provide less information about BEmONC and CEmONC compared to other health topics, and "health education at health facilities" is the least utilized outlet for informing communities about the availability of MISP/SRH services.

All the surveyed six health facilities **offer a range of post-abortion care services**, including counseling, postabortion family planning, reproductive health services, and other general health services. The most used methods for postabortion care are medical abortion and electric/manual vacuum aspiration.

50%

of the 12 surveyed SRH providers received formal training or mentorship on key topics, including family planning, child health, maternal health (including abortion care).

33.3%

of SRH providers received training on MISP in the past 24 months.

54.5%

of SRH service providers received training on the use of a vacuum extractor for assisted vaginal delivery, newborn resuscitation using a bag and mask, and managing newborn infections in the past three months.

54.5%

of providers delivered these services at least once in the past three months.

Referral systems were a major weakness. Only two-thirds of facilities had a functional transport system. Five out of the six health facilities provide free emergency referral transportation, while one requires clients to pay in cash. Many ambulances were out of service due to fuel shortages or maintenance issues. In some cases, families had to arrange and pay for their transport, sometimes resorting to wooden stretchers or informal vehicles.

Focus group discussant women and girls reported delays in various SRH care due to delay or absence of an ambulance, lack of accompaniment by service providers during referrals even if a mother is bleeding, and absence of follow-up services. Skilled health worker availability was also limited, with fewer than half of surveyed providers receiving formal training in the previous 24 months in MISP, including key maternal and newborn services. Clean delivery kits were inconsistently distributed, with limited community awareness of their availability. These **accessibility, resource constraints, and quality of care gaps** significantly endangered maternal outcomes.

According to the SRH provider survey data, most providers have a **favorable attitude toward visiting health facilities** for antenatal care, caring for newborns, and understanding couples' responsibilities for their children's health.

MISP OBJECTIVE 5

Prevent Unintended Pregnancies

Data from the HFA indicates that a broad range of contraceptive methods—both short-acting and long-acting reversible options—are available at the assessed health facilities. All six facilities reported having oral contraceptive pills, emergency contraceptives (EC), intrauterine devices (IUDs), injectables, and implants. However, usage data and provider interviews revealed **inconsistent service delivery despite the availability of contraception**. Despite the availability of IUDs, only half of providers had inserted an IUD in the previous three months, and counseling quality varied. Community members in both regions, especially IDPs, reported limited or no access to family planning services at the clinic level, with many relying on private pharmacies or external referrals, and adolescent girls expressed a lack of access to emergency contraception.

A **low level of awareness and myths surrounding family planning** persisted, including among healthcare providers. These beliefs could influence service delivery and undermine women's reproductive autonomy.

Despite some availability, participants from both Tigray and Amhara regions reported **significant gaps in consistent access to contraceptive services** mainly due to unavailability of services during weekends and recurring stockouts of FP commodities limiting contraceptive choices.

FIGURE 1

Attitude of service providers toward maternal and newborn care (N=12)

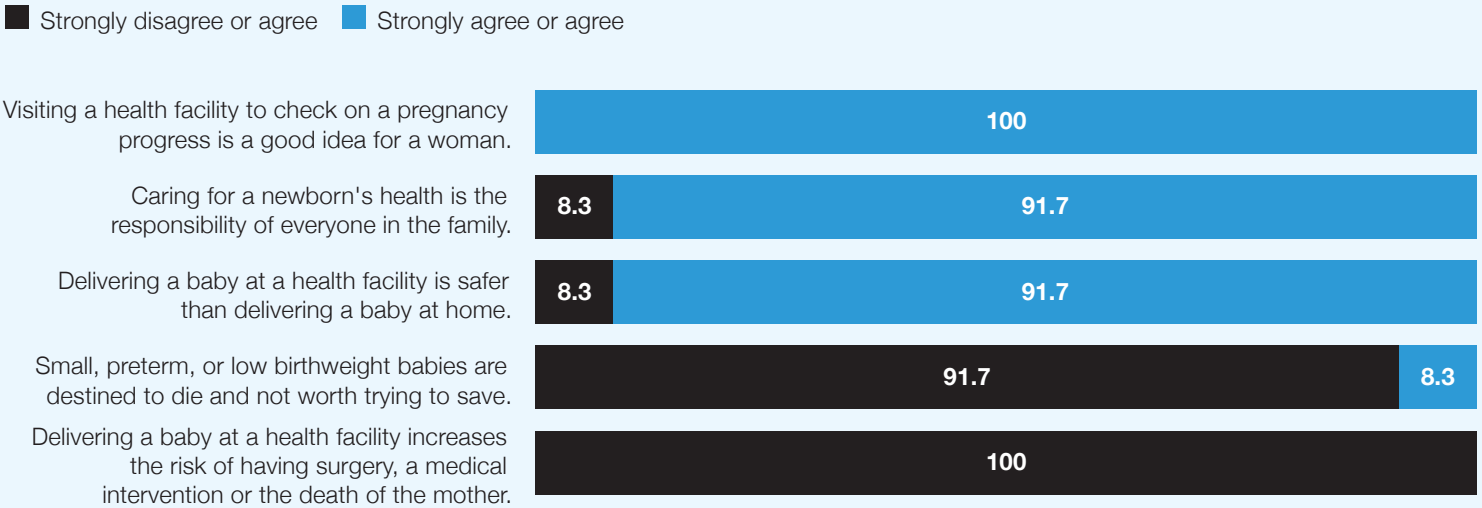


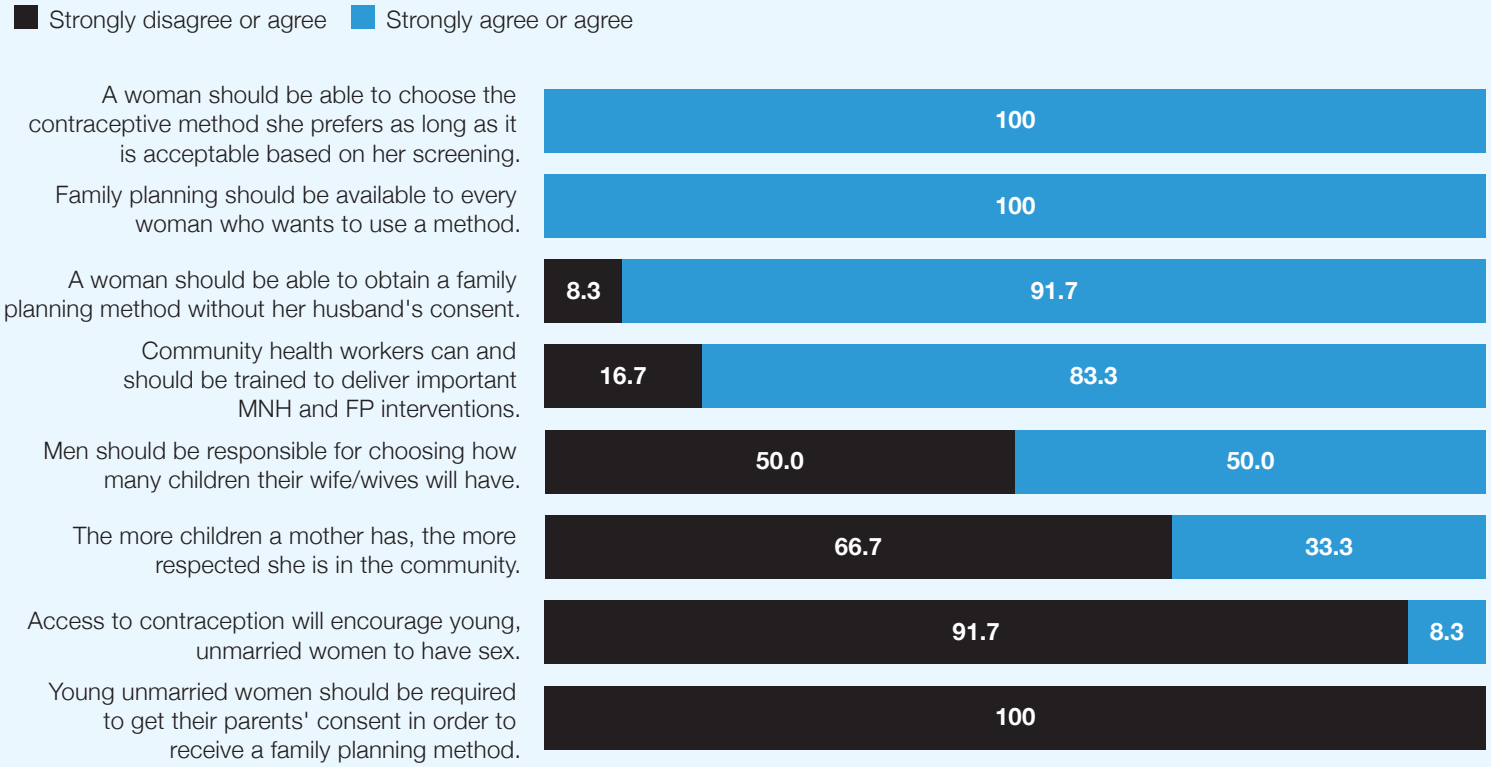
TABLE 1

Percentage of SRH providers who answered FP/contraceptive-related questions correctly (N=12)

Provider knows:	Percent
Contraceptive methods that are appropriate for young, unmarried women	83.3
When she/he should offer contraception to a young, unmarried woman who has been treated for complications of abortion	75.0
Contraceptives that can be delivered by a non-medical health worker, e.g., CHW	66.7
How programs should make family planning more acceptable and more accessible to clients	58.3
Contraceptive methods that can be used by the breastfeeding woman as early as six weeks postpartum	58.3
Contraceptive methods which can be used as emergency contraception to prevent pregnancy up to 5 days after unprotected sex	41.7

FIGURE 2

Attitude of service providers toward family planning and contraceptives (N=12)



MISP OBJECTIVE 6

Integration of Comprehensive SRH Services

The **transition from MISP to comprehensive SRH services has begun in some areas**, particularly in Tigray. A key informant from UNFPA highlighted the government's commendable efforts to rapidly restore health services in conflict-affected areas through a "twinning" approach, where Addis Ababa-based hospitals support the reconstruction and staffing of damaged regional facilities in the Amhara region. This approach has been effective in reviving services at referral hospitals.

According to established standards, comprehensive SRH services should be integrated into primary healthcare as early as possible, ideally within three to six months following the onset of an emergency. However, as per the qualitative findings, **integration into primary healthcare remains uneven**. MISP has not yet been integrated into the pre-service training curricula for health professionals. The lack of dedicated financing is a major barrier to transitioning from MISP to comprehensive SRH services. There is a need for a timely transition and recovery plan for the SRH WG/Cluster system, sustained funding, and coordination between humanitarian and development actors to ensure that MISP services are embedded into the broader primary healthcare system. Staff training, infrastructure repair, and community health education were all cited as prerequisites for sustainable service delivery.

Access to Safe Abortion Services

Five of six assessed facilities (excluding one in Amhara) provide safe abortion care per national guidelines, and all six offer post-abortion care, with most using vacuum aspiration methods. One maternal death from unsafe abortion was reported in the past three months. Despite the availability of some abortion care, **safe abortion services are critically needed**. Key informants noted that unsafe abortions are underreported, especially among rape survivors who often seek help from private pharmacies, increasing health risks. In Amhara, there is a surge in abortion care demand, mostly linked to rape cases following conflict. Traditional unsafe abortion methods, once rare, have resurfaced during crises and continue to contribute to maternal mortality. Survey data also highlighted capacity gaps: only 25% of SRH providers are trained in D&C, and 50% use MVA and misoprostol for induced abortion.

Additional Concerns and Priorities in MISP Implementation

Across both the Amhara and Tigray regions, **service delivery challenges remain acute**, with clinics in IDP sites lacking specialized care, essential supplies, and adequate staffing, according to community members. Key informants indicated that MISP implementation was often reactive, with preparedness and response plans initiated only after emergencies occurred. Despite some positive developments, such as improved surge capacity and resource mobilization, transitions to comprehensive SRH services have been inconsistent, largely due to prolonged displacement and limited integration between emergency and development actors.

Marginalized communities have disproportionate challenges. According to community members, adolescents and people with disabilities remain underserved. Youth centers are absent from IDP sites, and physical, social, and attitudinal barriers continue to hinder access to SRH services for people with disabilities. The accessibility of MISP or SRH services for sex workers and people in same-sex relationships is not well documented; however, there are indications that these groups face various forms of stigma. Community engagement mechanisms—such as coffee ceremonies and committee involvement—are in place to educate IDPs and communities about sexual violence prevention, family planning services, available clinic services, and referral pathways.

Conclusion

The implementation of the MISP in Ethiopia's Tigray and Amhara regions has faced significant challenges due to ongoing conflict, limited resources, and infrastructural deficits. While efforts have been made to maintain basic services, critical gaps persist in delivering the full package of interventions. Coordination at both national and regional levels has been inconsistent, with political and security realities heavily influencing the responsiveness and sustainability of initiatives. The capacity of local healthcare providers, particularly in areas such as sexual violence care, HIV/STI prevention, and family planning, remains insufficient due to limited access to relevant training.

The strain on health infrastructure, including looting, vandalism, unreliable electricity, water shortages, and inadequate referral systems—has further compromised the delivery of SRH services. Access to essential services, especially in conflict zones and IDP sites, is hampered by logistical barriers, weak coordination, low community awareness, and entrenched societal stigma and traditional norms. Despite some progress in recovery efforts, such as the "hospital twinning" approach and the adaptation of regional coordination structures, the transition to comprehensive sexual and reproductive health (SRH) services has been slow and uneven.

Beyond addressing immediate health service gaps, longer-term interventions must prioritize strengthening healthcare systems, improving service integration, and ensuring that vulnerable populations, such as adolescents and people with disabilities, are not left behind. Given the persistent challenges, sustained multi-sectoral collaboration, adequate funding, and targeted interventions are essential to address the full spectrum of SRH needs and to ensure that comprehensive services are accessible, sustainable, and responsive to the evolving humanitarian context.

Recommendations

The following recommendations were developed based on suggestions for improvement provided by key informants and focus group discussions, as well as by the researchers through the synthesis of findings from the rigorous desk review and the analysis conducted for this study. These recommendations were also shared with and endorsed by members of the national SRH Working Group. These key recommendations are arranged by MISP objective and system actors who are best positioned to take these actions forward.

MISP OBJECTIVE 1

Coordination and Leadership

For the Ministry of Health or the Ethiopian Public Health Institute

- Institutionalize regional/sub-national SRH coordination bodies with clear Terms of Reference (ToRs), regular meeting schedules, and mandated reporting lines to the national coordination platform to ensure continuity in leadership and decision-making, even if conditions change locally.
- Develop and implement a robust Emergency Preparedness and Response Plan (EPRP) specific to SRH services, disaggregating resources and funding to ensure the availability of SRH MISP emergency kits,[14] trained personnel, and rapid logistical support during emergencies.
- Develop and implement joint annual or emergency work plans for SRH, GBV, and HIV sub-clusters with shared objectives, activities, and resource allocation frameworks to reduce redundancy and strengthen integrated service delivery, especially for GBV survivors and people living with HIV.
- Assign trained, full-time SRH coordinators in each crisis-affected region, equipped with decision-making authority and logistical support, to enhance accountability and technical leadership for effective MISP implementation across all humanitarian phases.
- Establish a surge model, in collaboration with UN agencies and implementing partners, to deploy technical coordination teams (SRH, GBV, and HIV experts) within 72 hours of a crisis, supported by pre-positioned resources and a rapid needs assessment toolkit.

For Donors, UN agencies, Implementing Partners, or Professional Associations

- Advocate for or secure more direct funding for frontline services, thereby reducing administrative costs that dilute their impact.

For Local Governments, Woreda Health Offices, Health Facilities, or Community-based Structures

- Enhance access to SRH services for people with disabilities by improving the physical accessibility of health facilities (e.g., entrances, toilets, consultation rooms), providing disability-friendly information and communication, and training healthcare workers to deliver respectful, competent care.

For Regional Health Bureaus, Regional Public Health Institutes, or the Women and Social Affairs Bureau

- Enhance coordination among regional authorities, health agencies, NGOs, and international organizations, particularly in Amhara, to ensure more effective prevention and response to GBV, including equipping local health facilities with trained staff and adequate resources to manage GBV cases.

MISP OBJECTIVE 2

Prevent and Manage the Consequences of Sexual Violence

For Donors, UN agencies, Implementing Partners, or Professional Associations

- Increase the number of One-Stop Centers (OSCs) in underserved regions, especially in Amhara, to expand access to comprehensive care for survivors; train additional healthcare workers on Clinical Management of Rape (CMR) and extend OSC outreach to rural and isolated areas.
- Expand the number of safe houses for GBV survivors, particularly in remote and conflict-affected areas, and strengthen services provided—medical care, legal support, vocational training, and reintegration assistance—to help survivors rebuild their lives in safe environments.

For Local Governments, Woreda Health Offices, Health Facilities, or Community-based Structures

- Strengthen the sustainability of cash assistance and vocational training programs in collaboration with donors and UN agencies to support the long-term socioeconomic reintegration of GBV survivors.
- Ensure survivor confidentiality when accessing services, especially during collaboration with local authorities or stakeholders for resource allocation and economic reintegration support.
- Utilize midwife-led community dialogues, home visits, and informal gatherings (e.g., coffee ceremonies) to raise awareness about GBV, available services, safe abortion care, and intimate partner violence (IPV).

MISP OBJECTIVE 3

Prevent HIV and STI Transmission

For the Ministry of Health or the Ethiopian Public Health Institute

- Collaborate with Regional Health Boards (RHBs) to strengthen STI screening and data collection systems, ensuring accurate prevalence data for effective response and resource allocation.

For Regional Health Bureaus, Regional Public Health Institutes, or the Women and Social Affairs Bureau

- Implement targeted training programs for SRH service providers on current WHO guidelines for HIV-positive mothers and the role of PrEP in prevention to address stigma and misinformation related to HIV, STIs, and key populations (e.g., sex workers, people in same-sex relationships).
- Scale up targeted HIV/STI education and outreach programs for key populations, particularly in IDP camps, to address prevention gaps for women with multiple sexual partners and sex workers.

For Local Governments, Woreda Health Offices, Health Facilities, or Community-based Structures

- Address community-level neglect of HIV/AIDS by enhancing collaboration with local leaders and stakeholders to prioritize HIV prevention and care.)
- Re-establish community-based programs such as HIV/AIDS clubs, civic associations, and grassroots education initiatives to increase awareness and reduce stigma around HIV/AIDS.

MISP OBJECTIVE 4

Prevent Maternal and Newborn Morbidity and Mortality

For the Ministry of Health or the Ethiopian Public Health Institute

- Strengthen accountability mechanisms for maternal and neonatal outcomes by revitalizing maternal and perinatal death surveillance and response (MPDSR) systems in partnership with RHBs.

For Donors, UN agencies, Implementing Partners, or Professional Associations

- Promote maternal and newborn health through targeted community engagement and culturally sensitive health education campaigns on skilled birth attendance, postnatal care, newborn danger signs, and available services.
- Conduct targeted training and mentorship (refresher and in-service sessions) on emergency obstetric and newborn care, postpartum family planning, post-abortion and safe abortion care, and emergency contraception, with an emphasis on inclusive care for adolescents and unmarried women, rights-based family planning, and regular knowledge assessments through supportive supervision.

For Regional Health Bureaus, Regional Public Health Institutes, or the Women and Social Affairs Bureau

- Integrate FP services with confidential, safe, and timely post-abortion care aligned with national guidelines—provide post-abortion FP counseling and method provision before discharge, train providers on stigma-free abortion care, and include commodities for both medical and surgical options in essential kits.)

For Local Governments, Woreda Health Offices, Health Facilities, or Community-based Structures

- Strengthen the referral system and ensure 24/7 emergency transport availability through a coordinated network of reliable, fuel-supported ambulance services, including coverage on nights and weekends.

MISP OBJECTIVE 5

Prevent Unintended Pregnancies

For Local Governments, Woreda Health Offices, Health Facilities, or Community-based Structures

- Engage IDP leaders, HEWs, peer educators, and youth clubs to raise awareness about FP options, including safe emergency contraception (EC) and postpartum contraception, empowering women and girls with accurate information on service availability.

For Donors, UN agencies, Implementing Partners, or Professional Associations

- Integrate comprehensive family planning services, including long-acting reversible contraception (LARC) and emergency contraception (EC), into all Mobile Health and Nutrition Team (MHNT) operations; train MHNTs on method mix provision and counseling (including IUDs and implants) and equip teams with mobile kits and IEC materials tailored for IDPs and youth, and ensure FP services are available, including weekends where feasible.

MISP OBJECTIVE 6

Plan for Comprehensive SRH Services

For the Ministry of Health or the Ethiopian Public Health Institute

- Establish a centralized oversight mechanism to address data integration and report discrepancies between national and sub-national levels, enabling real-time tracking of SRH activities.
- Integrate MISP-related topics into pre-service curricula for health professionals (doctors, nurses, midwives), including theoretical and practical training on emergency SRH services, reproductive rights, and gender-based violence.
- Allocate dedicated budget lines for SRH and GBV programs within national health budgets to ensure sustainable funding for MISP objectives, particularly during the transition from emergency response to comprehensive SRH service delivery.

For Regional Health Bureaus, Regional Public Health Institutes, or the Women and Social Affairs Bureau

- Address resistance from local authorities regarding the redistribution of SRH MISP emergency kits by adopting alternative strategies, such as unpacking or "de-kitting," to distribute essential items across multiple service points, including different woredas, thereby preventing supplies from expiring unused.
- Ensure RH kits are complete, supply chain delays are minimized, and facilities maintain consistent access to essential items (e.g., condoms, STI treatment kits, clean delivery kits, essential newborn equipment, family planning commodities/IUD sets); implement timely restocking and monitor stock status monthly using real-time dashboards or mobile reporting tools.
- Strengthen last-mile delivery mechanisms for essential SRH commodities by improving coordination between national and regional supply hubs/warehouses.

For Local Governments, Woreda Health Offices, Health Facilities, or Community-based Structures

- Collaborate with local NGOs and community-based organizations to deliver tailored educational materials and services to marginalized groups.
- Create dedicated, age-appropriate spaces within health facilities for adolescent boys and girls in IDP camps, offering comprehensive counseling, access to contraceptives, and safe spaces for reporting issues such as sexual violence.
- Strengthen community engagement through regular, structured feedback mechanisms, such as suggestion boxes, community meetings, and mobile surveys, to ensure community involvement in SRH service planning and evaluation.
- Introduce community-based outreach programs and mobile health units tailored to adolescents, especially in conflict-affected areas, to ensure timely and safe access to SRH services.

Endnotes

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14. This refers to Inter-Agency Emergency Reproductive Health (IARH) Kits, designed to facilitate the implementation of the Minimum Initial Service Package (MISP) for Sexual and Reproductive Health in crisis situations. These kits contain essential medicines, devices, and commodities needed to address critical SRH needs at the onset of a crisis.

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