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SRH Baseline Assessment Report

**Sexual and Reproductive Health (SRH) Baseline
Assessment in Ukraine: Understanding the SRH and GBV
availability of supplies, services, and access to care for women**



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Introduction

Russia's invasion of Ukraine since February 2022 has profoundly impacted the lives of people across Ukraine and caused the largest population movement in Europe since World War II, with 6.28 million displaced within Ukraine and over 8 million refugees having fled Ukraine. According to WHO, healthcare in Ukraine is severely impacted due to security concerns, restricted mobility, increased costs, lack of staff and supplies and mass displacement. Healthcare is under attack with 10,631 civilian casualties, 323 attacks on healthcare and 4,731 civilian deaths¹. Women's access to sexual and reproductive health (SRH) services has fallen sharply, lacking access to clinical management of rape (CMR), contraceptive services, and safe abortion care. LGBTQIA+ communities face specific health and SRH challenges.

In 2019, 67% of women in Ukraine have experienced psychological, physical or sexual violence by a partner or a non-partner². Now, violence against women and girls in Ukraine has been exacerbated by war, with people being sexually abused and raped in Ukraine and while they flee to other countries³. However, services for GBV survivors are not provided in full in Ukraine. Cases of GBV are most prevalent in insecure areas, transit/collective centres, etc. Increasing media reports of conflict-related sexual violence (CRSV) are emerging in Ukraine.⁴ Loss of resources, homes and inadequate accommodation, family separation, breakdown of law and order due are increasing the risks of human trafficking.⁵ LGBTQIA+ people are at heightened risk of exclusion, exploitation, violence, and abuse, facing barriers in accessing humanitarian assistance and services.⁶

Methodology

Objectives

The primary purpose of the baseline assessment is to assess the current status of Sexual and Reproductive Health (SRH) and GBV services including clinical management of rape (CMR), in Kyiv, Odesa, Poltava and Kirovohrad regions. This will inform the SRH programming in these oblasts and assess the knowledge of providers, availability of commodities, and access to services for the population at risk. The eventual aim is to determine the program's influence on the quality, availability and utilisation of SRH & GBV services. Secondary objectives include shedding light on needs and findings for other health and gender-based violence (GBV) specialists in Ukraine.

The objectives are:

¹ WHO's Response to the Ukraine Crisis: Interim Report February to June 2022. Copenhagen; WHO Regional Office for Europe; 2022.

² Organisation for Security and Co-operation in Europe (OSCE) (2019) OSCE-led Survey on Violence Against Women: Ukraine - Results Report. 27 November, 2019. Source: <https://www.osce.org/secretariat/440312>

³ UN News (2022) *Reports of sexual violence in Ukraine rising fast, Security Council hears*. 6 June 2022. Source: [Reports of sexual violence in Ukraine rising fast, Security Council hears | UN News](#)

⁴ Gender-based violence, Secondary data review, GBV AoR / GBV sub-cluster, 27 April 2022

⁵ Preventing human trafficking of refugees from Ukraine A rapid assessment of risks and gaps in the anti-trafficking response, Suzanne Hoff & Eefje de Volder, May 2022

⁶ Protection of LGBTIQ+ people in the context of the response in Ukraine, UNHCR, 17 May 2022

- to provide information on the health facility status, such as: to identify health staff to be trained (e.g., obstetricians-gynaecologists, family doctors and nurses) and to identify needs in essential commodities to enable access to post-rape care in the targeted facilities;
- To identify health care provider's knowledge and attitude on sexual and reproductive health (SRH) including clinical management of rape (CMR);
- To assess barriers and enablers for community members, particularly women. to access SRH services including where and how to access services in case of need.
- To map the various actors and services for survivors of SGBV including referrals.

The baseline assessment used a qualitative approach for data collection. The study was conducted across four oblasts in Ukraine (Kyiv, Odesa, Poltava and Kirovohrad oblasts).

Target groups:

1. Health facility management staff (health facility director or deputy director)
2. Health care providers in the health facilities (OBGYNs and nurses/midwives)
3. Women-IDPs (18+) in SGBV risk

Data collection methods and tools

Three main methods were used for data collection:

1. Focus groups discussion with women-IDPs in SGBV risk (online)
2. Health facility SRH needs assessment tool
3. Self-administered tool on the health providers' attitudes

Focus group discussions (FGDs) were conducted with women at risk – internally displaced women – with the aim to study their attitude towards and knowledge about particular aspects of sexual and reproductive health, the issue of violence against women, and access to respective health care services. FGDs were conducted through the professional platform Zoom following the principles of voluntariness, confidentiality and anonymity.

The FGDs guide includes the following topics:

- Attitude towards particular aspects of sexual and reproductive women's health and access to respective health care services in places of residence;
- Attitude towards different family planning methods, availability of contraceptives in places of residence of target group representatives;
- Attitude towards HIV/STIs issues and access to respective health care services in places of residence of target group representatives;
- Access to health care services related to pregnancy and childbirth among women IDPs;
- Attitude towards particular issues of violence against women and access to respective health care services in places of residence of target group representatives.

Questionnaire for health providers contains a set of statements (33 statements in total) reflecting popular opinions/stereotypes concerning various aspects of women's sexual and reproductive health, as well as attitude towards sexual / violence against women. Respondents were supposed to agree or disagree with each of the proposed statements and comment on their responses. It is a self-administered tool.

Health facility SRH needs assessment tool aims to assess capacity of HF to provide SRH/specialized services, including CMR. The tool involves data collection on population and SRH health providers, availability of FP and abortion care services, management of sexual violence, prevention of transmission of HIV and other STIs, referral system, inventory of commodities and equipment.

An enumerators training was conducted for orientations on the tools, ethical considerations, safety and confidentiality of the data and the study participants before the field work on data collection. The enumerators signed 'non-disclosure agreement' to ensure no harm and data privacy.

Sampling design

For identifying study participants and facilities following process was adopted:

- The list of health facilities for baseline assessment was randomly selected from the general list of facilities that will participate in the project in the region.
- For the provider knowledge and attitude assessment at first, lists of health care providers of the health facilities (OBGYNs / family planning doctors and nurses/midwives) was created and a random selection was conducted for each category and at least 3 health care providers from each facility were invited to participate in the assessment.
- The focus groups participants were selected through local NGOs/social services centers, including those providing services to internally displaced people, and then women (18+ y.o.) were invited to participate in the discussion.

The selection of samples takes into consideration the unique geographical, political and socio-cultural differences of Ukraine especially among oblasts. In order to better understand the differences, the methodology includes at least one facility and one FGD proposed in each targeted oblast of the project:

1. Health Facility Assessment – Total 4 including one in each oblast.
2. Health Care Provider Assessment – at least 3 from each facility, selected for the assessment – Total 13 (9 female and 4 male).
3. Focus Group Discussions (FGDs) among women from the community – Total 4, including one in each Oblast.

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"I know people who already have a child, but it so happened that God gave them another one. But because of this war, people sat down, talked and decided that now is not the time (to have a child)." (city of Poltava)

'It seems to me that most (in the case of violence) do not ask for help. We have problems here, women's fear that she will be judged, it's a shame...Of course, we need to go to the doctor's examination, pass some kind of test and be sure that there is no infection. If I will need psychological help, then for sure I would use the Internet, looking for the hotline and ask them to direct me somewhere' (city of Poltava)

"Yes, there are many such cases that are addressed (for help), but no one looks for them (a person who raped), because they (police) have nothing to do with it. Well... if they were raped mean they were raped. Simply no one wants to deal with it. But corruption also happens, if you were raped by some rich man, he will simply give money to the police, the case will be closed and you will remain guilty." (city of Dobroslav)

Acronyms

ARV – Antiretroviral Therapy

CMR – Clinical Management of Rape

CRSV – conflict-related sexual violence

CTG – Cardiotocography

D&C – Dilation and Curettage (method of abortion)

EVA – Electric Vacuum Aspiration

FGD – Focus Group Discussions

IDP – Internally Displaced People

HIV – Human Immunodeficiency Virus

HF – Health Facility

GBV – Gender Based Violence

LGBTQIA+ people – Lesbian, Gay, Bisexual, Transgender, Queer or Questioning, Intersex, Asexual people, and more

MA – Medical Abortion

MVA – Manual Vacuum Aspiration

OBGYN – Obstetrician-Gynaecologist

OC – Oral Contraceptives

SGBV – Sexual and Gender Based Violence

STI – Sexually Transmitted Infections

SRH – Sexual and Reproductive Health



RESULTS

I. Women's knowledge about and attitude towards particular aspects of sexual and reproductive health, violence against women, and assessment of access to respective health care services

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SUMMARY

Attitude towards particular aspects of general sexual and reproductive women's health and access to respective health care services in places of residence

1. Key issues of sexual and reproductive health in women IDPs include various sexual system diseases, issues related to the prescription/procurement of contraception and family planning, as well as issues related to women's health during pregnancy or after childbirth.
2. Emphasis is put on the aspects of sexual and reproductive health of women IDPs related to the stress factor caused by the war and temporary displacement, as well as new, sometimes unfavourable living conditions. It is pointed out that women IDPs have more frequent stress-induced hormonal disorders, as well as infectious diseases associated with living in shared accommodations (e.g., school sports halls).
3. Adolescent girls are considered to be the most vulnerable group among women IDPs and demonstrate the following problems: lack of understanding of the mechanism of doctor's consultations, diagnostics, and treatment in general, distrust of adults and a high level of trust towards information from social media, online sources and same-age friends.
4. No problems have been identified with accessing health care services by women IDPs in places where the study was conducted. It is stated that the most accessible institutions providing health care services to women IDPs are state hospitals because the services are free, medical staff are friendly and there are no complicated bureaucratic procedures when registering at the hospital.
5. The key obstacle to accessing health care services in places of temporary residence is the need to find a doctor who would meet women IDPs' needs (e.g., with regard to expertise, friendly attitude towards the patient). It is pointed out that, when looking for a doctor, women IDPs follow the recommendations of their relatives/acquaintances and use feedback from the Internet.

Attitude to different family planning methods, availability of contraceptives in places where representatives of the target group live

6. The majority admitted that women most frequently make joint decisions and seek advice from their husband or partner in the process of family planning. It has also been noted that the role of woman has changed in the war period. In some cases, it was pointed out that after the start of the war women (especially if the woman's husband or partner is in the military) assumed more responsibility for their family and had to make independent decisions concerning family planning and childbirth.
7. No problems have been identified with accessing to any contraceptives by women IDPs in places under study. The most common contraceptives are condoms and oral contraceptives. Condoms can be bought in many places and sometimes received for free. It is noted that a doctor's

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prescription is required only for long-term contraceptives (OCs were mostly mentioned) or contraceptives that the woman cannot apply herself (intrauterine device was mostly mentioned). At the same time, knowledge about some types of contraception and the specifics of their use are not accurate. Some of the FGDs participants mistakenly consider emergency contraception drugs to be drugs used for medical termination of pregnancy. Moreover, women highlighted that the lack of funds affects access to contraception.

8. The topic of contraception and abortions can be considered sensitive for women IDPs. It is noted that, when choosing contraception, a woman will choose a female friend or relative as an accompanying person, and only if relations in the couple are trust-based will she choose the husband or partner. Also, part of women is inclined to seek advice concerning contraceptives from female friends or a pharmacist or search for information on the Internet. As far as abortions are concerned, focus group participants insisted that they are not familiar with this situation and have never turned to a medical institution for this manipulation, so they cannot assess the availability of this service in places of residence.

9. It was emphasised that there are certain categories of women (low-income, living in small villages, and adolescent girls) who can terminate the pregnancy on their own for certain reasons (lack of funds, fear of disclosure, lack of experience and distrust of adults), which may lead to irreversible health consequences.

Availability of health care services related to pregnancy and childbirth among women IDPs

10. No problems have been identified with accessing health care services related to pregnancy and pre-natal care among women IDPs. Women IDPs usually turn to state medical institutions for pre-natal care, less frequently (and only provided favourable financial situation in the household) to private medical institutions.

11. The key obstacle to accessing pre-natal care is the place of residence. It is noted that if a woman IDP lives in a village or a small town, she has to go to a bigger city because of a limited range of health care services in small towns.

12. It is noted that the doctors' attitude to an unmarried woman who turned for pre-natal care will usually not differ from the attitude to a married pregnant woman. However, individual cases have been reported when doctors demonstrated an unprofessional attitude to single or low-income mothers of many children who decided to give birth.

Attitude to HIV/STIs issues and access to respective health care services in place of residence among target group representatives

13. Reportedly, the problem of HIV/STIs has not intensified since the beginning of the war and is not considered relevant for places of temporary residence of women IDPs.

14. Following hygiene rules, regular health control (laboratory and hospital tests) and using condoms during sexual intercourses have been named as the most common ways of HIV/STIs prevention.

15. No problems have been identified with testing for HIV/STIs in settlements under study. Reportedly, tests can be done at a local hospital upon referral from a gynaecologist, or independently in a private laboratory.

16. It is stated that nowadays women and youth have a high level of awareness about HIV/STIs. It is emphasised that after educational institutions switched online, the issues of HIV/STIs have received less attention and that most of the youth have an irresponsible attitude to these problems.

Attitude to particular aspects of violence against women and access to respective health care services in places of residence of target group representatives

17. Individual experience of violence was not studied or mentioned during focus group discussions. Participants did not mention witnessing or hearing about violence, including sexual, in their immediate environment. It is emphasised that due to higher tension and aggression in society because of war, women now experience more violence than before. It is also noted that mass media cover the topic of violence, including sexual, more than before the war.

18. The most common types of violence against women are physical, sexual and psychological. There are individual opinions that cases of psychological violence against women IDPs are more frequent with a woman being subjected to indignities or humiliation because of her IDP status.

19. It is believed that violence against women is mostly committed by husbands or partners. It is also noted that violence against women can be committed by the troops of the aggressor state, people with mental disorders or alcoholic intoxication, and managers at work.

20. It is stated that any woman can become the target of violence, regardless of age, social status or other characteristics. The most vulnerable are young women and adolescent girls, residents of occupied territories and women with “soft” character traits.

21. Focus group participants believe that a woman can provoke violence against herself if she looks approachable, i.e., if she is dressed or behaves provocatively, or if she is among men in the state of alcoholic or drug intoxication. Examples were provided when women experienced violence because of their flamboyant appearance and behaviour. There is also an opinion that some women who experience violence have a certain set of psychological and behavioural characteristics, which, according to the FGDs participants, is the reason for their own choice to be in a violent relationship (continue to be in the role of a victim).

22. Places that may be dangerous for women are mostly considered to be dark, unlit and empty streets and parks. Sometimes places where alcohol is used (night clubs, restaurants) and many men are gathered (e.g., checkpoints, police stations) are reported as dangerous.

23. The majority noted that, in the first place, women who were subjected to violence have to turn to the police and a specialised psychologist. It was emphasised that a medical institution is not considered necessary in the system of services for violence survivors because it is associated with severe physical or sexual violence. Also, there was distrust of state law-enforcement agencies, and it was mentioned that women try to avoid turning to the police in case of violence because they believe that police officers will not treat these cases responsibly and because they fear disclosure and revenge from the abuser in the future. There is a perception that when contacting a doctor after a case of rape, the doctor is obliged to inform the police about the case, even without the consent of the victim woman to such information.

24. It was noted that some women may not seek medical abortion services due to a number of reasons: lack of information about this possibility (not aware of the medical method as such); impossibility to purchase appropriate drugs at one's own expense because of the low level of household income; if a woman lives in a small settlement – she may not want to buy a medicine (EC, medicine for medical abortion) at a local pharmacy due to fear that other residents of the settlement will find out about such a purchase.

25. The mistrust of state law enforcement structures was expressed, and it was noted that women try to avoid reporting to the police in case of violence, due to perceptions of the irresponsible attitude of the police to such cases, as well as fears about publicizing the situation and fear of revenge from the perpetrator in the future.

26. Participants were aware of the existence of a specialised hotline to which women can turn for assistance or consultations in case of violence, and of the existence of support centres for the survivors of violence. It is noted that contact details of the hotline and support centres can be found on the Internet. It was also mentioned that these organisations were advertised at local medical institutions.

27. It was emphasised that access to services for survivors of violence can be improved by raising women's awareness of a well-defined action plan in case of violence: where she must turn and in which order she must turn to particular bodies, institutions or organisations. The level of awareness about hotline numbers, the availability of women's assistance centers in a specific city or region, work schedules, etc. is low. But it is stated that it is essential that women build trust towards all institutions and organisations involved in the system of violence prevention and support of survivors (through positive examples of case-solving by the police or punishment of offenders, or through examples of positive effects of other types of support, e.g., psychological, medical, etc.).

1. Attitude towards particular aspects of sexual and reproductive women's health and access to respective health care services in places of residence

- **Definition of the terms "sexual" and "reproductive"**

During focus group interviews, target group representatives defined the meaning of terms "sexual" and "reproductive".

Thus, when defining the term "sexual", women more frequently use characteristics related to attractiveness and physiology and less frequently characteristics related to sexual health.

Attractiveness and physiology: *"something you want to touch and try, something that catches the eye and causes the desire to be closer", "attractive and seductive", "something that can turn you on and prompt to do more", "desired and attractive"*.

Sexual health: *"sexually healthy means that you're healthy, that all your women's organs are healthy"*.

When defining the term "reproductive", characteristics related to the fertilisation and childbirth potential were mostly used: *"procreation, childbirth", "woman of reproductive age in whom an ovum is matured and who is able to get pregnant and bear the foetus", "ability to give birth", "reproduction is propagation of part of herself and part of the man"*.

- **Sexual and reproductive health issues faced by internally displaced women in places of their residence**

The following key sexual and reproductive health issues faced by women IDPs have been reliably reported:

- Various sexual and reproductive diseases if a woman is susceptible to illnesses or used to have illnesses before forced displacement as a result of military actions;
- Issues related to the woman's health if she is pregnant or has just given birth;
- Issues related to the choice of contraception or family planning (for example, making decisions about having children).

"For example, thrush – women very often go to doctors with this disease. Apart from that, ovarian inflammation and cervical erosion, this is something I experienced myself, so I'm saying it." (Dobroslav)

"I know people who already have a child, but it so happened that God gave them another one. But it's war now, so people sat down and talked and made a decision that it's not time now." (Poltava)

It is emphasised that women IDPs are vulnerable because they are affected by stress due to forced displacement, so their emotional state prevents from timely identification of health issues.

"It's difficult to assess because, for example, I'm under stress now, so it's very difficult to take a detached view on myself... I have anxiety and fear. With all these emotions, it's even difficult to assess my physical state. Because you live mechanically, you survive." (Kropyvnytskyi)

It is also noted that women IDPs may face the issue of infectious diseases due to unprotected sex or unfavourable living conditions, with women's health issues associated with stress (hormonal disorders, etc.), or injuries caused by traumatic events, such as rape, etc.

"Displaced women can live in different conditions, it's a matter of luck. Many of them live in kindergartens, in schools. I don't know cases like this very well, but everything may happen. In these cases, as one of the girls said before, they also need a psychologist." (Poltava)

"Now that it's war, many people can be raped or contract different diseases or things like that." (Dobroslav)

"In terms of the mental state, a displaced woman is nervous, so she can have a hormonal disorder. As far as I understand, the period may be delayed or premature." (Dobroslav)

▪ Access to reproductive and sexual health care services

The majority mentioned that women IDPs mostly do not have problems with accessing reproductive and sexual health care services if they need any. They most frequently turn for health care to state medical institutions (e.g., maternity welfare departments). Key reasons for choosing state medical institutions include free services, friendly personnel, and absence of complicated bureaucratic procedures when registering at the hospital.

"I have recently been to hospital, and they were very friendly there. They didn't take any money; on the contrary, people were very sympathetic, they were asking who I am and where I come from. In a word, they were sympathetic, and there was nothing negative... We went to hospital in Dobroslav, and we received a very decent treatment." (Dobroslav)

"Well, look, I came and they gave me a card and forwarded me to a doctor without any questions although I came through acquaintances and by appointment. And in 2014 I had to bring an IDP certificate, a copy of the passport and identification code, I was asked then where I was registered and I was told that I didn't belong to that hospital and I had to go to a different hospital. There were difficulties like this and a lot of paperwork, so it was hard." (Poltava)

“I don’t know what other documents are needed aside from the passport and IDP certificate. I don’t know what other documents may be required. For example, in Kropyvnytskyi it’s well organised; whoever you turn to will never say no.” (Kropyvnytskyi)

“For example, it was different before the war, one could feel that they were expecting money from you. I’ve been to hospital here, and there were no hints at it at all. The doctor even took out the medicine from the purse and gave it to me and said, “Take it, you will feel better.” (Dobroslav)

In some cases, respondents mentioned that private hospitals are more client-oriented, which is more attractive if a woman requires a sensitive or tolerant approach or if the patient is an adolescent girl.

“I believe it’s a private clinic because it provides a higher qualification and a more tolerant approach to adolescents and people in general because you pay money and they are more tolerant. If you go to a state hospital, it can be like, “Where are you going on clean floor?!” or “Come on, move your legs apart”. People are sometimes rude, and it’s not only in Boiarka, it’s everywhere. So, if it’s a delicate matter, I can go to a private clinic.” (Boiarka)

The main obstacle for women IDPs in a new place of residence is the need to find a doctor who would deserve trust and be a good professional.

“I’m not in my home city, otherwise I would turn to my gynaecologist I have known since long ago. Since I’m a displaced person... as a rule, there are close people and through them I learnt from locals who I can turn to with health issues, and this is how I chose the gynaecologist I could go to.” (Poltava)

“It’s very difficult for me to just come to hospital and make an appointment with a gynaecologist. No. I will ask 3-5 girls, read feedback on some websites and go to someone who made the best impression.” (Poltava)

It is emphasised that the key problem for adolescent girls is lack of experience in situations when it becomes necessary to solve sexual and reproductive health problems, lack of understanding of the mechanism of doctor’s consultations, diagnostics, and treatment in general, distrust of adults (even parents) and a high level of trust towards information from social media, online sources and same-age friends.

“Perhaps in families that moved places, in conditions when they need to live, work and earn somewhere, if there was not enough time or knowledge to explain it to the child, it’s even more difficult now. It sometimes seems to me that, regardless of sexual education, some girls don’t understand the basics, they don’t know where to turn to. There is no open dialogue with the parents, and who should they ask? If you look up some symptom on the Internet, why you feel pain down there, you can die right away. Someone who is more sensitive can think up too much and do what they don’t need to do. They probably don’t have a person to ask for advice and learn some basic things from.” (Poltava)

“Adolescent girls take information from the Internet, and it’s very wrong. Most frequently, it’s a mistake that girls are ashamed of approaching their mums or grandmas or seeing a doctor. They most frequently make a huge mistake because they turn to their friends or the Internet.” (Dobroslav)

“Assuming that parents do not pay enough attention to a child, calm it down and give it emotional and moral protection, it can face sexual problems and, say, find someone on the side. Someone may take advantage of the child’s inexperience and age.” (Kropyvnytskyi)

2. Attitude towards different family planning methods, availability of contraceptives in places of residence of target group representatives

The majority noted that nowadays a woman either makes independent decisions about how many children to have and when, or discusses it with the husband if she is married.

“I believe a woman can choose, but we’ve agreed it with the husband. Yes, we discuss it with the husband whether to have children or not, now or later, but overall, a woman has the right to say based on her experience that she can’t or doesn’t want to do it now. The man can’t make her, it’s 100%, but they can discuss it and make a decision together.” (Poltava)

“The husband can also have a word, I think. If necessary, they can sit and discuss it. Of course, it’s if the woman is married. If not, it’s her decision.” (Dobroslav)

“I think it’s not only the woman who decides, it’s a joint decision with the husband. It’s not like, let’s sleep together and have children. It’s not done like that. If people are responsible, they certainly plan it. Can it be any different? It can’t be any different, I believe.” (Kropyvnytskyi)

According to some opinions, the role of woman has changed during the war because she assumed more responsibility for the future of her family, especially if her husband is in the military. In such situations, the woman has to make independent decisions concerning family planning and childbirth.

“I think now a woman has more responsibility than a man. Men are fighting, they are in the Armed Forces and in hot spots and come on furlough. And it’s the woman who must decide about the future even if it’s their joint decision. For example, if they already have three children, she must see if they should have a fourth one or wait for now. And whether they need a child now. I think women have more responsibility and make more decisions now. They also need to understand how to live on, and just having children...” (Boiarka)

▪ Availability of contraceptives in places of residence of women IDPs

It is emphasised that there are no problems with any contraceptives in places where women IDPs live.

Condoms and oral contraceptives are the most available contraceptives. Women IDPs note that these means of contraception can be bought in any pharmacy. Condoms are the most common contraceptives because, according to respondents, in addition to pharmacies they can be bought in trade centres, at gas stations and received free of charge at specialised hospital departments (if available).

It is noted that a condom can be bought without consulting a doctor, whereas other means of contraception that are long-term (e.g., OCs) or require application (e.g., intrauterine device) require visiting a doctor.

“Of course, a woman should go to the doctor. And the doctor should choose the medicine as we all know the consequences of self-treatment. But you know, if it’s a one-nighter, one can go to the pharmacy.” (Kropyvnytskyi)

“Well, if these are ordinary condoms, then yes, but nobody will buy pills on their own because it’s dangerous, only through the doctor.” (Boiarka)

“It’s very frequent by word of mouth as they say – what did you take and what did you take? But I believe that one should first of all go to a competent doctor because one should have tests done to check if this medicine suits or doesn’t suit you, so that it doesn’t do you any harm.” (Dobroslav)

In some cases, respondents noted that not all women make decisions concerning the choice of contraceptives with the help of a doctor. These women most frequently follow the recommendations of experienced friends or a pharmacist, or search for information on the Internet themselves.

“I’m sure that there are some women who just go to a pharmacy and ask a pharmacist or read the Internet to choose protection methods. 100% there are people like this, but it’s right to go to a doctor, I absolutely agree.” (Poltava)

It is noted that if a woman requires support when choosing contraception, she will most often be accompanied by a friend, less often by the mother. If the relations in the woman’s family are trust-based, she will be accompanied by the husband.

As far as adolescent girls are concerned, it was noted that this category will rather study information themselves using the Internet and social media and in particular cases will turn to their peers or relatives they trust (it may be mother, father, or sister) if they have to make a decision about the choice of contraception. It is emphasised that adolescent girls do not usually go to the doctor in the first place due to shyness and inexperience.

“Adolescents mainly find everything on the Internet or listen to people and make note, and then do harm to their health. If they turn to the mother, it doesn’t mean that if it’s suitable for the mother, it will be suitable for her.” (Dobroslav)

“It seems to me that many young people are reserved and decide everything through social media and OK Google – they read everything there. I have a brother who is 17 years my junior and I see that he asks very many questions there. It’s the Internet for them. We used to have a dictionary, and they have the Internet, they look everything up there.” (Poltava)

“Generally speaking, everyone finds information themselves if parents don’t give a hand and talk about condoms, children, marriage, and sex at a certain age.” (Boiarka)

- **Access to abortion services in places of residence of women IDPs**

The topic of abortion was quite sensitive for focus group participants. They insisted that they didn’t have experience with abortion, so they would not be able to characterise the availability of this service in places of their residence. Also, they were not familiar with the service of medication-induced abortion at medical institutions (although they mentioned that they are aware of this manipulation) and availability of respective medicines.

It was stated in individual cases that medicines for postcoital contraception are available at pharmacies and it was possible to consult a pharmacist and buy them if need be.

Discussing a hypothetical situation of a friend needing advice regarding abortion, women IDPs said they would recommend turning to the gynaecologist or to the maternity welfare department of the local hospital.

“In the first place, one should ask the doctor because nobody would be more professional and do less harm; only a doctor can do it correctly to avoid consequences.” (Dobroslav)

“If we imagine such a situation, I would go to a doctor and say that I want to have an abortion and listen to his recommendations if I can or cannot do this and what the consequences might be. Whether I can do it based on medical indicators because it may lead to me not being able to have children in the future or it may threaten my life. If there are no threats and I decide that I will do it, I will go where the doctor refers me. It’s all legal here...” (Poltava)

“Consult a doctor at the maternity welfare department. I know that there are medicines that can help if it’s within 48 hours after fertilisation.” (Boiarka)

It was emphasised that some categories of women (low-income or living in small towns where the issue of information spreading is relevant) and adolescent girls can terminate the pregnancy on their own, which may lead to irreversible health consequences.

“As far as a woman is concerned, she should see a doctor. As far as adolescents are concerned, I remember from my young age that there were girls who tried to find some pills at pharmacies, take something, insert something, lift weights, etc. It’s as far as adolescents are concerned. And a woman who understands that health is not a joke should go to the doctor. Maybe there is some percentage of women who would try taking some pills or something, I don’t know... I’m sure there is some percentage, but, in my opinion, one should go to the doctor.” (Poltava)

“First of all, I believe there are women who cannot afford these drugs because they are expensive. On the other hand, maybe they don’t want anyone to find out. If it’s an undesired pregnancy and the woman doesn’t want anyone to know about it. It’s often the case that people know each other in small towns and the woman wants to avoid spreading information. But in general, I think that in many cases a woman just can’t afford it because the medicine is too expensive.” (Dobroslav)

- **Availability of health care services related to pregnancy and childbirth among women IDPs**

It is noted that health care services related to pregnancy and prenatal care for women IDPs are available in places of residence of target group representatives. It was problematic to assess the quality of these services because focus group participants did not seek them in places where they currently live.

Women IDPs most frequently turn for pre-natal care to local state medical institutions or to private hospitals if the financial situation allows.

“There are private hospitals, but they are very expensive now and it was also expensive before the war. Women mainly go to a state institution and receive pre-natal care there.” (Dobroslav)

“Well, I don’t know, it depends, someone may be happy, someone may be unhappy. Well, it’s fine in most cases. I know many women who received pre-natal care in private hospitals. I haven’t heard any horrible things from anyone.” (Kropyvnytskyi)

It was noted that access to pre-natal care is geographically limited – if a woman lives in a village or a small town, she will have to go to a big city because the range of services in small towns is limited.

“It depends on the place where the woman lives. If it’s a city, not a village, there are no problems with receiving any consultation.” (Poltava)

“My friend gave birth this spring in the district, but she is now living in a small village and the only service they have is weighing the child. They have to go to the doctor with a small child all the time and even during the last months of pregnancy in March they had to go somewhere to have tests done, and it was a huge problem.” (Poltava)

It was mentioned that unmarried women who turn to medical institutions for pre-natal care do not face condemnation by the medical staff in most cases. However, there were individual cases of doctors' unprofessional behaviour towards single women who decided to give birth.

"I think it all depends on the person who a pregnant woman turns to, married or not. I was told that there was a situation when even a married woman came with her fifth pregnancy and the doctor looked at her and said, "Why are you spreading this poverty?!" – the family is not very well off. I've heard stories like that. Even ordinary people... If there are 100 houses in the street, there will be a woman who would say "Why does she need so many?" (Poltava)

"We are all married, so we don't have this information. But I will be straight, sometimes when you come you get asked if you are married or not, and the doctor looks at you from behind the glasses and weighs up whether you became pregnant on the side. As I say, it all depends on the doctor, whether it matters to him or not. I believe that if a woman comes, married or not, and wants to have a child, no-one owes anything to anyone, she must give birth to a healthy, strong child. And the woman should be healthy to be able to give birth to a child." (Dobroslav)

3. Attitude towards HIV/STIs issues and access to respective health care services in places of residence of target group representatives

It is stated that, nowadays, women, including youth, are more aware of HIV/STIs issues. Specialised courses for teenagers and youth were mentioned that were held at educational institutions to prevent the spreading of HIV/STIs.

"Children get more information at educational institutions now. I think, in every family, parents who realise they have adolescent or older children can easily explain and discuss what problems may arise and how to solve them." (Kropyvnytskyi)

In some cases, it was mentioned that after the transition to online education, the issues of HIV/STIs have become less relevant and do not receive sufficient attention. It was also pointed out that the youth often have an irresponsible attitude to these problems.

"All children and teenagers are online now, and it seems that this information is not enough and they can only receive information from their parents now. At this age they should learn about it, but they are studying online and have not received this information." (Poltava)

"Even now there are no programmes for the youth that would raise awareness about these issues. I don't know, maybe there are not so many affected people now or we are not told about it as much as before because we now have coronavirus or something else, and it has moved to the background." (Boiarka)

"They never think about it, and when they get it, they switch on the brain and start understanding something. And now they have heard about it and have seen it, but they don't think it can happen to them. I believe that some young people don't do well enough although they write (I don't know if it's true) that just the condom protects from HIV and AIDS in 70% of cases, and they don't think about it." (Dobroslav)

Focus group participants named condoms, hygiene rules and regular health control (laboratory and hospital tests) as the most common ways to prevent HIV/STIs.

It is pointed out that women IDPs can test for HIV/STIs at a local hospital upon referral from a gynaecologist, or independently in a private laboratory. Special testing rooms at AIDS centres and support centres were mentioned, but participants reportedly have not used these services.

It is also noted that women have mandatory HIV/STIs tests during pregnancy at maternity welfare departments.

4. **Attitude towards particular issues of violence against women and access to respective health care services in places of residence of target group representatives**

- **Perception of particular aspects of violence against women**

It is emphasised that after the beginning of the war women experience more violence than before due to higher tension and aggression in society. It is also noted that mass media cover the topic of violence more than before. However, focus group participants said they had not experienced violence personally and had not heard about such cases in places of their residence.

“I believe it’s just more public now. It seems there used to be violence between people, and it’s war now, those madmen came to occupied territories and not only women are suffering there, but also children. Due to the war it’s more publicised now.” (Dobroslav)

The most common types of violence against women are physical, sexual and psychological. Sexual violence includes harassment and rape. Psychological violence includes moral humiliation, stalking, threatening, indignity, prohibition of expressing personal opinions.

It was sometimes pointed out that cases of psychological violence against women IDPs have become more frequent with a woman being subjected to indignities and moral humiliation because she is deprived of the permanent place of residence and job and because of her IDP status.

“A woman can also be subjected to moral or psychological violence. Not all people treat displaced people well, as was shown in the video. It sometimes happens that they are not respected, and this may cause violence.” (Dobroslav)

“Perhaps people have become more violent, they are moving... We are not talking only about sexual violence, but also about psychological violence. People have become more aggressive because displaced people have come to their cities and different situations may happen. That’s why I think women and children are particularly subjected to violence now.” (Boiarka)

It is stated that violence against women is mostly committed by men. It is also believed that violence against a woman on the part of her partner/husband is quite common.

Respondents also noted that violence against women can be committed by the troops of the aggressor state (common for women in occupied territories of Ukraine), strangers or even familiar people with mental disorders or alcoholic intoxication, as well as managers at work.

“I think anyone can commit violence against a woman, it may be a mentally ill person or a rapist. It may be husband, step-father, brother, neighbour, anyone. It may be a military man, there are many such cases now, especially with the Russian military.” (Poltava)

The majority believe that any woman regardless of age, social status or other characteristics can be subjected to violence. The most vulnerable are young women and adolescent girls, residents of

occupied territories and women with particular character traits (who cannot repulse or stand up for themselves).

“There is a category of people who are always in the state of a victim, and they like it, it’s a personality type. Even psychologists found that such a woman will not want a calm, quiet man, she will look for another one because she likes to be humiliated, to be a victim... They take pleasure in it.” (Kropyvnytskyi)

Respondents remembered cases when an adolescent girl experienced psychological violence at school (bullying).

“For example, it can be among teenagers, especially at school, because teenagers have become very violent now, they are brought up in a different way and they have a different worldview. It can be about some simple things, for example, I have this phone and you have a smaller phone, or judging by the clothes. Because of that some children commit suicide because they can’t stand it and they are ashamed of telling their parents about it. Or, for example, they tell teachers, and teachers say that it’s nothing serious and that you have to put up with it. Some teachers support other children because their parents are different.” (Dobroslav)

It was also mentioned in some cases that a woman can provoke violence against herself if she behaves in a particular way, wears provocative clothes, or if a woman abuses alcohol and takes drugs (does not control herself and looks approachable).

“For example, I know girls who are provoking men, and when the boyfriend or the husband loses control, they run to the mother or to the police and cry that they have been raped. And she was playing cat and mouse with him. There are many nuances and I think that one has to look into what has happened when it comes to adolescent rapes.” (Dobroslav)

“I think there are young girls and teenagers who provoke men with revealing clothes and looks, they can wink, touch, wag and go. It happened in the clubs before the war. She teased and left. And it can just blow the man’s mind if he is drunk.” (Poltava)

“For example, if a girl goes out a lot, drinks, takes drugs in different companies and leads an unscrupulous life, she doesn’t control herself, and the rapist sees that she is weak and can take advantage of it.” (Dobroslav)

Places that may be dangerous for women are mostly considered to be dark, unlit and empty streets and parks. Sometimes places where alcohol is used (night clubs, restaurants) and many men are gathered (e.g., checkpoints, police stations) are reported as dangerous.

- **Access to services for helping violence survivors in places of residence of target group representatives**

The majority believe that, in the first place, women who were subjected to violence have to turn to the police and a specialised psychologist.

According to respondents, only women who sustained injuries and whose health is at risk should turn to a medical institution. A medical institution is not considered necessary in the system of services for violence survivors because it is associated with severe physical or sexual violence. Only in individual cases it was reported that a rape survivor should go to a medical institution to assess her real health status.

“Women go to a medical institution when they feel after the rape that something is wrong or they are pregnant or if it was a very violent rape and a woman got all beaten up. Only then can a woman turn to a medical institution for help.” (Dobroslav)

“If you come to a doctor and get asked what has happened, the doctor must call the police to the medical institution because there was a rape. Even if you don’t want to go to the police, the doctor is obliged to inform the police about this situation, otherwise the doctor can get punished.” (Dobroslav)

Some respondents pointed out that a woman can call a special hotline where she can receive adequate help or consultation concerning further steps.

“A hotline like support centres. I haven’t heard about them. Maybe they exist in some cities, maybe there are volunteers or psychologists or even a doctor who might help.” (Dobroslav)

It was noted that women avoid turning to the police because of distrust of state law-enforcement agencies (assumingly, the police do not investigate such cases because they don’t treat them as important; there are also fears of disclosure and involvement of undesired third parties, e.g., witnesses or family members). It is also mentioned that women can avoid going to the police in order not to provoke revenge from the abuser.

“I believe most people do not go to the police. There are problems, women are afraid that they would be condemned and that it is shameful. Most women don’t go to the police if everything is fine... Well, it’s not quite fine. Of course, one should go to the doctor and get examined and tested to make sure there is no infection. In terms of psychological assistance, I would look up a hotline on the Internet and call there to get some guidance.” (Poltava)

“Sorry, but they will be looking for that rapist for ages, in my opinion. For example, from my experience, there was a rape attempt, and the only person who defended me was my brother. I know my rapist will be punished and it’s thanks to my brother. It was my brother who asked me if we should go to the police. I said there was no point in it.” (Dobroslav)

“It’s also about psychological aspects because you can’t be sure they can really help you, and not just mock at you.” (Boiarka)

“I had a friend, she wasn’t a teenager, she was a young woman when she had an incident. She went to the police and they sent her away. They said she was to blame herself. It was long ago, she was young and beautiful. She was to blame. They didn’t pay attention to her and didn’t treat this case as important. Because she was safe and sound, without anything serious, so they decided like this. So, she went away empty-handed.” (Kropyvnytskyi)

“Yes, there are many cases when a woman goes to the police and nobody looks for the rapist because they don’t care. You just live with that rape, nobody wants to deal with it. There is also corruption. If a rich man rapes a woman and then gives money to the police, they will close the case and you will be the one to blame.” (Dobroslav)

Focus group participants could not assess the availability of services for women who suffered from rape in places of their residence because they had not heard about such situations. However, they mentioned information posters with hotline numbers at local medical institutions and support centres for violence survivors, whose contact details can be found on the Internet.

II. Healthcare providers' attitude towards sexual and reproductive healthcare services

SUMMARY

1. Findings show that about half of the health care providers expressed attitudes and beliefs that could present as barriers to access for SRHR and GBV services for women
2. The attitude towards SRHR and GBV is slightly different depending on the professional experience
3. The below statements are characterised by the highest agreement and similar justifications. These statements are mostly related to women's rights during family planning and knowledge, attitudes and around various aspects of sexual and reproductive health of adolescent girls:
4. The majority of the health care providers agreed with the following:
 - an unmarried girl should be able to use a family planning method if she wants to (13 out of 13 respondents)
 - a woman should be encouraged to give birth to a child at a medical institution because it increases the likelihood of a better health outcome for mothers and new-borns (12 out of 13 respondents).
5. The majority of the health care providers disagreed with the following:
 - an unmarried girl who got pregnant must be expelled from school (13 out of 13 respondents);
 - I would perform a tubal ligation for a woman without children if she wants it (13 out of 13 respondents);
 - if a young unmarried woman got pregnant, it is a sign of her bad life (12 out of 13 respondents);
 - a medical professional must demand a consent from parents of an unmarried girl who wants to use a family planning method (13 out of 13 respondents);
 - if an unmarried girl asks about family planning methods, I must inform her family that she has sex (13 out of 13 respondents);
 - a woman who came for post-abortion care deserves the same level of respect as any other client (13 out of 13 respondents);
 - a married woman must not use condoms (12 out of 13 respondents)
6. Among opinions/stereotypes related to the problem of violence against women, the ones that are related to the rights of the violence survivor to high-quality health care are characterised by the highest agreement and similar justifications.
7. The majority of the health care providers agreed with the following:
 - a person who suffered from violence must receive care without discrimination (12 out of 13 respondents)
 - a person who suffered from violence must receive care as they see fit (11 out of 13 respondents)
 - as a healthcare professional I play a role in supporting the recovery of women/girls who experienced violence (12 out of 13 respondents)

8. A significant part of the proposed opinions/stereotypes are characterised by rather ambiguous perception or different justifications of the same attitude to an opinion/stereotype. It suggests that the pilot health facilities lack a single system of acquiring information, knowledge and skills concerning women's sexual and reproductive health and the issue of violence against women.

9. Opinions/stereotypes that demonstrated most ambiguous attitudes were related to the topic of abortions, the role of man in the family planning process and his influence on the woman's decisions, doctor's recommendations concerning the choice of family planning methods, as well as the topic of the woman's appearance and behaviour as a way to provoke the rapist. The attitude towards these opinions/stereotypes is mostly justified through the healthcare professional's personal attitude to the issues or through the personal medical experience of working with the issue.

10. With regard to the awareness about institutions providing psychosocial support to survivors of sexual and gender violence, most healthcare providers point out that in the first place they would recommend turning to local social services and hotlines or to familiar psychologists. Fewer healthcare professionals would also recommend shelters for survivors or local NGOs.

Beliefs / stereotypes characterised by agreement and similar justifications

According to the findings, completely or mostly agreed responses were given to less than half of the proposed statements (13 statements) as follows:

Issues of women's sexual and reproductive health

- **An unmarried girl should be able to use a family planning method if she wants to:** all respondents agreed with this statement.

In their comments, respondents focused on the fact that the ability to plan a family is above all the right of a woman to independent decisions and a prerequisite of her and her children's health.

- **An unmarried girl who got pregnant must be expelled from school:** all respondents disagreed with this statement.

In their comments, respondents were convinced that this statement violates the young woman's right to education, and her decision to give birth should not influence the ability to receive education.

- **If a young unmarried woman got pregnant, it is a sign of her bad life:** 12 out of 13 respondents disagreed with this statement and one respondent refused to answer this question.

In their comments, respondents underlined that one cannot make a negative and definitive conclusion concerning the causes of pregnancy of a young unmarried woman because they may be different (for example, it may be her conscious choice).

- **I would perform a tubal ligation for a woman without children if she wants it:** all respondents disagreed with this statement.

In their comments, respondents insisted that contraception with irreversible consequences cannot be used.

- **A medical professional must demand a consent from parents of an unmarried girl who wants to use a family planning method:** all respondents disagreed with this statement.

In their comments, respondents underlined that the choice of the family planning method is a woman's personal choice even if she is young (an exception is when a girl is younger than 14 years old, in which case parents must be involved).

- **If an unmarried girl asks about family planning methods, I must inform her family that she has sex:** all respondents disagreed with this statement.

In their comments, respondents underlined that this statement violates the woman's right to confidentiality.

- **A woman who came for post-abortion care deserves the same level of respect as any other client:** all respondents agreed with this statement.

In their comments, respondents insisted that, in general terms, an abortion is a surgery for a medical institution, so a woman must receive post-operative care at the same level as other clients of the hospital. Some respondents believed that a doctor must not condemn a patient.

- **As a healthcare professional I play a role in supporting the recovery of women/girls who experienced violence:** 12 out of 13 respondents agreed and one respondent disagreed (for lack of experience of working with such patients) with this statement.

In their comments, respondents underlined that health care for women/girls who experienced violence plays an important role in their recovery because it is directly related to the treatment of injuries and damage that may have been done to the patient's health.

- **If an adolescent girl demands a condom, I will give it to her:** 11 out of 13 respondents agreed and 2 out of 13 respondents disagreed with this statement.

In their comments, most of the respondents stated that they agreed with the statement because they are convinced that a condom helps prevent an undesired pregnancy, which is very relevant for adolescent girls who have not learnt to plan the family. According to some opinions, before giving a condom to an adolescent girl one should assess the situation and have a conversation about her sexual education.

- **A married woman must not use condoms:** 12 out of 13 respondents disagreed and only 1 out of 13 respondents agreed with this statement.

In their comments, respondents pointed out that the choice of contraception is a personal decision of an adult woman. It was also noted that a condom is not a convenient contraceptive for married women with a regular sexual partner, so they mostly choose other methods.

- **A woman should be encouraged to give birth to a child at a health facility because it increases the likelihood of a better health outcome for mothers and new-borns:** 12 out of 13 respondents agreed and 1 out of 13 respondents disagreed with this statement.

In their comments, respondents mentioned that only a medical institution can guarantee the safety and favourable outcome of childbirth and professionally control the process.

Issues of violence against women

- **A person who suffered from violence must receive care without discrimination:** 12 out of 13 respondents agreed with this statement and 1 out of 13 respondents refused to answer this question.

In their comments, respondents noted that women who suffered from violence are survivors in the first place, so discrimination against them at a medical institution is unacceptable.

- **A person who suffered from violence must receive care as they see fit:** 11 out of 13 respondents agreed and 2 out of 13 respondents disagreed with this statement.

In their comments, most of the respondents were certain that a survivor of violence cannot be forced to do anything against her will because this person is very vulnerable. According to some opinions, a doctor must first of all take into account the patient's health status, age and complaints, and only then her wishes.

Beliefs / stereotypes characterised by agreement and different justifications of the same attitude

According to the findings, five statements received agreement, but the justifications were rather different (depending on the respondent's personal attitude and experience), namely:

Issues of women's sexual and reproductive health

- **Intrauterine device or implant may be a good method for a woman after manual vacuum aspiration:** 12 out of 13 respondents agreed and only 1 out of 13 respondents disagreed with this statement.

In their comments, respondents stated that the effectiveness of these contraception methods has been proved in practice; however, some respondents believed that the choice of contraception should be made on a case-by-case basis and may not always be good.

- **An abortion is a crime:** 11 out of 13 respondents disagreed and 2 out of 13 respondents agreed with this statement.

In their comments, most of the respondents insisted that a woman has the right to an abortion and this decision is her personal matter. However, some respondents believed that an abortion is a deprivation of life, so it can be considered a crime against the unborn child.

- **Women should choose a family planning method only based on facts and should not be influenced by others' opinions:** 11 out of 13 respondents agreed and 2 out of 13 respondents disagreed with this statement.

In their comments, most of the respondents were convinced that women have the right to make independent choices; however, it is noted that the information that women use for making decisions may be unreliable, so it is necessary to inform women about the availability of professional consultations regarding family planning methods.

Issues of violence against women

- **A woman/girl is raped because she is dressed in a wrong way:** 12 out of 13 respondents disagreed with this statement and 1 out of 13 respondents refused to answer this question.

In their comments, part of the respondents noted that a woman's appearance cannot be considered as a cause of rape because the rapist is a criminal in any case. Another part of respondents was inclined to disagree with this statement because it mentions only one cause of rape, whereas there may be numerous or concurrent causes (i.e., it is considered that a woman may provoke the rapist).

- **A woman/girl is raped because she behaves inappropriately:** 12 out of 13 respondents disagreed with this statement and only 1 out of 13 respondents refused to answer this question.

In their comments, part of the respondents noted that a woman's inappropriate behaviour cannot be considered as a cause of rape because the rapist is a criminal in any case. Another part of respondents was inclined to disagree with this statement because it mentions only one cause of rape, whereas there may be numerous or concurrent causes (i.e., it is considered that a woman may provoke the rapist).

Beliefs / stereotypes characterised by ambiguous attitude

The following statements demonstrated ambiguous attitudes on the part of healthcare professionals (15 statements):

Issues of women's sexual and reproductive health

- **A woman must have the husband's consent to use a family planning method:** 8 out of 13 8 out of 13 respondents disagreed with this statement, 3 out of 13 3 out of 13 respondents agreed, and 2 out of 13 2 out of 13 respondents refused to answer this question.

COMMENTS: *Those who disagreed mostly noted that the choice of the family planning method is a woman's personal decision because she bears most of health-related risks, especially during childbearing and birth.*

Those who agreed with this statement mostly mention the man's right to be involved in the family planning process provided trust-based relations in the couple.

- **A healthcare professional must obtain a consent from the woman's husband before she uses a family planning method:** 9 out of 13 respondents disagreed with this statement, 1 out of 13 respondents agreed, and 3 out of 13 respondents refused to answer this question.

COMMENTS: *In their comments, respondents who disagreed with this statement were convinced that adult women do not and should not depend on others' consent in their decision-making. According to some opinions, obtaining the husband's consent before the woman uses a contraception method may help preserve the family.*

- **If a woman has short intervals between pregnancies (every year), it indicates lack of self-control:** 9 out of 13 respondents disagreed and 4 out of 13 respondents agreed with this statement.

COMMENTS: *Those who disagreed with this statement pointed out that the decision to give birth with short intervals between pregnancies is a woman's conscious choice that may be related to the lack of awareness about consequences of such decisions. Respondents who agreed with this statement are convinced that a woman may fail to control the frequency of pregnancies for lack of knowledge about how the body recovers after delivery and about risks*

for her and her future child's health that arise due to non-observance of recommended intervals.

- **An intrauterine device may be a good method for the woman who does not have children but wants to wait for several years before giving birth to the first child:** 6 out of 13 respondents disagreed and 7 out of 13 respondents agreed with this statement.

COMMENTS: *In their comments, respondents agreed or disagreed with this statement referring to their practical experience (thus, part of respondents were convinced of the effectiveness of this contraception method, whereas the others, on the contrary, considered other contraception methods safer for the woman's health).*

- **If I received training and a client asks for a permanent method (vasectomy or tubal ligation), I will provide this service because it is their choice:** 8 out of 13 respondents agreed and 5 out of 13 respondents disagreed with this statement.

COMMENTS: *Those who agreed with this statement pointed out that the doctor must perform the manipulation at the woman's choice informing her of all potential risks and consequences, except for cases when the choice contradicts the woman's health state.*

Those who disagreed with this statement are convinced that the choice of voluntary surgical sterilisation indicates lack of awareness about other, more considerate family planning methods, so the doctor must provide a high-quality consultation before performing such surgeries.

- **A family planning injection may be a good method for women who do not have children:** 9 out of 13 respondents disagreed with this statement, 3 out of 13 out of 13 respondents agreed, and 1 out of 13 respondents refused to answer this question.

COMMENTS: *Respondents who disagreed with this statement insist that, to their knowledge, this method is not among the safest for preserving woman's reproductive health, so they recommend other contraception methods to women without children.*

Part of respondents who agreed with this statement noted that based on their practical experience they can make a conclusion about effectiveness of this contraception method for women who did not have children. Another part of respondents points out that the choice of any contraception method is the responsibility of the woman, not the doctor.

- **Family planning injections (for example, Depo-Provera) often lead to infertility in women:** 8 out of 13 respondents disagreed with this statement, 4 out of 13 respondents agreed, and 1 out of 13 respondents refused to answer this question.

COMMENTS: *Respondents who disagreed with this statement underline that there is no sufficient evidence of a large number of infertility cases in women using family planning injections to make definitive conclusions. Those who agreed with this statement point out that this drug is not safe for women who did not give birth but can be used by women who have children.*

- **I feel comfortable talking about abortions even with residents of the place where I live:** 7 out of 13 respondents disagreed with this statement, 3 out of 13 respondents agreed, and 3 out of 13 respondents refused to answer this question.

COMMENTS: Respondents who disagreed with this statement point out that conversations about abortions make sense if there are respective questions from patients (doctors note that they do not feel discomfort during consultations), but educational activity among fellow residents is not considered part of the doctor's activity. Respondents who agreed with this statement assure that they feel comfortable in any situations (as far as artificial abortions are concerned).

- **An abortion is a sin:** 8 out of 13 respondents disagreed with this statement, 4 out of 13 respondents agreed, and 1 out of 13 respondents refused to answer this question.

COMMENTS: Respondents who disagreed with this statement insist that it is the woman who is responsible for the decision to perform an artificial abortion, and the doctor must provide adequate care regardless of religious beliefs.

Among those who agreed with this statement religious beliefs are prevalent, but it is noted that they are not a reason to turn down the patient's request for the respective medical service.

- **Women and girls who have an abortion must pay for post-abortion care:** 6 out of 13 respondents disagreed with this statement, 4 out of 13 respondents agreed, and 3 out of 13 respondents refused to answer this question.

COMMENTS: Respondents who disagreed with this statement are convinced that post-abortion care must be free for the patient if she receives healthcare services at a state or communal healthcare institution according to the law.

It is a prevalent opinion among respondents who agreed with this statement that post-operative care must be paid for by women because it is part of the woman's personal health care. It was also emphasised that paid services (in terms of value) develop the woman's responsibility for her health in the future.

- **The husband must always make decisions about contraception together with his wife:** 5 out of 13 respondents disagreed and 8 out of 13 respondents agreed with this statement.

COMMENTS: In their comments, respondents referred to their personal ideas about family functioning. Thus, for the majority of respondents family planning is viewed as a joint decision of the married couple, whereas for the rest of respondents the dominant role in these decisions belongs to the woman (because woman bears more health-related risks during childbearing, birth, etc.).

- **Although my religion is against abortions, I feel comfortable and can provide this service consciously as a healthcare professional:** 8 out of 13 respondents agreed with this statement, 4 out of 13 respondents disagreed, and 1 out of 13 respondents refused to answer this question.

COMMENTS: Respondents who agreed with this statement are aware that abortion care is above all part of their professional duties and note that this attitude allows them to feel comfortable when providing services. Those who disagreed with this statement included healthcare professionals who do not provide abortion services to their patients. The rest of respondents noted that, being healthcare professionals, they perform this operation but try to convince women to reconsider their decision.

- **My duty is to inform the husband/wife about his/her partner's HIV status:** 10 out of 13 respondents disagreed with this statement, 1 out of 13 respondents agreed, and 2 out of 13 respondents refused to answer this question.

***COMMENTS:** Most of the respondents point out that healthcare professionals do not have the legal right to disclose their patients' HIV status without their consent.*

- **There are reproductive health services that I will never provide to my clients:** 9 out of 13 respondents disagreed with this statement, 2 out of 13 respondents agreed, and 2 out of 13 respondents refused to answer this question.

***COMMENTS:** Respondents who disagreed with this statement point out that a healthcare professional must fulfil their professional duties and provide patients with the full range of services offered by the medical institution. Respondents who agreed with this statement mention that they do not provide pregnancy termination services but do not mention reasons for this decision.*

- **A survivor of SGBV should be provided with abortion services if necessary:** 10 out of 13 respondents agreed with this statement, 1 out of 13 respondents disagreed, and 2 out of 13 respondents refused to answer this question.

***COMMENTS:** Most respondents underline that the need for providing artificial abortion services to a survivor of SGBV must be justified by the woman's decision or her health status.*

III. Health care facilities situation

SUMMARY

With martial law in force and combat actions taking place in the territory of Ukraine, health facilities are receiving extremely limited funding. This fact above all affects access to and quality of health care for women, particularly with regard to sexual and reproductive health. Notably, there is a decrease in the level of material support, lack of medical devices and medicines, antiseptics, absence of free contraceptives and medicines for medication-induced abortions, as well as rapid tests for HIV, syphilis and pregnancy. All health facilities can provide services for the clinical treatment of rapes and sexual violence, however none of the facilities provide comprehensive SRH and GBV assistance including healthcare providers have not received adequate training.

A more detailed analysis for each of the health facility please find in Annex 1

A group of experts based on the baseline results developed **recommendations** in order to improve the quality of sexual and reproductive health care services, healthcare institutions first and foremost recommended:

1. To coordinate the activities in the field of preventing and combating gender-based violence and providing coordinated assistance to the survivor, a responsible person from the deputies of the head of the institution should be appointed (paragraph 42 of the Resolution of the Cabinet of Ministers of Ukraine of 22.08.2018 «On approval of the Procedure for interaction of entities carrying out activities in the field of preventing and combating domestic violence and gender-based violence» and Order of the Ministry of Health of Ukraine of 01.02.2019 No. 278)
2. Conduct training for the medical staff involved in providing women with services for the clinical treatment of rapes, post-contact prevention of HIV and STIs, emergency contraception and preventive vaccination. At the same time, attention must be paid to improving women's access to the service of medication-induced abortion.
3. Ensure additional material and technical support with medical devices and medicines, free contraceptives, and medicines for medication-induced abortions.
4. Develop an algorithm of actions for medical workers in case of detection of domestic and gender-based violence, as well as a mechanism for referral of survivors of gender-based violence and approve the relevant regulation.
5. Develop action plan of interaction with actors involved in preventing and combating gender-based violence in the community and establish communication with non-

governmental organizations helping people who experienced sexual violence for psychosocial support and rehabilitation.

6. Increasing awareness-raising among the population on reproductive health and prevention of gender-based violence and the possibility of receiving assistance to survivors. Create information stands in the institution.

ANNEXES

Annex 1. Health facility situation per facility

Boiarka, Kyiv Oblast

Summary

Communal Non-Commercial Enterprise “Intensive Care Hospital of Boiarka City Council” is a specialised multi-field health facility providing obstetric and gynaecological care. The hospital covers a population of approximately 34,000 people (according to the head of the institution), including approximately 15,000 women of reproductive age (15-49 years old). For the past three months, inpatient obstetric and gynaecological care (incl. services for the preservation of sexual and reproductive health) was provided to 714 women. Information about providing outpatient and consultative services, including to IDPs, was absent from the questionnaire. Obstetricians/Gynaecologists note that there is no information about requests from women concerning sexual violence.

The health facility is currently staffed with doctors and nursing personnel involved in providing obstetric and gynaecological care and services for pregnancy termination, clinical treatment of rapes, etc.

The facility provides consultations on family planning by obstetricians/gynaecologists; however, nursing personnel, including obstetric nurses, are not involved in this process. Patients do not have access to injection and barrier (condoms) contraceptives due to the lack of free contraceptives at the institution and absence of demand.

At the institution, women have access to free pregnancy termination services. At the outpatient level, medication-induced abortions and MVA methods are widely used at the maternity welfare department, whereas there are no data in the questionnaire for the gynaecological department. Women do not have access to free medicines for medication-induced abortions (misoprostol) or free contraception after a medication-induced abortion.

The institution can also provide services for the clinical treatment of rapes, but specialists did not receive training because there is no information about requests from women concerning sexual violence.

Vaccination for hepatitis B, injections of anti-tetanus anatoxin and emergency contraception for women are not performed at the institution because there is no demand or need.

Post-contact HIV prevention services are provided, ARV medicines are available at the institution.

There is no well-defined algorithm of women’s referral or communication with non-governmental organisations helping people who experienced sexual violence for psychosocial support and rehabilitation.

According to the inventory, there are no available medicines for medication-induced abortions (mife- and misoprostol), antiseptics (chlorhexidine), free contraceptives or antibacterial agents.

Additional material and technical support is needed – medical equipment for examination and IUD insertion, disinfectants, gynaecological examination chairs (incl. automatic), blood pressure monitors, rapid tests for pregnancy, HIV and syphilis, and MVA equipment.

Conclusions

In order to improve the quality of sexual and reproductive health care services at Communal Non-Commercial Enterprise “Intensive Care Hospital of Boiarka City Council”, it is necessary to:

1. Determine a responsible person from among the deputy heads of the institution to coordinate measures to prevent and combat gender-based violence and provide coordinated assistance to the survivor.
2. Conduct training for the medical staff involved in providing women with services for the clinical treatment of rapes, post-contact prevention of HIV and STIs, emergency contraception and preventive vaccination.
3. Ensure additional material and technical support with medical devices and medicines, free contraceptives, and medicines for medication-induced abortions.
4. Develop an action plan for health care workers in case of detection of domestic and gender-based violence, as well as a mechanism for referral of survivors of gender-based violence and approve the relevant regulation.
5. Develop an action plan to engage with entities implementing measures to prevent and respond to gender-based violence in the community and establish communication with non-governmental organisations helping people who have experienced sexual violence for psychosocial support and rehabilitation.

Recommendations:

Taking into account that Kyiv Oblast is now unsafe, the number of women IDPs is low. However, in order to improve the quality of sexual and reproductive health care services at Communal Non-Commercial Enterprise “Intensive Care Hospital of Boiarka City Council”, it is necessary to:

1. Determine a responsible person from among the deputy heads of the institution to coordinate activities in the field of prevention and counteracting gender-based violence and to provide coordinated assistance to the survivor.
2. Conduct training for the medical staff involved in providing women with services for the clinical treatment of rapes, post-contact prevention of HIV and STIs, emergency contraception and preventive vaccination.
3. Ensure additional material and technical support with medical devices and medicines, free contraceptives and medicines for medication-induced abortions.
4. Develop an action plan for health care workers when domestic violence and gender-based violence is detected and a referral mechanism for survivors of gender-based violence and approve it with the relevant regulation.

5. Establish communication with non-governmental organisations helping people who experienced sexual violence for psychosocial support and rehabilitation.
6. Increasing awareness-raising among the population on reproductive health and prevention of gender-based violence and the possibility of receiving assistance to survivors. Create information stands in the institution.

Dobroslav, Odesa Oblast

Summary

Communal Non-Commercial Enterprise “Dobroslav Multi-Field Hospital” is a specialised multi-field medical institution providing obstetric and gynaecological care. The hospital covers a population of approximately 50,000 people (according to the head of the institution). No information was provided in the questionnaire about the number of women of reproductive age (15-49 years old). For the past three months, obstetric and gynaecological care (incl. services for the preservation of sexual and reproductive health) was provided to 2082 women, including 6% of IDPs. 76% of women received care at the maternity welfare department and 23% at inpatient departments. The medical institution is currently staffed with doctors and nursing personnel involved in providing obstetric and gynaecological care and services for pregnancy termination and clinical treatment of rapes, etc. Obstetricians/Gynaecologists note that there is no information about requests from women concerning sexual violence.

The institution provides consultations on family planning by doctors and obstetric nurses. Patients do not have access to injection, hormonal or barrier (condoms) contraceptives due to the lack of free contraceptives at the institution.

At the institution, women have access to free pregnancy termination services. At the outpatient level, medication-induced abortions and MVA methods are widely used at the maternity welfare department, whereas EVA and other methods are used at the gynaecological department. Women do not have access to free medicines for medication-induced abortions (misoprostol).

Post-contact HIV prevention services are not provided because there are no such requests from women or demand for this service, no adequate skills among doctors and nurses, and no ARV medicines at the institution.

The institution can also provide services for the clinical treatment of rapes, but specialists did not receive adequate training. Obstetricians/Gynaecologists point out that there is no information about requests from women concerning sexual violence.

Vaccination for hepatitis B, injections of anti-tetanus anatoxin and emergency contraception for women are not performed at the institution because there is no demand or need.

There is no algorithm of women’s referral or communication with non-governmental organisations helping people who experienced sexual violence for psychosocial support and rehabilitation, if necessary.

According to the inventory, there are no available medicines for medication-induced abortions (mife- and misoprostol), ARV medicines, free contraceptives, antibacterial agents (in sufficient amounts), or anti-tetanus anatoxin.

Additional material and technical support is needed – medical equipment for examination, gynaecological examination chairs (incl. automatic), CTG devices, and rapid tests for pregnancy, HIV and syphilis.

Conclusions

In order to improve the quality of sexual and reproductive health care services at Communal Non-Commercial Enterprise “Dobroslav Multi-Field Hospital”, it is necessary to:

1. Determine a responsible person from among the deputy heads of the institution to coordinate activities in the field of prevention and counteracting gender-based violence and to provide coordinated assistance to the survivor.
2. Conduct training for the medical staff involved in providing women with services for the clinical treatment of rapes, post-contact prevention of HIV and STIs, emergency contraception and preventive vaccination.
3. Ensure additional material and technical support with medical devices and medicines, contraceptives and medicines for medication-induced abortions.
4. Develop an action plan for health care workers in cases of domestic violence and gender-based violence, as well as a referral mechanism for survivors of gender-based violence, and approve by relevant regulation.
5. Develop an algorithm and establish communication with non-governmental organisations helping people who experienced sexual violence for psychosocial support and rehabilitation.
6. Increase awareness-raising work among the population on issues of reproductive health and prevention of gender-based violence and the availability of assistance to survivors. Create information stands in the institution.

Recommendations:

Taking into account that Odesa Oblast is now unsafe, the number of women IDPs is low. However, in order to improve the quality of sexual and reproductive health care services at Communal Non-Commercial Enterprise “Dobroslav Multi-Field Hospital”, it is necessary to:

1. Determine a deputy head of the institution to coordinate the prevention and response to gender-based violence and to provide coordinated assistance to the survivor.
2. Conduct training for the medical staff involved in providing women with services for the clinical treatment of rapes, post-contact prevention of HIV and STIs, emergency contraception and vaccination.
3. Ensure additional material and technical support with medical devices and medicines, contraceptives, rapid tests, and medicines for medication-induced abortions.

4. Develop an action plan for health care workers when domestic violence and gender-based violence is identified, as well as a referral mechanism for survivors of gender-based violence, and approve by relevant regulation.
5. Establish communication with non-governmental organisations helping people who experienced sexual violence for psychosocial support and rehabilitation.
6. Increase awareness of reproductive health issues among the population and prevention of gender-based violence and the availability of assistance to survivors. Create information stands in the institution.

Kropyvnytskyi, Kirovohrad Oblast

Summary

Communal Non-Commercial Enterprise “Level II Municipal Maternity Hospital with Perinatal Centre” of Kropyvnytskyi City Council is an institution providing specialised obstetric and gynaecological care. The hospital covers a population of 231,162 people, including 55,601 women of reproductive age (15-49 years old), which amounts to 24% of the general population and indicates a worsening demographic crisis at the background of combat actions and migration. For the past three months, obstetric and gynaecological care (incl. services for the preservation of sexual and reproductive health) was provided to 4433 women, including only 4% of IDPs. 78% of women received care at the maternity welfare department and 22% at inpatient departments. The medical institution is currently 100% staffed with doctors and nursing personnel involved in providing obstetric and gynaecological care and services for pregnancy termination and clinical treatment of rapes. Obstetricians/Gynaecologists note that there is no information about requests from women concerning sexual violence.

The institution provides free consultations on family planning by doctors and obstetric nurses. However, there are currently no free contraceptives at the institution except for barrier contraceptives (condoms).

At the institution, women have access to free pregnancy termination services. Medication-induced abortions are widely used and there are free medicines for medication-induced abortions (misoprostol). At the gynaecological department, EVA, dilation and curettage methods are used. The vacuum aspiration method (MVA) is not used at outpatient or inpatient departments because there is no access to an MVA set and the staff lacks knowledge and practical skills.

The institution can provide services for the clinical treatment of rapes, but specialists did not receive adequate training. Obstetricians/Gynaecologists point out that there is no information about requests from women concerning sexual violence.

Post-contact HIV prevention services are not provided because there are no such requests from women or demand for this service, no adequate skills among doctors and nurses, and no ARV medicines at the institution.

Vaccination for hepatitis B and injections of anti-tetanus anatoxin for women are not performed at the institution because there is no demand or need.

There is no algorithm of women's referral or communication with non-governmental organisations helping people who experienced sexual violence for psychosocial support and rehabilitation, if necessary.

According to the inventory, there are no ARV medicines, anti-tetanus anatoxin, free contraceptives or antibacterial agents (in sufficient amounts) at the institution.

Additional material and technical support is needed – medical equipment for examination and IUD insertion, disinfectants, gynaecological examination chairs (incl. automatic), blood pressure monitors, rapid pregnancy tests, and an MVA device.

Conclusions

In order to improve the quality of sexual and reproductive health care services at Communal Non-Commercial Enterprise “Level II Municipal Maternity Hospital with Perinatal Centre” of Kropyvnytskyi City Council, it is necessary to:

1. Determine a responsible person from among the deputy heads of the institution to coordinate activities in the field of prevention and counteracting gender-based violence and to provide coordinated assistance to the survivor.
2. Conduct training for the medical staff involved in providing women with services for the clinical treatment of rapes, MVA abortion, post-contact prevention of HIV and STIs, emergency contraception and preventive vaccination.
3. Ensure additional material and technical support with medical devices and medicines, contraceptives and an MVA device.
4. Develop an action plan for health care workers in cases of domestic violence and gender-based violence, as well as a referral mechanism for survivors of gender-based violence, and approve by relevant regulation.
5. Develop an algorithm and establish communication with non-governmental organisations helping people who experienced sexual violence for psychosocial support and rehabilitation.
6. Increase awareness-raising among the population on reproductive health issues and the prevention of gender-based violence and access to assistance for survivors. Create information stands in the institution.

Recommendations:

Taking into account that Kirovohrad Oblast is quite far from frontline regions, the number of women IDPs is not high. However, in order to improve the quality of sexual and reproductive health care services at Communal Non-Commercial Enterprise “Level II Municipal Maternity Hospital with Perinatal Centre” of Kropyvnytskyi City Council, it is necessary to:

1. Determine a responsible person from among the deputy heads of the institution to coordinate activities in the field of prevention and counteracting gender-based violence and to provide coordinated assistance to the survivor.
2. Conduct training for the medical staff involved in providing women with services for the clinical treatment of rapes, medication-induced abortions, post-contact prevention of HIV and STIs, and emergency contraception.

3. Ensure additional material and technical support with medical devices and medicines, contraceptives, and rapid tests.
4. Develop an action plan for health care workers when domestic violence and gender-based violence is identified, as well as a referral mechanism for survivors of gender-based violence, and approve by relevant regulation.
5. Establish communication with non-governmental organisations helping people who experienced sexual violence for psychosocial support and rehabilitation.
6. Increase awareness of reproductive health issues among the population and prevention of gender-based violence and the availability of assistance to survivors. Create information stands in the institution.

Poltava

Summary

Communal Enterprise “Municipal Clinical Hospital No. 4 of Poltava City Council” is an institution providing specialised obstetric and gynaecological care. The hospital covers a population of 279,593 people, including 46,800 women of reproductive age (15-49 years old), which amounts to only 16.7% and indicates a worsening demographic crisis at the background of combat actions and migration. For the past three months, obstetric and gynaecological care (incl. services for the preservation of sexual and reproductive health) was provided to 5382 women, including 18% of IDPs. 89% of women received outpatient care at the maternity welfare department and 10% at inpatient departments. The medical institution is currently 100% staffed with doctors and nursing personnel involved in providing obstetric and gynaecological care and services for pregnancy termination and clinical treatment of rapes. Obstetricians/Gynaecologists note there are requests from women concerning sexual violence. However, absence of HIV/STI services (according to the questionnaire) is not clear.

The institution provides free consultations on family planning by doctors and obstetric nurses. Patients do not have access to injection and barrier (condoms) contraceptives due to their absence at the institution.

At the institution, women have access to free pregnancy termination services. MVA is used for outpatient care, and EVA is used at the gynaecological department. The medication-induced abortion is not used at outpatient or inpatient departments, which is contrary to applicable requirements and standards. Based on the questionnaire, it is because there is no demand, but according to the expert it is because there is no access to free medicines (misoprostol) at the institution.

The institution provides services for the clinical treatment of rapes, but specialists did not receive specialised training. Post-contact HIV prevention services are not provided because there are no adequate skills among doctors and nurses and no ARV medicines at the institution.

Vaccination for hepatitis B is not performed at the institution. This service is provided by the First Medical and Sanitary Aid Centre.

There is no well-defined algorithm of women's referral or communication with non-governmental organisations helping people who experienced sexual violence for psychosocial support and rehabilitation.

According to the inventory, there are no iron-containing medicine, anti-tetanus anatoxin vaccines, medicines for medication-induced abortions (mife- and misoprostol), ARV medicines, free contraceptives, or antibacterial agents.

Additional material and technical support is needed – medical equipment for examination and IUD insertion, disinfectants, gynaecological examination chairs (incl. automatic), blood pressure monitors, and rapid tests for pregnancy, HIV, and syphilis.

Conclusions

In order to improve the quality of sexual and reproductive health care services at Communal Enterprise "Municipal Clinical Hospital No. 4 of Poltava City Council", it is necessary to:

1. Determine a responsible person from among the deputy heads of the institution to coordinate measures to prevent and combat gender-based violence and provide coordinated assistance to the survivor.
2. Conduct training for the medical staff involved in providing women with services for the clinical treatment of rapes, MVA abortion, post-contact prevention of HIV and STIs, emergency contraception and preventive vaccination.
3. Ensure additional material and technical support with medical devices and medicines, contraceptives and an MVA device.
4. Develop an action plan for health care workers in cases of domestic violence and gender-based violence, as well as a referral mechanism for survivors of gender-based violence, and approve by relevant regulation.
5. Develop an algorithm and establish communication with non-governmental organisations helping people who experienced sexual violence for psychosocial support and rehabilitation.
6. Increase awareness-raising among the population on reproductive health issues and the prevention of gender-based violence and access to assistance for survivors.
Create information stands in the institution.

Recommendations:

Taking into account that Poltava Oblast borders on two frontline regions (Sumy and Kharkiv) and the population has increased by around 250,000 IDPs for the past 3 months, including by 60,000 people within the coverage of the institution (according to the survey), within the Project for improving the quality of sexual and reproductive health care services, at Communal Enterprise "Municipal Clinical Hospital No. 4 of Poltava City Council" it is necessary to:

1. Determine a responsible person from among the deputy heads of the institution to coordinate activities in the field of prevention and counteracting gender-based violence and to provide coordinated assistance to the survivor.
2. Conduct training for the medical staff involved in providing women with services for the clinical treatment of rapes, medication-induced abortions, post-contact prevention of HIV and STIs, and emergency contraception.

3. Ensure additional material and technical support with medical devices and medicines, contraceptives, and rapid tests.
4. Develop an action plan for health care workers when domestic violence and gender-based violence is identified, as well as a referral mechanism for survivors of gender-based violence, and approve by relevant regulation.
5. Establish communication with non-governmental organisations helping people who experienced sexual violence for psychosocial support and rehabilitation.
6. Increase awareness of reproductive health issues among the population and prevention of gender-based violence and the availability of assistance to survivors. Create information stands in the institution.