# EGYPT MISP READINESS ASSESSMENT

**2024**

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

## Egypt MISP READINESS ASSESSMENT REPORT

## 2024

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ABBREVIATIONS

| | |
|---|---|
| **ARV** | Antiretroviral |
| **BEmONC** | Basic obstetric and newborn care |
| **CEmONC** | Comprehensive emergency obstetric and newborn care |
| **CHWs** | Community Health Workers |
| **CPR** | Contraceptive prevalence rate |
| **CSO** | Civil society organization |
| **EmONC** | Emergency Obstetric and Newborn Care |
| **GBV AGAINST WOMEN AND GIRLS** | Gender-based violence against women and girls |
| **HIV** | Human Immuno-deficiency Virus |
| **IEC** | Information, Education, and Communication |
| **IOM** | International Organization for Migration |
| **IPC** | Infection prevention and control |
| **IUDs** | Intrauterine devices |
| **MISP** | Minimum Initial Service Package |
| **MOHP** | Ministry of Health and Population |
| **MRA** | MISP Readiness Assessment |
| **NCCH** | National Council for Childhood & Motherhood |
| **NGO** | Non-governmental organization |
| **NPC** | National Population Council |
| **NCW** | National Council for Women |
| **PEP** | Post-Exposure Prophylaxis |
| **PHC** | Primary Health Care |
| **PMTCT** | Prevention of mother-to-child transmission |
| **PPE** | Personal protective equipment |
| **RH** | Reproductive Health |
| **RMNCAH** | Reproductive, Maternal, Newborn, Child, Adolescent Health |
| **SOGIESC** | People with diverse sexual orientations, gender identities, and expressions |
| **SRH** | Sexual and reproductive health |
| **STIs** | Sexually transmitted infections |
| **TFR** | Total Fertility Rate |
| **UHI** | Universal Health Insurance |
| **UN** | United Nations |
| **UNFPA** | United Nations Population Fund |
| **UNHCR** | United Nations High Commissioner for Refugees |
| **WHO** | World Health Organization |

# EXECUTIVE SUMMARY

Disasters and conflicts disrupt essential healthcare services, particularly those critical for reproductive health (RH). The Minimum Initial Service Package (MISP) steps in during these emergencies, outlining a set of priority RH activities to be implemented immediately. It focuses on life-saving interventions aims to prevent illness and death, especially among women and girls.

The importance of MISP is multifaceted. Firstly, RH complications are a leading cause of death and illness for women globally, and emergencies exacerbate these risks. MISP prioritizes essential services to prevent these complications, safeguarding lives. Secondly, everyone has a fundamental right to RH, including during emergencies. MISP ensures displaced communities have access to these vital services, upholding this fundamental human right. Finally, effective MISP services are not a one-size-fits-all approach. They are tailored to the specific needs of the affected population while respecting their cultural and religious backgrounds.

However, neglecting MISP in emergencies has serious consequences. When essential care is unavailable, preventable maternal and newborn deaths rise. The risk of sexual violence also increases during crises, and MISP provides crucial support for survivors. Limited access to contraception and safe abortion services during emergencies leads to unwanted pregnancies and unsafe abortion practices. Additionally, limited access to sexual health services can contribute to the spread of HIV and other sexually transmitted infections (STIs).

The implementation of MISP is essential for effective emergency response and aligns with global best practices. As such, it is crucial to incorporate MISP into operations from the outset of every emergency.

The MISP is one of the Sphere standards, and it aligns with the life-saving criteria set forth by the United Nations Central Emergency Response Fund. Adhering to this standard is a critical requirement, not a voluntary measure, in emergency response efforts[1].

[1] https://www.unhcr.org/sites/default/files/legacy-pdf/4e8d6b3b14.pdf

In a significant step towards bolstering its humanitarian response capabilities, Egypt undertook its inaugural MISP Readiness Assessment (MRA) in 2024. This report compiles the findings from this comprehensive assessment, which involved a diverse team of experts. These specialists, representing a wide range of backgrounds including sexual and reproductive health (SRH), gender-based violence against women and girls (GBV against women and girls), and humanitarian response, came from the Egyptian government, National Councils, Non-Governmental Organizations (NGOs), and Civil Society Organizations (CSOs), UN organizations, and academia.

While the assessment acknowledged the significant progress Egypt has made in strengthening its health system and establishing policies for improved service delivery, it also outlined several critical gaps in the provision of MISP services during emergencies. The main gaps include fragmented coordination among sectors, lack of integration of GBV against women and girls' services, shortage of medical teams, unequal distribution of services, limited access to essential SRH services, inadequate policies and strategies, insufficient stockpiles of supplies, knowledge gaps among service providers, and limited accessibility for persons with disabilities.

The action plan proposed by stakeholders is comprehensive and multi-faceted, aiming to improve coordination, integrate GBV against women and girls' services, enhance human resources, ensure equitable distribution, raise awareness, strengthen policies, secure resources, and improve data management. Key actions included activating the role of the crisis room at the Ministry of Health and Population (MOHP), creating formal platforms for communication and collaboration, integrating the MISP into strategic plans, implementing training programs, developing service distribution maps, expanding access to SRH services, and advocating for policy changes.

The action plan also focused on improving the emergency healthcare system by converting or designating areas for specialized SRH care, leveraging existing facilities, and training personnel. Additionally, there was a strong emphasis on addressing GBV against women and girls through the establishment of referral mechanisms, safe spaces, and engaging religious leaders.

The action plan finally emphasized the importance to allocate sufficient resources, both financial and human, to support the implementation of the MISP during emergencies. Furthermore, it underscored that strengthening the legal frameworks and policies on GBV against women and girls is essential to create a supportive environment for victims.

# BACKGROUND

## COUNTRY CONTEXT

Egypt has a complex, multi-tiered healthcare system that aims to provide universal coverage to its population. The public sector is the primary provider, with the MOHP operating a network of primary, secondary, and tertiary care facilities across the country.  Healthcare access and health outcomes in Egypt have improved in recent decades, though challenges remain in terms of affordability, regional disparities, and the management of the country's disease burden, which includes communicable and non-communicable diseases. Ongoing reforms seek to strengthen the public system, improve health insurance coverage, and enhance the coordination between the public and private sectors.

The Universal Health Insurance Law (UHI) of 2018 was issued to address healthcare system's challenges in Egypt and create a more equitable healthcare landscape. By aiming for universal coverage and reducing out-of-pocket expenses, the UHI Law aims to improve access to quality healthcare, including SRH services. The high cost of healthcare is a significant barrier, with out-of-pocket expenses constituting 59.3% of current health expenditure in 2019 [2].

With respect to reproductive health, Egypt has made significant strides in recent decades. Maternal mortality rates have seen a dramatic decline, dropping from 174 per 100,000 live births in 1990 to an estimated 49 in 2023[3]. Similarly, child health has improved, with the under-five mortality rate falling to 20.8 per 1,000 live births in 2021[4]. Despite commendable progress, Egypt still faces significant regional disparities in healthcare access. The Universal Health Insurance Law aims to address this by creating a more equitable healthcare landscape, especially since urban areas currently enjoy significantly better access to healthcare facilities and qualified personnel. Furthermore, the majority of maternal deaths occur around childbirth, often due to delays in reaching healthcare facilities, receiving necessary care, or being referred for emergency obstetric services. These challenges are compounded by regional disparities in healthcare provision, uneven distribution of trained health providers, and a lack of emergency obstetric care facilities.

[2] The 2019-20 National Health Accounts (NHA) study
[3] CAPMAS Annual Bulletin for Births and Death 2023
[4] CAPMAS 2021: Annual Bulletin of Births and deaths

Despite being a high-burden country for child malnutrition, Egypt has achieved significant progress. Between 2014 and 2021, stunting rates in children under five dropped from 21% to 13%, wasting rates fell from 8% to 3%, and underweight prevalence decreased from 6% to 4%. However, a new challenge has emerged: "double burden" malnutrition, where undernutrition coexists with a rise in childhood obesity. The proportion of overweight children under five has jumped from 14.9% in 2014 to 20.4% in 2020 [5].

In 2014, the Total Fertility Rate (TFR) in Egypt was reported to be 3.5 births per woman, which was higher than the rate of 3.0 reported in 2008. This increase was attributed to the societal unrest that followed the country's revolution in January 2011 [6]. By 2020, the TFR saw a slight decrease to 3.2 births per woman, and in 2021, it further dropped to 2.8 according to the Egyptian Family Health Survey 2021 [7]. Furthermore, according to the Egyptian Family Health Survey 2021, the national contraceptive prevalence rate is 66.4%, with a 13.8% unmet need for family planning services. Regional variations are evident, with the lowest rates found in Upper Egypt, specifically Sohag (31%) and Qena (37.8%), while Cairo has a higher rate of 64%. Concerns arise about the contraceptive prevalence among younger age groups, revealing rates of 39% for married women aged 15-19 and 52.3% for those aged 20-24, as per the same survey. Notably, a significant percentage of married women aged 15-19 experience pregnancies with less than two years of spacing (69%), along with 26% for those aged 20-24[8].

Egypt remains a low prevalence country for HIV/AIDS among general populations, with some evidence of concentrated epidemics among people who inject drugs and men who have sex with men[9]. Despite an active national AIDS program offering testing, counseling, and antiretroviral therapy, Egypt faces challenges in maintaining its low HIV/AIDS prevalence. Weak STD prevention and surveillance, limited access to reproductive health information, an influx of refugees from high-risk areas, Egyptians working abroad returning potentially infected, pervasive fear and stigma surrounding HIV/AIDS, and low condom demand and use all contribute to this complex public health issue.

Gender-based violence against women and girls is a significant issue in Egypt, with an estimated 7.8 million women suffering from various forms of violence annually. Gender inequality remains a challenge, as evidenced by the high illiteracy rate among women compared to men. In response, the National Council for Women has developed a national strategy to combat violence against women and is collaborating with UNFPA and other

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[5] https://rho.emro.who.int/Indicator/TermID/33

[6] Radovich E, El-Shitany A, Sholkamy H, Benova L. Rising up: Fertility trends in Egypt before and after the revolution. PLoS One. 2018 Jan 18;13(1):e0190148. doi: 10.1371/journal.pone.0190148. PMID: 29346389; PMCID: PMC5773010.

[7] https://www.capmas.gov.eg/Pages/Publications.aspx?page_id=5109&Year=23639

[8] https://egypt.unfpa.org/sites/default/files/pub-pdf/dp.fpa_.cpd_.egy_.11_-_egypt_cpd_-_final_0.pdf

[9] https://www.unaids.org/sites/default/files/country/documents/EGY_2020_countryreport.pdf

institutions to provide essential services and support for survivors of gender-based violence against women and girls [10].

Despite a narrow medical exception allowing doctors to perform abortions to save a pregnant woman's life (requiring written consent from two specialists), safe abortion care in Egypt remains severely restricted. This is due to the country's restrictive laws, with Articles 260-264 of the Penal Code criminalizing abortion and imposing penalties on both providers and women. Additionally, the law doesn't permit abortion for rape or incest victims, and the criminalization discourages healthcare providers from offering the procedure due to fear of legal repercussions. These limitations create significant legal and social barriers to safe abortion access in Egypt.

Egypt, like many other countries, has faced its share of crises, emergencies, and epidemics in recent years. The COVID-19 pandemic has posed significant challenges, as has the influx of refugees from regions of political unrest, such as Syria, Sudan, and Gaza.

In its latest assessment of migrant stocks in Egypt, International Organization for Migration (IOM) revealed that the current number of international migrants residing in Egypt is over 9 million migrants, which is equivalent to 8.7% of the Egyptian population[11].

Furthermore, Egypt hosts more than 670,000 registered refugees and asylum-seekers from 62 nationalities. As of October 2023, the Sudanese nationality has become the top nationality, followed by Syrians. Other relevant countries of origin include South Sudan, Eritrea, Ethiopia, Yemen, Somalia and Iraq. With many refugees lacking a stable source of income, coupled with soaring inflation, basic needs are barely covered. Other challenges include limited livelihood opportunities and the language barrier facing non-Arabic-speaking refugees. Some also lack access to sustainable formal education that could support their development. In addition, a considerable number of refugees and asylum-seekers rely on humanitarian assistance to meet their basic needs and to receive medical or psychosocial support[12].

Moreover, the impacts of climate change, such as extreme weather events, droughts, and the proliferation of vector-borne diseases, have further taxed the health system. These climate-related health emergencies have required rapid response and adaptation, diverting resources away from routine healthcare delivery.

Collectively, the compounding effects of the COVID-19 pandemic, refugee influxes, and climate change have created an unprecedented burden on Egypt's health system. Addressing these multifaceted challenges will necessitate a comprehensive, coordinated, and well-resourced approach to strengthen the resilience of the healthcare infrastructure and ensure equitable access to quality care for all.

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[10] https://egypt.unfpa.org/en/node/22540

[11] https://egypt.iom.int/news/iom-egypt-estimates-current-number-international-migrants-living-egypt-9-million-people-originating-133-countries

[12] https://www.unhcr.org/eg/about-us/refugee-context-in-egypt#:~:text=As%20of%2020%20June%202024,more%20than%2054%20other%20nationalities.

## THE MINIMUM INITIAL SERVICE PACKAGE (MISP)

Providing comprehensive SRH care to all individuals affected by crises is a vital goal for the health sector. In humanitarian emergencies, these critical needs are often overlooked, leading to potentially life-threatening consequences. Globally, over 500 women die daily during pregnancy or childbirth in fragile settings. Timely access to SRH services can drastically reduce deaths, diseases, and disabilities related to unintended pregnancy, obstetric complications, sexual violence, HIV infection, and other reproductive issues.

The MISP for SRH is a critical program offering essential SRH care within 48 hours of a crisis **(BOX 1).** The MISP is developed by the Inter-Agency Working Group for Reproductive Health in Crisis (IAWG). It complements Inter-Agency Reproductive Health Kits (IARH) and requires no extensive assessment before implementation. Focused on preventing deaths and illnesses related to pregnancy, childbirth, sexually transmitted infections, and violence, the MISP ensures lifesaving care for vulnerable populations during emergencies, where such needs are often overlooked[13] [14].

**BOX 1: The six objectives of the MISP**[15]

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. Work with the Health Sector/Cluster partners to address the six-health system building blocks.

[13] https://www.unfpa.org/resources/minimum-initial-service-package-misp-srh-crisis-situations
[14] https://www.fp2030.org/resources/resources-misp-readiness-assessment-english-georgian-russian-and-turkish/
[15] https://www.unfpa.org/resources/minimum-initial-service-package-misp-srh-crisis-situations

## READINESS ASSESSMENT (MRA)

To ensure effective MISP implementation, the MISP Readiness Assessment (MRA) is used. The aim of the MRA is to provide a snapshot of national and/ or sub-national readiness and capacity to ensure access to essential SRH services as outlined in the MISP. It helps to identify key areas that need further investment, and acts as a starting point for structured and targeted SRH preparedness work. This assessment gathers a diverse group of stakeholders, including governments, UN agencies, NGOs, and others, to evaluate a country's preparedness to deliver MISP services in emergencies. The MRA identifies areas needing improvement and helps create a plan for strengthening overall SRH preparedness.

**The MRA includes:**

Part 1: MRA Questionnaire (Annex 1)

A set of questions looking at the following elements:

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

Part 2: Action Plan template (Annex 2)

A template to identify prioritized activities which partners will work on in the next 18 months.

# OBJECTIVES OF THE MRA

The aim of conducting the Minimum Initial Service Package (MISP) Readiness Assessment (MRA) in Egypt is to Strengthen National Readiness for Essential Sexual and Reproductive Health Services in Emergencies.

Specific objectives:

i. Explore all policies, plans and strategies which guide SRH service delivery during emergencies and associated gaps.

ii. Assess the country's preparedness and capacity to implement the MISP during emergencies.

iii. Develop a national MISP Preparedness Action Plan based on the assessment findings that addresses gaps identified in the MRA.

## THE METHODOLOGY

The MRA exercise in Egypt, conducted from June to July 2024, was guided by a comprehensive consultative process. This process was structured into several key phases:

- **Preparation:** This phase involved a thorough desk review of pertinent MRA documents, meticulous workshop preparation including the development of an agenda, identification of stakeholders, and logistical arrangements, as well as the revision of the MRA questionnaire and action plan template.
- **Data Collection and Action Planning:** During this phase, the MRA questionnaire and action plan template were administered during the workshop. Additionally, consultations with experts were conducted to gather comprehensive insights.
- **Data Analysis:** The collated results from the questionnaires were analyzed, and the identified gaps were prioritized based on the findings.
- **MRA Report Writing**: The final phase involved the compilation of the MRA report, encapsulating the findings, analysis, and recommendations derived from the consultative process.

### *MRA workshop:*

The MOHP, supported by UNFPA, organized a two-day workshop for key stakeholders, including MOHP representatives, SRH experts, national councils, NGOs, CSOs, academia, and international organizations (Annexes 2-3). A national consultant further facilitated the process.

Workshop participants were divided into working groups to complete the MRA questionnaire collaboratively. Following questionnaire completion, participants engaged in a structured analysis to translate responses into actionable steps:

1. **Capacity and needs assessment**: Responses were reviewed to identify existing strengths (answered as "yes" or "ideal") and areas requiring improvement (answered as "no" or "don't know").

2. **Gap prioritization:** The MOSCOW methodology, a prioritization technique used in project management, was employed to categorize identified needs (**BOX 2)**.
3. **Action plan development**: The team that completed the MRA questionnaire then developed a comprehensive action plan, a crucial step in the assessment process.

   This comprehensive approach ensured a thorough evaluation of Egypt's MISP preparedness and the creation of a concrete action plan for improvement.

**BOX 2: MOSCOW Methodology**

**Priority 1 (P1)—Must have (Mo):** These issues are essential to address to ensure MISP readiness. If these are not available, provision of the MISP during an emergency will not happen.

- **Priority 2 (P2)—Should Have (S):** Group here the issues that are important, but not essential, and could be done later
- **Priority 3 (P3)—Could Have (Co):** Group here the issues that would be nice to have but are not absolutely necessary given your context.
- **Priority 4 (P4)—Won't have (W):** Group here the issues that provide little to no additional value and that do not require action at this point.

# MRA RESULTS

This report presents an in-depth analysis of the responses to the MISP Readiness Assessment (MRA) questionnaire. The questionnaire serves as a thorough assessment tool, assessing Egypt's level of preparedness to provide MISP services in emergency situations. It highlights both the current capabilities and the aspects that necessitate enhancement, organized in accordance with the thematic elements of the MRA questionnaire.

## I. SECTION 1: NATIONAL-LEVEL OVERALL READINESS: POLICIES, COORDINATION AND RESOURCES

This section assesses Egypt's overall emergency preparedness at both the national and subnational levels. It specifically focuses on how well the MISP for SRH is integrated into existing disaster management policies, coordination mechanisms, and resource allocation.

Overall, Egypt has a National Emergency Preparedness and Response Strategy. There are several policies and committees dedicated to crisis management, disaster risk reduction, and response to emergencies.

**The National Strategy for Disaster Risk Reduction (NSDRR) 2030** outlines a multi-pronged approach to emergencies in Egypt. It aims to integrate disaster preparedness into national development plans, build public capacity for crisis response, and significantly reduce both deaths and economic losses from disasters by 2030. The strategy also emphasizes improving disaster forecasting, strengthening critical infrastructure, and fostering collaboration between government, NGOs, and citizens to reduce overall disaster risks [16].

Furthermore, the **Law No. 152 of 2021** [17]established a framework for addressing epidemics and communicable diseases. The law creates a new entity called the "Supreme Committee for Crisis Management of Epidemics and Communicable Diseases," headed by the Prime Minister and including relevant ministers and heads of institutions. The committee is tasked with issuing decisions and taking emergency measures necessary to mitigate the risks of spreading epidemics and diseases. Additionally, the committee is responsible for preparing periodic reports for the Prime Minister, detailing the health situation, the state of outbreaks, and any recommended actions.[18]

The policies and plans are designed to be rolled out at the sub-national level (governorate level) in Egypt. **Prime Minister Decision No. 905 of 2024** mandates the establishment of crisis,

[16] National Strategy for Disaster Risk Reduction 2030: The Cabinet of Egypt-Crisis Management and DRR Sector-Information and Decision Support Center, 2017.

[17] Law No. 152 of 2021

[18] https://sendaiframework-mtr.undrr.org/media/86091/download?startDownload=20240618

disaster, and risk management centers within each governorate's organizational structure. These centers operate under the governor's direct administrative control and receive technical guidance from the national Cabinet Secretariat[19]. The decision also requires governorates to adhere to national crisis management standards set by the Cabinet Secretariat. This ensures a consistent approach across all regions. Each governorate is responsible for creating annual field training plans for potential disasters specific to their region. These plans require technical approval and involve relevant government agencies before implementation. The governor holds responsibility for managing crises or disasters within their jurisdiction. In situations with a broader impact or requiring expertise from multiple sectors, the Prime Minister can form a working group for coordinated response. These measures promote a decentralized emergency management system, empowering governorates to prepare and respond effectively to emergencies within their regions while maintaining national coordination and support.

While these policies and plans establish a robust emergency response system, a crucial gap exists which is the integration of SRH policies or plans into the disaster management framework. They don't explicitly mention provisions for ensuring SRH services during emergencies.

On the other hand, the **Updated National Population and Development Strategy** 2023-2030 prioritizes expanding access to reproductive health and family planning services. This includes offering a wider range of methods in government, private, and civil healthcare settings, along with ensuring service availability through universal health insurance. Importantly, the strategy emphasizes integrating reproductive health into emergency preparedness and response plans. It calls for developing specific strategies to ensure these services continue functioning effectively during crises like economic downturns, disease outbreaks, and climate change.

Additionally, Egypt's **National Health Strategic Plan** prioritizes strengthening healthcare systems to ensure everyone has access to quality services throughout their lives, including sexual and reproductive health for various age groups. It also focuses on building health system resilience through improved emergency preparedness, response, and disaster recovery, while maintaining essential services. This aligns with global health security initiatives and includes providing comprehensive healthcare to refugees and migrants, as well as making healthcare facilities more sustainable in the face of climate change.

There is a national coordination mechanism responsible for disaster management during crisis. The Egyptian Cabinet reformed its **National Committee for Crisis, Disaster and Risk Management** through the **Prime Minister decision, No. 905 of 2024**. This committee aims to create a robust national system for handling emergencies and reducing disaster risks. This is achieved through establishing a specialized national entity, integrating risk reduction into development plans, and fostering collaboration between government bodies. Additionally, the

[19] Prime Minister decision, No. 905 of 2024

committee focuses on public awareness and ensuring a swift and effective response to emergencies, minimizing losses and aiding recovery efforts.

While the National Strategy for Disaster Risk Reduction (NSDRR) 2030 and the national coordination mechanism responsible for disaster management during crisis under the Prime Minister decision, No. 905 of 2024 outline a disaster management structure in Egypt, they don't explicitly mention dedicated entities responsible for coordinating health, including SRH and GBV against women and girls, during emergencies. There is no formal coordination mechanism, such as an SRH working group, at either the national or sub-national level to specifically address SRH in emergencies. There also is no SRH focal points appointed at the national or sub-national level to support emergency preparedness and response efforts related to SRH.

Despite the fact that the Prime Minister decision, No. 905 of 2024 states the inclusion of a representative from the General Union of NGOs in the National Committee for Crisis, Disaster and Risk Management. However, it does not explicitly state whether this NGO or any other CSOs or community-based organizations working with marginalized and underserved groups are systematically included in the coordination mechanisms. The decision allows the committee to call upon anyone it deems necessary to assist with its tasks.

Finally, there is a mechanism for rapid mobilization of funds to support health response in crisis situation. **Law No. 139 of 2021** and **Law No. 5 of 2024** establish the **Medical Emergency Fund**, which aims to support and finance medical services, including during disasters and emergencies (Article 3). The Fund is chaired by the Prime Minister and receives resources from various channels like the MOHP, suggesting significant financial backing (Article 2). While the laws don't explicitly mention SRH services, the broad scope of "medical services" funded during emergencies suggests it could potentially cover SRH needs as well. In addition, **Law No. 1063 of 2014** mandates all medical facilities and hospitals to provide free treatment for emergencies and accidents for 48 hours. This could potentially cover initial SRH needs arising from emergencies.

## Questionnaire analysis results of section 1

The results highlight key MRA findings as perceived by the respondents based on their workplace policies and performance in the field of SRH. They cover key areas such as the existence of disaster management policies, coordination mechanisms, and resource allocation for MISP.

All respondents (100%) reported having emergency preparedness plans in place, with the majority (80%) reported that these plans are integrating SRH considerations. These plans are also implemented at the sub-national level. Strong coordination mechanisms exist (over 80%) for discussing SRH in emergencies, and these mechanisms involve CSOs representing marginalized groups (80%).

The majority (80%) indicated that SRH considerations are integrated into their emergency health response plans. This is further reinforced by the same proportion (80%) stating that SRH policies or plans themselves include provisions for disaster management and emergency response.

All respondents refuted the existence of any national legislation or policies that restrict access to SRH care for specific groups. These groups include migrants, refugees, youth, unmarried individuals, people with diverse sexual orientations, gender identities, and expressions (SOGIESC), people living with HIV, sex workers, and ethnic minorities.

The majority of respondents (70%) indicated that SRH is included in recovery plans when the response transitions from acute to more comprehensive services. Furthermore, a strong coordination mechanism exists for disaster management during crises (reported by 90%). Nearly two-thirds (60%) of respondents stated that this disaster management mechanism includes an entity responsible for health, encompassing both SRH and GBV against women and girls during the response phase.

Over 80% of respondents reported a national-level coordination mechanism (e.g., SRH working group) to discuss SRH in emergencies across preparedness, response, and recovery efforts. Additionally, 60% indicated the presence of a similar structure or coordination mechanism (e.g., SRH working group/disaster committee) at the sub-national level for SRH discussions in emergencies.

Half of the respondents (50%) reported having SRH Focal Points appointed at national and/or sub-national levels to assist with emergency preparedness and response.

A significant majority of respondents (80%) reported that civil society organizations and community-based organizations are incorporated into their coordination mechanisms. These

entities represent a diverse array of marginalized and underserved groups, such as women and men with disabilities, individuals living with HIV, people with diverse SOGIESC, various youth groups, religious leaders, sex workers, and ethnic minorities.

A considerable proportion of respondents (70%) affirmed that their current risk assessments take into account the impact on a variety of populations. This approach ensures that emergency preparedness planning does not neglect vulnerable groups, including women, individuals with disabilities, persons living with HIV, people with diverse SOGIESC, young people, sex workers, and ethnic minorities.

Only 40% of respondents reported that some of the MISP-related indicators are integrated into existing health information systems (HIS).

Half (50%) of the respondents indicated that the rapid needs assessment forms for emergency response (covering both rapid assessments and health sector assessments) include disaggregated data by sex, age, and disability, along with key SRH questions. However, only 40% reported that the data collection tools used during emergencies (e.g., health forms) include MISP-related indicators.

Over half of respondents (60%) reported having established mechanisms for the rapid mobilization of funds to facilitate an SRH response in emergency situations. Such mechanisms may encompass contingency funds, country-based pooled funds, or other comparable resources.

Half (50%) of the respondents indicated a system for rapid sourcing of SRH supplies and equipment, including IARH kits, at the national or international level. This rapid sourcing could be facilitated through pre-positioning, buffer stocks, standing agreements with suppliers, or pre-identification of reliable vendors. Similarly, 50% of respondents reported having warehouses or storage facilities where medical supplies for SRH can be pre-positioned or stored. This ensures greater accessibility to critical supplies during emergencies.

Finally, 60% of respondents stated that there are funds available to support both health and SRH emergency preparedness efforts at the national or sub-national level.

# II. SECTION 2: READINESS TO PROVIDE SERVICES AS OUTLINED IN THE MISP

Section II focuses on assessing the readiness to provide services as outlined in the MISP during stable times and identifies potential areas for improvement in emergency situations. This section addresses the following MISP objectives:

- MISP objective 2 – Prevent sexual violence and respond to the needs of survivors
- MISP objective 3 – Prevent the transmission of and reduce morbidity and mortality due to HIV and other STIs
- MISP objective 4 – Prevent excess maternal and newborn morbidity and mortality
- MISP objective 5 – Prevent unintended pregnancies
- Other priority activity: Safe abortion care to the full extent of the law

The Ministry of Health and Population's Family Planning sector has developed a strategic plan for 2023-2030. This plan aims to reduce the TFR from 2.85 in 2021 to 2.1 in 2030 by increasing the CPR from 66.4% in 2021 to 71.6% by 2030. To achieve this goal, the MOHP offers a wide range of family planning services. This includes providing various contraceptive methods like intrauterine devices (IUDs), birth control pills, injections, implants, and male condoms. Additionally, they offer counseling services, social marketing campaigns to promote family planning, programs for women's empowerment, and broader reproductive health services.

Furthermore, primary healthcare facilities across Egypt are committed to providing comprehensive healthcare services to all age groups, fostering overall well-being and ensuring access to quality healthcare. This includes providing comprehensive healthcare services for women, including maternal, antenatal, and neonatal care, as well as child healthcare from birth to the age of five.

Despite an active national AIDS program offering testing, counseling, and antiretroviral therapy, Egypt faces challenges in maintaining its low HIV/AIDS prevalence. Weak STD prevention and surveillance, limited access to reproductive health information, an influx of refugees from high-risk areas, Egyptians working abroad returning potentially infected, pervasive fear and stigma surrounding HIV/AIDS, and low condom demand and use all contribute to this complex public health issue[20].

[20] https://www.emro.who.int/egy/programmes/hiv-aids.html

With respect to GBV against women and girls, several Egyptian entities share responsibility for ensuring GBV against women and girls services in the country, according to the "National Strategy to Combat Violence Against Women 2015-2020". These include:

- Government Ministries:
  - Ministry of Health and Population: Plays a crucial role by developing protocols for healthcare providers to manage GBV against women and girls' cases.
  - Ministry of Interior: Handles GBV against women and girls through specialized departments focused on investigations, victim reintegration, and combating online harassment.
  - Ministry of Justice: Offers legal support through a dedicated department, increased penalties for violence and harassment, and training for legal personnel.
  - Ministry of Social Solidarity: Provides shelters, economic empowerment programs, and awareness campaigns against GBV against women and girls.
- Other Important Actors:
  - National Council for Women (NCW): Established complaint offices, a legal aid helpline, and advocates for stronger legislation against violence and harassment.
  - National Council for Childhood and Motherhood (NCCM): Provides hotlines for child rescue and maternal health counseling, and works to combat child trafficking and FGM.
  - CSOs & NGOs: Play a vital role by documenting GBV against women and girls' cases, offering legal assistance, raising awareness, advocating for stricter laws, and supporting victims.

Despite a narrow medical exception allowing doctors to perform abortions to save a pregnant woman's life (requiring written consent from two specialists), safe abortion care in Egypt remains severely restricted. This is due to the country's restrictive laws, with Articles 260-264 of the Penal Code criminalizing abortion and imposing penalties on both providers and women. Additionally, the law doesn't permit abortion for rape or incest victims, and the criminalization discourages healthcare providers from offering the procedure due to fear of legal repercussions. These limitations create significant legal and social barriers to safe abortion access in Egypt.

## Questionnaire analysis results of section 2

Section II focuses on assessing the readiness to provide services as outlined in the MISP during stable times and identifies potential areas for improvement in emergency situations. The assessment is grounded in the respondents' workplace policies and performance related to Sexual and Reproductive Health (SRH). It includes critical areas such as preventing sexual violence, addressing the needs of survivors, curtailing the spread of HIV and other STIs, reducing maternal and newborn health risks, preventing unintended pregnancies, and ensuring safe abortion care within legal boundaries.

**MISP services – General**

Half (50%) of the respondents reported that all the essential SRH commodities needed for implementing the MISP are included in the national essential medicines list.

Systems for digital health platforms, telemedicine, or online consultations are in place as reported by 40% of respondents and 80% of respondents reported having plans and opportunities to scale up personal protective equipment (PPE) and Infection Prevention and Control (IPC) materials for SRH facilities in the event of epidemics or pandemics.

A significant proportion of respondents (70%) reported the presence a healthcare training curriculum or other relevant training programs, including online options, to equip health staff with the skills to integrate health emergency management and/or the MISP into their practices.

A mechanism exists as reported by 80% of respondents to mobilize or redeploy health staff, or have them take on new roles during emergencies (e.g., surge or task shifting). This flexibility helps to better support affected areas in times of crisis. Only 40% of respondents reported the inclusion of specialist SRH providers in health response teams.

The majority, 80% of respondents reported having diverse communication channels available, such as radio, text messaging, and WhatsApp, which can be used to inform communities about the availability of MISP-related services during emergencies.

Only 10% of respondents reported significant barriers for marginalized and underserved groups (e.g., women with disabilities, adolescents, sex workers, people with diverse SOGIESC, people living with HIV, refugees, migrants, undocumented migrants, and ethnic minorities) to access SRH services. This is a positive indicator of accessibility, but continued efforts are needed to ensure it remains low for all populations.

A significant majority of respondents (80%) reported having provisions in place to ensure that crisis-affected populations have free access to health services, including those outlined in the MISP. This measure helps to guarantee that essential healthcare is available during emergencies.

**MISP objective 2 – Prevent sexual violence and respond to the needs of survivors**

The responsibility for ensuring the provision of Gender-Based Violence (GBV) services against women and girls is shared among multiple actors. These include the Ministry of Health and Population (MOHP), the Ministry of Social Solidarity (MOSS), university hospitals, safe women's clinics at Primary Health Care (PHC) centers affiliated with MOHP, and the Psychological Support Unit within the Egyptian Red Crescent. Each of these entities plays a crucial role in offering critical services such as case management and referral (CMR), protection, and legal support, thereby contributing to the protection and well-being of women and girls affected by GBV.

However, only 40%, reported that safe, private, and confidential spaces are consistently identified and accessible—an important consideration for providing sensitive care.

A substantial proportion of respondents, 70%, reported having a clear and up-to-date referral system. This system is vital during emergencies as it connects survivors with a range of GBV against women and girls service providers, including health, case management, legal, and protection services.

A large proportion of respondents (80%) reported partnerships with protection clusters or GBV against women and girls' sub-clusters/actors to implement preventative measures at the community, local, and district levels and 70% of respondents indicated that clinical care and referral to other supportive services (legal, protection, psychosocial, shelter, etc.) are available for survivors of sexual violence.

While 60% of respondents have reported the availability of confidential and safe spaces within health facilities, there is a need for continued efforts to ensure broader access for survivors.

A substantial number of respondents (70%) reported having Information, Education, and Communication (IEC) materials that provide information on services for sexual violence survivors. These materials are prepared in the languages spoken by the most at-risk groups in areas prone to emergencies.

When asked about the existing medical and non-medical structures' capacity to address GBV against women and girls, 30% of respondents reported qualified staff (e.g., clinical care providers and GBV against women and girls case managers) were ideal, and another 30% reported facilities (clinics, safe spaces, hotlines) were ideal. However, 40% reported supplies and equipment for clinical care were ideal.

**MISP objective 3 – Prevent the transmission of and reduce morbidity and mortality due to HIV and other STIs**

The National AIDS Control Programme, fever hospitals, and university hospitals are the principal entities responsible for ensuring the provision of HIV and STI services.

A notable proportion of respondents (40%) have confirmed the presence of a clear and current referral system for HIV/ARV services, which can be effectively used during emergencies.

Respondents were queried about the capacity of health facilities to deliver services aimed at preventing the transmission of and reducing morbidity and mortality from HIV and other STIs. Half of the respondents indicated that the MOHP (fever hospitals) and university hospitals provide antiretroviral therapy (ARVs), syndromic management of STIs, prevention of mother-to-child transmission (PMTCT), and condom distribution.

Regarding the adequacy and immediate availability of MISP elements in case of an emergency, the responses were as follows:

- 40% confirmed the implementation of safe and rational blood transfusion practices.
- 60% reported the consistent practice of standard precautions.
- 50% stated the availability of free lubricated male condoms, while none confirmed the availability of female condoms.
- 40% confirmed the availability of ARVs for continuing users.
- 40% confirmed the availability of ARVs for women enrolled in PMTCT programs.
- 50% confirmed the availability of Post-Exposure Prophylaxis (PEP) for survivors of sexual violence and for occupational exposure.
- 20% reported the provision of co-trimoxazole prophylaxis for opportunistic infections for patients diagnosed with or found to have HIV.
- 20% confirmed the availability in health facilities of syndromic treatment for STIs.
- 30% reported the existence of Information, Education, and Communication (IEC) materials and STI/HIV counseling services that emphasize informed choice, effectiveness, and support client privacy and confidentiality in case of an emergency.

Respondents were asked to evaluate the existing health systems' capacity to manage HIV and STIs as outlined in MISP for SRH in their respective locations. The evaluations were as follows: 30% of respondents rated the availability of qualified medical personnel as ideal, 10% rated the facilities such as clinics and hotlines as ideal, and 30% rated the supplies and equipment as ideal.

**MISP objective 4 – Prevent excess maternal and newborn morbidity and mortality**

Respondents were asked to identify the entities responsible for ensuring the provision of Maternal and Newborn services. They mentioned the Ministry of Health and Population's Primary Health Care (PHC) and Curative sectors, Governmental hospitals, NGOs, and CSOs.

Nearly half (40%) of respondents indicated the presence of a clear, up-to-date Emergency Obstetric and Neonatal Care (EmONC) referral system that can be utilized during emergencies.

Regarding the levels of health facilities capable of providing services to prevent excess maternal and newborn morbidity and mortality, the following was reported:

- The MOHP PHC and Curative sectors and Government hospitals provide Skilled birth attendance.
- Government hospitals and the MOHP Curative sector offer Basic EmONC.
- Government hospitals and the MOHP Curative sector provide Comprehensive EmONC.
- The MOHP and government hospitals deliver post-abortion care.
- The MOHP Ambulance sector offers a 24/7 Ambulance/transport service.

On the adequacy and immediate availability of MISP elements in case of an emergency, respondents stated the following:

- 10% confirmed that at the referral hospital level, skilled medical staff and supplies for the provision of comprehensive emergency obstetric and newborn care (CEmONC) are available.
- 10% reported that at the health facility level, skilled birth attendants and supplies for vaginal births and the provision of basic obstetric and newborn care (BEmONC) are available.
- 40% stated that at the community level, information on the availability of safe delivery and EmONC services, and the importance of seeking care from health facilities, is provided.
- 50% confirmed a 24 hours per day, 7 days per week referral system for obstetric complications.
- 40% reported the availability of post-abortion care in health centers and hospitals.
- 40% stated the availability of supplies and commodities for clean delivery (e.g., clean delivery kits) and immediate newborn care where access to a health facility is not possible or unreliable.
- 30% confirmed the existence of IEC materials on priority maternal and neonatal services for pregnant women and girls in each linguistic group of the most at-risk areas.

Respondents were asked to assess the existing health systems' capability to deliver maternal and newborn care services as detailed in the MISP for SRH in their respective locations. The assessments were as follows: No respondent rated the availability of qualified medical

personnel, such as skilled birth attendance, BEmONC, and CEmONC, as ideal; 50% reported it as either insufficient or that the minimum needed is available. Similarly, no respondent rated the facilities, including clinics and hospitals, as ideal; 40% reported them as insufficient. Regarding supplies and equipment, 20% rated them as ideal, while 50% reported them as either insufficient or that the minimum needed is available.

**MISP objective 5 – Prevent unintended pregnancies**

Respondents were tasked with identifying the entities responsible for ensuring the provision and removal of long-acting reversible and short-acting contraceptive methods and services in the selected area. They named the Ministry of Health and Population's Family Planning sector, the Ministry of Social Solidarity, and NGOs. International organizations such as the United Nations Population Fund supported the provision of such services.

Over half of respondents (60%) have affirmed the presence of a clear and current referral system for accessing both short-term and long-term contraceptive methods, which is operational during emergencies.

Regarding the levels of health facilities capable of providing contraceptives to prevent unintended pregnancies, the following was reported:

- The MOHP Family Planning sector and NGOs provide male condoms, while the availability of female condoms was not reported.
- The MOHP Family Planning sector, university hospitals, and NGOs offer Oral Contraceptive Pills, Intra-uterine devices (IUDs), Injectables, Implants, and Emergency Contraception.

When respondents were asked about the adequacy and immediate availability of MISP elements in case of an emergency, the following was reported:

- 30% confirmed the availability of a range of long-acting reversible and short-acting contraceptive methods, including male condoms and emergency contraception, at primary health care facilities to meet demand.
- 40% reported the existence of IEC materials on contraceptive choice that emphasize informed choice, effectiveness, and support client privacy, confidentiality, and access to services.

Respondents were asked to evaluate the existing health system's capacity to provide contraceptive services in their location. The evaluations were as follows: For qualified medical personnel, 20% rated the availability as ideal, while 40% reported it as either insufficient or that the minimum needed is available. Regarding facilities such as clinics, pharmacies, and hotlines, 20% rated them as ideal, and 40% reported them as either insufficient or the minimum needed is available. In terms of supplies and equipment, 40% rated them as ideal, and 40% reported them as either insufficient or the minimum needed is available.

**Other priority activity: Safe abortion care to the full extent of the law**

A number of respondents (20%) have highlighted the conditions under which safe abortion care can be provided, identifying the Ministry of Health and Population's Curative sector and university hospitals as the entities responsible for ensuring the availability of such care. Additionally, a portion of respondents (30%) have confirmed the existence of a clear referral system that is operational during emergencies, with a smaller percentage (10%) reporting the availability of IEC materials that detail the types of services available and their locations, which can be utilized during emergencies.

Respondents were queried about the capabilities of health facilities to provide abortion services. They reported that the Ministry of Health and Population's Curative sector and university hospitals perform medication abortion, vacuum aspiration, dilatation and evacuation, and induction procedures, as recommended by the World Health Organization.

With respect to the evaluation of the existing medical structures and services that offer safe abortion care in respondents' location. The assessments for various elements were as follows: None of respondents rated the availability of qualified medical personnel, including those trained in medical procedures, abortion values clarification, and attitude transformation, as ideal. For facilities such as clinics and hotlines, 30% rated them as insufficient or meeting the minimum needed, with 10% rating them as ideal. Regarding supplies and equipment, 30% rated them as insufficient or meeting the minimum needed, and 30% rated them as ideal.

## MISP preparedness action plan

PRIORITIZED ACTION PLAN FOR ADDRESSING GAPS IDENTIFIED DURING MISP READINESS ASSESSMENT

| Priority level | Gap | Activities/Interventions | Key organization | Partner organization/s | Timeframe | Resources |
|---|---|---|---|---|---|---|
| P1 | Fragmented coordination between different sectors involved in SRH service provision during emergency | Activating the role of the crisis room at MOHP to coordinate tasks for SRH services during emergencies.<br>Create a formal platform or a committee for regular communication and collaboration between different government agencies, national councils, healthcare providers, NGOs/CSOs, and private sector during crisis situations.<br>Conduct a review of the National RMNCAH Strategic Plan to integrate the MISP for SRH. | MOHP - Crisis Room | All relevant sectors of the MOHP<br>International organizations<br>Specialized national councils<br>NGOs, CSOs<br>General Authority for Unified Procurement<br>Secretariat General for Mental Health<br>Relevant ministries | 3 months | Assign a coordinator from each sector for communication and coordination<br>Financial support |
| P1 | National emergency and crisis policies and strategies often fail to adequately integrate SRH services. | Advocate for the inclusion of SRH services in national emergency preparedness plans/strategies.<br>Roundtable discussions for all relevant sectors to create comprehensive model policies that outline protocols for delivering essential SRH services during various crises, including natural disasters, conflicts, and pandemics.<br>Equip emergency responders, healthcare workers, and volunteers with the knowledge and skills to identify and address SRH needs during emergencies. | MOHP<br>UNFPA<br>WHO<br>UNAIDS | Ministry of Justice<br>Ministry of Interior<br>Ministry of Social Solidarity<br>National Council for Population<br>International organizations UNFPA, WHO, UNAIDS<br>NGOs, CSOs<br>Egyptian Red Crescent | 12 months | Advocacy plan and materials<br>Recruit legal expert<br>Awareness campaign prerequisites<br>Capacity building: technical and financial prerequisites |

| Priority level | Gap | Activities/Interventions | Key organization | Partner organization/s | Timeframe | Resources |
|---|---|---|---|---|---|---|
| P1 | Lack of integration of GBV against women and girls' services in emergency response which hinders effective support and protection for women and girls facing violence in times of crisis. | Awareness campaign about the available services for GBV against women and girls for the concerned authorities and relevant stakeholders.<br>Implement joint training programs for emergency responders and GBV against women and girls service providers to ensure a coordinated approach, equipping responders to identify and address GBV against women and girls during emergencies.<br>Public awareness campaign to inform the public about the available services for GBV against women and girls and how to access these services during both stable and crisis situations. | MOHP | All relevant ministries<br>Ministry of Social Solidarity<br>Ministry of Higher Education<br>Ministry of Interior<br>International organizations<br>National Media Authority<br>NGOs, CSOs | 6 months | Media campaign prerequisites<br>Capacity building: technical and financial prerequisites |
| P1 | Lack of accessible referral mechanisms and dedicated safe spaces for the victims of GBV against women and girls. | Establish a system with accessible referral mechanisms and safe spaces to ensure continuous support for GBV against women and girls' victims during emergencies.<br>Increase the number of safe women clinics to 250 to ensure national coverage.<br>Implement programs that raise awareness about GBV against women and girls within communities while simultaneously equipping them with the skills to support victims.<br>Engage religious leaders as GBV against women and girls' awareness advocates. | MOHP<br>National Media Authority<br>Ministry of Social Solidarity<br>Religious institutions | International organizations: UNFPA, WHO, UNHCR<br>Ministry of Social Solidarity<br>National Women Council<br>National council for childhood and motherhood<br>NGOs, CSOs<br>Ministry of Education | 12 months | Comprehensive plan to support the victims of GBV against women and girls and its communication to the public<br>Financial support<br>Awareness campaign prerequisites |

| Priority level | Gap | Activities/Interventions | Key organization | Partner organization/s | Timeframe | Resources |
|---|---|---|---|---|---|---|
| | | | | | | Financial and technical support |
| P2 | Weak legal frameworks and limited policies on GBV against women and girls create significant barriers to effectively address and prevent violence against women and girls. | Technical working groups in the parliament to enact comprehensive laws that clearly define and criminalize various forms of GBV against women and girls<br>Increase funding and resources for victim support services such as hotlines, shelters, legal aid, and counseling | Ministry of Justice<br>Parliament | MOHP<br>Ministry of Social Solidarity<br>NGOs, CSOs<br>International organizations: UNFPA<br>National Women Council<br>National Council for Childhood and Motherhood | 18 months | Financial support<br>Legal experts |
| P1 | Shortage in medical teams and service providers for SRH services | Implement training programs for healthcare professionals on delivering SRH services<br>Provide continuing education opportunities for existing healthcare workers to update their knowledge and skills in SRH.<br>Create a supportive and well-equipped work environment for healthcare workers, including opportunities for professional development and advancement.<br>Collaborate with universities to develop educational programs in SRH to attract more students.<br>Develop programs that allow medical students and professionals to volunteer in | MOHP | Ministry of Social Solidarity<br>Ministry of high Education<br>Universities/Academia<br>NGOs, CSOs<br>UNFPA | 18 moths | Capacity building technical and financial prerequisites<br>Regulations for task sharing and delegations |

| Priority level | Gap | Activities/Interventions | Key organization | Partner organization/s | Timeframe | Resources |
|---|---|---|---|---|---|---|
| | | SRH service delivery, fostering interest in the field.<br><br>Expand access to SRH services by using task sharing and by delegating specific tasks to qualified non-physician healthcare providers. | | | | |
| P2 | Knowledge gaps among health service providers (physicians, nurses, Community Health Workers (CHW)) regarding SRH that hinder effective care delivery. | Develop and implement standardized training programs focused on essential SRH services.<br><br>Training of house officers on basic SRH services.<br><br>Establish ongoing educational resources and workshops for health service providers to stay updated on best practices and the latest advancements in SRH care. | Ministry of Higher Education<br><br>MOHP | NGOs, CSOs<br><br>International Federation of Medical Students' Associations<br><br>International organizations: UNFPA, WHO<br><br>National Council for Women | 12 months | Capacity building: technical and financial prerequisites |
| P2 | Task shifting to address other healthcare needs has exacerbated the shortage of specialists equipped to handle SRH services, particularly during emergencies. | Create strategies to rapidly deploy specialist teams to respond to SRH needs during emergencies, potentially through partnerships with other regions or organizations.<br><br>Explore the use of telemedicine technology to connect specialists with remote healthcare workers in emergencies, allowing for remote consultation and guidance.<br><br>Identify specific SRH tasks that can be safely delegated to appropriately trained non-physician providers like nurses, midwives, or CHWs. | MOHP | Ministry of higher Education<br><br>NGOs, CSOs<br><br>International Federation of Medical Students' Associations<br><br>Private sector | 12 months | Capacity building: technical and financial prerequisites |

| Priority level | Gap | Activities/Interventions | Key organization | Partner organization/s | Timeframe | Resources |
|---|---|---|---|---|---|---|
| | | Create training programs that equip non-physician providers with the necessary skills and knowledge to deliver specific SRH services, freeing up specialists for more complex cases. | | | | |
| P1 | Unequal distribution of SRH services creates pockets of service deprivation in certain areas. | Develop a service distribution map that visually identifies underserved areas and prioritizes resource allocation.<br>Expanding the establishment and operation of SRH clinics in areas deprived of the service to be supported by NGOs and CSOs.<br>Implement mobile outreach clinics equipped with essential SRH services to reach underserved and remote areas.<br>Expand telehealth services for SRH consultations and remote patient monitoring, particularly for geographically isolated populations.<br>Offer incentives to healthcare providers to encourage them to practice in underserved areas.<br>Train and equip community health workers to provide basic SRH services, education, and referrals within their communities. | Ministry of Social Solidarity<br>MOHP | International organizations: UNFPA, WHO<br>National Council for Population<br>Physicians' and nurses' syndicates | 12 months | Financial and technical support<br>Technology transfer and use |
| P2 | Lack of access to essential SRH services among vulnerable groups due to a lack of | Develop culturally sensitive and age-appropriate educational materials to raise the awareness among the vulnerable groups. | MOHP | NGOs, CSOs<br>National Media Authority<br>Religious institutions | 18 months | Family planning methods |

| Priority level | Gap | Activities/Interventions | Key organization | Partner organization/s | Timeframe | Resources |
|---|---|---|---|---|---|---|
| | awareness about available services and limited choices in family planning methods. | Partner with local influencers, religious leaders and healthcare professionals to disseminate information about SRH services.<br>Increase availability of a wider range of safe and effective contraceptive methods.<br>Streamline processes for obtaining long-acting reversible contraceptives such as intrauterine devices (IUDs) and implants, which are highly effective and convenient.<br>Equip healthcare professionals with the skills to provide informed and non-judgmental counseling on all available family planning methods. | | International organizations: UNFPA, WHO | | Media campaign prerequisites<br>Capacity building: technical and financial prerequisites |
| P1 | Inadequate stockpiles of family planning methods and SRH supplies within health units during emergencies. | Implement a robust forecasting and inventory management system for family planning methods and SRH supplies in health units to ensure sufficient stockpiles and timely replenishment to avoid stockouts during emergencies.<br>Integrate family planning methods and SRH supplies into emergency response plans and protocols.<br>Sufficient supply of family planning methods particularly the long-acting methods and the female condom. | MOHP | International organizations: UNFPA, WHO<br>General Authority for Unified Procurement<br>NGOs, CSOs | 18 months | Procurement and supply plan<br>Warehouses management<br>Financial support |

| Priority level | Gap | Activities/Interventions | Key organization | Partner organization/s | Timeframe | Resources |
|---|---|---|---|---|---|---|
| P2 | Limited resources available for MISP implementation during emergencies | Advocate for a designated percentage of emergency and humanitarian response funds to be allocated specifically for supporting SRH during crises.<br>Strengthen existing systems for the rapid procurement, transportation, and distribution of Interagency Reproductive Health Kits (IARH Kits) and other essential SRH supplies during emergencies. | MOHP | International organizations: UNFPA, WHO<br>General Authority for Unified Procurement | 12 months | Financial and technical support |
| P2 | The emergency healthcare system lacks dedicated facilities specializing in providing SRH services. | Convert or designate specific areas within existing emergency hospitals or clinics to provide specialized SRH care during crises.<br>Allocate resources towards establishing mobile clinics equipped to deliver essential SRH services in disaster-affected areas or remote locations.<br>Collaborate with non-governmental organizations and private healthcare providers to leverage their existing facilities for SRH service provision during emergencies.<br>Train emergency responders to identify and refer patients with SRH needs to dedicated facilities. | MOHP | International organizations: UNFPA, WHO<br>NGOs, CSOs<br>Egyptian Red Crescent<br>Private sector | 18 months | Designated clinics<br>Medical equipment<br>Financial and technical support |

| Priority level | Gap | Activities/Interventions | Key organization | Partner organization/s | Timeframe | Resources |
|---|---|---|---|---|---|---|
| P2 | Limited accessibility of SRH services for persons with disabilities | Implement physical modifications in SRH facilities to ensure accessibility for persons with disabilities.<br>Provide mandatory disability sensitivity training for all SRH staff, including doctors, nurses, CHWs and administrative personnel.<br>Train CHWs on sign language. | MOHP | International organizations: UNFPA, WHO | 18 months | Sign language interpreters and training requirements<br>Financial support for physical modifications in SRH facilities |
| P3 | Low community utilization of SRH services, especially in emergencies, due to lack of awareness about their availability | Develop culturally sensitive and context-specific messaging highlighting the importance of SRH services during emergencies, and utilize various communication channels to deliver such messages.<br>Develop a publicly accessible map of SRH service locations, indicating availability in both private and public clinics and hospitals. Complement this with a public awareness campaign to inform the community about these locations. | MOHP | NGOs, CSOs<br>Ministry of Information and Communication<br>International organizations: UNFPA, WHO<br>Private sector | 12 months | Awareness campaign prerequisites<br>Service survey map<br>Financial and technical support |
| P2 | Lack of robust data and information on SRH and poor integration of this data into national Health Information Systems (HIS) | Invest in robust and user-friendly data reporting systems that facilitate timely and accurate reporting of SRH data to the national HIS.<br>Establish clear and consistent data standards to facilitate the seamless integration of SRH data into the existing national HIS infrastructure. | MOHP<br>Ministry of Higher Education | Ministry of Information and Communication<br>International organizations<br>NGOs, CSOs<br>Relevant ministries | 6 months | Human and financial resources<br>Technology transfer and use |

| Priority level | Gap | Activities/Interventions | Key organization | Partner organization/s | Timeframe | Resources |
|---|---|---|---|---|---|---|
| | | Establish a multi-sectoral committee to review and recommend updates to SRH indicators within the national HIS.<br>Allocate resources to upgrade and strengthen the IT infrastructure of the national HIS to accommodate the inclusion of additional SRH data sets.<br>Collaborate with relevant stakeholders such as civil society organizations and community-based healthcare providers to ensure their data collection efforts contribute to a comprehensive national SRH data set. | | | | |

# CONCLUSION

Egypt has a National Emergency Preparedness and Response Strategy, including the National Strategy for Disaster Risk Reduction (NSDRR) 2030 and Law No. 152 of 2021, which establish a comprehensive framework for addressing epidemics and communicable diseases. These strategies and laws demonstrate a commitment to reducing disaster risks and improving health outcomes during emergencies. The Updated National Population and Development Strategy 2023-2030 and the National Health Strategic Plan for Egypt 2023–2030 both prioritize expanding access to reproductive health and family planning services, integrating these into emergency preparedness and response plans, indicating a strategic approach to ensuring SRH services are maintained during crises.

The establishment of the National Committee for Crisis, Disaster, and Risk Management through Prime Minister decision No. 905 of 2024 shows a coordinated effort to handle emergencies and reduce disaster risks. However, there is a gap in the explicit inclusion of SRH and GBV against women and girls in the coordination mechanisms. The Medical Emergency Fund, established by Law No. 139 of 2021 and Law No. 5 of 2024, provides a mechanism for rapid mobilization of funds to support medical services during emergencies, potentially including SRH needs.

The MISP preparedness assessment results revealed a high level of commitment to emergency preparedness at the organizational level, with all respondents reported having plans in place and the majority integrating SRH considerations. This commitment is further evidenced by the strong coordination mechanisms at the national level for discussing SRH in emergencies, which actively involve civil society organizations representing marginalized groups. SRH considerations are not only well-integrated into emergency health response plans at the organizational level but also feature prominently in policies or plans that include provisions for disaster management and emergency response.

The absence of reported national legislation or policies restricting access to SRH care for specific groups underscores an inclusive approach to service provision. This inclusivity is mirrored in the inclusion of SRH in recovery plans, ensuring a seamless transition from acute to comprehensive services. The strong coordination mechanism for disaster management during crises further solidifies the commitment to addressing SRH needs in emergency contexts.

At both the national and sub-national levels, coordination mechanisms for SRH in emergencies are well-established at the organizational level, with significant engagement from civil society organizations and community-based organizations representing marginalized and underserved groups. This inclusive approach ensures that the needs of these groups are considered and addressed in emergency preparedness and response.

Risk assessments are designed to consider the impact on various populations, with a particular focus on ensuring that vulnerable groups are not overlooked in emergency preparedness planning. This comprehensive approach to risk assessment is crucial for tailoring responses to the diverse needs of different populations.

While there is a strong foundation for SRH emergency preparedness, there is also room for improvement. Specifically, the integration of MISP-related indicators into existing health information systems and the inclusion of disaggregated data and key SRH questions in rapid needs assessment forms can be enhanced. These improvements would facilitate a more targeted and effective response to SRH needs during emergencies.

Mechanisms for the rapid mobilization of funds to support an SRH response during emergencies are in place as reported by a significant proportion of respondents, demonstrating a proactive approach to financial preparedness. Similarly, systems for rapid sourcing of SRH supplies and equipment, along with warehouses or storage facilities for pre-positioning or storing medical supplies, are available. These logistical preparations are essential for ensuring the timely delivery of critical SRH services during emergencies.

Additionally, a moderate level of preparedness for providing essential SRH services during emergencies, with half of the respondents confirming the inclusion of all necessary SRH commodities in the national essential medicines list. Systems for digital health platforms, telemedicine, or online consultations are in place as stated by 40% of respondents, indicating a need to expand these services for broader access. There is a strong emphasis on scaling up PPE and IPC materials for SRH facilities in the event of epidemics or pandemics, with 80% of respondents reported having plans and opportunities to do so. Training programs for health staff to integrate health emergency management and the MISP into their practices are available as indicated by 70% of respondents, suggesting a focus on capacity building.

Mechanisms for mobilizing or redeploying health staff during emergencies are in place are indicated by 80% of respondents, with a notable inclusion of specialist SRH providers in health response teams for 40% of respondents. Diverse communication channels are widely available for informing communities about MISP-related services during emergencies, with 80% of respondents reported having these channels. Access to SRH services for marginalized and underserved groups is generally good, with only 10% of respondents reporting significant barriers.

For preventing sexual violence and responding to the needs of survivors, 80% of respondents have provisions for free access to health services, and 70% stated that a clear and up-to-date referral system is in place. Collaboration with protection clusters or GBV against women and girls' sub-clusters/actors is extensive, with 80% of respondents reporting such partnerships. Clinical care and referral to other supportive services for survivors of sexual violence are

reported by 80% of respondents, with an emphasis on improving the availability of safe spaces within health facilities.

For preventing the transmission of and reducing morbidity and mortality due to HIV and other STIs, the National AIDS Control Programme, fever hospitals, and university hospitals are the key entities responsible. A clear, up-to-date referral system for HIV/ARV services is confirmed by 40% of respondents, with various essential services available at different levels of health facilities. The availability of essential SRH elements in case of an emergency varies, with some services like safe and rational blood transfusion practices and standard precautions being more consistently available.

For preventing excess maternal and newborn morbidity and mortality, the MOHP PHC sector, Curative sector, NGOs, and CSOs are identified as the main actors. A clear, up-to-date EmONC referral system is present as indicated by 40% of respondents, with various levels of care available at different facilities. The availability of essential SRH elements for maternal and newborn care is reported, but there are concerns about the sufficiency of qualified medical personnel and facilities.

For preventing unintended pregnancies, the MOHP Family Planning sector, the Ministry of Social Solidarity, and NGOs are responsible. A referral system for contraceptive methods is confirmed by 60% of respondents, with various contraceptive services available at different levels of health facilities. The availability of a range of contraceptive methods and IEC materials is reported, but the sufficiency of qualified medical personnel, facilities, and supplies/equipment is reported as critical concerns by the respondents.

Safe abortion care is available under certain circumstances, with the MOHP Curative sector and university hospitals responsible. However, there are concerns about the sufficiency of qualified medical personnel, facilities, and supplies/equipment for providing safe abortion care.

# RECOMMENDATIONS

**Integrating Policies and Enhancing Coordination and Communication:**

1. Integrate SRH and GBV against women and girls' services into national strategic disaster and emergency policies, plans, and coordination mechanisms.
2. Advocate for the inclusion of SRH in national emergency preparedness plans.
3. Integrate MISP into the National Reproductive, Maternal, Newborn, Child, and Adolescent Health Strategic Plan.
4. Enhance coordination through the MOHP crisis room and regular stakeholder communication.
5. Establish a formal platform for regular communication and collaboration between all stakeholders.

**Policy Development and Legal Framework:**

6. Establish a coordinated system for addressing GBV against women and girls with accessible referral mechanisms.
7. Strengthen legal frameworks and policies on GBV against women and girls by working with technical working groups in the parliament.
8. Develop and implement policies and programs to regulate access to safe abortion care within the legal framework.

**Service Distribution and Accessibility:**

9. Address unequal SRH service distribution through service mapping and mobile outreach.
10. Expand SRH clinics and use mobile outreach and telehealth services, especially in emergency contexts.
11. Improve accessibility for persons with disabilities by modifying SRH clinics.
12. Increase access to family planning methods and SRH services for vulnerable groups.
13. Establish dedicated SRH facilities within emergency hospitals or clinics.
14. Address the gaps in the sufficiency of qualified medical personnel, facilities, and supplies/equipment for MISP services.
15. Collaborate with NGOs and private providers to expand service availability.

**Capacity Building and Training:**

16. Expand SRH services by training healthcare professionals and providing continuing education.
17. Scale up training programs for health staff on emergency management and the MISP.
18. Ensure the inclusion of specialist SRH providers in health response teams.

**Supply Chain and Resource Management:**

19. Enhance the Medical Emergency Fund's capacity to support SRH services.
20. Develop mechanisms for the rapid sourcing of SRH supplies and equipment.
21. Establish and equip warehouses dedicated to medical supplies for SRH.
22. Ensure adequate stockpiles of SRH supplies through forecasting and inventory management systems.

**Data Management and Reporting:**

23. Integrate SRH data into the national HIS with robust reporting systems.
24. Invest in robust data reporting systems and establish clear data standards.

**Community Engagement and Awareness:**

25. Develop and implement comprehensive risk assessments that address the SRH needs of vulnerable populations.
26. Reduce barriers for marginalized and underserved groups to access SRH services.
27. Increase community utilization of SRH services through culturally sensitive messaging.
28. Develop accessible service location maps.
29. Launch awareness campaigns to address the gaps in the utilization of Gender-Based Violence (GBV against women and girls) services during emergencies.

By implementing these recommendations, Egypt can further strengthen its preparedness and response to SRH needs during emergencies, ensuring that critical health services are accessible to all populations, including the most vulnerable.

# ANNEX 1: COMPLETED MRA QUESTIONNAIRE

| Overall structure of the MRA questionnaire | |
|---|---|
| **Section 0 – GENERAL INFORMATION** | |
| **Section I – NATIONAL-LEVEL OVERALL READINESS: POLICIES, COORDINATION AND RESOURCES (related to MISP objective 1)** | |
| *National and sub-national disaster management policies and plans* | Question 1 – 7 |
| *Coordination mechanisms for SRH disaster management* | Question 8 – 13 |
| *SRH data at national and sub-national level* | Question 14 – 17 |
| *Resources for MISP implementation* | Question 18 – 21 |
| **Section II – READINESS TO PROVIDE SERVICES AS OUTLINED IN THE MISP** | |
| *MISP Services – General* | Question 22 – 30 |
| *MISP objective 2 – Prevent sexual violence and respond to the needs of survivors* | Question 31 – 36 |
| *MISP objective 3 – Prevent the transmission of and reduce morbidity and mortality due to HIV and other STIs* | Question 37 – 42 |
| *MISP objective 4 – Prevent excess maternal and newborn morbidity and mortality* | Question 43 – 47 |
| *MISP objective 5 – Prevent unintended pregnancies* | Question 48 – 52 |
| *Other priority activity: Safe abortion care to the full extent of the law* | Question 53 – 58 |

## Section 0 – General Information

| Section 0 – GENERAL INFORMATION | | | | |
|---|---|---|---|---|
| **Who led the assessment?** | **Date of the assessment** | **At what level was the assessment conducted?** *Hereafter referred to as 'selected area' or 'your location'* | **If sub-national level, specify the province, district, region, etc:** | **Participants involved in the assessment** *(You can attach participants' list)* |
| | | • **National level**<br>• **Sub-national level** | | |

## Section I – NATIONAL-LEVEL OVERALL READINESS: POLICIES, COORDINATION AND RESOURCES

| **Section I – NATIONAL-LEVEL OVERALL READINESS: POLICIES, COORDINATION AND RESOURCES (related to MISP objective 1)** | | | | | |
|---|---|---|---|---|---|
| # | | Yes | No | Don't know | Comment/Reference/Details |
| *National and sub-national Disaster Management Policies and Plans* | | | | | |
| **1** | Does your country have a **National Emergency Preparedness and/or Response Policy and/or Plan**?<br>• *If yes, please specify and mention in the comment box the type of emergencies it covers (e.g., natural hazard, conflict, public health emergencies, etc.)* | √ | | | There is National Emergency Preparedness and Response strategy. |
| **2** | Does your country have a **National Health Preparedness and/or Emergency Response Plan**?<br>• *If yes, please specify* | √ | | | There is a National Health Preparedness and/or Emergency Response Plan developed by MOHP.<br>It includes all types of emergencies and crisis level. |
| **3** | Are these plans rolled out at **sub-national level**?<br>• *If yes, please specify* | √ | | | There are emergency teams at the level of the districts. |
| **4** | Is **SRH and/or the MISP** integrated into any **national** or **sub-national emergency health response policy and/or plan**?<br>• *If yes, please specify if all MISP components are integrated as well as the title, the region and year or the policy/plan.* | | √ | | At the organizational level, MISP is seamlessly integrated into the national and sub-national emergency health response plans. Furthermore, there are dedicated safe women's clinics within the PHC sector of the MOHP at the sub-national level, which specifically address gender-based violence (GBV) against women and girls. Additionally, the "Equal Opportunity Unit" within the Family Planning sector of the MOHP tackles a range of issues, including sexual and reproductive health (SRH). |

| | | | | | |
|---|---|---|---|---|---|
| **5** | Are there any SRH policies or plans that include provisions for **disaster management and/or emergency response**?<br><br>● *If yes, please specify* | | √ | | However, while these plans exist, they are often found to be insufficient in addressing the comprehensive needs of affected populations, particularly in the context of gender-based violence and reproductive health care during emergencies. |
| **6** | To your knowledge, are there national legislation and/or **policies with provisions limiting access to SRH care** for certain groups (e.g., migrants, undocumented migrants, refugees, youth, unmarried individuals, people of diverse sexual orientation, gender identity and expression and sex characteristics (SOGIESC), people living with HIV, sex workers, etc.)?<br><br>● *If yes, please list which populations* | | √ | | |
| **7** | To your knowledge, is **SRH included in recovery plans** when response moves from acute to more comprehensive services? | | √ | | At the organizational level, SRH services are included in recovery plans when response moves from acute to more comprehensive services. |
| *Coordination Mechanisms for SRH disaster management* | | | | | |
| **8** | Is there a **coordination mechanism** responsible for **disaster management** during a crisis?<br><br>● *If yes, which one and mention in the comment box the type of emergencies it covers (e.g., natural hazard, conflict, pandemics, etc.)* | √ | | | At the Ministry of Health and Population (MOHP), there exists a dedicated committee focused on emergency and crisis preparedness. This committee plays a pivotal role in coordinating its efforts with the emergency and crisis management committee at the Ministers' Council. Together, they work to ensure a cohesive and effective response to any potential health emergencies or crises at both the national and sub-national levels. |
| **9** | In this disaster management mechanism, is there an entity responsible for **health, including SRH and GBV against women and girls**, during response?<br><br>● *If yes, please specify* | | √ | | However, it is important to note that while this entity exists, there is currently insufficient representation and focus on SRH and GBV issues. |

| | | | | | |
|---|---|---|---|---|---|
| **10** | Is there a coordination mechanism (e.g., SRH working group) to discuss SRH in emergencies at the **national level** when it comes to:<br><br>● *If yes, please specify which one(s) in the comment box, mention the frequency of the meetings, and the type of emergencies covered by the group* | √ | | | However, it is important to note that while this committee exists, there is currently an insufficient focus on SRH and GBV within its mandate.<br><br>Additionally, the rapid response teams at the governorates, under the Preventive sector of the MOHP, are responsible for addressing health emergencies and crises. These teams play a crucial role in the immediate response to health-related issues during disasters.<br><br>The UPA provides all necessary supplies and commodities to support SRH interventions in emergencies. |
| | Preparedness | √ | | | |
| | Response | √ | | | |
| | Recovery | √ | | | |
| **11** | Is there a structure/coordination mechanism (e.g., SRH working group/disaster committee) to discuss SRH in emergencies at the **sub-national level** when it comes to:<br><br>● *If yes, please specify which one(s) in the comment box, mention the frequency of the meetings, and the type of emergencies covered by the group* | √ | | | At the organizational level (e.g. MOHP), there is a structure/coordination mechanism to discuss SRH in emergencies at the sub-national level |
| | Preparedness | √ | | | |
| | Response | √ | | | |
| | Recovery | √ | | | |
| **12** | If there are no coordination mechanisms, are **SRH focal points** appointed at national and/or sub-national level to assist with emergency preparedness and response?<br><br>● *If yes, please specify in the comment box* | √ | | | Existent in some organizations but insufficient. |

| 13 | Are civil society organizations and community-based organizations working/representing marginalized and underserved groups (e.g., women and men with disabilities, people living with HIV, people of diverse SOGIESC, youth groups, religious leaders, sex workers, ethnic minorities, etc.) included in the coordination mechanisms?<br><br>● *If yes, please specify and list participants* | √ | | | This also includes NGOs, CSOs, international organizations, WHO, UNFPA, Red Crescent |
|---|---|---|---|---|---|
| ***SRH Data at national and sub-national level*** | | | | | |
| 14 | Do current risk assessments address impacts on different populations (e.g., women, people with disabilities, People living with HIV, people of diverse SOGIESC, youth, sex workers, ethnic minorities, etc.)<br><br>● *If yes, please specify in the comment section.* | | √ | | Insufficient as it does not include all population categories. |
| 15 | Are MISP-related indicators (see MISP checklist) integrated within the existing health information systems (HIS)? | | √ | | Insufficient as not all MISP-related indicators are integrated within the existing HIS. |
| 16 | Do rapid needs assessment forms for emergency response (rapid assessments and health sector assessments) include sex, age and disability (SADD) disaggregated data and key SRH questions?<br><br>● *If yes, please specify the type of questions in the comment section* | | √ | | The current forms are insufficient as they do not capture all the required disaggregated data comprehensively. |
| 17 | Do data collection tools (e.g., health forms) for emergency response include MISP-related indicators (see MISP checklist)? | √ | | | |
| ***Resources for MISP preparedness and implementation*** | | | | | |
| 18 | Do mechanisms for **rapid mobilization of funds** exist to support an SRH response? (e.g., contingency funds, country-based pooled funds, etc.)<br><br>● *If yes, please specify in the comment box* | | √ | | These mechanisms are often insufficient, lacking the necessary flexibility and resources to fully meet the SRH needs during emergencies. |

| | | | | | This is performed through the emergency preparedness fund at MOHP. |
|---|---|---|---|---|---|
| **19** | Do you have a mechanism in place for **rapid sourcing – at a national or international level – of SRH supplies and equipment and/or IARH kits** (e.g., pre-positioning, buffer stocks, standing agreements, pre-identified suppliers, etc.)?<br><br>● *If yes, please specify* | | √ | | These mechanisms are often insufficient, facing challenges in terms of availability, accessibility, and adequacy of supplies, particularly during large-scale emergencies.<br><br>This is through the UPA |
| **20** | Do you have **warehouses or storage facilities** where medical supplies for SRH are prepositioned or could be stored?<br><br>● *If yes, please specify* | √ | | | This is through the UPA |
| **21** | Are there any **funds** to support health and/or SRH **emergency preparedness** at the national or sub-national level?<br><br>● *If yes, please specify* | | √ | | Specifically, there is an emergency preparedness fund at the MOHP. However, these funds are often insufficient, facing limitations in terms of availability and allocation, particularly during large-scale emergencies. |

## Section II – READINESS TO PROVIDE SERVICES AS OUTLINED IN THE MISP

**Section II – READINESS TO PROVIDE SERVICES AS OUTLINED IN THE MISP**

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

### MISP services – General

| *MISP Services – General* | | | | | |
|---|---|---|---|---|---|
| # | | Yes | No | Don't know | Comment/Reference/Details |
| **22** | Are all the SRH commodities needed for MISP implementation (see IARH kit booklet) part of the national **essential medicines list**?<br><br>• *If no, please specify the ones where there are no equivalent available and may affect MISP implementation* | √ | | | |
| **23** | Do you have the systems in place to support **remote delivery of services** (e.g., digital health, telemedicine, online consultation, etc.)?<br><br>• *If yes, please specify which in the comment box* | √ | | | This include mobile clinics and telemedicine |
| **24** | In the event of **epidemics/pandemics**, are there opportunities and plans for **scaling up PPE and IPC materials** for SRH facilities?<br><br>• *If yes, please specify in the comment box* | √ | | | The Infection Control Department within the Preventive Health sector of the MOHP plays a pivotal role in ensuring the coordination of all sectors to facilitate the provision of essential supplies and commodities necessary for effective infection control. |
| **25** | Does the **health care training curriculum or other relevant trainings**, including on online platforms, for health staff integrate health emergency management and/or the MISP?<br><br>• *If yes, specify which one: nursing, doctors, midwives, etc.* | | √ | | The integration is often insufficient, with limited focus and depth on these critical areas. |

| | | | | | |
|---|---|---|---|---|---|
| **26** | Does a mechanism exist for **health staff** to be **moved or take on new roles** in times of emergencies to better support affected areas? (e.g., surge or task shifting)<br><br>● *If yes, please specify in the comment box* | | √ | | This mechanism is often insufficient, facing challenges in terms of coordination, logistics, and the availability of trained personnel. |
| **27** | Do **health response teams** contain specialist SRH providers? | | √ | | The inclusion of these specialists is often insufficient, with limited numbers and uneven distribution across teams and affected areas. |
| **28** | Are there **diverse communication channels** (e.g., radio, text messaging, WhatsApp, etc.) available which can be leveraged to inform the community on the availability of MISP-related services in case of an emergency?<br><br>● *If yes, specify what these are and how hard-to-reach populations are being considered.* | | √ | | The availability and utilization of these channels are often insufficient, with limited reach |
| **29** | Are there any barriers for marginalized and underserved groups (e.g., women with disabilities, adolescents, sex workers, people of diverse SOGIESC, PLHIV, refugees, migrants, undocumented migrants, ethnic minorities, etc.) to access SRH services?<br><br>● *Please clarify which in the comment box* | | √ | | |
| **30** | Are there provisions for **free access** to health services (consider the MISP) for crisis-affected populations?<br><br>● *Please specify in the comment box* | √ | | | |

## MISP Objective 2 – Prevent sexual violence and respond to the needs of survivors

| | *MISP Objective 2 – Prevent sexual violence and respond to the needs of survivors* | | |
|---|---|---|---|
| | | **Answer** | **Comment** |
| **31** | Which actors are **responsible** for ensuring the **provision of GBV against women and girls services** (e.g., CMR, protection, legal services, etc.) in the selected area?<br>● *Please list all agencies (e.g., name of the government unit, INGOs, civil society, community-based organization, private sector, etc.)* | MOHP<br>MOSS<br>University hospitals<br>Safe women's clinics at PHC affiliated to MOHP<br>Psychological support unit in the Egyptian Red Crescent | |
| **32** | Are **safe, private, and confidential spaces** identified and available which are accessible for survivors of GBV against women and girls?<br>● *If yes, please specify* | √ | The availability and accessibility of these spaces are often insufficient, particularly in emergency settings. |
| **33** | Is there a clear up-to-date **referral system,** which links the various GBV against women and girls service providers (e.g., health, GBV against women and girls case management, legal, protection etc.) that can be leveraged during emergencies?<br>● *If yes, please specify* | √ | The effectiveness and accessibility of this system are often insufficient, particularly during emergencies. Challenges such as coordination, communication, and the availability of resources can hinder the smooth functioning of the referral system, limiting the support that survivors of GBV can access. |
| **34** | Which level of health facilities can provide the following health services (see CMR) to respond to **the needs of survivors** in the selected area? (Consider the lowest level of providers) | | |
| | Emergency Contraception (EC) | MOHP<br>University hospitals<br>MOSS | |
| | Pregnancy testing, pregnancy options information | MOHP<br>University hospitals | |
| | Antibiotics to prevent and treat STIs | MOHP<br>University hospitals | |

| | | | |
|---|---|---|---|
| | Post-exposure prophylaxis (PEP) | MOHP<br>University hospitals | |
| | HepB vaccine | MOHP<br>University hospitals | The Preventive Health sector has established a comprehensive program dedicated to the routine HepB vaccination of both children and adults |
| | Care of wounds and prevention of tetanus (Tetanus toxoid/Tetanus immunoglobulin) | MOHP<br>University hospitals | |
| | Psychosocial support | MOHP<br>University hospitals | |
| | Safe abortion care/referral to safe abortion care (to the full extent of the law) | MOHP<br>University hospitals | |
| | Forensic evidence collection | Ministry of Justice<br>University hospitals | |

| | | | | | |
|---|---|---|---|---|---|
| **35** | Given the current state of services in your setting, do you think the following MISP elements are **adequate** and **readily available in case of an emergency**? | Yes | No | Don't know | Comment/Reference |
| | **Collaboration/partnerships** with the protection clusters or gender-based violence sub-cluster/actors to put in place preventative measures at community, local and district levels | | √ | | Insufficient |
| | **Clinical care and referral** to other supportive services available for survivors of sexual violence (e.g., legal, protection, psychosocial, shelter, etc.) | | √ | | Insufficient |
| | **Confidential and safe spaces within the health facilities** to receive and provide survivors of sexual violence with appropriate clinical care and referral | | √ | | Insufficient |
| | Existence of **Information, Education and Communication (IEC) materials** on services for sexual violence survivors are prepared for each linguistic group of the most at-risk areas in case of emergency. | | √ | | Insufficient |
| **36** | Based on the above services, how would you rate the existing medical and non-medical structures' (e.g., safe homes, women's associations, etc.) ability to provide **services to prevent and respond to sexual and gender-** | Ideal | Minimum needed | Insufficient | Comment/Reference<br>*Provide here a rational for the rating* |

| | | | | | |
|---|---|---|---|---|---|
| | **based violence** in your location with regards to the following elements: | | | | |
| | Qualified Staff (e.g., clinical care of rape, GBV against women and girls case management, etc.) | | | √ | insufficient qualified staff to provide comprehensive services for preventing and responding to sexual and gender-based violence. There is a shortage of trained professionals, including clinicians, counselors, and case managers, which limits the ability to deliver essential care and support to survivors. |
| | Facilities (e.g., Clinics, safe spaces, hotlines, etc.) | | | √ | |
| | Supplies/equipment (e.g., for clinical care) | | | √ | This is through the UPA and Curative sector MOHP |

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

| *MISP Objective 3 – Prevent the transmission of and reduce morbidity and mortality due to HIV and other STIs* | | | |
|---|---|---|---|
| | | **Answer** | **Comment** |
| **37** | Which actors are **responsible** for ensuring the provision of HIV **services** in the selected area?<br>• *Please list all agencies (e.g., name of the government unit, INGOs, civil society, community-based organization, private sector, etc.)* | MOHP (fever hospitals)<br>University hospitals<br>National AIDS Control Programme (MOHP) | In addition to Egypt Shelter Association in coordination with the National AIDS Program |
| **38** | Which actors are **responsible** for ensuring the provision of STI **services** in the selected area?<br>• *Please list all agencies (e.g., name of the government unit, INGOs, civil society, community-based organization, private sector, etc.)* | MOHP (fever hospitals)<br>University hospitals<br>National AIDS Control Programme (MOHP) | In addition to Egypt Shelter Association in coordination with the National AIDS Program |
| **39** | Is there a clear, up-to-date **referral system** for **HIV/ARV** services that can be leveraged during emergencies?<br>• *If yes, please specify.* | √ | The system is often insufficient, facing challenges in terms of coordination, communication, and resource availability. |
| **40** | Which level of health facilities can provide the following services to **prevent the transmission of and reduce morbidity and mortality due to HIV and other STIs** in the selected area? (Consider the lowest level) | | |
| | ARV | MOHP (fever hospitals)<br>University hospitals | |
| | Syndromic management of STI | MOHP (fever hospitals)<br>University hospitals | |
| | PMTCT | MOHP (fever hospitals)<br>University hospitals | |
| | Condom Distribution | MOHP (fever hospitals)<br>University hospitals | |

| | | | | | |
|---|---|---|---|---|---|
| **41** | Given the current state of health services in your location, do you think the following MISP elements are **adequate** and **readily available in case of an emergency**? | Yes | No | Don't know | Comment/Reference |
| | Safe and rational blood transfusion in place | √ | | | Minimum needed |

| | | | | | |
|---|---|---|---|---|---|
| | Standard precautions consistently practiced | | √ | | Insufficient |
| | Availability of free lubricated male condoms and where applicable female condoms | | √ | | Insufficient |
| | ARVs for continuing users | √ | | | Minimum needed |
| | ARVs for women enrolled in PMTCT programs | √ | | | Minimum needed |
| | PEP to survivors of sexual violence as appropriate and for occupational exposure | | √ | | Insufficient |
| | Provision of co-trimoxazole prophylaxis for opportunistic infections for patients found to have HIV or already diagnosed with HIV | | √ | | Insufficient |
| | Availability in health facilities of syndromic treatment of STIs | | √ | | Insufficient |
| | Existence of IEC materials and STI/HIV counseling services (that emphasizes informed choice, effectiveness, and supports client privacy and confidentiality) in case of emergency | | √ | | Insufficient |
| **42** | Based on the above services, how would you rate the **existing** health systems' ability to provide **HIV and STI Management as outlined in the MISP for SRH** in your location with regards to the following elements: | Ideal | Minimum needed | Insufficient | Comment/Reference<br>*Provide here a rational for the rating* |
| | Qualified Medical Personnel | | | √ | There is a shortage of specialized staff, particularly in remote and underserved areas, which limits the ability to deliver essential services. |
| | Facilities (e.g., Clinics, hotlines, etc.) | | | √ | |
| | Supplies/equipment | | | √ | |

MISP Objective 4 – Prevent excess maternal and newborn morbidity and mortality

| ***MISP Objective 4 – Prevent excess maternal and newborn morbidity and mortality*** | | | | | | |
|---|---|---|---|---|---|---|
| | | **Answer** | | | **Comment** | |
| **43** | Which actors are **responsible** for ensuring **the provision of Maternal and Newborn services** in the selected area?<br>● *Please list all agencies (e.g., name of the government unit, INGOs, civil society, community-based organization, private sector, etc.)* | MOHP PHC sector and Curative sector | | | The Preventive sector (MOHP) has implemented an inclusive vaccination program designed to ensure that immigrant mothers and their newborns have access to routine immunizations | |
| **44** | Is there a clear up-to-date Emergency Obstetric and Neonatal Care (EmONC) **referral system** that can be leveraged during emergencies?<br>● *If yes, please specify (e.g., MoUs with hospitals, ambulance available, phone numbers shared, back-referral structure, etc.)* | √ | | | | |
| **45** | Which level of health facilities can provide the following services **to prevent excess maternal and newborn morbidity and mortality** in the selected area? (consider the lowest level) | | | | | |
| | Skilled birth attendance | MOHP PHC sector and Curative sector<br>Government Hospitals | | | | |
| | Basic EmONC | MOHP PHC sector and Curative sector<br>Government hospitals | | | | |
| | Comprehensive EmONC | MOHP PHC sector and Curative sector<br>Government hospitals | | | | |
| | Post-abortion care | MOHP PHC sector and Curative sector<br>Government hospitals | | | | |
| | 24/7 Ambulance/transport service | MOHP Ambulance sector | | | | |
| **46** | Given the current state of health services in your location, do you think the following MISP elements | Yes | No | Don't know | Comment/Reference | |

| | | | | | |
|---|---|---|---|---|---|
| | are **adequate** and **readily available in case of an emergency**? | | | | |
| | At referral hospital level: Skilled medical staff and supplies for provision of comprehensive emergency obstetric and newborn care (CEmONC) | | √ | | Insufficient |
| | At health facility level: Skilled birth attendants and supplies for vaginal births and provision of basic obstetric and newborn care (BEmONC) | | √ | | Insufficient |
| | At community level: Provision of information to the community about the availability of safe delivery and EmONC services and the importance of seeking care from health facilities. | | √ | | Insufficient |
| | 24 hours per day, 7 days per week referral system for obstetric complications | | √ | | Insufficient |
| | Availability of post-abortion care in health centers and hospitals | | √ | | Insufficient |
| | Availability of supplies and commodities for clean delivery (e.g., clean delivery kits) and immediate newborn care where access to a health facility is not possible or unreliable | | √ | | Insufficient |
| | Existence of IEC materials on priority maternal and neonatal services for pregnant women and girls for each linguistic group of the most at-risk areas | | √ | | Insufficient |
| **47** | Based on the above services, how would you rate the **existing** health systems' ability to provide **maternal and newborn care services as outlined in the MISP for SRH** in | Ideal | Minimum needed | Insufficient | Comment/Reference<br>*Provide here a rationale for the rating* |

| | your location with regards to the following elements: | | | | |
|---|---|---|---|---|---|
| | Qualified Medical Personnel (e.g., Skilled Birth Attendance, BEmONC, CEmONC) | | | √ | |
| | Facilities (e.g., Clinics, hospitals, etc.) | | | √ | |
| | Supplies/equipment | | | √ | |

MISP Objective 5 – Prevent unintended pregnancies

| *MISP Objective 5 – Prevent unintended pregnancies* | | | |
|---|---|---|---|
| | | **Answer** | **Comment** |
| **48** | Which actors are **responsible** for ensuring **the provision and removal of long-acting reversible and short-acting contraceptive methods and services** in the selected area?<br>• *Please list all agencies (e.g., name of the government unit, INGOs, civil society, community-based organization, private sector, etc.)* | MOHP Family Planning sector<br>MOSS<br>University hospitals | UPA ensures that contraceptive methods are available<br><br>International organizations such as the United Nations Population Fund supported the provision of such services |
| **49** | Is there a clear up-to-date **referral system for access to short and long term contraceptive methods** that can be leveraged during emergencies?<br>• *If yes, please specify* | √ | Insufficient |
| **50** | Which **level of health facilities** can provide the following **contraceptives to prevent unintended pregnancies** in the selected area? (consider the lowest level) | | |
| | Male and Female (where already used) Condoms | MOHP Family Planning sector<br>University hospitals<br>NGOs | Female Condoms are not available |
| | Oral Contraceptive Pills | MOHP Family Planning sector<br>University hospitals<br>NGOs | |
| | Intra-uterine device (IUD) | MOHP Family Planning sector<br>University hospitals<br>NGOs | |
| | Injectables | MOHP Family Planning sector<br>University hospitals<br>NGOs | |
| | Implants | MOHP Family Planning sector<br>University hospitals<br>NGOs | |
| | Emergency Contraception (EC) | MOHP Family Planning sector<br>University hospitals<br>NGOs | |

| 51 | Given the current state of health services in your location, do you think the following MISP elements are **adequate** and **readily available in case of an emergency**? | Yes | No | Don't know | Comment/Reference |
|---|---|---|---|---|---|
| | Availability of a range of long-acting reversible and short-acting contraceptive methods (including male and female condoms and emergency contraception) at primary health care facilities to meet demand | √ | | | Minimum needed<br>MOHP and UPA are in charge of ensuring the availability of a wide range of contraceptive methods.<br>There is a need to incorporate female condoms into the range of available contraceptive options. |
| | Existence of IEC materials on contraceptive choice (that emphasizes informed choice, effectiveness, and supports client privacy and confidentiality, access to services) | √ | | | Minimum needed |
| **52** | Based on the above services, how would you rate the **existing** health system's ability to provide **contraceptive services** in your location with regards to the following elements: | Ideal | Minimum needed | Insufficient | Comment/Reference<br>*Provide here a rational for the rating* |
| | Qualified Medical Personnel | | | √ | |
| | Facilities (e.g., Clinics, pharmacies, hotlines, etc.) | | | √ | |
| | Supplies/equipment | | | √ | |

Other priority activity: Safe abortion care to the full extent of the law

| | *Other priority activity: Safe abortion care to the full extent of the law* | | | | |
|---|---|---|---|---|---|
| | | Yes | No | Don't know | Comment/Reference |
| **53** | Are there any situations in your context in which safe abortion care can be provided?<br><br>• *If yes, specify the provisions stated in the national law and policies*<br>• *If no, please include the legal language in the policy/legal documents (you can then skip questions 54-58)* | | √ | | Insufficient<br>Safe abortion care in Egypt remains severely restricted. |
| | | **Answer** | | | **Comment** |
| **54** | Which actors are **responsible** for ensuring the provision of safe abortion care in the selected area?<br><br>• *Please list all agencies (e.g., name of the government unit, INGOs, civil society, community-based organization, private sector, etc.)* | MOHP Curative sector<br>University hospitals | | | |
| **55** | Is there a clear **referral system** that can be leveraged during emergencies?<br><br>• *If yes, please specify* | √ | | | Insufficient<br>Safe abortion care in Egypt remains severely restricted. |
| **56** | Are there IEC materials outlining types of services available, and where, that can be leveraged during emergencies? | √ | | | Insufficient<br>Safe abortion care in Egypt remains severely restricted. |
| **57** | Which level of health facilities can provide the following abortion services in the selected area? (Consider the lowest level) | | | | |
| | Medication abortion | MOHP Curative sector<br>University hospitals | | | |
| | Vacuum aspiration, dilatation and evacuation | MOHP Curative sector<br>University hospitals | | | |
| | Induction procedures as recommended by WHO | University hospitals | | | |
| **58** | Based on the above services, how would you rate the **existing** medical structures and services that provide **safe abortion care** in | Ideal | Minimum needed | Insufficient | Comment/Reference<br><br>*Provide here a rational for the rating* |

| | your location with regards to the following elements: | | | | |
|---|---|---|---|---|---|
| | Qualified Medical Personnel (e.g., trained on medical procedures, abortion values clarification and attitude transformation) | | | √ | |
| | Facilities (e.g., Clinics, hotlines, etc.) | | | √ | |
| | Supplies/equipment | | | √ | |

## ANNEX 2: ACTION PLAN

| Priority level | Identified gap | activities | Lead agency | Collaborating agency/ies | Timeframe | Resources |
|---|---|---|---|---|---|---|
| | | | | | | |
| | | | | | | |
| | | | | | | |

## ANNEX 3: PARTICIPANTS LIST

| Name | Position | Organization |
|---|---|---|
| Dr. Talaat Abdel-Qawi | President of the General Union of Community Associations<br>Member of the House of Representatives | General Union of Community Associations |
| Dr. Saadat Abdel-Maguid | Head of the Healthcare and Nursing Sector | Ministry of Health and Population |
| Dr. Merfet Fouad | Director General of the General Administration for Monitoring and Evaluation – Population and Family Planning Sector | Ministry of Health and Population |
| Dr. Khaled Atef | Director General of Population Planning – Population and Family Planning Sector | Ministry of Health and Population |
| Ms. Randa Fares | Advisor to the Minister of Social Solidarity for Family Health and Development Affairs | Ministry of Social Solidarity |
| Dr. Amira El-Hanafi | Member of the Technical Office for the Healthcare and Nursing Sector | Ministry of Health and Population |
| Dr. Maha Moafy | Director of Reproductive Health Programs | United Nations Population Fund (UNFPA) |
| Dr. Hossam Abbas | Head of the Population and Family Planning Sector | Ministry of Health and Population |
| Dr. Wagdy Amin | Director General of Chest Diseases | Ministry of Health and Population |
| Dr. Sherine El-Giar | Member of the Health Committee | National Council for Women |
| Dr. Ghada Nasr | Consultant | United Nations Population Fund (UNFPA) |
| Dr. Rashah Hafez | Program Analyst for Reproductive Health Services and Gender | United Nations Population Fund (UNFPA) |
| Dr. Reymonda Refaat | Health Economics Specialist | Unified Procurement Authority |
| Dr. Ayhab Ahmed Shahin | Responsible for Health Offices and Digitalization – Preventive Sector | Ministry of Health and Population |
| Dr. Samir Wahid El-Demiry | Director General of Maternal and Child Health – Healthcare and Nursing Sector | Ministry of Health and Population |
| Dr. Omar Ahmed Mohamed Ezzam | Vice Dean for Community Service and Environmental Development | Faculty of Medicine, Qasr El-Eyni Cairo University |
| Dr. Nagwa Al-Aghbami | Medical Doctor, Technical Office, Therapeutic Medicine Sector | Ministry of Health and Population |
| Dr. Naglaa Fathi Lithy | Project Manager, Family Project | Egyptian Red Crescent Society |
| Dr. Mohamed Zaki | Assistant Secretary of the Supreme Council of University Hospitals | Supreme Council of University Hospitals |

| Name | Position | Organization |
|---|---|---|
| Dr. Samia Abdou Girgis | Advisor to the Authority's President – Professor at Ain Shams Faculty of Medicine | Unified Procurement Authority |
| Dr. Hala Ezzam | Director General of Research and Foreign Agreements | |
| Ms. Sahar Youssef | Director General of Planning | National Population Council |
| Ms. Soheir El-Said Amin | Director General of the Technical Secretariat | National Population Council |
| Ms. Mona Gamal | Central Plans Manager | National Population Council |
| Hany Izzat Kamal MR. | Office of the Deputy Minister of Health and Population for Population Affairs | National Population Council |
| Ms. Ahejar Mohamed Abdel-Had | Office of the Deputy Minister of Health and Population for Population Affairs | National Population Council |
| Ms. Shimaa Youssef Bashir | Office of the Deputy Minister of Health and Population for Population Affairs | National Population Council |
| Mr. Ihab Hilmy Zakari | Media Specialist | National Population Council |
| Ms. Amira El-Sayed | Director General of Local Plans | National Population Council |

## ANNEX4: AGENDA

**Workshop**
**"Assessing Readiness to Provide the Minimum Initial Service Package for Reproductive Health Services in Crisis and Emergency Situations in Egypt"**

**3-4 July 2024**

| Day One: Assessing Readiness to Provide the Minimum Initial Service Package for Reproductive Health Services | | |
|---|---|---|
| Time | Session | Title Speakers |
| 9:30-09:45 | Registration | |
| 09:45-10:00 | Opening Session and Welcome | Ms. Germain Haddad, Acting Representative of UNFPA, Egypt Office<br>Dr. Tarek Tawfik, Deputy Minister of Health and Population for Population Affairs |
| 10:00-10:15 | Overview of Workshop Objectives and Agenda | Dr. Maha Mowafy<br>Director of Reproductive Health Programs at UNFPA, Egypt Office |
| 10:15-10:45 | Introduction to the Minimum Initial Service Package for Reproductive Health Service Providers<br>Introduction to the Readiness Assessment Questionnaire | Dr. Ghada Nasr<br>UNFPA Consultant |
| 10:45-11:15 | Work Groups to Complete the Questionnaire | |
| 11:15-02.00 | Group Presentations and Discussions<br>Identifying Gaps and Priorities | |
| 02:00-02:30 | Summary and Next Steps | Dr. Ghada Nasr<br>UNFPA Consultant |
| *02:30-03:00* | Lunch Break | |

<table>
<tr><th colspan="3">Day Two: Formulating an Action Plan for Readiness to Provide the Minimum Initial Service Package for Reproductive Health Services</th></tr>
<tr><th>Time</th><th>Session</th><th>Title Speakers</th></tr>
<tr><td>10:00-12:30</td><td>Work Groups: Identifying Priorities and Formulating the Readiness Plan</td><td></td></tr>
<tr><td>12:30-12:45</td><td colspan="2">Coffee Break</td></tr>
<tr><td>12:45-01:15</td><td>Group Presentations and Discussions</td><td></td></tr>
<tr><td>01:15-02:00</td><td>Group Discussions<br>Reviewing the Readiness Plan<br>Discussing the Implementation of the Readiness Plan<br>Approving the Final Version of the Readiness Plan</td><td></td></tr>
<tr><td>02:00-02:30</td><td>Summary of Workshop Results, Future Steps, Closing Remarks</td><td>Dr. Tarek Tawfik, Deputy Minister of Health and Population for Population Affairs</td></tr>
<tr><td>02:30-03:00</td><td colspan="2">Lunch Break</td></tr>
</table>