



📍 **CROSS-CONTEXTS SYNTHESIS:
CHAD, ETHIOPIA, GAZA, AND MOZAMBIQUE**

The Minimum Initial Service Package for Sexual and Reproductive Health

PROCESS EVALUATION

OCTOBER 2025

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Abbreviations List

ANC	Antenatal care
ARVs	Antiretrovirals
BEmONC	Basic emergency obstetric and newborn care
CEmONC	Comprehensive emergency obstetric and newborn care
CHW	Community health worker
DMPA-SC	Self-injectable contraceptive (Subcutaneous Depot Medroxyprogesterone Acetate)
EC	Emergency contraception
EmONC	Emergency obstetric and newborn care
FGD	Focus group discussion
GBV	Gender-based violence
HFA	Health facility assessment
HIV	Human immunodeficiency virus
IAWG	Inter-Agency Working Group for Reproductive Health in Crises
IARH	Inter-Agency Reproductive Health kits
IOM	International Organization for Migration
IUD	Intra-uterine device
KAP	Knowledge, attitudes and practice
KI	Key informant
KII	Key informant interview
KMC	Kangaroo mother care
LBW	Low birth weight
MISP	Minimum Initial Service Package
MOH	Ministry of Health
MVA	Manual vacuum aspiration
NGO	Non-governmental organization
PAC	Post-abortion care
PEP	Post-exposure prophylaxis for HIV
PLWHIV	People living with HIV
PMTCT	Prevention of mother-to-child transmission of HIV
SRH	Sexual and reproductive health
STI	Sexually transmitted infection
TBA	Traditional birth attendant
UNFPA	United Nations Population Fund
USG	United States Government
WHO	World Health Organization

Introduction

The Minimum Initial Service Package (MISP) for Sexual and Reproductive Health (SRH) in crisis situations, developed by the Inter-Agency Working Group on Reproductive Health in Crises (IAWG), comprises the minimum lifesaving SRH needs that humanitarians must address at the onset of an emergency. It includes six key objectives: 1) Ensure the Health Sector/Cluster identifies an organization to lead implementation of the MISP, 2) Prevent sexual violence and respond to the needs of survivors, 3) Prevent the transmission of and reduce morbidity and mortality due to HIV and other STIs, 4) Prevent excess maternal and newborn morbidity and mortality, 5) Prevent unintended pregnancies, 6) Plan for comprehensive SRH services, integrated into primary health care as soon as possible and an additional objective for preventing mortality and morbidity due to unintended pregnancy by ensuring safe abortion care to the full extent of the law. 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.

While implementation of the MISP has been evaluated over the past 25 years in diverse settings, the sector has experienced recent upheaval, i.e. recent cuts in funding from the US government (USG), and it has been nearly 8 years since the last formal MISP process evaluation.¹ Since then, informal reports have suggested delivery of SRH services has become disorganized and/or deprioritized amidst some global restrictions on women's health and empowerment. Understanding how SRH services are being delivered within current emergency responses is crucial for improving processes in humanitarian crises, effectively directing limited funds, and better defining the roles that global stakeholders can and should play in strengthening MISP implementation.

In 2024-2025, the Global Health Cluster SRH Task Team undertook process evaluations of MISP implementation in selected recent responses. The objectives of these cross-sectoral, mixed methods case studies were to evaluate MISP implementation within crisis-affected settings in Chad, Ethiopia, Gaza, and Mozambique and to inform recommendations and policies to strengthen consistent and accountable MISP implementation moving forward.

Methods

Site selection

A shortlist of countries was initially developed in 2024 from the following criteria: 1) The country experienced a crisis in 2023, or otherwise has frequent resurgences of conflict, 2) The SRH working group was active at national level, 3) The global study team and/or country partners had reasonable access to study sites, affected communities, and health facilities, and 4) A mapping was available of health partners, facilities, and services delivered in the affected areas. In partnership with the Global

Health Cluster, cluster coordinators from the shortlisted countries were then requested to express interest for consideration. Lastly, global relevance and donor interest were considered to narrow down the list of study sites. The SRH working groups (SRH WGs) in country were then asked to identify/propose appropriate research sites, recognizing the desire to focus on recent acute responses. The selected assessment sites included: Ouaddaï and Wadi Fira provinces in Chad, Amhara and Tigray regions in Ethiopia, the Gaza Strip, and Cabo Delgado Province in Mozambique.

Humanitarian context from each country's evaluation



Methodology

Studies aimed to answer the following research questions:

- To what extent were the MISP objectives implemented, and what was the reach and quality?
- What were the barriers and enablers to MISP implementation?
- Who were the key players in MISP implementation and coordination? Who were not?
- To what extent were underserved groups, such as adolescents, people with disabilities (PWDs), and LGBTQIA+, served by the MISP during the crisis?
- What was the experience of different client groups during the MISP response?
- To what extent was funding available and used for the MISP, and where did this funding come from?

Additional research questions were identified by country stakeholders as appropriate, allowing for individual studies to further explore questions such as “what, if anything, should be changed in the MISP to address protracted crises?” and “what other local factors (such as COVID, cholera, political instability, and climate shocks) have affected the MISP and/or other SRH service delivery in this setting?”

Chad, Mozambique, and Ethiopia employed a quantitative approach, which included health facility assessments (HFAs) and questionnaires of providers’ knowledge, attitudes and practices (KAP), and a qualitative approach using focus group discussions (FGDs) and key informant interviews (KIIs). Given access challenges, service delivery needs, existing learnings, and competing partner activities, the methodology in Gaza was adjusted to remove HFAs, provider surveys, and FGDs. Due to the breadth of existing evidence from other recent assessments on the humanitarian situation in Gaza, a comprehensive desk review was undertaken to consolidate 1) reports and assessments from UN agencies (UNFPA, UNRWA, WHO, OCHA), the MoH, and international and local NGOs active in SRH and GBV service provision, 2) previous evaluations and research studies, including emergency preparedness and response plans, SRH Working Group

documentation, and published humanitarian updates, and 3) health information system data and annual health reports where available, including maternal mortality, contraceptive prevalence, skilled birth attendance, and service availability. This desk review was then complemented / triangulated by KIIs, and the final implications and recommendations were vetted by the SRH WG in Gaza.

Health Facility Assessments

Select health facilities serving internally displaced persons (IDPs) and/or refugees in Chad, Ethiopia, and Mozambique were assessed with regards to availability, quality, and utilization of MISP services. Facilities were sampled using different procedures in each setting:

- In Chad, facilities in or near the 8 visited refugee camps in Wadi Fira and Ouaddai provinces were assessed with approval of the supporting organization. A few facilities in the selected camps were not assessed due to closure at the time of arrival or lack of time during the camp visit.
- In Ethiopia, facilities were sampled purposively, with collaboration from UNFPA regional coordinators in the Amhara and Tigray regions as well as regional public health institutes leading emergency response efforts, and selection criteria included accessibility (with a focus on areas not experiencing active conflict during the data collection period), a balance of rural and urban settings, and facility caseload. High-volume facilities were prioritized over low-volume ones.
- In Mozambique, public health facilities that have received the largest number of MISP kits since 2022 were randomly selected from a list provided by UNFPA. The assessment was conducted in collaboration with the consenting Medical Director of the selected health facilities in rural and peri-urban areas. Of note, the designation of the facility (primary, secondary, tertiary, etc.) was not considered when developing the sample.

HFAs were administered via observation and interviews with health facility managers, using a structured HFA tool to evaluate facilities.

Health provider surveys

Confidential questionnaires were administered to health providers who provided SRH services in Chad, Ethiopia, and Mozambique to measure knowledge, attitudes, and practices related to MISP implementation. The only selection criterion across all three settings was that the provider was involved in some form of SRH service delivery. Respondents were selected using convenience sampling in Chad and Ethiopia, while in Mozambique, three providers per facility were purposively sampled. Most selected providers were staff of health facilities already selected for the HFAs, with the exception of 4 providers in Chad who work in camps not visited as part of the HFAs.

Key informant interviews

KIIs were conducted in all four settings with purposively selected stakeholders considered to be relevant experts in SRH, GBV, and HIV. KIIs aimed to assess awareness of the MISP, MISP coordination, emergency response efforts, and gather recommendations for future MISP implementations. Most interviews were conducted individually in private locations or via telephone/online platform, such as Microsoft Teams. All respondents provided informed consent to participate in the interview and have their interview recorded for transcription purposes.

Focus group discussions

FGDs were held with community members (refugees, IDPs and host community members) in Chad, Ethiopia, and Mozambique to explore community perceptions and knowledge of SRH services, specifically in relation to the components of the MISP. Participants included men, women, adolescent boys, and adolescent girls who lived within the catchment areas of assessed health facilities. Participants were 15-49 years, stratified into groups based on sex and age. Eligible participants were identified with the support of community health workers (CHWs), community leaders, and local program staff.

Data collection took place between June and September 2025, with the exception of Ethiopia where data was collected between December 2024 and January 2025.

Data collection by method

Chad

- 9 HFAs (1 hospital, 7 health centers and 1 health post)
- 22 provider surveys
- 16 KIIs
- 10 FGDs (including 100 participants)

Ethiopia

- 6 HFAs (1 district hospital and 5 primary healthcare centers)
- 12 provider surveys
- 8 KIIs
- 8 FGDs (including 77 participants)

Gaza

- 11 KIIs
- Comprehensive desk review

Mozambique

- 7 HFAs (1 secondary level facility and 6 primary level facilities)
- 23 provider surveys
- 13 KIIs
- 6 FGDs (including 49 participants)

Data collection tools were adapted from IAWG's MISP Process Evaluation Tools⁹ and were translated into the local languages in Ethiopia (translated to Amharic and Tigrigna), Chad (French) and Mozambique (Portuguese). In Mozambique, FGDs were hosted in Emacua (the prominent local language in Cabo Delgado) and transcriptions were translated to Portuguese. In Chad, FGDs were facilitated by a multilingual (French-Arabic) speaker and translated to French. Data collection tools were not translated in Gaza but interviewers spoke English and Arabic so that interviews could be multilingual as needed.

Ethical approval was obtained from the International Rescue Committee's internal ethical approval board as well as the Ministries of Health from each country/the Ethiopian Public Health Association (EPHA).

Data analysis

Quantitative data were analyzed using SPSS (Chad and Ethiopia), Excel (Ethiopia and Mozambique), and STATA (Mozambique), with the exception of HFA data in Chad which were reviewed on paper forms and summarized in tables. KII and FGD recordings were transcribed and reviewed by evaluation teams in each country, and qualitative data was thematically analyzed using Dedoose or manually.

Limitations

The small sample size of assessed sites within each country may lead to limited generalizability of the results. The requirement that study sites/health facilities be accessible to study teams excluded facilities (and thus, providers and communities) in higher-risk areas, potentially prohibiting the evaluation of the delivery of the MISP in the most affected settings. Selection bias may have been present in the selection of assessed facilities – the assessment team in Chad, for example, was hosted by an active SRH Working Group member who facilitated visits to health facilities managed by their NGO, which prioritized SRH, leading to possible overestimation of the strength of implementation. In Gaza, ongoing conflict and movement restrictions limited primary data collection. Data on several topics such as GBV, serving LGBTQ populations, and abortion care may not reflect reality due to legal constraints, stigma, and discrimination. Finally, the long (and comprehensive) length of both the KAP survey tool and the KII interview guide were described as a limiting factor.

Results

Infrastructure and awareness of MISP Implementation

Stakeholder awareness of the MISP varied, with those working at national levels, i.e. UN agencies, often familiar with it due to UNFPA/ MOH trainings or previous work in emergency response efforts, while many local NGO staff and frontline providers were less familiar with the MISP as an emergency framework, although they delivered relevant services without recognizing them as MISP components. Key informants at the local and regional levels in several countries called for broader MISP training. Across the four settings, prominent confusion was observed in several areas. Specifically, there was uncertainty regarding the applicability of the MISP and its strategic value, with respondents questioning whether it functions primarily as an emergency framework or as a minimum standard against which all settings should be evaluated. Finally, the role of MOH in implementing and ensuring delivery of the MISP was not clearly understood.

Infrastructure: Improvements in health facility infrastructure are needed – in Mozambique, only 3 of 7 facilities (43%) were observed to have functional bathrooms specifically for providers, none of which were gender-segregated and only 1 of which was observed to have a lock and an adjacent hand-washing station. For the facilities that did not have provider bathrooms, providers reported using bathrooms in nearby homes.

Health facility infrastructure and staffing faced significant challenges in several countries due to ongoing conflicts. Desk reviews highlighted that recent conflicts left a majority of health facilities damaged in some of the settings – in Tigray, only 13% of facilities were found to be operational during a HeRAMS mapping exercise conducted in 2023¹⁰ and as of October 2025, WHO reports show that 94% of hospitals in Gaza have been damaged or destroyed, with only a small number of health facilities in Northern Gaza partially functioning.¹¹ Basic utilities (consistent power/

water) were noted as a major concern according to surveyed facility managers in Ethiopia, and less than half of assessed facilities in Mozambique reported having sufficient power or water to meet needs. Despite most facilities across the three surveyed countries having at least one provider available or “on call” 24/7, key informants reported that staffing was generally insufficient, with 0 of 9 assessed facilities in Chad reporting that they had sufficient health workers to handle their client load.

Health workforce investment: Poor investments both in SRH pre-service training and in health workforce staffing hindered emergency response - in Chad, only 27% of surveyed midwives correctly answered more than half of the 18 knowledge questions. In one health facility, newly qualified midwives reported being unable to provide key MISP services due to lack of training.

OBJECTIVE 1

Coordination and Leadership

In order to effectively deliver the MISP, Objective 1 requires that a coordinator or lead entity is identified, and that coordination between SRH, GBV, and HIV stakeholders is prioritized. Across all 4 countries assessed in this evaluation, UNFPA served as the lead entity of the SRH working group, with the exception of Ethiopia where 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.

Coordination and preparedness for MISP implementation varied widely across contexts. In Chad, the SRH working group functioned at the national level, but coordination was ad hoc and absorbed into broader health cluster meetings at subnational levels due to limited staff. In Ethiopia, national-level coordination between the MoH/EPHI and UNFPA was relatively strong, but regional mechanisms fractured under political and security pressures: in Amhara, government-led platforms dissolved, leaving partner forums to fill the gap, while in Tigray, leadership and

resources remained insufficient for effective coordination. In Gaza, UNFPA-led SRH and GBV groups enabled technical exchange, prepositioning, and rapid learning, but coordination on response activities/implementation was hindered by access restrictions, supply disruptions, inconsistent data, and limited local representation. In Mozambique, coordination was generally described as organized and inclusive, reducing duplication, and strengthening partnerships with government, but there was room for improvement regarding how specialty areas coordinate with each other (as opposed to internally within their own SRH, GBV, or HIV specialty). Notably, the use of WhatsApp chat groups and checklists, along with the involvement of focal points, was considered a crucial tool to support such coordination.

“...we have dozens of partners implementing health. We have over 200 facilities - 13 CEmONC, about 200 PHCs or mobile teams. So ... you have a MOH, you have UNWRA, you have big actors that have many facilities and then you have smaller, smaller actors [with] one or two ...service points. So we come together and we discuss together on types of action, triggers, needs for support from the coordination level”

KI FROM GAZA

In both Chad and Mozambique, recent USG funding cuts and changes were described as leading to significant gaps in coordination. Staff reductions at some agencies due to funding cuts limited partner participation in working groups, and in Chad, led to SRH coordination being absorbed into health cluster meetings. However, these challenges were not always insurmountable. In Chad, for example, an international NGO that previously led district level GBV/Protection meetings closed operations in 2025 after the loss of USG funding, and a local NGO subsequently hosted GBV/Protection meetings.

OBJECTIVE 2

Prevent and Manage the Consequences of Sexual Violence

Objective 2 of the MISP aims to prevent and mitigate the harms of sexual violence within conflict-affected communities as well as to coordinate response efforts to attend to sexual assault survivors through clinical care, referrals, and on-going support through confidential safe spaces. Most health facilities across settings reported providing clinical management of rape (CMR) services including emergency contraception, post-exposure prophylaxis for HIV, antibiotics to prevent sexually transmitted infections (STIs), and referrals for psychosocial support (Table 3). For the only assessed facilities that did not provide CMR services (n=2, both in Chad), one was a health center staffed by new midwives who reported lack of training on CMR, and the other was a health post that referred to a nearby higher-level facility. In Gaza, CMR and broader GBV response were integrated into SRH interventions (co-locating health, nutrition, and psychosocial services) from the early days of the war, reducing stigma and enhancing accessibility.

“The most important point about [my organization is that] we provided SRH and GBV services in the same place in the same medical point. They were not separated.”

KI FROM GAZA

Efforts to respond to the consequences of sexual violence faced challenges across all four settings: In Ethiopia, FGD participants cited ongoing threats of sexual violence, particularly in displacement settings and during daily activities such as traveling to school or accessing health services, and KIs reported that rape remains highly underreported in both regions, with less than half of the survivors presenting for care at a health facility within the critical 72-hour window. In Chad, trained psychosocial and case management staffing was reported as inadequate and follow-up of referrals was weak. In Mozambique, only 60% of providers reported having received some form of GBV training, likely impacting quality of care. In Gaza, GBV service delivery was challenged by security constraints (continuous displacement, overcrowding, and the collapse of formal protection systems), resource shortages (lack of supplies such as emergency contraception, PEP kits, and sterilization materials, compounded by fuel and electricity constraints) and the destruction/delayed construction of safe spaces. KIs across settings emphasized the need to scale up safe spaces and One Stop Centers (OSCs) to better meet survivor needs.

In Ethiopia, Tigray regional government trained at least two healthcare providers per facility in CMR and translated and distributed the national GBV management guidelines into local language Tigrigna, strengthening the GBV response.

TABLE 1

Clinical management of rape services per data from HFAs and self-reported by providers

	Chad (n=9)	Ethiopia (n=6)	Mozambique (n=7)
GBV services (CMR) provided in this health facility	7	6	7
Emergency contraception (EC)	7	6	7
Post-exposure prophylaxis (PEP) for HIV	7	6	7
Antibiotics to prevent sexually transmitted infections (STIs)	7	6	7
Treatment of injuries	7	6	7
Referrals for protection/psychosocial support	8	6	6
Safe abortion care provided for unintended pregnancies due to sexual assault	1	5	5

Community awareness of GBV services ranged from very low (Ethiopia) to quite high (Mozambique), according to FGD respondents. To address low community awareness in Ethiopia, respondents spoke to organizing informal gatherings such as coffee ceremonies to discuss GBV, emphasizing confidentiality and availability of private rooms for counseling:

"IOM (International Organization for Migration) women representatives conduct home visits, inviting us to attend tea and coffee ceremonies. During these gatherings, they educate us on the importance of seeking care in the event of sexual assault. They also assure us that our situation will be handled with strict confidentiality. Additionally, they inform us that private rooms are available to provide guidance on what steps to take if we experience sexual violence."

FGD PARTICIPANT WOMAN FROM ETHIOPIA

OBJECTIVE 3

Prevent HIV and STI Transmission

Objective 3 aims to prevent HIV transmission during health care provision, support the prevention of STI and HIV transmission among crisis-affected populations, provide HIV care and treatment to people already diagnosed with HIV/AIDS and diagnose and treat STIs. All surveyed health facilities offered ARVs, co-trimoxazole prophylaxis for opportunistic infections for PLHWA, and provided syndromic diagnosis and management of STIs (Table 4). In Mozambique, the clinical management of HIV was cited by KIs as a strength of the health system – particularly the availability of services beyond the MISP such as self-testing & pre-exposure prophylactic treatment, and the suppression of viral loads & vertical transmission, as well as the support of mobile HIV clinics:

"The mobile clinics really support us at this moment...We desperately need support from mobile clinics to reach more people with HIV in the communities, because health units are very far away... but due to reduced funding, some partners have closed"

KI IN MOZAMBIQUE

TABLE 2

HIV/STI services as per data from HFAs and self-reported by providers

	Chad (n=9)	Ethiopia (n=6)	Mozambique (n=7)
Male condoms available	9	6	6
Female condoms available	7	1	6
ARVs available for continuing users (People living with HIV/AIDS, "PLWHA")	9	6	7
Co-trimoxazole prophylaxis for opportunistic infections for PLHWA	9	6	7
ARVs given to HIV+ mothers for PMTCT	8	6	7
ARVs given to newborns born to HIV+ mothers in maternity	8	6	7
Syndromic diagnosis and management of STIs	9	6	7
Laboratory available	6	6	5
There are ARV treatment protocols for continuing users	6	4	7

According to key informants, HIV prevention and treatment have been deprioritized in the Gaza emergency response due to low HIV prevalence (only around 36 cases are reported in Gaza, with four newly discovered during the war). Despite this, HIV/STI kits remain pre-positioned for emergencies, ensuring at least minimal readiness. In Mozambique, HIV service lapses were widely reported by HIV Specialists due to the reduced availability of technical staff, the diversion of resources to meet IDP's needs (resulting in the neglect of host community members' needs), frequent (re)displacement of IDPs resulting in lost patients, loss /robbery of key stock, and shame with having to re-present for services. Shortages of HIV/STI test kits were reported in Chad and Ethiopia.

All four settings depend on syndromic management of STIs, despite a majority of surveyed facilities in both Chad and Mozambique reporting having a laboratory for testing. KIs in Gaza explicitly identified training of frontline staff in syndromic management to be a priority, due to the collapse of laboratory infrastructure.

Public SRH commodity leakage poses a threat to larger commodity security – in Mozambique, both male and female FGD participants indicated that health workers provide treatments outside of health centers as a way of supplementing their individual incomes, which is a significant challenge for stock maintenance.

OBJECTIVE 4

Prevent Maternal and Newborn Morbidity and Mortality

Preventing maternal and infant mortality is fundamental to the MISP, and the package includes the availability of skilled birth attendants, the availability of supplies for vaginal births, the facilitation of basic emergency obstetric and newborn care (BEmONC) at the primary health facility level, and the facilitation of comprehensive emergency obstetric and newborn care (CEmONC) at the secondary and tertiary health facility levels. This objective also includes (1) the promotion of effective referral systems, (2) community

engagement, and (3) the provision of post abortion care (note: we have moved these findings to an abortion-specific section later in the report).¹ For this objective, the MISP prioritizes the distribution of kits and personnel to ensure that the birthing process, the neonatal phase, and the post-birth phase are well supplied and attended.

Maternal and newborn health services were a focus across all four settings, with 100% of assessed facilities performing normal deliveries, but access, quality, and outcomes varied sharply depending on crisis intensity, infrastructure, and workforce capacity.

KIs and FGD participants in Chad reported persistent shortages of trained midwives, referral delays, and transport costs leading many refugees to rely on home births, with some expressing dissatisfaction with facility-based maternity care. One FGD participant in Chad noted,

Most women give birth at home because the health center is very far from our camp, and our husbands don't have the money to take us to the center to give birth. Sometimes when we give birth at home and there are complications, they take us to the health center."

Similarly, in Ethiopia, access to CEmONC care was limited, and referral systems were noted as weak, ambulances often out of service/lacking fuel (sometimes requiring clients to pay to refuel), and midwives reported limited training, while insecurity and movement restrictions pushed many women toward home births.

In Gaza, births attended by skilled personnel remained high and UNFPA's midwifery-led delivery model expanded access, yet destruction of facilities, disrupted referrals, and uneven CEmONC coverage (after the destruction of Al Awda hospital, North Gaza was left without CEmONC services entirely) undermined safe delivery. Cultural preferences for hospital births, gaps in midwife training, and severe maternal malnutrition further constrained care. Emergency delivery clinics and monthly maternal mortality reviews were noted as interventions to help mitigate mortality and morbidity risks in Gaza.

¹ While PAC is a component of MISP objective 4 and should always be delivered, we have included our findings on PAC service delivery in the abortion care section later in the report, as a reflection of how the HFA tool was organized.

TABLE 3**Provision of Delivery and EmONC services per data from HFAs and self-reported by providers**

	Chad (n=9)	Ethiopia (n=6)	Mozambique (n=7)
Normal deliveries performed	9	6	7
BEmONC signal functions provided:			
Parenteral antibiotics	8	6	7
Parenteral uterotonic drugs	7	6	7
Parenteral anticonvulsant drugs	7	5	7
Manual removal of retained products of conception using appropriate technology (post-abortion care)	7	6	5
Manual removal of placenta	8	6	7
Assisted vaginal delivery (vacuum or forceps delivery)	1	6	5
Newborn resuscitation	7	6	7
CEmONC signal functions provided:			
Caesarean section	0	2	3
Blood transfusion	1	1	4
Newborn care – essential elements provided:			
Support for immediate & exclusive breastfeeding	9	6	7
Prevention of infection (cleanliness, hygienic cord cutting and care, eye care)	9	6	7
Newborn infection management (including injections and antibiotics)	7	6	7
Thermal care (including immediate drying and skin-to-skin care)	8	6	7
Kangaroo mother care (KMC)	4	6	7
Special delivery care for HIV prevention	8	6	7
Management of low birth weight (LBW)/preterm babies	1	5	6

In Mozambique, support for institutional births was similarly strong, but barriers included transport costs, limited after-hours services, and insufficient provider training (training rates associated with life-saving maternal and infant services hovered between 48-52% of providers, and 50% of maternal and infant health services are taking place in health facilities amongst providers who have not been recently trained in the provision of those services). While maternal deaths were rare in recent Mozambique data, high newborn mortality highlighted gaps in equipment and supplies, particularly in conflict-affected areas.

Almost all assessed facilities provided post abortion care (PAC) except for 2 in Chad, which reported a lack of training or equipment, e.g. manual vacuum aspiration (MVA) kits and misoprostol, and 2 in Mozambique.

Most assessed health facilities provided at least 7 of 8 essential elements of newborn care, with management of low weight/preterm babies as the outlier signal function (1 facility in Mozambique, 1 facility in Ethiopia, and 8 facilities in Chad did not provide management of low birthweight babies). KIIs across Chad, MZ, and Ethiopia all noted the distribution of clean delivery kits during responses, but few

facilities assessed as part of this evaluation reported to have distributed kits in the last three months. Clean delivery “mama kits” in Chad are “mostly no longer available,” which refugee FGD participants mentioned reduced the incentive to deliver at the health facility.

OBJECTIVE 5

Prevent Unintended Pregnancies

Objective 5 of the MISP aims to prevent unintended pregnancies by (1) ensuring that both short-term and long-acting reversible family planning methods are available at health facilities to meet demand, (2) guaranteeing that communities are aware of the availability of these methods, and (3) ensuring that information, education, and communication materials / counseling about family planning methods are quality-driven, inclusive, and effective.

Family planning services were available across all contexts, but access was commonly constrained by supply chain weaknesses, provider training gaps, and sociocultural barriers. In Chad, contraceptives were widely offered but frequent stockouts of popular methods (injectables and implants), midwife training gaps, and recent USG funding cuts undermined consistent provision. Despite mixed male

perceptions and stigma, many refugee women expressed support for contraception. In Ethiopia, a broad range of methods (including pills, IUDs, injectables, implants, and EC) were technically available at facilities, but service delivery was inconsistent: few providers regularly inserted IUDs, counseling quality varied, stockouts were frequent, and adolescents and IDPs in particular reported poor access, sometimes relying on pharmacies or referrals instead. In Gaza, availability of contraceptive methods was challenged by conflict-related supply shortages (stockouts of IUD kits and oral pills), sociocultural sensitivities (i.e. the distribution of condoms outside of health facilities), and provider bias against certain methods (injectables, due to perceived side effects). In Mozambique, FP methods were present in most facilities (most commonly distributed methods were condoms and injectables), but provider training (especially on IUDs and implants) was limited or outdated. Adolescent access to FP in Mozambique was inconsistent, with most facilities offering all FP methods to adolescents (except for 2 facilities that did not offer the IUD due to lack of demand and sociocultural sensitivities around method insertion) but most facilities requiring parental consent for adolescent FP access. Encouragingly, most providers expressed support for women’s right to choose their method, and outreach efforts on long-term methods were ongoing.

TABLE 4
Provision of contraceptive methods per data from HFAs and self-reported by providers

	Chad (n=9)	Ethiopia (n=6)	Mozambique (n=7)
Male condoms	8	5	6
Female condoms	8	2	6
Oral contraceptive pills	9	6	7
Emergency contraceptive pills	8	6	6
IUDs	9	6	4
Injectable contraceptives	7	6	7
Implants	7	6	5
All contraceptive methods offered to adolescents	8	6	5

Common challenges across countries included frequent stockouts, weak provider training in long-acting methods, sociocultural stigma (particularly affecting adolescents and male users), and uneven service delivery despite the presence of commodities. Differences emerged in emphasis: Chad faced funding-linked supply risks, Ethiopia struggled with service consistency amid conflict, Gaza's barriers were compounded by cultural resistance and conflict-related supply chain gaps, while Mozambique's access was shaped by policy restrictions on adolescents and gaps in long-term method training.

Some providers in Gaza began newly promoting emergency contraception beyond post-rape care contexts, framing it as a way to preserve women's autonomy during displacement.

■ OBJECTIVE 6

Integration of Comprehensive SRH Services

Progress towards transitioning from the MISP to comprehensive SRH services was generally limited across settings, constrained by weak health systems, funding shortfalls, and protracted crises. In Chad, most stakeholders reported still being in an emergency response phase, with limited movement toward integration beyond antenatal/postnatal care, partial contraceptive education, and provider-administered HIV testing. In Ethiopia, early steps toward integration were observed, including a "twinning" approach linking Addis Ababa hospitals with conflict-affected referral hospitals, but gaps in staff training, infrastructure repair, financing, and curriculum integration slowed the transition, underscoring the need

for a recovery plan linking humanitarian and development actors. In Gaza, attempts to sustain comprehensive SRH services were severely undermined by bombardment, the destruction of key facilities, workforce displacement, supply restrictions, and funding shortfalls, with MISP integration into national systems remaining partial and at risk of deprioritization post-ceasefire. In Mozambique, the challenge was rooted in a pre-conflict health system that was already under-resourced; while SRH services are broadly embedded in primary care and laws and policies are supportive, sustained integration of HIV and GBV services requires consistent funding, community engagement, improved data systems, and standardized training. All contexts faced persistent barriers to financing, reliance on external aid, gaps in provider training, and challenges embedding the MISP into national health and training systems.

"I would say Objective 6 should get more attention because when you move from crisis to comprehensive services, you must improve and provide routine services. Now there is peace, so the primary attention should be given to Objective 6 – for planning the transition from crisis to better service provision. After planning, the second focus should be on activities under Objective 4."

KI FROM ETHIOPIA

In Ethiopia, a "twinning" initiative paired 12 Addis Ababa hospitals with conflict-hit referral hospitals, sending staff, drugs & equipment to rebuild and successfully accelerating critical SRH service restoration.

Other priorities of the MISP: Safe abortion care

Access to safe abortion care (SAC) varied sharply across settings, shaped by legal frameworks, stigma, and service availability. SAC was largely absent in Chad (only 1 of 9 facilities provided SAC) due to legal ambiguity (Chad's Reproductive Health law 006 permits abortion to save the health or life of the woman or in cases of fetal anomaly; however the guidelines to implement this law have not been put in place), lack of provider training, and high levels of stigma, with unsafe abortions reportedly common among refugees according to KIs and FGD respondents. In Ethiopia, five of six assessed facilities offered SAC services in line with national guidelines, though coverage was inconsistent, provider training was limited, and demand surged in conflict areas, especially linked to rape cases. In Gaza, safe abortion care was legally and culturally restricted to medically eligible cases approved by the

Ministry of Health, leaving women reliant on limited post abortion care amid a reported sharp rise in spontaneous abortions, with humanitarian actors offering only partial support. In Mozambique, abortion is legally permitted up to 12 weeks (16 in cases of rape/incest), but uptake of safe abortion was extremely low. Community accounts revealed reliance on traditional healers, pharmacies, or continuation of unintended pregnancies – sometimes ending in infanticide – reflecting deep stigma, financial barriers, and limited awareness. Providers reported more training in safe abortion care than opportunities to apply it, underscoring the disconnect between policy and practice.

“Unsafe abortions were also carried out using traditional methods—practices that had nearly been eliminated but resurfaced during times of crisis. Unsafe abortion remains one of the significant contributors to maternal death.”

KI FROM ETHIOPIA

TABLE 5

Provision of abortion services per data from HFAs and self-reported by providers

	Chad (n=9)	Ethiopia (n=6)	Mozambique (n=7)
Safe abortion care provided	1	5	5

Discussion

While the MISP was first developed in 1995 and has been the global standard for 30 years, there are still no systematic mechanisms through which to monitor and document whether and to what extent the MISP is implemented during emergency response. This is the first formal assessment of MISP implementation since IAWG's 2012-2014 global evaluation¹² and since the MISP was revised as part of the Interagency Field Manual for Sexual and Reproductive Health in Humanitarian Settings (IAFM) in 2018. Since 2018, the humanitarian SRH sector has faced several upheavals, including the COVID-19 pandemic, large cuts to foreign aid, and a backsliding of progressive policies and enabling environments in some countries. These evaluations offer important insight into how the MISP is being implemented on the ground and what actions key stakeholders must take at all levels to accelerate progress.

Findings suggest that progress has been made on specific gaps identified in the 2012-14 global evaluation. For example, family planning was more widely available, emergency contraception was more available beyond CMR/IPV, and ARVs for PLWHA were available at the primary care level in most health facilities assessed in 2025. However, other gaps are more persistent, such as the lack of availability safe abortion care to the full extent of the law (an additional priority), limited availability of EmONC and incomplete referral systems, supply chain issues and stock-outs, and insufficient funding for the MISP more generally.

While significant progress has been achieved nationally in building MISP awareness and buy in, sustaining this uptake and coordination at the sub-national level remains a critical challenge. In districts in Ethiopia, the government-led SRH collaboration platform dissolved within a year; in Chad, sub-national meetings are folded into generic Health Cluster meetings, diluting accountability. Robust, well-funded sub-national coordination bodies with fixed TORs and reporting lines are essential to sustain leadership when staff rotate, access deteriorates, or cuts to funding are made. These mechanisms also allow for deeper relationship building with local health authorities and policy makers, and with impacted communities, both of which can influence

sustained service delivery, and help triangulate solutions when future disruptions occur. In places such as Cabo Delgado, Mozambique, that experience cyclical crises, these long-term relationships with government and local authorities have proven valuable for MISP delivery.

The widespread awareness of the MISP brings both the benefits of name recognition as well as the challenges of pre-conceived notions. The IAFM defines the MISP as the most important package of SRH services to be delivered at the onset of an emergency - the "what to do," while leaving the "how" adaptable to a given context and encouraging transition to comprehensive services as soon as feasible. Yet our evaluations show that these definitions and distinctions have not been effectively communicated to the implementation level, leading at times to confusion and/or resistance that need more focused attention at global, national and local levels. In Gaza for example, there was resistance to the MISP among stakeholders, and particularly the government, who believed it was a package designed for low-income or traditionally aid-dependent settings. KIs also viewed the MISP as too narrow, choosing to prioritize comprehensive maternal and newborn care, for example, over other minimal lifesaving priority services prioritized in the MISP like HIV/STI care. In Mozambique, the MISP was seen as the foundational routine package for services, rather than something to be delivered singularly in times of acute crisis. Indeed, stakeholders even spoke to the ways the government had supported sustained supply chain for some MISP services. These findings echo anecdotal evidence from Ukraine, Colombia, and other middle- and high-income countries that have experienced crises in recent years. Moreover, confusion remains across settings about when and under what circumstances transition to comprehensive SRH services is feasible.

These evaluations are landing in a markedly volatile humanitarian landscape, with recent dramatic cuts to USG humanitarian assistance alongside the more gradual reductions of other public donors. The "Humanitarian Reset" aims to streamline and "hyper-prioritize" humanitarian assistance, focusing pooled resources on the highest need

locations, with so far unclear accountability for standards such as the MISP¹³. These trends threaten to roll back decades of progress on SRHR in humanitarian settings without focused attention to what works and continued prioritization of women and adolescent girls. As a global community, we cannot allow hyper-prioritization and funding cuts to risk eliminating the structures that have enabled progress in this space over decades, such as the national and sub-national SRH working groups under the Health Cluster and the SRH Task Team of the Global Health Cluster. However, we also cannot insist on “business as usual” when the landscape is anything but. There needs to be:

- **Accountability:** Ensure better accountability for the streamlining of the MISP within multi-sectoral emergency responses and pooled funds (including earmarked resources for the MISP within these funds)
- **Localization:** Provide stronger support and funding for governments and local partners to lead MISP responses, with documentation of best practices and considerations for various humanitarian typologies
- **Systematic integration:** Systematically integrate MISP service indicators into proposed health and protection priorities, inter-agency humanitarian community feedback mechanisms, and cash programming.

Moreover, we need better evidence on what preparedness activities at the national level best translate to locally led responses during emergencies at the sub-national level, which requires operationalization of the humanitarian-development nexus, moving beyond rhetoric to foster intentional, on-the-ground collaboration between government-focused development initiatives and UN-centric humanitarian response structures. The completion and analysis of 64 country-level MISP readiness assessments, conducted between 2021 and 2024 and led by UNFPA, provide a significant opportunity to generate this critical evidence. To ensure coherence and impact, the relevant recommendations emerging from these MISP readiness assessments should be synchronized with those from this process evaluation ensuring that future MISP preparedness and response efforts are mutually reinforcing and contextually grounded.

Key Global Recommendations

Global Health Cluster and SRH Task Team

Provide direct support to national SRH WGs to implement the recommendations below and conduct targeted advocacy for SRHR as part of the Humanitarian Reset.

The Global Health Cluster and SRH Task Team should:

- **Develop, disseminate, and socialize tools and resources to support SRH WGs and health cluster coordinators on how to plan, advocate, budget, and implement the MISP, and ensure strong coordination at both national and sub-national levels. These tools should be translated into key languages and available in one central location.**
- Establish a mechanism to systematically track the extent of MISP implementation in emergencies (perhaps as part of broader humanitarian accountability efforts).
- Systematically track and organize routine MISP trainings for SRH coordinators and key SRH WG stakeholders (including MOH and sub-national health authorities of crisis-affected regions).

IAWG

Support coalition members to implement the recommendations below and align efforts with new IAWG organizational structure

- **Document and disseminate case studies and best practices from frontline workers and implementers in delivering, advocating for, and ensuring accountability for the MISP.**
- Develop harmonized advocacy materials to ensure that the full package of MISP services (including SAC to the full extent of the law) is systematically prioritized and implemented as part of acute emergency response.
- Conduct a new IAWG global evaluation to comprehensively assess the state of SRHR in humanitarian settings.

- Develop recommendations for how to incorporate MISP into business development opportunities, with targeted messaging and agendas for various donors (development, humanitarian).
- Document and share learnings and technical resources for promising program models, such as evidence-based community or self-delivered care models aligned with the MISP
- Promote new Reproductive Health kits with operational guidance for impacts on MISP service delivery.
- Support, document, track ongoing efforts to strengthen capacity of frontline providers and implementers.

Country Health Cluster and SRH Working

Group *Institutionalize the operations of SRH working groups under the supervision of the Health Cluster to better support implementing partners to address key MISP challenges.*

Each SRH WG should:

- **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.**
- **Have clear Terms of Reference (ToRs), a regular meeting schedule, and mandated reporting lines to the Health Cluster.**
- Socialize the MISP among partners and key stakeholders, focusing on its adaptability. Emphasize that the MISP defines what must be done (its technical content is universally relevant), while the implementation strategy (the how) must be adapted to meet urgent local and context-specific needs.
- Organize interagency clinical trainings for frontline providers to build and maintain clinical capacity. The SRH Clinical Outreach Refresher Trainings (S-CORTs) can be used to rapidly address competency gaps during emergencies.

- Coordinate the pre-positioning of commodities, including IARH kits, ahead of predictable or likely emergencies.
- Liaise with implementing partners to ensure supplies reach the last mile. If feasible, support the pooling of freight with logistics-heavy agencies (WFP, ICRC, private couriers) and embed SRH supplies on existing convoys.
- Hold standing community forums to discuss SRH and referral pathways (i.e. coffee-ceremony dialogues in Ethiopia IDP camps) and maintain consistent funding for them.
- Clarify and disseminate relevant policies related to SRHR, especially for safe abortion care.

Implementing Partners

Increase program budget allocations and technical assistance for MISP services and operations with persistent gaps, including as part of primary health care or multi-sectoral programs.

Partners supporting MISP implementation should:

- **Double check that all MISP components are adequately financed as part of larger primary health care and multi sectorial funding.**
- **Bolster “last-mile logistics” budget lines for SRH (fuel, third-party haulage, micro-grants for camp-level stores) in all proposals/budgets.**
- **Actively participate in SRH coordination, MISP preparedness and response efforts.**
- Invest in high-quality training and supervision for clinical competencies.
- Recruit and supervise qualified / trained SRH providers.
- Strengthen referral pathways for EmONC, ensuring referral policies and procedures exist with cost-coverage for every BEmONC facility; support low-cost, low-tech transport (donkey carts in Chad, motor-bike ambulances in Ethiopia’s rural zones) where appropriate; subsidise patient & caregiver transport with fuel vouchers, cash-for-transport, or ambulance fuel pools, if possible.
- Ensure that PAC training and supplies are incorporated as a component of EmONC service delivery.
- Verify the abortion policy and ensure the program has a clear approach to safe abortion care, i.e., provision under all or some circumstances, referral to other safe abortion providers, etc.

- Include community based/self-delivered care strategies in program designs to reach the last mile.
- Support national technical working groups, when appropriate, to operationalize the findings of MISP Readiness Assessments (MRAs), when available, by leading the development and tracking of a dedicated MISP preparedness action plan. This ensures that identified capacity gaps and coordination weaknesses are addressed well before a crisis occurs.
- Budget for and implement client responsiveness mechanisms for SRH and staff time to review and act on complaints submitted through grievance mechanisms.
- Integrate SRH and GBV services, with special attention to the expressed needs of women and girls.

Humanitarian Donors

Invest in and hold implementing partners accountable for strategies that fill critical gaps and ensure equitable access to the MISP.

Humanitarian donors should:

- **Require and ensure sufficient budget for MISP implementation as part of primary health care, and multi-sectoral responses to emergencies.**
- **Hold implementing partners accountable for all MISP objectives.**
- **Fund SRH WG coordination activities, particularly a full time SRH coordinator position. Acknowledge the value-add of a secretariat that can lead on advocacy, knowledge management, community sensitization, and partnerships.**
- Include crisis modifiers (or built in grant provisions that allow programs to flexibly and quickly redirect funding to respond to unexpected emergencies) for the MISP in multi-year humanitarian programs.

Development Donors

Invest in and hold implementing partners accountable for MISP preparedness and meaningful collaboration with humanitarian actors and systems

Development donors should:

- **Ensure that future systems strengthening grants reflect MISP preparedness as appropriate (pre-service and in-service training curriculums, supply chain support, capacity building for providers/cadres, support for establishment and training of deployment rosters or cohorts).**
- **Where the enabling environment for SRHR is weak, support advocacy and policy efforts accordingly, including to improve the legal and protection frameworks. Aim to ensure all humanitarian principles are incorporated within SRHR policies, and vice versa.**
- Incorporate key MISP indicators into DHIS/HMIS systems.
- Fund and evaluate the MISP preparedness cycle:
 1. Funding the Action Plan: Prioritize funding for the operationalization of MRA Action Plans, ensuring that identified capacity gaps and coordination weaknesses are addressed well before a crisis occurs.
 2. Funding the Learning: Invest strategically in the rigorous evaluation of MRA Action Plan outcomes to identify which preparedness strategies are most effective at enabling robust, locally led responses.

Governments

Institutionalize MISP within emergency preparedness frameworks, empower local actors, ensure health system readiness for MISP response, and foster MISP accountability through community engagement

Governments should:

- **Earmark and increase domestic health and emergency preparedness financing for MISP implementation.**
- **Integrate the MISP into forthcoming humanitarian health financing strategies like country pooled funds and country emergency response funds.**
- **Integrate MISP into pre-service and in-service training curricula for the health workforce; supply chain and M&E systems; capacity building efforts for health providers; and establish and train deployable cohorts of frontline MISP implementers.**
- Include MISP in national and sub-national disaster risk reduction and health emergency response frameworks, and RH / SRH / MNH policies.
- Actively work to embed comprehensive SRH preparedness plans, protocols, and the MISP into existing national and sub-national health emergency preparedness frameworks, disaster risk reduction strategies, and contingency plans. This includes advocating for a legislative environment that supports the provision of the MISP during any emergency, adopting an all-hazards approach.
- Advocate for the integration of disaster management and emergency response considerations into SRH development policies and, conversely, ensure development perspectives inform preparedness to build community and institutional resilience. This approach ensures preparedness is a core component of development work, with dedicated funding and focus.
- Provide funding to and support for local organizations implementing the MISP and include them in coordination and decision-making platforms.
- Pre-position SRH commodities and strengthen last mile health delivery systems.
- Include SRH indicators in community engagement feedback systems and ensure participation of crisis-affected women and girls in preparedness planning and ongoing emergency feedback loops.

Endnotes

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