IMPROVING READINESS TO PROVIDE THE MINIMUM INITIAL SERVICE PACKAGE OF SEXUAL AND REPRODUCTIVE HEALTH CARE DURING A HUMANITARIAN CRISIS IN EASTERN EUROPE AND CENTRAL ASIA

Results of the 2nd MISP Readiness Assessment 2014-2017

UNFPA

IPPF International Planned Parenthood Federation
European Network

Executive Summary

The Minimum Initial Service Package (MISP) for reproductive health in crises outlines the life-saving sexual and reproductive health care to be provided at the outset of a crisis. To assess a country's readiness to provide these services, the Eastern Europe and Central Asia (EECA) Inter-Agency Working Group (IAWG) for Sexual and Reproductive Health (SRH) in crises developed the MISP readiness assessment tool in 2013. This is a unique tool that allows a team of experts in a country to evaluate the country's capacity to implement the MISP at the outset of a crisis. Such an assessment takes into account 38 indicators grouped according to the five MISP objectives. These provide a general picture of a country's legal environment, the integration of the MISP into national health emergency response plans, the country's capacity to set up efficient response coordination, and the capacities and resources available in the country.

The baseline was conducted in 2014, and a second assessment was undertaken by 19 countries/territories in the EECA region in 2017. This report shows the overall results regarding MISP preparedness in the region as of today and highlights some key achievements over the last three years with regard to some specific indicators.

The main results show that there has been a significant improvement in the region from a fair level of preparedness in 2014 to a good level of preparedness in 2017.[1] The most important achievements are linked to the establishment of national sexual and reproductive health working groups, which now exist in 16 countries. This is an extraordinary achievement, as this was one of the weakest areas from the baseline in 2014. Improved coordination at the national level had an impact on several other indicators, and the overall results reflect the importance of having coordination in place so as to be better prepared.

* Kosovo UNSCR 1244

Map disclaimer: The designations employed and the presentation of the material on this map do not imply the expression of any opinion whatsoever on the part of UNFPA, IPPF EN and the regional EECA IAWG concerning the legal status of any country, territory, city or area or of its authorities, or concerning the delimitation of its frontiers or boundaries

[1] These results are based on the scoring for the indicators: 2 points for a fully fulfilled indicator, 1 point for a partially fulfilled indicator and no points for an indicator that has not been fulfilled at all. Poor = an average from 0 to 0.79; Fair = an average from 0.8 to 1.29; Good = an average from 1.3 to 2.

Table of contents

Acronyms and abbreviations

ARV	*Anti-retro viral*
DRR	*Disaster Risk Reduction*
EECA	*Eastern Europe and Central Asia*
GBV	*Gender-Based Violence*
HIV/AIDS	*Human immunodeficiency virus/acquired immunodeficiency syndrome*
IAFM	*Inter-agency field manual*
IAWG	*Inter-Agency Working Group*
IEC	*Information, Education and Communication*
IPPF	*International Planned Parenthood Federation*
LGBTI	*Lesbian, gay, bisexual, transgender and intersex*
MISP	*Minimum Initial Service Package for Reproductive Health*
MNH	*Maternal and neonatal health*
MoH	*Ministry of Health*
PMTCT	*Prevention of Mother-to-child Transmission of HIV*
RH	*Reproductive Health*
SDG	*Sustainable Development Goals*
SRH	*Sexual and Reproductive Health*
STIs	*Sexually Transmitted Infections*
UNFPA	*United Nations Population Fund*
WHO	*World Health Organization*

List of ministries, organizations and institutions involved in the 2017 assessment

Albania
Action Plus
Albania Community Assist
Albanian Centre for Population and Development
Albanian Red Cross
Caritas
Centre for Legal Civic Initiatives
Children's Human Rights Centre of Albania
Today for the Future Community Development Centre
Prefecture emergency units
Institute of Public Health
Maternity hospitals in Tirana
Ministry of Health (Department of Emergencies, Health Care Directory, Hospital Care Directory, Legal Department)
Ministry of Interior (Department of Emergencies)
Ministry of Social Welfare and Youth (Department of Gender Equality)
Observatory for Children's Rights
STOP AIDS
UNAIDS
UNFPA
UNICEF
WHO

Armenia
Family Health Care Network NGO/IPPF member association of Armenia
Ministry of Emergency Situations DRR Platform
Ministry of Health
Oxfam
Support to Communities NGO
UNDP
UNFPA

Azerbaijan
Ministry of Health
Public Health and Reforms Centre, MoH
UNFPA

Belarus
UNFPA

Bosnia and Herzegovina
Partnership for Public Health Association
Ministry of Civil Affairs of Bosnia and Herzegovina
Ministry of Health and Social Welfare of Republika Srpska
Ministry of Health of Bosnia and Herzegovina
UNFPA
University Clinical Hospital
XY Asocijacija (IPPF member association)

Bulgaria
Bulgarian Family Planning and Sexual Health Association (IPPF member association)
IOM (International Organization for Migration)
Ministry of Health
National Centre for Health Information and Analyses
University Hospital

Georgia
Crisis Management Council
Emergency Management Agency under the Ministry of Health, Labour and Social Affairs (MoLSHA)
Health Care Department (MoLSHA)
HIV/AIDS and Infection Diseases, Clinical Immunology Research Centre
Emergency Situations Coordination and Urgent Medical Assistance Centre (MoLSHA)
Ministry of Internal Affairs
National Centre for Disease Control and Public Health
Maternal and Child Health Care Division
State Fund on Protection and Support of the Victims of Trafficking - ATIP Fund (MoLSHA)

Kazakhstan
Kazakhstan Association on Sexual and Reproductive Health
UNFPA

Kyrgyzstan
Ministry of Health of the Kyrgyz Republic
Republican Blood Centre
State Medical Institute for Retraining and Enhancement of Qualifications
Ministry of Emergency Situations
National Red Crescent Society of the Kyrgyz Republic
World Health Organization
Kyrgyz Russian Slavic University
National Centre for Maternal and Child Health Protection
Public Association Alliance for Reproductive Health
UN OCHA (Office for the Coordination of Humanitarian Affairs)
UNFPA

Moldova
Emergency Medicine Training Centre
Ministry of Health, Labour and Social Protection
Nicolae Testemiţanu State University of Medicine and Pharmacy
Reproductive Health and Medical Genetics Centre, Mother and Child Institute
UNFPA

Romania
General Inspectorate for Emergency Situations
Ministry of Health
Societatea de Educaţie Contraceptivă şi Sexuală (IPPF member association)

Serbia
Ministry of Health
UNFPA

Tajikistan
Committee for Emergency Situations and Civil Defence under the President of Tajikistan
Committee for Women and Family Affairs under the Government of Tajikistan
Ministry of Health and Social Protection of the Population of the Republic of Tajikistan
National and Oblast Reproductive Health Centres
National Red Crescent Society of Tajikistan
Regional Emergency Departments under the Local Government Executive Authorities
Republican HIV/AIDS Centre
Republican Scientific Blood Centre
UNDRMP (United Nations Disaster Risk Management Project)
UNFPA
UNICEF
UN OCHA
UN WOMEN
WHO (World Health Organization)

The former Yugoslav Republic of Macedonia
HERA
Institute of Public Health
Ministry of Health
UNFPA

Turkey
Prime Ministry Disaster and Emergency Management Presidency
ASAM
KAMER
Ministry of Health
Positive Life
Red Umbrella
Turkish Red Crescent Society
UNFPA

Turkmenistan
MCH Institute
Ministry of Health and the Medical Industry of Turkmenistan
UNFPA

Ukraine
Ministry of Internal Affairs
Ministry of Health
UNFPA
HIV Alliance Ukraine (NGO)
State Service on HIV and TB
Women's Health and Family Planning (IPPF member association)

Uzbekistan
Ministry of Health (Mother and Child Health and Disease Prevention/Health Response in Crisis Unit)
UNFPA

Kosovo (UNCSR 1244)
Kosovo Red Cross
Ministry of Health
UNFPA

Introduction

Regional background

The countries/territories of Eastern Europe and Central Asia are prone to both natural and manmade disasters, which pose a threat to the survival and well-being of their populations, particularly children and women.[2] Over the last three years, the region has faced several humanitarian situations, from the arrival of migrants and refugees in Europe, particularly through the Balkan route, to floods and other natural disasters in various parts of the region.

To better coordinate all efforts for humanitarian response and emergency preparedness, the Inter-Agency Working Group (IAWG)[3] on Reproductive Health (RH) in Crises for Eastern Europe and Central Asia (EECA IAWG) was established in 2011 at the 13th annual meeting of the Global Inter-Agency Working Group on RH in Crises.[4]

In 2012, a mapping exercise was conducted that provided an overview of the status of humanitarian responses and emergency preparedness in terms of sexual and reproductive health (SRH) at the country level in the EECA region. This exercise highlighted the need for technical assistance for national stakeholders and governments to ensure better integration of SRH into national preparedness and inter-agency contingency plans. To address this gap, the MISP readiness assessment tool was developed in 2013 to help countries assess their readiness for SRH in crisis situations. The tool is aimed at assessing the extent to which a country is ready to develop and implement an adequate response to SRH needs in emergency situations. It is designed to be used by national SRH stakeholders, whether familiar or not with the MISP concept. It is also intended to serve as an internal tool for national partners to monitor the progress of their readiness to provide MISP services.

The baseline was conducted in 2014, when 18 country teams completed an assessment. The main findings revealed that, overall, there was a good enabling environment in most countries of the region to provide SRH services during emergencies: the integration of MISP services into national health emergency response plans and compliance with international standards were, on average, rated as fair. One very weak but key area for improvement in terms of preparedness was coordination, whether this involved national partners from one entity or sector or external actors from other sectors and neighbouring countries. To address the issue of coordination and to contribute to progress in MISP preparedness in general, all countries involved in the process agreed during the IAWG Forum in 2014 to take actions to improve national coordination.

From 2014 to 2017, with the support of the EECA IAWG, the country teams developed yearly national action plans to address, among other things, the lack of coordination. The purpose of these national action plans was to monitor improvement and to structure work at the country level to ensure focused actions.

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[2] See Annex 4: INFORM risk rating for EECA countries.

[3] Launched in 1995, the global Inter-Agency Working Group (IAWG) on Reproductive Health in Crises is a broad-based, collaborative coalition composed of United Nations (UN), nongovernmental, governmental, research, and donor organizations as well as committed individual members that work to expand and strengthen access to quality sexual and reproductive health services for people affected by conflict and natural disaster. IAWG currently has almost 2,500 members representing 450 organizations and is led by a 20-member Steering Committee.

[4] The following countries/territories in the EECA region participated in the MISP readiness assessment process: Albania, Armenia, Azerbaijan, Belarus, Bosnia and Herzegovina, Bulgaria, Georgia, Kazakhstan, Kyrgyzstan, the former Yugoslav Republic of Macedonia, Moldova, Romania, Serbia, Turkey, Tajikistan, Turkmenistan, Ukraine and Uzbekistan, as well as Kosovo (UNSCR 1244).

The second MISP readiness assessment was conducted in 2017, and this report highlights the main achievements and improvements regarding MISP preparedness in the EECA region.

The MISP readiness assessment tool

The development of the MISP readiness assessment tool was a joint initiative of the IPPF European Network Regional Office and the UNFPA Eastern Europe and Central Asia Regional Office.

The MISP for SRH in crises is a coordinated set of life-saving priority activities to be implemented at the outset of any humanitarian crisis. It forms the starting point for reproductive health programming and should be sustained and built upon with comprehensive reproductive health services throughout protracted crises and recovery.

The tool is made up of a set of indicators that measure a country's readiness to implement the MISP in comparison with an ideal state of SRH-related emergency preparedness. In total, there are 38 qualitative and quantitative indicators linked to the five MISP objectives.

The indicators describe some elements of the disaster management system in place in the country in question, while others concern health coordination and SRH coordination. Yet other indicators focus on capacities and minimum services for sexual and reproductive health to be implemented from the outset of an emergency.

Assessment of **national capacity** to respond to SRH needs:

- Enabling environment
- Efficient response coordination
- Integration of the MISP in emergency response plans
- Capacities and resources

In each country, the assessment was completed by national experts from the relevant institutions involved in sexual and reproductive health, such as the Ministry of Health, IPPF member associations, the UNFPA, the national society of the Red Cross/Red Crescent, NGOs and other institutions. A total of 126 organizations participated in the assessment. (A list of participating institutions and organizations for each country can be found at the beginning of this report.)

The analysis in this report is based on the rating of the indicators provided by each national team,[5] as well as on detailed answers to the questionnaires.

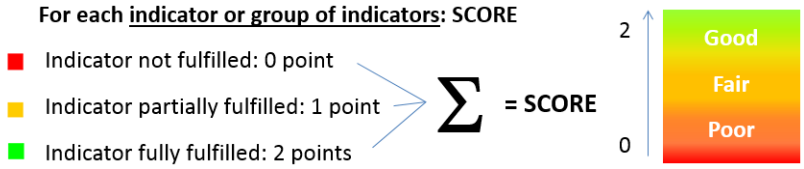
Quantitative and qualitative analysis of the indicators

Each indicator was rated by the relevant country team based on their answers to the questionnaire. Indicators could be rated as "fully fulfilled", "partially fulfilled" or "not fulfilled".[6]

The purpose of this analysis is not to propose a ranking of countries' readiness to provide MISP in case of an emergency but to help both the EECA IAWG and the countries involved set priorities to improve their readiness. The analysis provides an average region-wide readiness status for each MISP objective.

For the purpose of this analysis and to present a clear picture of countries' readiness for each objective, an average score for each indicator for the 19 countries/territories was calculated. On average for the region, an indicator can be rated as "good", "fair" or "poor". This terminology will be used throughout the report.

For each objective, one graphic is provided that illustrates the proportion of indicators rated "fully fulfilled", "partially fulfilled" and "not fulfilled", using the usual traffic-light colours of green (fully fulfilled), orange (partially fulfilled) and red (not fulfilled). Qualitative analysis was also performed, and special highlights are provided based on the answers to the questions for each indicator.

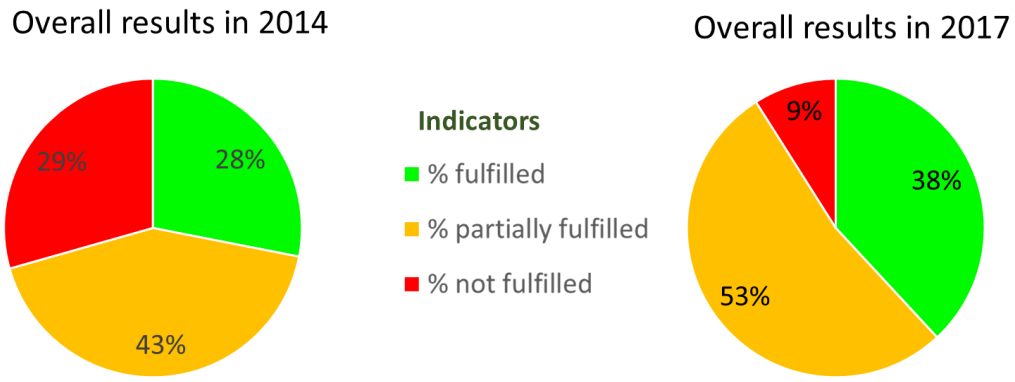


[5] National teams, or country teams, consist of government representatives, civil society organizations and UN agencies. The composition of teams can vary from one country to another.

[6] Details can be found in the 2014 report at http://eeca.unfpa.org/sites/default/files/pub-pdf/EN_REPORT%20_%20EECA-IAWG-MISP-Readiness-Report_final.pdf.

General regional overview to provide the MISP in case of an emergency

Overall MISP preparedness in the region



The results of the MISP readiness assessment for 2017 show that there has been a significant improvement regarding preparedness in the region compared to the baseline conducted in 2014. The results regarding the indicators are very promising, going from fair preparedness overall (0.98 out of 2) in the region to good preparedness overall (1.3 out of 2). More than half of the indicators were partially fulfilled, and 38 per cent of the indicators were rated as fully fulfilled (compared to 28 per cent in 2014).

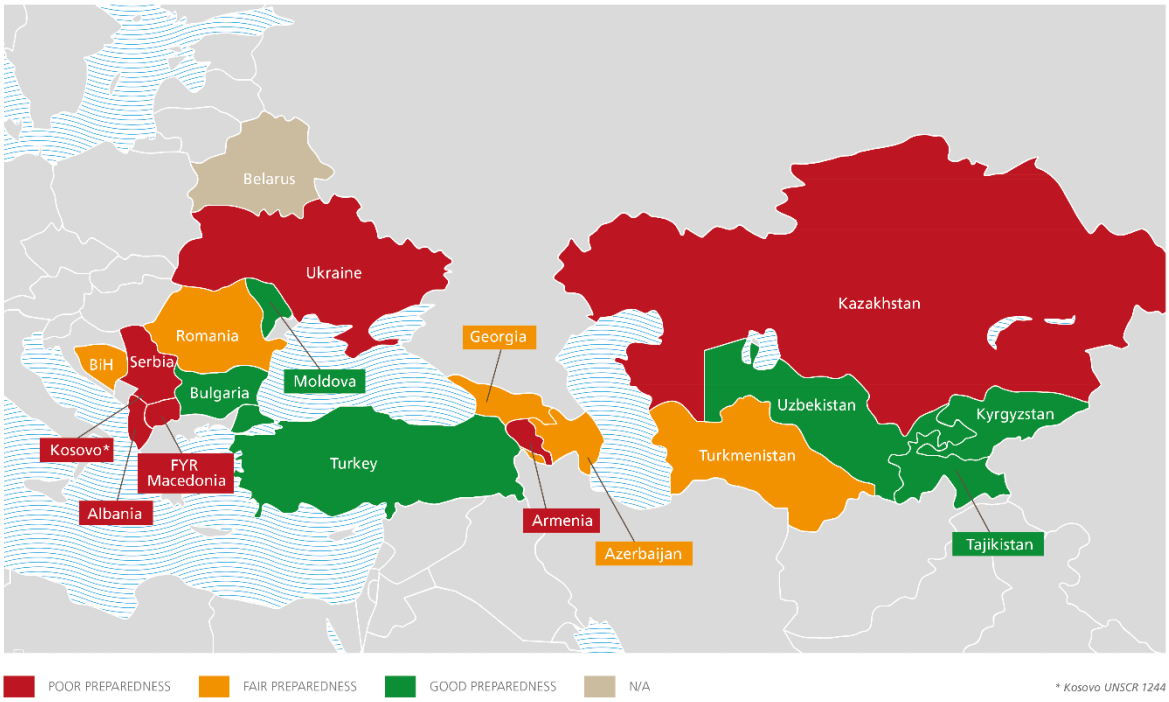
These results show that more countries are considering the importance of including SRH in their preparedness and emergency response plans. The percentage of indicators that were "not fulfilled" has dropped significantly, meaning that these countries are adopting a more comprehensive approach to SRH preparedness and have started addressing more indicators compared to 2014.

Significant improvements can be observed for all MISP objectives and particularly for those on disaster risk management, coordination (objective 1) and prevention of sexual violence (objective 2).

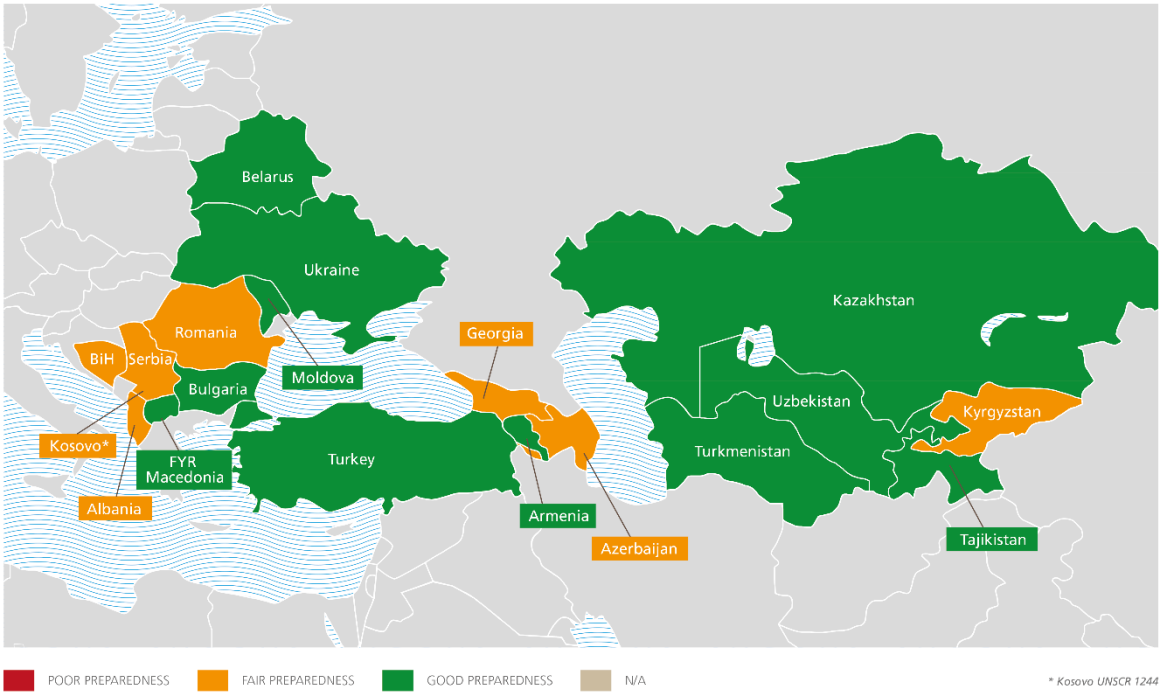
The maps below show improvements at the country/territory level[7]. In 2017, none of the countries/territories were rated as having a poor level of preparedness. Some very promising results show that with the work conducted over the last three years, some countries went from a poor level of preparedness in 2014 to a good level of preparedness in 2017. This was the case for Armenia, Kazakhstan, the former Yugoslav Republic of Macedonia and Ukraine.

[7] The maps are not meant to compare the state of one country/territory with another country/territory in the same year. They are to show the improvement a country/territory made from 2014 to 2017.

MISP READINESS ASSESSMENT RESULTS IN 2014



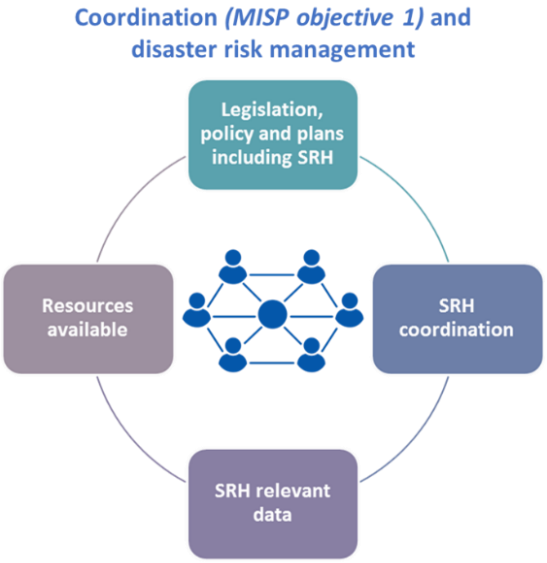
MISP READINESS ASSESSMENT RESULTS IN 2017



Key findings per MISP objective

MISP objective 1 (SRH coordination): disaster management system (including emergency response preparedness) and the national health emergency management system and plans

General overview of the indicators



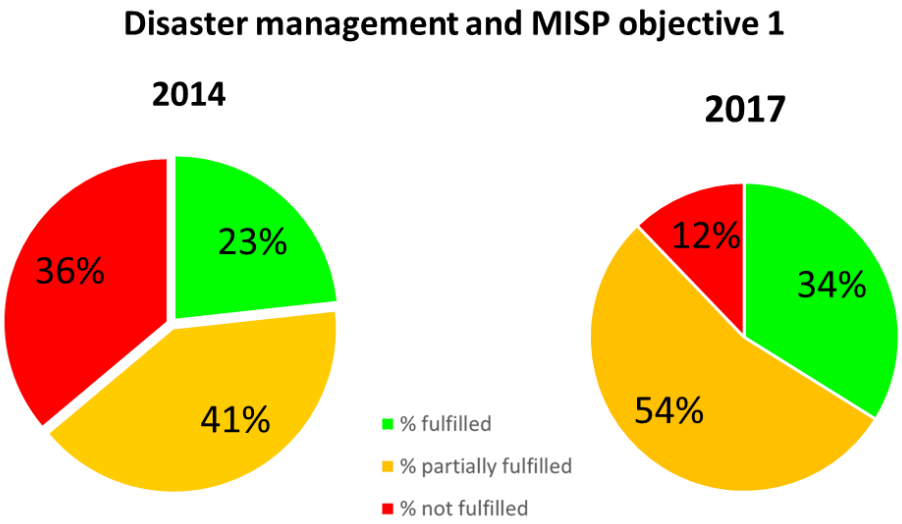
The first block is made up of 16 indicators that take account of both a country's disaster management system and the elements of MISP objective 1. They are aimed at capturing a broad picture of the global disaster management system in the respective country, gradually zooming into the health sector and looking more precisely at the space for sexual and reproductive health both in normal times and in crisis situations within the disaster management system. They also evaluate the resources allocated to sexual and reproductive health in humanitarian settings and the efficiency of SRH coordination in both normal (established coordination) and crisis times (foreseen coordination).

MISP objective 1 (SRH coordination), disaster management system (including emergency response preparedness) and the national health emergency management system and plans	
1	Existence of national disaster legislation and policy that has health sector related provisions
2	Existence of national health legislation and policy corresponding with the national disaster legislation
3	Existence of a health sector emergency response plan which entitles SRH priority services as outlined in the MISP
4	Existence of other emergency response plans, contingency plans or action plans with provisions of SRH priority services as outlined in the MISP
5	Comprehensiveness of different crisis scenarios covered within the health sector emergency response plan and other response plans, incl. sub-national small-scale crisis
6	Existence of a health coordination body in charge of health-related emergency preparedness and response
7	Existence of an effective SRH working group within the health coordination
8	Evidence of effective cooperation of the SRH working group with other relevant sectors
9	Existence of a risk assessment providing updated SRH-related information on population at national and sub-national level with sex and age-disaggregated data
10	Integration of SRH Indicators within existing health information systems (HIS)
11	Availability of resources at national level and sub-national levels to implement the 5 objectives of the MISP (financial resources, human resources and supplies) for the affected population, from the onset of an emergency

12	Existence of appointed SRH Focal Points at national level and sub-national levels for emergency preparedness and response
13	Evidence that existing structures providing SRH services are prepared to respond to an emergency
14	Evidence that members of the SRH working group are prepared to respond to an emergency
15	# and type of medical and non-medical personnel trained to the MISP at national and sub-national levels
16	Mapping of stakeholders (public, non-governmental, private) involved in SRH per region

Summary of key findings

Overall, the results of the region-wide analysis on disaster management systems and health disaster legislation were fair. Six out of 16 indicators received a good score, nine out of 16 a fair score and only one indicator (indicator 14) a poor score. There was a general trend of improvement for this objective. Most of the indicators saw an increase in their scores, and some a very significant increase, such as indicators 7 (existence of an effective SRH working group), 9 (existence of an SRH-related risk assessment) and 12 (existence of an appointed SRH focal point).



- **The overall results of the preparedness assessment regarding MISP objective 1 (SRH coordination), disaster management system (including emergency response preparedness) and the national health emergency management system and plans improved by 40 per cent from 0.87 to 1.22 (out of 2) with, on average, a fair score;**
- **The indicators linked to coordination (indicators 7, 8, 12, 14 and 16) improved significantly from a poor rating (0.5 out of 2) in 2014 to a fair rating (1 out of 2) in 2017;**
- **Indicator 7, which considers the existence of an effective SRH working group, showed the most improvement (+144 per cent) out of all indicators;**
- **These results show that the efforts made to improve coordination over the last three years have had a positive impact on the overall preparedness results in the region.**

Focus on some key findings for MISP objective 1

Improving national SRH coordination

SRH coordination is an essential part of preparedness and response work. A group of indicators (7, 8, 12, 14, and 16) can be used to make a qualitative assessment of coordination for SRH in crisis settings. While these indicators received a poor score in 2014, all their scores doubled in 2017. Indicator 7 (effective SRH working group) improved from poor to fair over the last three years. This indicator was particularly worrying in the 2014 MISP assessment, with no country having an effective SRH working group in place. Most of the countries (63 per cent) assessed had neither an established SRH working group nor terms of reference for a national SRH working group. Therefore, the regional IAWG decided to focus its effort on this specific area. Over the last three years, with the support of the EECA IAWG, the country teams developed yearly national action plans to address, among other priorities, this lack of coordination. The purpose of these national action plans was to monitor improvement and to structure work at the country level to ensure focused actions. The results of the 2017 assessment show that only two countries have an officially approved SRH working group to date (Albania and Turkmenistan), while 14 additional countries (74 per cent) have established an SRH working group that still needs a formal endorsement from the Ministry of Health (MoH). The work on coordination also had a significant impact on other indicators linked to coordination: 11 countries have an effective SRH working group, 12 countries have developed terms of reference for their SRH working group, and eight countries have appointed an SRH focal point.

Number of countries/territories (out of 19)	
Number of countries/territories with a health emergency response plan	16
Inclusion of MISP in the health emergency response plan	11
Number of countries/territories with an effective SRH working group	11

Whereas the countries/territories in the EECA region have really improved in terms of coordination, the assessment shows that additional efforts are needed to ensure that the SRH working groups are also prepared and equipped to respond to an emergency (indicator 14).

Considering different crisis scenarios and being better prepared

Indicator 5 considers the comprehensiveness of the different crisis scenarios covered within countries' health sector emergency response plan and other response plans, including for small-scale crises that could happen at the subnational level. Since 2014, every country assessed improved drastically in this aspect in terms of preparedness. It was particularly important for each country to increase its readiness to implement the MISP in case of a crisis. Since most countries in the EECA region can be affected by a broad spectrum of crises, as varied as localized floods, large-scale earthquakes that could lead to a complex humanitarian crisis affecting several countries or the sudden influx of thousands of migrants and refugees from neighbouring countries. While Serbia and Ukraine did not fulfil this indicator in 2014, the 2017 results show that both countries now have some provision with regard to considering temporary/small-scale crises and population movements.

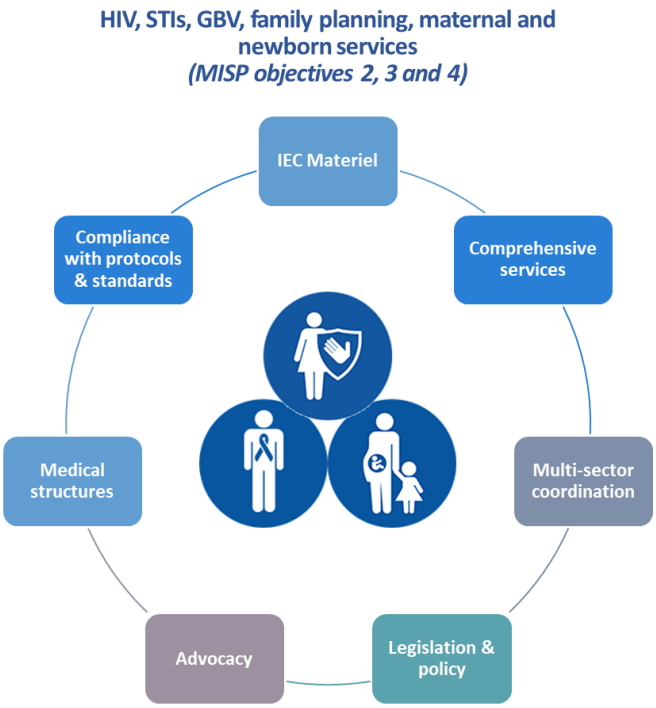
Assessing and improving safety at existing medical structures

Since the safety of medical structures in case of natural disasters is one of the keys to providing services in the early phase of a crisis, the EECA IAWG organized a specific session in 2016 on the WHO Safe Hospital Initiative. While working on their preparedness plans each year, country teams were encouraged to cooperate with the WHO and to ensure that such safety assessments are conducted in

their countries. The results show that from only two countries where a safety assessment had been conducted in 2014 (the former Yugoslav Republic of Macedonia and Moldova), there are now eight additional countries/territories: Armenia, Bulgaria, Georgia, Kyrgyzstan, Tajikistan, Turkmenistan and Ukraine, as well as Kosovo (UNSCR 1244).

Consequently, this contributed to improving the general score regarding indicator 13 (whether existing facilities involved in SRH are prepared to respond to an emergency), which increased significantly, with all 19 countries/territories partially fulfilling the indicator.

Minimum services for Sexual and Reproductive Health



The indicators linked to MISP objectives 2, 3 and 4 are all structured in a similar way. For each of these objectives, seven indicators measure the readiness of the respective country at both the legislative (laws and policies) and practical levels. They consider the existing medical and non-medical structures that usually provide services for survivors of sexual violence, HIV and STI services and minimum maternal and neonatal health services and contraception, under normal conditions, and the knowledge that national experts have of these existing structures. At the same time, the indicators evaluate the type of planned emergency services with regard to the MISP and international standards. Finally, they take account of coordination and information on the services to be provided to survivors of sexual violence, to reduce HIV transmission, to treat STIs, to prevent excess maternal and neonatal mortality and morbidity and to meet the demand for contraceptives in times of crisis.

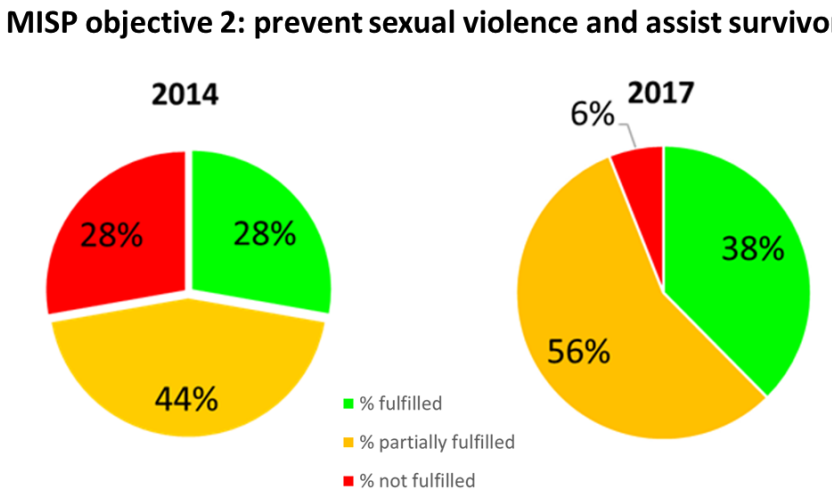
MISP objective 2: prevent sexual violence and assist survivors

General overview of the indicators

MISP objective 2: prevent sexual violence and assist survivors	
17	Existence of national legislation and policy with provisions supporting prevention and response to sexual violence
18	Existence of advocacy on provisions within the national legislation and policies that restrict prevention and response to sexual violence
19	#, type and capacities of existing medical and non-medical structures and networks involved in prevention and response to sexual violence at national and sub-national levels
20	Evidence of compliance of planned services provided under this objective with national and international protocols and standards
21	Comprehensiveness of the services of SRH in emergency provisioned in the national health sector emergency response plan and planned by the SRH Working Group and other stakeholders at national and sub national level in accordance with the MISP Objective 2 (1- Protection System in place, especially for women & girls; 2 - Medical services available for survivors; 3 - Psychosocial support available for survivors; 4 - Community aware of services)
22	Existence of multi-sectoral coordination mechanisms between health and other sectors stakeholders for prevention and response to sexual violence from the onset of an emergency
23	Accessibility and availability of information for the community, including vulnerable groups from the onset of an emergency

Summary of key findings

Overall, the readiness of most countries/territories in the EECA region to implement MISP objective 2 improved since the 2014 assessment. Six of the indicators assessing the readiness to implement this objective saw an improvement in their scores (indicators 17, 18, 20, 21 and 22), with the remaining indicator (indicator 19) receiving the same score. Three indicators (17, 18 and 23) received good scores, and the remaining four indicators (19, 20, 21 and 22) received fair marks.



- **Overall, the seven indicators describing the state of readiness in the region to implement the second MISP objective increased significantly, improving from a fair state of preparedness in 2014 to a good state of preparedness in 2017 (0.92 to 1.31 out of 2)**
- **Focusing on priority services for survivors of sexual violence in the health emergency response plan or in any other plan (indicators 20 to 23), the readiness to provide minimum services as entailed in objective 2 of the MISP is assessed as fair, with an improvement compared to 2014 (going from 0.75 in 2014 to 1.12 in 2017).**

Focus on some key findings for MISP objective 2

Ensuring the availability of information for the communities in the most-at-risk areas, including linguistic minorities

Indicator 23, which considers the availability and accessibility of information for the community, had a good score, showing improvement from 2014, when it received only a fair score. Eight countries (Armenia, Bulgaria, Moldova, Serbia, Tajikistan, the former Yugoslav Republic of Macedonia, Turkey and Turkmenistan) now ensure full accessibility and availability of information for the community, including vulnerable groups, from the outset of an emergency compared to only five countries in 2014. Eight countries, compared to six in 2014, are ready to provide information for linguistic groups in the most-at-risk areas. In addition, the number of countries not fulfilling this indicator dropped from nine in 2014 to three in 2017, which shows a significant improvement (62.4 per cent). Over the past three years, the regional EECA IAWG has emphasized the importance of developing and sharing relevant IEC materials within the region and making them available in different languages. Efforts still need to be made at the regional level to ensure that more information and materials are shared among peers, and this work has already started.

Improving multisectoral coordination mechanisms

Indicator 22, which considers the existence of multisectoral mechanisms, improved from poor (0.7) to fair (1.0). A multisectoral approach is essential when providing care in the area of sexual violence. In 2014, nine countries had no multisectoral coordination mechanism at all. This improved significantly in 2017, with only three countries not fulfilling the indicator. Efforts are still needed, however, as only three (Armenia, Moldova and Turkey) out 19 countries reported that they have adequate mechanisms for addressing multisectoral coordination between health and other sectors for prevention and response to sexual violence from the outset of an emergency.

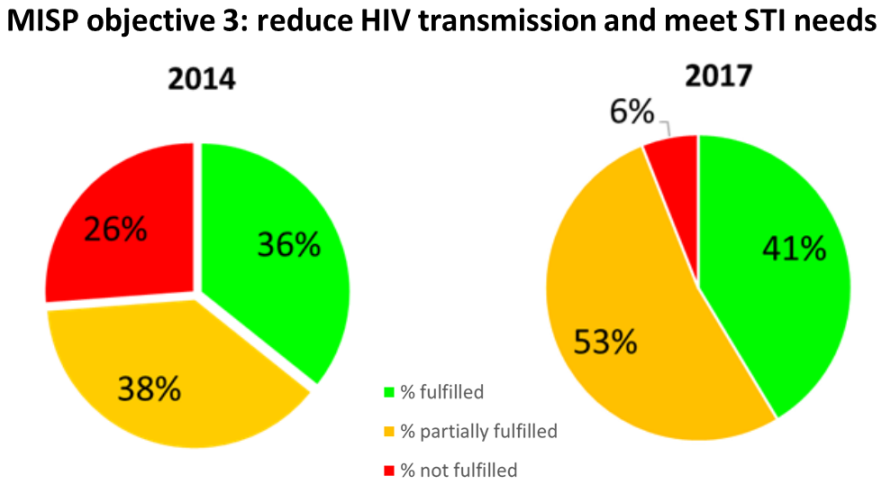
MISP objective 3: reduce HIV transmission and meet STI needs

General overview of the indicators

MISP objective 3: reduce HIV transmission and meet STI needs	
24	Existence of national legislation and policy with provisions supporting reducing HIV transmission and meeting STI needs
25	Existence of advocacy on provisions within the national legislation and policies that restrict reducing HIV transmission and meeting STI needs
26	#, type and capacities of existing medical structures providing HIV and STI services at national and sub-national levels
27	Evidence of compliance of planned services provided under this objective with national and international protocols and standards
28	Comprehensiveness of the services of SRH in emergency provisioned in the national health sector emergency response plan and planned by the SRH Working Group and other stakeholders at national and sub national level in accordance with the MISP Objective 3 (1 - Rational & safe blood transfusion in place; 2 - Standard Precautions practiced; 3 - Free condoms available and accessible; 4 - ARVs available for continuing users; 5 - PMTCT[1] in place; 6 - Needs of individuals with STIs met)
29	Existence of multi-sectoral coordination mechanisms between health and other sectors stakeholders to reduce HIV transmission and meet STI needs in crises from the onset of an emergency
30	Accessibility and availability of information for the community, including vulnerable groups from the onset of an emergency

Summary of key findings

Overall, the readiness of countries/territories to implement MISP objective 3 received a good score (1.35 out of 2). Six out of the seven indicators received a higher score in 2017 compared to 2014.



- **Overall, the seven indicators describing the state of readiness in the region to implement the third MISP objective improved significantly, going from a fair state of preparedness in 2014 to a good state of preparedness in 2017 (1.09 to 1.35 out of 2)**
- **The planned services in the health emergency response plan or any other plan for reducing HIV and meeting STI needs as entailed in MISP objective 3 (indicators 27 to 30) was fair, with an improvement compared to 2014 (0.82 to 1.16 out of 2).**

Focus on some key findings for MISP objective 3

Ensuring that the affected population is aware of available services for HIV and STIs

There was improvement in the accessibility and availability of information for the community, including vulnerable groups, from the outset of an emergency. While only five countries (Armenia, Bulgaria, Tajikistan, Turkey and Uzbekistan) can claim that this information is readily available in a way that meets MISP standards, another 12 ensure at least partial access to such information (indicator 30). This is an improvement compared to 2014, when only six countries reported partial availability and seven countries reported no availability.

Improving multisectoral coordination

Similar to MISP objective 2, multisectoral cooperation in relation to minimum services to reduce transmission of HIV and STIs improved from poor (0.7) to good (1.4). Most of the countries assessed (10[8]) reported having plans in place for multisectoral coordination mechanisms between health and other sectors to reduce HIV transmission and meet STI needs in crises from the outset of an emergency (indicator 29).

Provision for STI services as compared to HIV services

In 2014, an analysis showed that there was less inclusion of STI services than HIV services (six countries with minimum HIV services in their response plan did not have similar minimum provisions for STI services). This was brought to the attention of country teams when working on preparedness since then. The 2017 results show that this discrepancy was significantly reduced: there are now 17 countries that are provisioning for STI services when planning for HIV services.

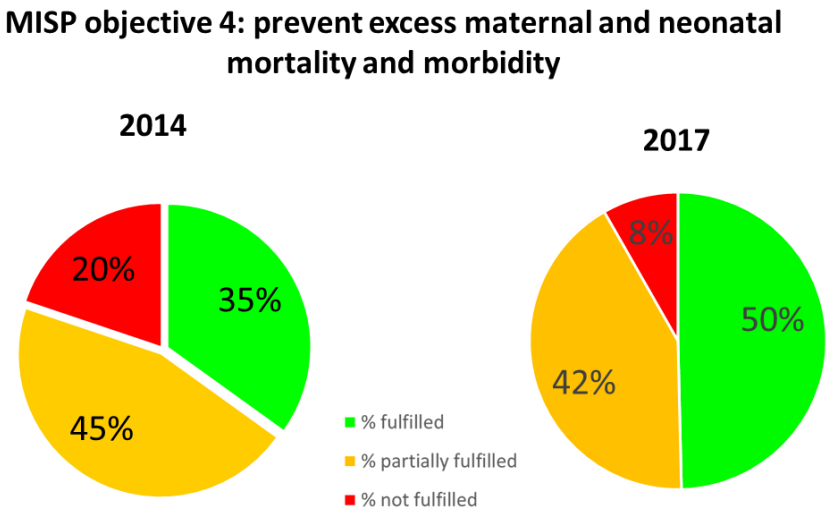
[8] Armenia, Bosnia and Herzegovina, Kazakhstan, Kyrgyzstan, Moldova, the former Yugoslav Republic of Macedonia, Turkey, Turkmenistan, Ukraine and Uzbekistan.

MISP objective 4: prevent excessive maternal and neonatal mortality and morbidity

General overview of the indicators

MISP objective 4: prevent excessive maternal and neonatal mortality and morbidity	
31	Existence of national legislation and policy with provisions supporting providing priority maternal and newborn health services in crises
32	Existence of advocacy on provisions within the national legislation and policies that restrict providing priority maternal and newborn health services in crises
33	#, type and capacities of existing medical structures providing priority maternal and newborn health services at national and sub-national levels
34	Evidence of compliance of planned services provided under this objective with national and international protocols and standards
35	Comprehensiveness of the services of SRH in emergency provisioned in the national health sector emergency response plan and planned by the SRH Working Group and other stakeholders at national and sub national level in accordance with the MISP Objective 4 (1 - Emergency Obstetric & Neonatal Care (EmONC) services available; 2 - 24/7 Referral System for obstetric & newborn emergencies established; 3 - Clean Delivery Kits provided to visibly pregnant women & girls & birth attendants; 4 - Community aware of services; 5 - Contraceptives available to meet demand)
36	Existence of multi-sectoral coordination mechanisms between health and other sectors stakeholders to support the implementation of priority maternal and newborn health services in crises from the onset of an emergency
37	Accessibility and availability of information for the community, including vulnerable groups from the onset of an emergency

Summary of key findings



- **Overall, the seven indicators describing the state of readiness in the region to implement the fourth MISP objective improved significantly from a fair state of preparedness in 2014 to a good state of preparedness in 2017 (from 1.15 to 1.41 out of 2)**

- **Planned services for the prevention of excessive maternal and neonatal mortality and morbidity in the health emergency response plan or in any other plan (indicators 34 to 37) were scored as fair, with an improvement compared to 2014 (going from 0.96 to 1.24).**

Focus on some key findings for MISP objective 4

Integrating post-abortion care as part of planned MNH services (as entailed in the MISP)
The results of the 2014 assessment showed that the integration of post-abortion care services in response plans, as included in the MISP, was not sufficient, with only 10 countries having such provisions. The data from 2017 shows that there has been an improvement, with 14 countries[9] providing post-abortion care as part of MNH services.

Meeting the demand for contraception in emergency settings
Provisions for contraception in emergency response plans were a concern in 2014, with only eight countries planning to meet the demand for contraception in humanitarian crises. This did not improve despite the presence of family planning associations within the country teams and regional and global efforts to highlight the problem. With a revised inter-agency field manual for SRH in crises to be published in the spring of 2018, there will be a stronger focus on the provision of contraception, including long-acting reversible contraception. National country teams will have to take this into account.

Ensuring the comprehensiveness of planned MNH services
With regard to the comprehensiveness of planned services (indicator 35), countries' preparedness is fair: no country had a successful rating for this indicator, but 18[10] out of 19 countries/territories had a significant part of such services planned, and only one country had no such services planned at all (compared to three in 2014).

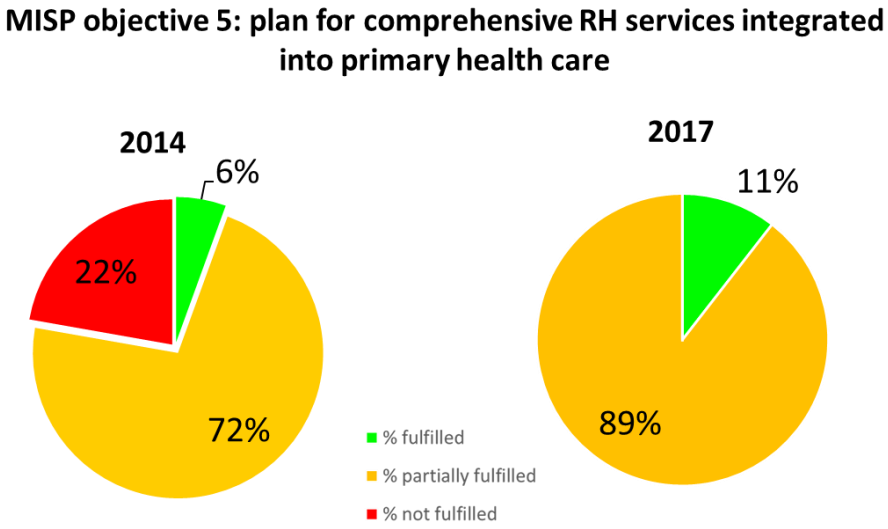
MISP objective 5: plan for comprehensive RH services integrated into primary health care (partial)

The assessment tool's last indicator looks at parts of MISP objective 5, which deals with planning for comprehensive RH services as soon as the situation allows. This objective can be achieved if monitoring and data collection tools are foreseen: this means in particular that SRH indicators must be integrated into the respective country's health information system, and that the response plan for each MISP objective must provide for monitoring tools, the measurement of MISP indicators from the outset of a response and the collection of SRH data on affected populations as the situation allows.

[9] Albania, Azerbaijan, Bosnia and Herzegovina, Bulgaria, Kazakhstan, Kyrgyzstan, Moldova, Serbia, Tajikistan, the former Yugoslav Republic of Macedonia, Turkey, Turkmenistan, Ukraine and Uzbekistan.
[10] Albania, Armenia, Azerbaijan, Bosnia and Herzegovina, Bulgaria, Georgia, Kazakhstan, Kyrgyzstan, Moldova, Romania, Serbia, the former Yugoslav Republic of Macedonia, Turkey, Tajikistan, Turkmenistan, Ukraine and Uzbekistan, as well as Kosovo (UNSCR 1244).

General overview of the indicators

MISP objective 5: plan for comprehensive RH services integrated into primary health care	
38	Monitoring and SRH data collection tools are prepared to be used from the onset of an emergency



- **Across the region, the readiness of countries/territories to monitor and collect SRH data from the outset of their response to an emergency remains fair, with an improvement of 33 per cent, from 0.83 in 2014 to 1.10 in 2017.**

Summary of key findings

Only two countries (Armenia and Turkmenistan) were able to fulfil this indicator's requirements. The remaining 17 countries/territories reported having some partial monitoring and data collection tools in place.

Since 2014, efforts have been made at the regional level to highlight the importance of having monitoring tools ready to use. The MISP checklist, which provides a basis for monitoring the implementation of each of the MISP components, was translated and shared among the countries of the region. Country teams started engaging the Ministry of Health in their respective country, advocating for the integration of SRH indicators into the national Health Information System (HIS). This is a long process that will require time and follow-up.

Recommendations

Recommendations for country teams

The results of the second MISP readiness assessment show that significant improvements regarding SRH preparedness have been achieved compared to the baseline conducted in 2014. The national partners that were involved in the MISP readiness assessment should review the results of their indicators and identify the remaining gaps regarding SRH preparedness. As for previous years, they should draw up meaningful action plans for those indicators that have not yet been successfully achieved. The questions behind each indicator are a powerful tool to guide national action planning. With regard to the achievements and results, the following recommendations should be considered by the country teams:

- **Continue investing in effective coordination through the SRH working group**
    - Major achievements have been reached in this area in the region. Close collaboration between civil society, the UN, governments and national parliaments is essential. In countries where the formal adoption of an SRH working group is a challenge, this should not prevent country teams from setting up informal groups where SRH issues are discussed. Drafting terms of reference helps structure the work of the working groups and mitigates the risks related to high staff turnover.
- **Continue investing in SRH services and supplies as part of an essential health package in emergencies and implementation of the Sendai Framework for Disaster Risk Reduction (DRR)**
- **Continue advocating for MISP integration in national emergency response plans**
    - Knowledge of the importance of including SRH in response plans in the region has increased over the years. At the 2016 EECA IAWG meeting, the country teams benefitted from a session on MISP advocacy. In line with the work done around preparedness and action planning, the country teams should develop national advocacy strategies around SRH in crises, identifying the areas that need improvement and tailoring their advocacy activities towards them. National SRH working groups are encouraged to frame their advocacy message in line with global commitments such as the 2030 Sustainable Development Goals (SDGs), which specifically require the scaling-up in emergency settings of maternal, neonatal and adolescent health services to ensure safe delivery, HIV prevention and treatment, improved access to information on SRH and reproductive rights, emergency contraceptive services, voluntary family planning, necessary medical and psychological services for GBV survivors, as well as improved capacity of health systems and health workers.
- **Ensure that preparedness work is put into action in case of a response phase**
    - Work on preparedness has been very important in the region. Country teams should ensure that preparedness work can be put swiftly and efficiently into action. In accordance with the “joint statement on SRH in emergencies” made at the 2016 World Humanitarian Summit and the commitments taken by many organizations and governments, national SRH working groups should work with the governments and national partners with the aim to reach a level of preparedness that will allow them to roll out the MISP within 48 hours of an emergency and implement comprehensive SRH services as soon as possible after an emergency.

- Some countries in the EECA region have faced humanitarian crises in recent years when emergency responses were needed. Monitoring and evaluation of the implementation of MISP-related activities and the collection of SRH data in response phases are needed to learn key lessons from the success and the mistakes of past responses and to inform continuous improvements of future preparedness work in the region.

❖ **Become familiar with and disseminate the upcoming inter-agency field manual (IAFM) for SRH in crises at the national and subnational levels**

- The revised IAFM will be available in the spring of 2018. The country teams should familiarize themselves with the manual and disseminate it among relevant stakeholders. This can be used as an opportunity to bring attention to SRH in crises.

❖ **Advocate for resource mobilization to support the regional EECA IAWG**

- The regional IAWG has been an incredible added value for the national teams. The regional support of the IAWG Secretariat has helped country teams improve their overall SRH preparedness. The positive feedback received from all SRH national working groups on the importance of the annual forum, the exchange of information, lessons learned and technical support from the IAWG Secretariat demonstrate the need to sustain the regional IAWG. There is thus a need for proactive resource mobilization at the country level to ensure the continuation of the EECA IAWG.

Recommendations for regional coordination (EECA IAWG)

The regional EECA IAWG is the only functional regional IAWG. The successes achieved in recent years have been significant. To ensure the sustainability of, and further improvements on, these results, the following recommendations should be considered for regional coordination:

- **Continue providing technical assistance, support and guidance to national country teams, with a focus on the countries that are most at risk**
    - The coordinating role of the EECA IAWG is essential for country teams. The EECA IAWG should continue liaising regularly with the national partners and should share relevant information, support national action planning, provide guidance for national implementation of activities and connect different regions and/or countries together where needed. The launch of the revised IAFM will be an opportunity to update all EECA IAWG members on new developments and changes regarding SRH provision in emergencies.
- **Provide the opportunity to country teams to learn from each other and share experiences**
    - From 2012 to 2016, the EECA IAWG organized yearly meetings to bring the country teams together to reflect on the work conducted, share good practices and learn from one another. These important gatherings were highly appreciated by the participants.
    - The EECA IAWG should engage in proactive resource mobilization by also liaising with the global IAWG. Opportunities to continue regular regional (or subregional) meetings will be crucial.
    - Organize and encourage effective sharing of IEC material and tools between country teams on all matters. Whereas improvements can be observed with regard to information sharing and availability, a more comprehensive library of relevant IEC materials should be set up.
- **Raise the visibility and impact of initiatives conducted in the EECA region**
    - Liaise with European and CIS partners and promote the humanitarian response and preparedness work on SRH in EECA countries.
    - Increase the number of organizations members of the regional EECA IAWG, and reach out to organizations with regional role, such as World Health Organization (WHO) or International Federation of the Red Cross Red Crescent (IFRC).
    - Continue liaising with the global IAWG, liaise with European partners and connect with other global partners working on DRR to promote the humanitarian response and preparedness work on SRH in EECA countries.
- **Ensure that national partners are equipped with knowledge and tools to integrate new topics at the forefront of the global agenda**
    - Make sure country teams fully commit to the 2030 Agenda and integrate the relevant SDGs into their preparedness activities. This should include consideration of the specific needs of adolescent girls and young female adults, unaccompanied children, LGBTI people and women and girls with disabilities or living with HIV in their preparedness activities, in line with the 2030 Agenda's "leave no one behind" pledge. This should also take into consideration the five recommendations of the Compact for Young People in

Humanitarian Action[11] to ensure that the SRH-related priorities, needs and rights of young women and young men, girls and boys affected by disaster, conflict, forced displacement and other humanitarian crises are addressed, and that they are informed, consulted and meaningfully engaged throughout all stages of humanitarian action.

Lessons learned from 2014 to 2017

The improvements between the baseline in 2014 and the 2017 results are quite encouraging and reflect the committed work of national country teams. At the regional level, the following lessons can be drawn:

- **The importance of regional meetings:** In 2012-2013, there was very little knowledge of SRH in crises and its importance in the region. The **yearly EECA IAWG meetings** made a real contribution to building knowledge and commitment in the region. They provided opportunities for networking and bringing different stakeholders together to discuss challenges, successes and lessons learned.
- **The successful multi-stakeholder approach:** Poor cooperation with non-governmental SRH bodies, such as ministries in charge of emergency situations, makes it challenging to access relevant plans, to cooperate, to have SRH services taken into account and to have technical staff (rescuers, civil defence) trained on SRH-related issues. The **multi-stakeholder approach** at the national level is instrumental in overcoming this challenge. Confirming the relevance of the approach chosen since 2014 in the EECA region, this assessment shows that countries that had a strong national team and also got non-traditional actors on board such as interior and emergencies ministries performed well. Engaging non-traditional actors, such as social workers in the former Yugoslav Republic of Macedonia, was crucial for improving the challenge of GBV management, for instance. The multi-stakeholder approach also allows for the delegation of activities and sharing of responsibilities.
- **Meaningful action planning based on an assessment:** The MISP readiness assessment tool has proven to be a very useful tool, but it is not sufficient by itself. Since it is comprehensive, many different stakeholders need to be involved for it to be complete. It is used to assess the situation and has to be considered as a first step. A joint planning exercise to improve MISP preparedness and response should take place subsequently with all stakeholders involved in the assessment. The completion of an MISP readiness assessment by a well-coordinated and committed SRH country team allows for meaningful action planning to improve SRH preparedness. It can also help get buy-in from government officials.
- **Sharing and learning from peers:** Sharing and learning were important parts of the process facilitated by the EECA IAWG Secretariat for the country teams. Policy documents, protocols and IEC materials were shared with peers and made available through an online platform.
- **Strategies tailored to the context:** With limited resources, there is a need to adapt strategies to the existing political environment. Close partnerships are needed with traditional and non-traditional partners to jointly strategize future actions to promote MISP preparedness.

[11] Compact for Young People in Humanitarian Action, launched during the World Humanitarian Summit (2016). See https://www.unfpa.org/sites/default/files/event-pdf/CompactforYoungPeopleinHumanitarianAction-FINAL_EDITED_VERSION.pdf.

- **Realistic approach:** Finally, when planning and working on comprehensive MISP preparedness, we recommend that SRH country teams prioritize SMART objectives, combining goals that can be achieved in the short term, allowing teams to earn some needed quick wins to get the buy-in of all partners, with more comprehensive goals that may be reached only in the longer term.

Conclusion

The achievements in the EECA region are unique, as they focus on assessing the existence of policies, infrastructures, capacities and an enabling environment for providing life-saving sexual and reproductive health services at the outset of a humanitarian crisis. The successes are the result of the joint efforts of 19 country teams composed of civil society organizations, UN agencies and relevant government counterparts. The country teams committed to focusing on improving the legal environment in case of an emergency, such as ensuring that the MISP is integrated into national health response plans and ensuring national SRH coordination through the establishment of national SRH working groups. For the future, it will be essential to maintain this momentum and continue improving SRH preparedness in the region. The way the work of the countries of the EECA IAWG was structured should ensure some sustainability of these actions.

Beyond the region, the work conducted in the EECA region was shared with the global IAWG at the annual meeting in Athens in November 2017. Other regions should seize the opportunity to learn from the EECA region and adapt it to other contexts and countries working on preparedness.

A lot of the MISP preparedness work is fully in line with the SDGs, and this work should be showcased more in that way, so as to show its alignment with global commitments.

We are also living at a unique time, when a light has been shone on sexual harassment and sexual violence against women and girls in developed and developing countries. In addition, refugees and migrants continue to arrive in Europe, fleeing war-ravaged countries. Although they are disappearing from the news, their situation has not improved enough in the region. Ensuring access to priority SRH services in every humanitarian crisis means making sure that everybody can receive life-saving SRH services. This includes preventing sexual violence and taking care of survivors. To ensure comprehensiveness, preparedness activities have to be enhanced to include, in a more systematic manner, adolescent girls and young female adults, unaccompanied children, LGBTI people and women and girls with disabilities or living with HIV, in line with the SDG pledge to “leave no one behind”.

Acknowledgements

This report was written by Nesrine Talbi, Programme Advisor at IPPF European Network, Sophie Pécourt, independent consultant; and Anna L. Thompson, an intern at IPPF EN. The report was reviewed by Emmanuel Roussier, Humanitarian Response Specialist at the UNFPA Eastern Europe and Central Asia Regional Office.

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Annexes

Annex 1: Results per indicator for 2014 and 2017

MISP objective 1 (SRH coordination), disaster management system (including emergency response preparedness) and the national health emergency management system and plans

#	Disaster management system (including emergency preparedness and response), the national health emergency management system and plans, SRH coordination (MISP objective 1), 2014: 18 countries/territories; 2017: 19 countries/territories	Fulfilled				Partially				No			
		2014		2017		2014		2017		2014		2017	
1	Existence of national disaster legislation and policy that has health sector related provisions	14	78%	16	84%	4	22%	3	16%	0	0%	0	0%
2	Existence of national health legislation and policy corresponding with the national disaster legislation	10	56%	12	63%	8	44%	7	37%	0	0%	0	0%
3	Existence of a health sector emergency response plan which entitles SRH priority services as outlined in the MISP	3	17%	8	42%	12	67%	10	53%	3	17%	1	5%
4	Existence of other emergency response plans, contingency plans or action plans with provisions of SRH priority services as outlined in the MISP	8	44%	16	84%	2	11%	1	5%	8	44%	2	11%
5	Comprehensiveness of different crisis scenarios covered within the health sector emergency response plan and other response plans, incl. sub-national small-scale crisis	2	11%	0	0%	14	78%	19	100%	2	11%	0	0%
6	Existence of a health coordination body in charge of health-related emergency preparedness and response	6	33%	5	26%	11	61%	14	74%	1	6%	0	0%
7	Existence of an effective SRH working group within the health coordination	0	0%	2	11%	7	39%	14	74%	11	61%	3	16%
8	Evidence of effective cooperation of the SRH working group with other relevant sectors	1	6%	1	5%	5	28%	12	63%	12	67%	6	32%
9	Existence of a risk assessment providing updated SRH-related information on population at national and	2	11%	7	37%	5	28%	7	37%	11	61%	5	26%

	sub-national level with sex and age-disaggregated data												
10	Integration of SRH Indicators within existing health information systems (HIS)	5	28%	10	53%	5	28%	6	32%	8	44%	3	16%
11	Availability of resources at national level and sub-national levels to implement the 5 objectives of the MISP (financial resources, human resources and supplies) for the affected population, from the onset of an emergency	1	6%	0	0%	13	72%	17	89%	4	22%	2	11%
12	Existence of appointed SRH Focal Points at national level and sub-national levels for emergency preparedness and response	3	17%	8	42%	3	17%	7	37%	12	67%	4	21%
13	Evidence that existing structures providing SRH services are prepared to respond to an emergency	0	0%	0	0%	10	56%	19	100%	8	44%	0	0%
14	Evidence that members of the SRH working group are prepared to respond to an emergency	0	0%	0	0%	8	44%	14	74%	10	56%	5	26%
15	# and type of medical and non-medical personnel trained to the MISP at national and sub-national levels	5	28%	6	32%	10	56%	11	58%	3	17%	2	11%
16	Mapping of stakeholders (public, non-governmental, private) involved in SRH per region	7	39%	12	63%	0	0%	3	16%	11	61%	4	21%

MISP objective 2: prevent sexual violence and assist survivors

#	MISP objective 2: prevent sexual violence and assist survivors, 2014: 18 countries/territories; 2017: 19 countries/territories	Fulfilled				Partially				No			
		2014		2017		2014		2017		2014		2017	
17	Existence of national legislation and policy with provisions supporting prevention and response to sexual violence	9	50%	15	79%	8	44%	4	21%	1	6%	0	0%
18	Existence of advocacy on provisions within the national legislation and policies that restrict prevention and response to sexual violence	12	67%	18	95%	4	22%	1	5%	2	11%	0	0%

19	#, type and capacities of existing medical and non-medical structures and networks involved in prevention and response to sexual violence at national and sub-national levels	1	6%	0	0%	16	89%	19	100%	1	6%	0	0%
20	Evidence of compliance of planned services provided under this objective with national and international protocols and standards	4	22%	4	21%	9	50%	15	79%	5	28%	0	0%
21	Comprehensiveness of the services of SRH in emergency provisioned in the national health sector emergency response plan and planned by the SRH Working Group and other stakeholders at national and sub national level in accordance with the MISP Objective 2[12]	0	0%	2	11%	10	56%	15	79%	8	44%	2	20%
22	Existence of multi-sectoral coordination mechanisms between health and other sectors stakeholders for prevention and response to sexual violence from the onset of an emergency	4	22%	3	16%	5	28%	13	68%	9	50%	3	30%
23	Accessibility and availability of information for the community, including vulnerable groups from the onset of an emergency	5	28%	8	42%	4	22%	8	42%	9	50%	3	30%

[12] 1- Protection System in place, especially for women & girls; 2 - Medical services available for survivors; 3 - Psychosocial support available for survivors; 4 - Community aware of services

MISP objective 3: reduce HIV transmission and meet STI needs

#	MISP objective 3: reduce HIV transmission and meet STI needs, 2014: 18 countries/territories; 2017: 19 countries/territories	Fulfilled				Partially				No			
		2014		2017		2014		2017		2014		2017	
24	Existence of national legislation and policy with provisions supporting reducing HIV transmission and meeting STI needs	11	61%	15	79%	6	33%	4	21%	1	6%	0	0%
25	Existence of advocacy on provisions within the national legislation and policies that restricts reducing HIV transmission and meeting STI needs	11	61%	18	95%	4	22%	0	0%	3	17%	1	5%
26	#, type and capacities of existing medical structures providing HIV and STI services at national and sub-national levels	8	44%	3	16%	9	50%	16	84%	1	6%	0	0%
27	Evidence of compliance of planned services provided under this objective with national and international protocols and standards	5	28%	4	21%	7	39%	14	74%	6	33%	1	5%
28	Comprehensiveness of the services of SRH in emergency provisioned in the national health sector emergency response plan and planned by the SRH Working Group and other stakeholders at national and sub national level in accordance with the MISP Objective 3[13]	0	0%	0	0%	14	78%	18	95%	4	22%	1	5%
29	Existence of multi-sectoral coordination mechanisms between health and other sectors stakeholders to reduce HIV	5	28%	10	53%	2	11%	6	32%	11	61%	3	16%

[13] 1 - Rational & safe blood transfusion in place; 2 - Standard Precautions practiced; 3 - Free condoms available and accessible; 4 - ARVs available for continuing users; 5 - PMTCT[1] in place; 6 - Needs of individuals with STIs met

	transmission and meet STI needs in crises *from the onset of an emergency*												
30	Accessibility and availability of information for the community, including vulnerable groups *from the onset of an emergency*	5	28%	5	26%	6	33%	12	63%	7	39%	2	11%

MISP objective 4: prevent excessive maternal and neonatal mortality and morbidity

#	**MISP objective 4: prevent excessive maternal and neonatal mortality and morbidity, 2014: 18 countries/territories; 2017: 19 countries/territories**	**Fulfilled**				**Partially**				**No**			
		2014		2017		2014		2017		2014		2017	
31	Existence of national legislation and policy with provisions supporting providing priority maternal and newborn health services in crises	10	56%	17	89%	6	33%	1	5%	2	11%	1	5%
32	Existence of advocacy on provisions within the national legislation and policies that restrict providing priority maternal and newborn health services in crises	14	78%	18	95%	0	0%	0	0%	4	22%	1	5%
33	#, type and capacities of existing medical structures providing priority maternal and newborn health services at national and sub-national levels	4	22%	5	26%	13	68%	14	74%	0	0%	1	5%
34	Evidence of compliance of planned services provided under this objective with national and international protocols and standards	6	33%	10	53%	10	56%	9	47%	2	11%	0	0%
35	Comprehensiveness of the services of SRH in emergency provisioned in the national health sector emergency	0	0%	0	0%	15	83%	18	95%	3	17%	1	5%

	response plan and planned by the SRH Working Group and other stakeholders at national and sub national level in accordance with the MISP Objective 4[14]												
36	Existence of multi-sectoral coordination mechanisms between health and other sectors stakeholders to support the implementation of priority maternal and newborn health services in crises *from the onset of an emergency*	6	33%	10	53%	4	22%	4	21%	8	44%	5	26%
37	Accessibility and availability of information for the community, including vulnerable groups *from the onset of an emergency*	4	22%	6	32%	8	44%	11	58%	6	33%	2	11%

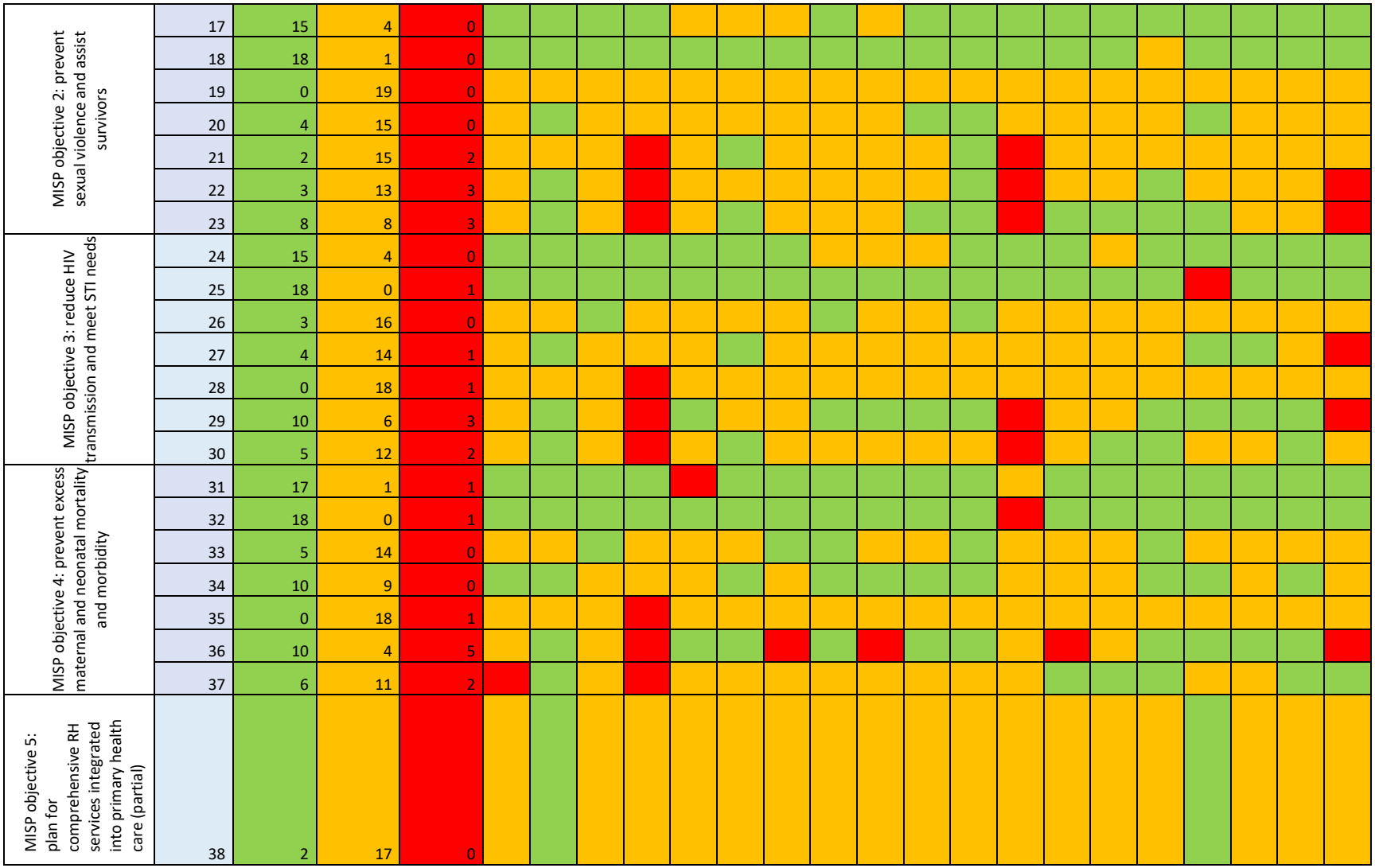
MISP objective 5: plan for comprehensive RH services integrated into primary health care (partial)

#	**MISP objective 5: plan for comprehensive RH services integrated into primary health care (partial), 2014: 18 countries/territories; 2017: 19 countries/territories**	**Fulfilled**				**Partially**				**No**			
		2014		2017		2014		2017		2014		2017	
38	Monitoring and SRH data collection tools are prepared to be used from the onset of an emergency	1	6%	2	11%	13	72%	17	89%	4	22%	0	0%

[14] 1 - Emergency Obstetric & Neonatal Care (EmONC) services available; 2 - 24/7 Referral System for obstetric & newborn emergencies established; 3 - Clean Delivery Kits provided to visibly pregnant women & girls & birth attendants; 4 - Community aware of services; 5 - Contraceptives available to meet demand

Annex 2: Results of the indicators per country/territory 2017

		# of indicators for the 18 countries																						
Bloc	**Indicator number**	number of Indicators	number of Indicators	number of Indicators	Albania	Armenia	Azerbaijan	Belarus	BiH	Bulgaria	Georgia	Kazakhstan	Kyrgyzstan	The former Yugoslav Republic of Macedonia	Moldova	Romania	Serbia	Tajikistan	Turkey	Turkmenistan	Ukraine	Uzbekistan	Kosovo (UNSCR 1244)
MISP objective 1: (SRH coordination), disaster management system (including emergency response preparedness) and the national health emergency management system and plans	1	16	3	0																			
	2	11	8	0																			
	3	8	9	2																			
	4	16	1	2																			
	5	0	19	0																			
	6	5	14	0																			
	7	2	14	3																			
	8	1	12	6																			
	9	7	7	5																			
	10	10	6	3																			
	11	0	17	2																			
	12	8	6	5																			
	13	0	19	0																			
	14	0	14	5																			
	15	6	11	2																			
	16	12	3	4																			


MISP objective 2: prevent sexual violence and assist survivors
MISP objective 3: reduce HIV transmission and meet STI needs
MISP objective 4: prevent excess maternal and neonatal mortality and morbidity
MISP objective 5: plan for comprehensive RH services integrated into primary health care (partial)
17 15 4 0
18 18 1 0
19 0 19 0
20 4 15 0
21 2 15 2
22 3 13 3
23 8 8 3
24 15 4 0
25 18 0 1
26 3 16 0
27 4 14 1
28 0 18 1
29 10 6 3
30 5 12 2
31 17 1 1
32 18 0 1
33 5 14 0
34 10 9 0
35 0 18 1
36 10 4 5
37 6 11 2
38 2 17 0

Annex 3: Results of the indicators per country/territory 2014

		Number of indicators for the 18 countries/territories			SG1					SG2			
Block	**indicator number**	number of indicators fully fulfilled	number of indicators partially fulfilled	number of indicators not fulfilled	Albania	Bosnia and Herzegovina	Serbia	The former Yugoslav Republic of Macedonia	Kosovo (UNSCR 1244)	Armenia	Azerbaijan	Georgia	Turkey
Disaster management S=system and MISP objective 1	**1**	14	4	0	Fully	Partially	Partially	Fully	Fully	Fully	Partially	Fully	Fully
	2	10	8	0	Fully	Fully	Partially	Fully	Fully	Partially	Partially	Fully	Fully
	3	3	12	3	Partially	Partially	No	Partially	Partially	Partially	No	Fully	Fully
	4	8	2	8	No	Partially	Fully	No	No	No	No	Fully	Fully
	5	2	14	2	Partially	Partially	No	Partially	Partially	Partially	Partially	Partially	Fully
	6	6	11	1	Partially	Fully	No	Partially	Fully	Fully	Partially	Partially	Partially
	7	0	7	11	No	Partially	No	Partially	No	No	No	No	No
	8	1	5	12	No	Partially	No	No	No	No	No	No	No
	9	2	5	11	No	No	No	No	No	No	No	No	Partially
	10	5	5	8	Fully	Partially	No	No	Partially	No	Partially	No	Partially
	11	1	13	4	No	Partially	No	No	Partially	Partially	Partially	Fully	Partially
	12	3	3	12	No	No	No	Partially	No	No	No	No	No
	13	0	10	8	No	Partially	No	Partially	No	No	No	Partially	No
	14	0	8	10	No	No	No	Partially	No	No	No	No	Partially
	15	5	10	3	No	Partially	Fully	Partially	Partially	Partially	Partially	Partially	Fully
	16	7	0	11	No	No	No	No	No	No	No	Fully	Fully
MISP objective 2	**17**	9	8	1	No	Fully	Partially	Partially	Partially	Partially	Partially	Fully	Fully
	18	12	4	2	No	Fully	Fully	Fully	Partially	Partially	Fully	Partially	Fully
	19	1	16	1	Partially	No	Partially	Partially	Partially	Partially	Partially	Partially	Partially
	20	4	9	5	No	Partially	Partially	No	No	Partially	Partially	Partially	Partially
	21	0	10	8	No	Partially	No	No	No	Partially	No	Partially	Partially
	22	4	5	9	No	Partially	No	No	No	Partially	No	No	Partially
	23	5	4	9	No	Partially	No	No	No	Partially	No	No	No
MISP objective 3	**24**	11	6	1	Fully	Fully	Partially	Partially	No	Partially	Partially	Partially	Fully
	25	11	4	3	No	Fully	Fully	Fully	No	Partially	Partially	Partially	Fully
	26	8	9	1	Partially	Fully	Partially	Fully	No	Fully	Partially	Partially	Fully

	27	5	7	6	Partially	Partially	No	No	No	No	Partially	No	Fully
	28	0	14	4	Partially	Partially	No	Partially	No	No	Partially	No	Partially
	29	5	2	11	No	Fully	No	No	No	No	No	No	Partially
	30	5	6	7	Partially	Partially	No	No	No	No	Fully	No	Fully
MISP objective 4	**31**	10	6	2	Partially	Fully	Partially	Partially	No	Partially	Partially	Fully	Fully
	32	14	0	4	Fully	Fully	Fully	Fully	No	No	Fully	Fully	Fully
	33	4	14	0	Fully	Partially	Partially	Fully	Partially	Partially	Partially	Partially	Partially
	34	6	10	2	Partially	Partially	Partially	Partially	No	Partially	Partially	Partially	Fully
	35	0	15	3	Partially	Partially	No	Partially	Partially	No	Partially	Partially	Partially
	36	6	4	8	Fully	Fully	No	No	No	No	No	Fully	Partially
	37	4	8	6	Partially	Partially	No	No	No	No	Partially	Partially	Fully
MISP objective 5 (partial)	**38**	1	13	4	Partially	Partially	No	Partially	Partially	No	Partially	Partially	Partially

		number of indicators for the 18 countries/territories			SG3					SG4			
Bloc	**indicator number**	number of indicators fully fulfilled	number of indicators partially fulfilled	number of indicators not fulfilled	Kazakhstan	Kyrgyzstan	Tajikistan	Turkmenistan	Uzbekistan	Bulgaria	Moldova	Romania	Ukraine
Disaster management system and MISP objective 1	**1**	14	4	0	Fully	Fully	Fully	Partially	Fully	Fully	Fully	Fully	Fully
	2	10	8	0	Fully	Partially	Partially	Fully	Fully	Partially	Fully	Partially	Partially
	3	3	12	3	Partially	Partially	Partially	Partially	Partially	Fully	Partially	Partially	No
	4	8	2	8	No	Fully	Fully	Partially	Fully	Fully	Fully	No	No
	5	2	14	2	Partially	Partially	Partially	Partially	Partially	Partially	Fully	Partially	No
	6	6	11	1	Partially	Partially	Fully	Partially	Partially	Partially	Fully	Fully	Partially
	7	0	7	11	No	Partially	Partially	Partially	Partially	No	Partially	No	No
	8	1	5	12	No	Partially	Partially	Partially	Partially	No	Fully	No	No
	9	2	5	11	No	Fully	Partially	Partially	Partially	Partially	Fully	No	No
	10	5	5	8	No	Fully	No	Fully	Fully	Partially	Fully	No	No
	11	1	13	4	No	Partially	Partially	Partially	Partially	Partially	Partially	Partially	Partially
	12	3	3	12	No	Fully	Partially	Fully	Fully	No	Partially	No	No
	13	0	10	8	No	Partially	Partially	Partially	Partially	Partially	Partially	Partially	No
	14	0	8	10	No	Partially	Partially	Partially	Partially	Partially	Partially	No	No
	15	5	10	3	Partially	Fully	Partially	Partially	Fully	No	Fully	Partially	No
	16	7	0	11	No	Fully	Fully	Fully	Fully	No	Fully	No	No
MISP objective 2	**17**	9	8	1	Partially	Fully	Fully	Partially	Fully	Fully	Fully	Fully	Partially
	18	12	4	2	Fully	Fully	Partially	Fully	Fully	Fully	Fully	Fully	No
	19	1	16	1	Partially	Partially	Partially	Partially	Fully	Partially	Partially	Partially	Partially
	20	4	9	5	Partially	Fully	Partially	Fully	No	Fully	Fully	Partially	No
	21	0	10	8	No	Partially	Partially	Partially	Partially	Partially	Partially	No	No
	22	4	5	9	No	Fully	Fully	Partially	Partially	Fully	Fully	No	No
	23	5	4	9	No	Fully	Fully	Fully	Partially	Fully	Fully	No	Partially
MISP objective 3	**24**	11	6	1	Partially	Fully	Fully	Fully	Fully	Fully	Fully	Fully	Fully
	25	11	4	3	No	Fully	Fully	Fully	Fully	Fully	Fully	Fully	Partially
	26	8	9	1	Fully	Partially	Fully	Partially	Fully	Fully	Partially	Partially	Partially
	27	5	7	6	No	Fully	Fully	Partially	Partially	Fully	Fully	Partially	Partially
	28	0	14	4	Partially	Partially	Partially	Partially	Partially	Partially	Partially	Partially	Partially
	29	5	2	11	No	Fully	Partially	No	Fully	Fully	Fully	No	No
	30	5	6	7	No	Partially	Fully	Partially	Partially	Fully	Fully	No	Partially

MISP objective 4	**31**	10	6	2	No	Fully	Fully	Fully	Fully	Fully	Fully	Fully	Partially
	32	14	0	4	Fully	Fully	Fully	Fully	No	Fully	Fully	Fully	No
	33	4	14	0	Fully	Partially	Partially	Fully	Partially	Partially	Partially	Partially	Partially
	34	6	10	2	No	Fully	Fully	Fully	Fully	Partially	Fully	Partially	Partially
	35	0	15	3	No	Partially	Partially	Partially	Partially	Partially	Partially	Partially	Partially
	36	6	4	8	No	Fully	Partially	No	Fully	Partially	Fully	Partially	No
	37	4	8	6	No	Fully	Fully	Partially	Partially	Partially	Fully	Partially	No
MISP objective 5 (partial)	**38**	1	13	4	No	Fully	Partially	Partially	Partially	Partially	Partially	Partially	No

Annex 4: INFORM (inform for risk management): risk rating for EECA countries

(release: 30 September 2017 v 0.3.1)

COUNTRY	Earthquake	Flood	Tsunami	Tropical Cyclone	Drought	**Natural**	Projected Conflict Risk	Current Highly Violent Conflict	**Human**	**HAZARD & EXPOSURE**	Development & Deprivation	Inequality	Aid Dependency	**Socio-economic Vulnerability**	Uprooted people	*Health Conditions*	*Children U5*	*Recent Shocks*	*Food Security*	Other Vulnerable Groups	**Vulnerable Groups**	**VULNERABILITY**	DRR	Governance	**Institutional**	Communication	Physical infrastructure	Access to health care	**Infrastructure**	**LACK OF COPING CAPACITY**	**INFORM RISK**	**RISK CLASS (Very low – very**	**Rank (1-191)**
	(0-10)																																
Ukraine	2,7	7,1	0,0	0,0	3,5	3,2	10,0	9,0	9,0	7,0	1,7	1,9	0,9	1,6	8,9	2,1	0,7	0,0	2,5	1,4	6,5	4,5	x	6,6	6,6	2,2	1,3	3,7	2,4	4,8	5,3	High	*37*
Turkey	9,3	6,1	6,3	0,0	3,8	6,0	9,9	9,0	9,0	7,8	2,9	4,3	0,9	2,8	9,2	0,2	0,7	0,0	1,3	0,6	6,6	5,0	2,1	5,0	3,6	2,8	1,8	3,5	2,7	3,2	5,0	High	*45*
Azerbaijan	8,2	4,9	0,0	0,0	5,3	4,5	7,8	0,0	5,5	5,0	1,7	2,0	0,2	1,4	9,0	0,5	1,8	0,0	1,6	1,0	6,5	4,4	x	6,4	6,4	2,1	3,6	2,2	2,6	4,8	4,7	Medium	*58*
Tajikistan	9,7	5,6	0,0	0,0	7,7	6,1	8,2	0,0	5,7	5,9	2,9	3,1	1,8	2,7	1,6	0,8	3,2	0,3	8,3	4,1	2,9	2,8	4,6	7,0	5,8	3,5	5,0	3,9	4,1	5,0	4,4	Medium	*62*
Serbia	6,6	8,6	0,0	0,0	2,7	4,6	6,9	0,0	4,8	4,7	1,5	1,8	1,7	1,6	7,9	0,3	0,5	5,8	3,0	2,7	5,9	4,1	4,9	5,4	5,2	2,3	1,0	3,5	2,3	3,9	4,2	Medium	*69*
Bosnia and Herzegovina	6,3	7,3	1,2	0,0	3,5	4,2	4,8	0,0	3,4	3,8	1,8	2,4	3,2	2,3	7,0	0,8	0,4	6,6	2,4	3,0	5,3	4,0	x	6,1	6,1	2,5	1,1	3,7	2,4	4,5	4,1	Medium	*74*
Georgia	7,8	5,7	0,0	0,0	5,4	4,5	4,0	0,0	2,8	3,7	1,6	4,5	3,7	2,9	8,4	0,8	0,6	0,2	2,7	1,1	5,9	4,6	4,7	4,4	4,6	2,3	1,1	2,6	2,0	3,4	3,9	Medium	*83*
Armenia	8,0	4,7	0,0	0,0	5,7	4,4	3,4	0,0	2,4	3,5	1,8	2,9	2,0	2,1	5,2	0,6	1,2	0,0	4,2	1,7	3,7	2,9	7,5	5,9	6,7	2,5	1,4	3,3	2,4	4,9	3,7	Medium	*91*
Kyrgyzstan	9,7	5,6	0,0	0,0	7,2	5,9	4,5	0,0	3,2	4,7	2,5	2,7	4,1	3,0	0,8	1,1	1,1	0,1	2,0	1,1	1,0	2,1	3,7	7,0	5,4	2,7	3,6	4,0	3,4	4,5	3,5	Medium	*98*
Turkmenistan	8,5	5,3	0,0	0,0	5,0	4,6	1,6	0,0	1,1	3,0	4,0	x	0,2	2,7	0,0	1,2	4,0	0,0	1,4	1,8	0,9	1,8	x	7,5	7,5	3,1	7,2	3,4	4,6	6,3	3,2	Low	*106*
Uzbekistan	9,9	6,3	0,0	0,0	6,7	6,1	7,2	0,0	5,0	5,6	2,3	2,6	0,3	1,9	0,0	1,0	2,0	0,0	1,9	1,3	0,7	1,3	2,6	7,2	4,9	3,1	3,6	3,3	3,3	4,1	3,1	Low	*108*
Albania	6,2	4,9	7,4	0,0	7,8	5,8	0,1	0,0	0,1	3,5	1,8	2,0	2,2	2,0	0,0	0,3	1,3	0,7	3,2	1,4	0,7	1,4	x	5,8	5,8	2,4	1,6	4,0	2,7	4,4	2,8	Low	*120*
Moldova	5,1	5,9	0,0	0,0	6,1	3,9	0,5	0,0	0,4	2,3	2,2	2,1	3,6	2,5	1,0	2,0	0,9	0,0	2,8	1,5	1,3	1,9	6,2	6,3	6,3	2,6	1,6	3,4	2,5	4,7	2,7	Low	*126*
The former Yugoslav Republic of Macedonia	6,6	4,4	0,0	0,0	4,5	3,6	2,5	0,0	1,8	2,7	1,7	3,5	2,5	2,4	1,3	0,3	0,4	2,6	2,8	1,6	1,5	2,0	3,8	5,3	4,6	2,1	1,9	3,1	2,4	3,6	2,7	Low	*126*
Kazakhstan	7,5	5,8	0,0	0,0	5,0	4,3	2,2	0,0	1,5	3,0	1,3	2,0	0,1	1,2	0,0	1,1	1,0	0,0	0,9	0,8	0,4	0,8	3,8	6,1	5,0	1,6	3,7	1,9	2,4	3,8	2,1	Low	*145*
Belarus	0,1	6,1	0,0	0,0	3,2	2,3	2,8	0,0	2,0	2,2	1,2	1,2	0,3	1,0	1,5	1,1	0,4	0,1	2,4	1,0	1,3	1,2	2,8	6,4	4,6	2,1	0,3	1,7	1,4	3,2	2,0	Low	*153*

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