

Ukraine Assessment Report
December 2022

Gender-based Violence and Sexual and Reproductive Health Rapid Assessment Report



I. Executive Summary



Prior to Russian invasion of Ukraine in February 2022, violence against women and girls (VAWG), including domestic violence and sexual violence, was widespread with three in four women in the country reportedly experiencing some form of violence since age 15. Anecdotal evidence and evidence from previous armed conflict in the country indicate that pre-existing forms of violence continue and are indeed being exacerbated by risks and threats associated with the conflict, including conflict-related sexual violence (CRSV). Nearly 60% of the estimated 6.5 million displaced in Ukraine are women and girls. As of August 2022, 9.5 million of women and girls inside Ukraine were in need of humanitarian assistance.

At the same time, there is a lack of reliable information and clarity regarding availability and accessibility of minimum essential gender-based violence (GBV) and sexual and reproductive health (SRH) services,² including clinical management of rape services, in Ukraine. The purpose of this rapid assessment was therefore to generate information on accessibility to minimum GBV and SRH services in specific locations across Ukraine to inform HIAS and VOICE humanitarian programming

and advocacy efforts to prevent and respond to GBV and promote the safety and rights of women and girls. The assessment took place between September 1st and October 15th, 2022, with a field mission conducted between 7th and 17th September. Validation of findings occurred in November and December 2022.









Findings from the assessment confirm that, in Ukraine (as is common in other humanitarian situations) pre-existing issues impacting women and girls' safety, dignity and well-being are being compounded by the ongoing conflict, with the war exposing women and girls to even greater GBV-related risks and threats as well as disrupting services and responses for survivors and other women and girls. The war has placed an unprecedented strain on health, justice and social support systems, including NGO and community-based, specialist, GBV services. The impact on survivors is that life-saving response services are unevenly distributed across Ukraine. GBV survivors are facing significant challenges in accessing care, support, and assistance to address the harmful consequences of the violence they are experiencing. This is true for survivors of domestic violence and sexual violence. Several intersecting factors create these limitations, including: gaps

in services; referral pathways and dissemination of information about services and how to access them; lack of an enabling environment and funding to support safe reporting and help-seeking after GBV; and institutional and community barriers, including community beliefs and norms surrounding GBV.

Similarly, across the assessed areas there are significant challenges women and girls encounter in accessing SRH services, including clinical management of rape. As noted in other recent reports, military attacks on medical facilities and health care settings, as well as serious disruptions in health-system functioning, are all significant problems.

The assessment identified several other priority issues concerning women and girls' safety, protection, and well-being, which are linked to the conflict and to the humanitarian response, which need to be addressed by the wider humanitarian community. These priority issues include giving greater attention to particularly vulnerable groups of women and girls; ensuring meaningful participation of women and girls across all aspects of humanitarian action to better center and address their needs and rights; and recognizing and supporting the work and role of women's organizations in the response. Addressing these issues will require humanitarian stakeholders to 'walk the talk' and start shifting resources and decision-making to local actors in line with localization commitments.

Icon Key

 <p>United Nations (UN) Entities</p>	 <p>European Union (EU)</p>	 <p>Host Country Governments</p>	 <p>Government of Ukraine</p>
 <p>Feminist Philanthropy/ Feminist Funds</p>	 <p>Member State Donors</p>	 <p>LNGO (Local Non Governmental Organization)</p>	 <p>INGO (International Non Governmental Organization)</p>

Recommendations

These recommendations are primarily intended to support the design and implementation of HIAS and VOICE GBV programming and advocacy efforts. However, recognizing that responding to GBV is a shared responsibility across sectors and clusters, the recommendations are also intended to encourage all humanitarian stakeholders to invest attention and resources in addressing women and girls’ safety, dignity, and rights. Moreover, the final two recommendations are specifically aimed at all humanitarian actors and duty-bearers with the intention of centering and empowering local actors—particularly women’s rights organizations (WROs)—in humanitarian response and in longer term peace and recovery efforts in Ukraine. While the recommendations are relevant to all assessed areas, access to services is lowest in rural areas, occupied territories, and areas close to occupied territories, and there is therefore a pressing need to prioritize humanitarian response and scale up support to local actors in these locations.

- Resource and support local WROs to lead in interagency coordination efforts, including leading adaptation and implementation of referral pathways for GBV survivors at the local level.** Local and national women’s organizations were doing the work before the war, are frontline humanitarian responders, and will continue to deliver care, support, and assistance services to GBV survivors when the war ends. It is the responsibility of international humanitarian actors to build on and support local actors and systems.



- 2. Facilitate the scale up and outreach of survivor-centered services to meet the health, psychosocial, safety, and legal needs of GBV survivors.** Focus on funding and capacity support to local organizations to establish entry points for safe disclosure, provision of information, referral and coordinated care, support, and assistance. Explore feasibility of different service delivery models to ensure accessibility issues can be addressed to reach survivors in different geographical locations, and marginalized communities. Explore the reasons why local hotlines are not being used and identify strategies to address those reasons. Provide sustained funding and other support to local organizations to deliver services.



- 3. Work with local women's organizations to develop targeted information campaigns so that women and girls know where they can safely and confidentially seek information about GBV and support in the current context.** Messaging should include a focus on the benefits of care.



- 4. Invest in developing longer-term, multipronged communication strategies to address stigma, help raise awareness about GBV within the community, and build demand for services.** Multipronged communication strategies should be developed and implemented by local organizations, drawing on good practice in communications to shift harmful beliefs, attitudes and social norms surrounding gender and GBV.



- 5. Strengthen health systems response to GBV.** Coordinate with Health Cluster actors to identify and address immediate training needs of health workers on clinical management of rape. Until survivor-centered health care is in place, resource local WROs and others providing GBV case management services so they can accompany rape survivors who wish to obtain medical care to health services and provide them with support and advocacy during the process. Support mobile health teams that offer a full complement of care, including SRH and clinical management of rape. Implement widespread community advocacy and aware-



ness campaigns to help reduce stigma, encourage accepting attitudes and help create the social awareness needed to support access to clinical care and support. Finally, support WROs who are participating in health-systems strengthening activities, including advocacy on policy and practice reform.

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- 6. Support local frontline humanitarian actors to implement minimum GBV interventions in line with good practice standards.** Partner with and fund WROs to implement GBV-specialized interventions, including safe spaces, safety audits, and community safety planning and mobile and outreach services. Also, strengthen capacity for integration of GBV risk mitigation across humanitarian programming to universally improve women and girls' rights, safety and protection.



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- 7. Fulfill commitments to localization by shifting power to WROs.** Implement the localization by increasing local actors' access to international humanitarian funding, partnerships, coordination spaces, and capacity building. Localization is one key to upholding the rights of women and girls in emergencies.



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- 8. Advocate to center and resource WROs in recovery and peace-building efforts.** Act now to center women's needs and rights in recovery, peace, and post-conflict reconstruction efforts. WROs need the space and resources to think about and inform recovery and reconstruction efforts, including how to build Ukraine back with the rights of women and girls at the center.



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Section 1:

Introduction to the assessment and context



1.1 Overview

Prior to Russian invasion of Ukraine in February 2022, violence against women and girls (VAWG), including domestic violence and sexual violence, was widespread. A 2019 survey conducted by Organization for Security and Cooperation in Europe (OSCE)² found that 75% of women in the country reported experiencing some form of violence since age 15,³ This includes intimate partner physical, sexual and psychological violence, non-partner sexual violence, sexual harassment and stalking.] and one in three had experienced physical or sexual violence in their lifetime. While there is no available data on the current nature and scope of VAWG, anecdotal evidence and evidence from previous armed conflict in the country indicate that pre-existing forms of violence continue and are indeed being exacerbated by risks and threats

2 Organization for Security and Co-operation in Europe (OSCE). Report OSCE-led survey on violence against women: Well-being and safety of women Ukraine results report. OSCE 2019. https://www.osce.org/files/f/documents/1/3/440312_0.pdf

3 This includes intimate partner physical, sexual and psychological violence, non-partner sexual violence, sexual harassment and stalking.

associated with the conflict, including conflict-related sexual violence (CRSV). At the same time, there is a lack of reliable information and clarity regarding availability and accessibility of minimum essential gender-based violence (GBV) and sexual and reproductive health (SRH) services,⁴ including clinical management of rape services, in Ukraine.

The purpose of this rapid assessment was therefore to generate information on accessibility to minimum GBV and SRH services in specific locations across Ukraine to inform HIAS and VOICE humanitarian programming and advocacy efforts to prevent and respond to GBV and promote the safety and rights of women and girls. The assessment builds on findings and recommendations

4 See Inter-Agency Minimum Standards for Gender-Based Violence in Emergencies Programming for an overview of essential GBV services, <https://gbvaor.net/gbvims>, and the Minimum Initial Service Package (MISP) for Sexual and Reproductive Health (SRH) in crisis situations for information on crucial, lifesaving activities required to respond to the SRH needs of affected populations at the onset of a humanitarian crisis, <https://www.unfpa.org/resources/minimum-initial-service-package-misp-srh-crisis-situations#:~:text=The%20Minimum%20Initial%20Service%20Package,onset%20of%20a%20humanitarian%20crisis>

from earlier humanitarian assessments highlighting concerns regarding GBV and SRH risks and responses in Ukraine.⁵ The assessment took place between September and October 2022, with a field mission conducted between 7 and 17 September, with validation of findings completed in December.

Findings from the assessment confirm that in Ukraine, as is common in humanitarian situations, pre-existing issues impacting women and girls' safety, dignity and well-being are being compounded by the ongoing conflict, with the war exposing women and girls to even greater GBV-related risks and threats and disrupting services and responses for survivors and other women and girls. Information collected during the assessment indicates that GBV survivors are facing significant challenges in accessing care, support, and assistance to address the harmful consequences of the violence they are experiencing. Similarly, across areas assessed there are significant challenges facing women and girls in accessing SRH services, including clinical management of rape. These challenges are linked to several intersecting factors including:

- lack of availability of services and referral pathways and mechanisms;
- lack of accurate and helpful information and messaging for women and girls about entry points and capacities for safe disclosure, support, and referral; and
- institutional and community barriers, including community beliefs and norms surrounding GBV, that influence attitudes and behaviors of service providers.

Some of these challenges are linked to pre-existing issues, such as beliefs, attitudes and social norms surrounding GBV, while others are directly related to the conflict and humanitarian response to affected populations—for example, inadequate coordination with local actors and organizations in a dynamic and insecure conflict setting. Given the increase in GBV and pre-existing reluctance

to report VAWG,⁶ there is a critical need to establish a minimum set of GBV interventions in line with good practice standards. This includes supporting humanitarian actors and services across sectors of humanitarian response, implementing GBV risk mitigation measures to promote women and girls' safety, and enabling safe and effective responses to the disclosure of GBV. Despite the extremely challenging context, it will be vital to ensure full and meaningful engagement of local actors providing GBV services in the development and implementation of shared systems and processes for referring GBV survivors, in line with survivor-centered principles and practices. Furthermore, while attention must urgently be given to GBV mitigation and response measures to protect and support women and girls in the current context, attention and resources must also be directed towards addressing risk factors for VAWG post-conflict.

The assessment identified several other key issues that urgently need to be addressed by the wider humanitarian community. These include the need to: give greater attention to the needs and rights of particularly vulnerable groups of women and girls; ensure meaningful participation of women and girls across all aspects of humanitarian action to better address and center their needs and rights; and the imperative to better recognize and support the work and role of women's organizations in the response. This will require humanitarian stakeholders to 'walk the talk' and start shifting resources and decision-making to local actors in line with localization commitments.

1.2 HIAS and VOICE overview and partnership

HIAS

HIAS, the international Jewish humanitarian organization that provides vital services to refugees and asylum seekers, has helped forcibly displaced persons find welcome, safety and opportunity for more than 130 years. Currently operational in more than 17 countries, HIAS is responding to the war in Ukraine through its core programming areas, including Economic Inclusion, Mental Health and Psychosocial Support, Legal Protection, and GBV Prevention and Response programming, with a focus on VAWG and individuals identifying as lesbi-

⁵ See VOICE and HIAS. *Waiting for the Sky to Close: The Unprecedented Crisis Facing Women and Girls Facing Ukraine*, May 2022. <https://voice-amplified.org/waiting-for-the-sky-to-close/>; UN Women and CARE International. *Rapid Gender Analysis Ukraine*. March 2022. <https://www.unwomen.org/en/digital-library/publications/2022/05/rapid-gender-analysis-of-ukraine>.

⁶ OSCE 2019

an, gay, bisexual, transgender, queer, intersex and asexual (LGBTQIA+). Using a survivor-centered approach, HIAS prioritizes the voices and needs of survivors and those disproportionately impacted by GBV: women and girls. HIAS' support of this assessment is just one example of its commitment to amplifying the voices of women, girls, and the leadership of women's rights and civil society organizations.

VOICE

VOICE believes that the humanitarian sector must deliver on its promise to protect women and girls—and that women and girls themselves must lead that revolution. VOICE challenges traditional, ineffectual methods of addressing VAWG in humanitarian emergencies, with a proven but chronically underused resource: the leadership of women and girls themselves.

VOICE's approach, steeped in women's rights practice, offers something new and necessary in the fight to end VAWG. We are working towards a world where girls and women are respected leaders in designing and implementing solutions to eradicate violence—both in their communities and within the halls of power. Ultimately, VOICE's goal is greater direct resourcing of local women's organizations and their solutions to address violence. We help meet the needs of women- and girl-led organizations in a growing number of countries, including Afghanistan, Bangladesh, Colombia, Hungary, Iraq, Moldova, Myanmar, Pakistan, Poland, Romania, Slovakia, South Sudan, Syria, Ukraine, the United States, Venezuela, and Yemen.

About the partnership

VOICE and HIAS share a vision in which the needs of women and girls in all their diversities are centered in humanitarian responses. In this joint vision, access to survivor support is top priority for the international community in word and action. With a unifying commitment to support women's rights organizations (WROs) and women's groups around the region to lead on the Ukraine humanitarian response, HIAS and VOICE continue a journey of reflection on how to make the localization agenda a reality. It is critical that humanitarian actions—both within Ukraine and regionally—build upon the advances in gender equality and women's empowerment made by Ukrainian and regional women's rights activists, women-led

groups, and civil society organizations (CSOs). In addition to supporting direct service delivery by local organizations, HIAS and VOICE together will continue to advocate for flexible and sustained support to WROs.

HIAS and VOICE are committed to ensuring contextually appropriate application of minimum standards and best practices within GBV and sexual and reproductive health (SRH) in emergencies service delivery in Ukraine, with a particular focus on GBV in emergencies (GBViE) programming both through direct service delivery (if needed) and through complementing and supporting partner organizations in Ukraine.

1.3 Assessment overview

Purpose and aims

Nearly 60% of the estimated 6.5 million displaced in Ukraine are women and girls.⁷ As of August 2022, 9.5 million of women and girls inside Ukraine were in need of humanitarian assistance.⁸ Independent global experts, including the World Health Organization, have expressed concerns about the availability of and access to GBV and SRH services in Ukraine, the lack of which could lead to heightened risk and increased morbidity and mortality.^{9,10} They have also identified a lack of reliable information on help-seeking behavior and on how the health system is responding to meet the GBV and other SRH needs of women and girls.

The impetus for doing an assessment was this lack of reliable information and clarity regarding availability and accessibility of minimum essential GBV and SRH services¹¹ in Ukraine, including clini-

7 International Organization for Migration (IOM Ukraine. Internal Displacement Report General Population Survey Round 10 (17-27 October 2022). <https://displacement.iom.int/reports/ukraine-internal-displacement-report-general-population-survey-round-10-17-27-october-2022?close=true>

8 Ukraine Flash Appeal (March to December 2022). <https://reliefweb.int/report/ukraine/ukraine-flash-appeal-march-december-2022>

9 Spiegel, P.B. Responding to the Ukraine refugee health crisis in the EU. *The Lancet* 2022; 399: 2084–2086.

10 WHO Health Cluster. Public Health Situation Analysis: Eastern Ukraine, Donetska & Luhanska Oblasts GCA – Long-Form, July 2022.

11 See Inter-Agency Minimum Standards for Gender-Based Violence in Emergencies Programming for an overview of essential GBV services (<https://gbvaor.net/gbvitems>), and the Minimum Initial Service Package (MISP) for Sexual and Reproductive Health (SRH) in crisis situations for information on crucial, lifesaving activities required to respond to the SRH needs of affected populations at the onset of a humanitarian crisis, (<https://www.unfpa.org/resources/minimum-initial-service-package-misp-srh-crisis-situations#:~:text=The%20Minimum%20Initial%20Service%20Package,onset%20of%20a%20humanitarian%20crisis>)

cal management of rape services, for women and girls in all their diversity.¹² The purpose of this rapid assessment was therefore to generate information on accessibility to minimum GBV and SRH services in specific locations across Ukraine to inform HIAS and VOICE programmatic interventions and advocacy efforts. It builds on findings and recommendations from earlier assessments, which highlighted concerns regarding GBV and SRH risks and responses in Ukraine.¹³

Prior to conducting the assessment, VOICE and HIAS identified the following potential challenges facing women and girls in all their diversity in accessing GBV and SRH services:

1. The deteriorating security environment;
2. Lack of clear and functional entry points and referral pathways to care; and
3. Beliefs, attitudes, and norms impacting help-seeking, service uptake, and service provision for GBV survivors.

The assessment explored these and other factors impacting access to critical GBV and SRH services in conflict-affected communities in Ukraine to inform programming and advocacy efforts. The assessment focused on three areas of inquiry:

1. Current availability and barriers to minimum GBV services;
2. Current availability and barriers to minimum SRH care, with a focus on clinical management of rape;
3. Other issues impacting women and girls' health, safety, protection, and rights.

The assessment took place between September 1st and October 15th, 2022, with a field mission conducted between 7th and 17th September, and validation of findings undertaken in November and December. Fieldwork took place in the following locations:

Lviv: Ukraine's seventh largest city before the

war (population 720,000), Lviv is in the west of the country—about 70 km from the border with Poland. The city's proximity to the Polish border has made it the de facto transit hub for millions fleeing the fighting. While many Ukrainians fled to neighboring countries, as many as 180,000 displaced women and girls remained in and around Lviv¹⁴.¹⁵ During the early days of the invasion, Lviv was targeted by Russian missiles. In October, Lviv's critical infrastructure was targeted by missile strikes, temporarily interrupting electricity and water supply. Still, Lviv remains relatively more stable than other parts of Ukraine.

Kyiv: Before the full-scale invasion, Kyiv was Ukraine's largest city with a population of almost 3 million. However, city officials estimated that as many as 1.5 million fled the city in the weeks following the invasion.¹⁶ More recent data suggests that most have made their way back to the Kyiv region.¹⁷

Poltava: An eastern-central city located between Kharkiv and Kyiv, Poltava had a population of almost 300,000 before the war. Since the invasion, more than 200,000 internally displaced people (IDPs) have come to Poltava region that borders Kharkiv, a region that is affected by active fighting (Kharkiv is 140 km away).¹⁸ Poltava has avoided direct attacks almost entirely, and as a result functions as a critical gateway for displaced women and girls headed west.

Chernihiv: A northern Ukrainian city located only 90 km from the Russian border, Russian forces occupied the region around Chernihiv briefly, but were pushed out in April 2022. This instability

14 International Crisis Group. "Picturing the Humanitarian Response in Western Ukraine." 30 July 2022. www.crisisgroup.org/europe-central-asia/eastern-europe/ukraine/picturing-humanitarian-response-western-ukraine

15 REACH. "Arrival and Transit Monitoring – Ukraine September 2022." September 2022. https://www.impact-repository.org/document/reach/62f09d8e/REACH_UKR2208_ATM_Factsheet_Round-3_September_2022.pdf

16 Al Jazeera. "Half of Kyiv Population Has Fled, Says Ukrainian Capital's Mayor", 10 March 2022. <https://www.aljazeera.com/news/2022/3/10/half-of-kyiv-population-has-fled-says-ukrainian-capitals-mayor>

17 IOM Ukraine. Ukraine Internal Displacement Report General Population Survey Round 9, 26 September 2022. https://displacement.iom.int/sites/g/files/tmzbd11461/files/reports/IOM_Gen%20Pop%20Report_R9_IDP_FINAL.pdf

18 UNICEF. "UNICEF Continues to Provide Critically Needed Humanitarian Aid to War-affected Areas in Ukraine." 12 Sept. 2022. www.unicef.org/ukraine/en/press-releases/unicef-continues-provide-critically-needed-humanitarian-aid-war-affected-areas

12 Due to the rapid nature of this assessment, the team did not collect specific data on the needs of LGBTQ+ community members. An upcoming assessment will include a more specific focus on those populations and the organizations supporting them.

13 See VOICE and HIAS, May 2022 and UN Women and CARE, March 2022.

resulted in an estimated 50% decrease in the city's population, which may now be as low as 130,000.¹⁹ However, with after a successful Ukrainian counteroffensive, many have started to return to the area despite the continued risk.²⁰

Sosnivka: A small post-industrial town located north of Lviv with a population of approximately 11,000, Sosnivka has one hospital with limited services. Most people rely on sustenance farming and have limited means of transportation.

Kolychivka: A small sustenance farming community located just south of Chernihiv and separated by the Uhor river. The population is estimated to be 5,000, although there is no official data available on the number of people currently there as the region has faced significant fighting and was isolated from the main city of Chernihiv when bridges were destroyed in an effort to prevent Russian advancement. While repairs have commenced to bridge infrastructure, the community is experiencing challenges with road infrastructure, building damage, and transportation. Currently a small mobile community health clinic is operating in the village but offers extremely limited services and is staffed by a nurse and *feldsher*²¹ during business hours.

Chervonohrad: A mining city approximately two hours north of Lviv, Chervonohrad has a population of approximately 65,000. Healthcare providers in the area report they are seeing an increase in IDPs relocating from Lviv to the area. The area is supported by two hospitals – a general hospital and a maternity hospital.

Methodology

Qualitative data collection and analysis methods were used, involving both primary and secondary data. Secondary data was collected through desk review, with primary data collected during the ten-day field mission. Information was gathered via the following methods:

- Desk review and analysis of existing data and information on VAWG, SRH and the broader humanitarian situation facing women and girls, with a focus on Lviv, Kyiv, Poltava and Chernihiv oblasts.
- Site visits and observation at hospitals, health centers, shelters for IDPs, and other accessible locations in rural and urban areas of each oblast where IDPs are congregated. Ten health sites and two shelters were visited during the field mission.
- Key informant interviews (KIIs) with representatives from local, national, and international organizations. A total of 59 KIIs were conducted with 41 women and 18 men from Ukrainian women and girl-led organizations (WGLOs) and other local and national NGOs, government municipal and health services (including hospital administrators, midwives, nurses, medical doctors), INGOs and UN agencies, including Health, SRH, GBV and Protection Cluster/Sub-Cluster Coordination leads.
- Focus group discussions (FGDs) with internally displaced women. Two FGDs were held with a total of 15 participants, (one group comprising seven women between the ages of 30 and 45 and the second comprising eight women with disabilities between the ages of 45 and 65).

Validation was undertaken in late November and early December to corroborate findings and ensure relevance of recommendations. Validation meetings were held with leadership from Ukrainian women-led organizations working on GBV, women's rights and LGBTQI+ issues, and with a representative from a donor organization.²²

Due to sensitivities associated with collecting information about GBV and SRH, all field research was conducted by experienced HIAS and VOICE staff, including Ukrainian staff with relevant cultural and language expertise. All staff involved with field data collection received refresher training on 'do no harm' and on safely and effectively responding to GBV disclosure, including making confidential referrals in line with best practice in GBV-related information gathering and assessment. The field-team were supported by Ukrainian and interna-

19 The Kyiv Independent. "Mayor of Chernihiv Estimates Over Half the Population Has Left Since Start of War". 23 June 2022. <https://kyivindependent.com/uncategorized/mayor-of-chernihiv-estimates-over-half-of-the-population-has-left-since-start-of-the-war>

20 Ibid

21 A feldsher is a health care professional who provides various medical services limited to emergency treatment and ambulance practice.

22 These were NGO Women's Perspectives, NGO Women's Association Sphere, NGO Zhiva-Ya, NGO Innovation Action, Transcarpathian Regional Center of Social and Psychological Assistance and the USAID office in Ukraine.



tional experts. The assessment methodology and tools were developed in line with guiding principles and minimum standards for GBV and SRH in humanitarian settings, including:

- WHO ethical and safety recommendations for researching, documenting, and monitoring sexual violence in emergencies
- Inter-Agency Minimum Standards for Gender-Based Violence in Emergencies Programming
- IASC Guidelines for Integrating Gender-Based Violence Interventions in Humanitarian Action
- Inter-agency Field Manual on Reproductive Health in Humanitarian Settings

Constraints and limitations

This was a rapid assessment undertaken in a complex, dynamic, and fluid environment with a specific purpose to inform programming and advocacy. The assessment collected information in relation to accessibility of priority GBV and SRH ser-

vices.²³ As it was a rapid assessment, the team did not collect detailed data on GBV and SRH services or information on GBV experiences. The findings therefore represent a snapshot of specific issues within a defined time-period, with data collection influenced by limitations of time, safety, and security concerns. Ethical and safety considerations were paramount and shaped both the collection and reporting of information. The assessment did not solicit direct information on the scope of GBV, or of survivor's experiences of GBV. Due to the rapid nature of the assessment, location-specific information is not detailed in this report. In this report, the findings are generalized across locations, with relevance of findings confirmed through validation exercises with VOICE and HIAS partner organizations working in Ukraine.

²³ These include basic essential services for GBV survivors which are provision of information, support and referral and clinical management of rape, as well as GBV risk mitigation across sectors. For minimum SRH services beyond the clinical management of rape, see Minimum Initial Services Package for Sexual and Reproductive Health, <https://www.unfpa.org/resources/minimum-initial-service-package-misp-srh-crisis-situations#:~:text=The%20Minimum%20Initial%20Service%20Package,onset%20of%20a%20humanitarian%20crisis>

1.3 Context

Women's rights in Ukraine

Prior to the war, Ukraine faced challenges related to achieving gender equality and ensuring women's access to equal rights and opportunities. Structural inequalities in public and private spheres were visible in different areas of public and private life, including political and economic participation, access to assets, income, and services, living standards and quality of life and labor market stratification, with women occupying lower paid and status roles.²⁴ A gender analysis of poverty rates in Ukraine²⁵ demonstrates that women faced increased risks of low income compared to men. In 2020, the share of the population that lived below the monetary poverty line was greatest among women compared with men. Women's labor force participation rate (56.3%) was also lower than that of men (68.5%). Compared to men, a considerably higher share of women – 29.7% – were economically inactive due to household and family responsibilities, versus 8.1% of men who were outside the labor force. Gender disparities in the labor market also included the lower employment rate of women (51.2%) as compared to men (61.8%).

Occupational segregation by sex was a feature of the Ukrainian labor market, with 2020 data indicating women were over-represented in services and sales sectors, with men dominating in sectors that require skilled workers using specific tools, plant and machine operators, and assemblers. The gender pay gap, one of the most important indicators used to monitor gender equality, indicated that in Ukraine women's average monthly wage was only 79.6% of men's average monthly wage.

Structural discrimination in Ukraine is reinforced through gendered expectations around women's reproductive and care roles and their subordinat-

ed position in the hierarchy of family relations.²⁶ Prior to the war, women had more roles and greater responsibilities in everyday life than men. For example, women performed the largest amount of unpaid child and family care work. These activities are excluded from labor market statistics and as a result, much of women's work in Ukraine remained invisible. Women's disproportionate burden of family responsibilities limited their opportunities for engaging in paid work and the absence of institutional mechanisms enabling women to balance employment and family responsibilities (e.g. childcare services, additional leave for workers with children, the inclusion of relevant provisions in collective agreements) impeded the full participation of women in the labor market, further entrenching gender inequality.²⁷

In recent years, women's rights gained some ground in Ukraine; for example, the Government signed the Council of Europe Convention on Preventing and Combating Violence Against Women and Domestic Violence (the 'Istanbul Convention') in 2015 and ratified it in 2022, and in 2016 adopted the first National Plan on UN Security Council Resolution 1325 on Women's Peace and Security during armed conflict.²⁸ In 2019, the Ukrainian Government adopted a decree on the Sustainable Development Goals, integrating all the goals, including SDG 5 on gender equality into state policy (see box).

Despite this progress, deeply entrenched gender-based discrimination, rising right-wing sentiments, eight years of conflict and displacement, and the disproportional socioeconomic impact of COVID-19, have eroded progress and exacerbated VAWG in Ukraine,²⁹ as highlighted in the next section. Progress on eliminating VAWG and ensuring universal access to sexual and reproductive health and rights (SRHR) is driven by the vibrant women's movements in Ukraine. One key example is advocacy by women's rights organizations (WROs) to ensure signing and ratification by Ukraine of the Council of Europe Convention on Preventing and

24 Klemparskyi, M, Pavlichenko, H, Prokopiev, R, Mohilevskyi, L, and Burniagina, Y. "Gender inequality in the labour market of Ukraine: Challenges for the future". Work Organisation, Labour & Globalisation, Vol. 16, No. 2.e, 2022.

25 State Statistics Service of Ukraine. Indicators for the Monitoring of Gender Equality in Ukraine, Monitoring Report. 2021. https://ukrstat.gov.ua/druk/publicat/kat_e/2021/2021_GEIndicators-MonitoringReport_ENG.pdf

26 United Nations Ukraine. UN Policy Options: Gender-Based Violence. 2021. https://ukraine.un.org/sites/default/files/2021-11/UN%20Policy%20Paper%20on%20GBV_FINAL%20ENG.pdf

27 State Statistic Service of Ukraine 2021.

28 Ukrainian women's organizations report that action plans for localizing the national plan on SCR 1325 during the current conflict have proven ineffective in practice.

29 VOICE and HIAS, May 2022

Ukraine and the SDGs

The Ukrainian Government supports the 2030 Agenda for Sustainable Development. President Zelensky adopted a decree on the 17 SDGs in 2019, including SDG 5, which is focused on achieving gender equality and empowering women and girls. The targets for SDG 5 include:

- Eliminate all forms of violence against all women and girls in the public and private spheres, including trafficking and sexual and other types of exploitation.
- Ensure universal access to sexual and reproductive health and reproductive rights as agreed in accordance with the Programme of Action of the International Conference on Population and Development and the Beijing Platform for Action and the outcome documents of their review conferences.
- Recognize and value unpaid care and domestic work through the provision of public services, infrastructure and social protection policies and the promotion of shared responsibility within the household and the family as nationally appropriate.

Prevalence and response to VAWG

VAWG, including intimate partner violence and sexual violence, was widespread and increasing even before the conflict escalated in February 2022. The 2019 survey conducted by OSCE found that 75% of women in the country reported experiencing some form of violence since age 15,³¹ and one in three had experienced physical or sexual violence.³² The 2014 conflict led to increases in VAWG, especially for those displaced as a result of the fighting in eastern Ukraine, with internally displaced women and girls reported to experience three times higher rates of VAWG than those who were not displaced,³³ and 1 in 5 displaced

women reporting violence by armed men.³⁴ As in other global humanitarian settings around the world, these conflict-related human rights violations can have disastrous short- and long-term physical, reproductive and mental health and social consequences for survivors and their families.³⁵ As elsewhere, the COVID-19 pandemic contributed to an increase in domestic violence in Ukraine; calls to helplines grew by 50% in the conflict-affected Donetsk and Luhansk regions, and by 35% in other regions of Ukraine. However, administrative data does not reflect the magnitude of VAWG in Ukraine; for example, only an estimated 15% of all cases of domestic violence are ever actually reported. Underreporting is linked to "a culture of silence, a sense of impunity, lack of confidentiality, acceptance of intimate partner violence as a private matter, the belief in own coping abilities, the average higher social status of men, fear of repeated abuser aggression and of stigma and public condemnation discourage seeking for help".³⁶ In Ukraine, government- and NGO-delivered services for VAWG survivors were inadequate before the war. There was insufficient access to a core set of quality services provided by the government health care, social service, police, and justice sectors that should be available to secure the rights, safety and well-being of any woman or girl who experiences GBV. Key elements of a holistic and best-practice service system for responding to VAWG—which include comprehensive legal framework, governance, accountability and oversight, resources and financing, training and workforce development, monitoring and evaluation of the VAWG service system—were also lacking in Ukraine prior to the war.³⁷ For example, there was a lack of funded

of Internally Displaced and Local Women Receiving Psychosocial Services". *J Interpers Violence* 2021; 08862605211063009.

34 UNFPA. Gender-based violence in the conflict-affected regions. 2018. <https://ukraine.unfpa.org/en/publications/gender-based-violence-conflict-affected-regions>

35 Savona-Ventura, C, Mahmood, T, Mukhopadhyay, S, et al. "The consequences of armed conflict on the health of women and newborn and sexual reproductive health – A position statement by the European Board and College of Obstetrics and Gynaecology (EBCOG)". *European Journal of Obstetrics & Gynecology and Reproductive Biology* 2022; 274: 80–82.

36 United Nations Ukraine. UN Policy Options: Gender-Based Violence. 2021. https://ukraine.un.org/sites/default/files/2021-11/UN%20Policy%20Paper%20on%20GBV_FINAL%20ENG.pdf

37 See UN Women, UNFPA, WHO, UNDP and UNODC Essential Services for Women and Girls Subject to Violence Package for an overview of essential services to be provided by the health, social services, police and justice sectors as well as guidelines for the coordination and the governance of coordination processes and mechanisms to ensure the

30 <https://kyivindependent.com/national/ukraine-ratifies-istanbul-convention-11-years-after-signing-treaty-to-curb-gender-based-violence>

31 This includes intimate partner physical, sexual and psychological violence, non-partner sexual violence, sexual harassment and stalking. See OSCE 2019 for further information.

32 OSCE 2019

33 Capasso, A, Skipalska, H, Chakrabarti, U, et al. "Patterns of Gender-Based Violence in Conflict-Affected Ukraine: A Descriptive Analysis

domestic violence services and qualified practitioners to provide services for survivors and their children escaping violence. In some areas, neither services nor providers were available at all. Support services for victims of psychological and sexual violence are scarce. Women from minority groups, older women and disabled women are at a particular disadvantage.³⁸ Legal protections and remedies remain inadequate with a lack of qualified personnel, first responder and law enforcement training, and financial resources to conduct their role in implementing and monitoring GBV legal frameworks.³⁹ A lack of perpetrator accountability mechanisms combined with limited awareness among women and girls of their rights contributed to the lack of effective health and justice sector responses to GBV, a problem magnified in conflict-affected areas.

The process for survivors to access care, support, and assistance in Ukraine outside the government law enforcement and health systems varied from oblast to oblast, depending on the presence and capacity of local NGOs and women's organizations providing services. For example, in larger cities, shelters run by women's organizations offered some support and temporary housing. One organization, Light of Hope, in Poltava, was implementing a more comprehensive intimate partner violence (IPV) service, offering shelter, case management and legal and financial support to survivors living with HIV. However, those services were disrupted due to the war. Overall, however, there was no national approach to holistic, coordinated survivor support in line with good practice, such as case management.

The war has now placed an unprecedented strain on the health, justice, and social support systems in Ukraine, including NGO and community-based specialist GBV services.

SRH data and services

In Ukraine, SRH care, including maternal and newborn care, adolescent health, clinical and psychosocial services for survivors of GBV, access to contraception, and HIV and other sexually

transmitted disease prevention and treatment⁴⁰ are delivered through the centralized government-supported health system. Primary and secondary healthcare services are located in large urban areas and have robust referral networks, and more remote areas supported by community health clinics, midwives, and ancillary health staff. Overall, the health system in Ukraine is still functioning notwithstanding the humanitarian impact of the war. However, access to care has become significantly more challenging, especially for IDPs, even in areas without active combat, and nearly impossible—if not nonexistent—in occupied regions.

Data on access to SRH care in Ukraine is scarce. Under current law, women have a right to abortion up to 12 weeks into pregnancy under Ukrainian law.⁴¹ From 12–28 weeks, abortion is only legal due to medical reasons or sexual assault. Prior to the war, medical abortions were limited in availability, but recent discussions have taken place within the Ukrainian Ministry of Health to increase access.⁴² Social and religious barriers often impact women's ability to access SRH services⁴³ and news reports from 2020 indicate that anti-abortion activities were actively increasing

40 For more information on elements of SRH services in crisis situations see the Inter-Agency Working Group on Reproductive Health in Crisis (IAWG) resources, available at: <https://iawgfieldmanual.com/manual/misp#srh-primary-care>. In stable settings elements of comprehensive SRH care include [comprehensive sexuality education, family planning, pre-conception care, antenatal and safe delivery care, post-natal care, services to prevent sexually transmitted infections \(including HIV\), and services facilitating preventive screening, early diagnosis and treatment of reproductive health illnesses including breast and cervical cancer](#). For more information on comprehensive SRH see UNFPA. *Sexual and Reproductive Health and Rights: An essential element of universal health coverage*. https://www.unfpa.org/sites/default/files/pub-pdf/SRHR_an_essential_element_of_UHC_SupplementAndUniversalAccess_27-online.pdf

41 Part 6 of Article 281 of the Civil Code of Ukraine provides that artificial termination of pregnancy can be carried out at a woman's request when a woman is up to twelve weeks pregnant and in cases stipulated by law – up to twenty-two weeks pregnant. This provision is also stipulated by Article 50 of the Law of Ukraine "Fundamental Healthcare Legislation of Ukraine".

42 This is according to a Health sector representative interviewed for the assessment. Women's rights activists are reportedly concerned the opposite may in fact occur when the war ends and highlight a May 2022 petition to have abortion banned as an example of anti-abortion mobilization in Ukraine.

43 For further information the position of religious organizations in Ukraine on abortion and other SRH issues see Karpenko, k. and Guzhva, A. Attitudes of Major Religious Organizations in Ukraine to Abortion and Reproductive Medicine, George Fox University Occasional Papers on religion in Eastern Europe. 2022. <https://digitalcommons.georgefox.edu/cgi/viewcontent.cgi?article=2372&context=ree>

delivery of high-quality services, particularly for low- and middle-income countries, for women and girls experiencing violence, <https://www.unwomen.org/en/digital-library/publications/2015/12/essential-services-package-for-women-and-girls-subject-to-violence>.

38 OSCE 2019

39 United Nations Ukraine 2021

in Ukraine at that time.⁴⁴ Despite being legal, the accessibility of abortion for women in practice in Ukraine is unclear.

It is important to note that the medical culture surrounding obstetrical and gynecological care in Ukraine remains heavily influenced by Soviet-era practices, which includes a significant amount of obstetrical violence.⁴⁵ Documented types of obstetrical violence include forced abdominal pressure and thrusts during labor, and drug-induced expeditious labor, which increases the rates of unnecessary cesarean sections, vaginal tearing, and post birth complications. Additionally, partner presence during birth is still not widely accepted and often women are left unaccompanied to navigate the birth process on their own. Furthermore, the Ukrainian health system is still predominately male dominated, and especially in more rural areas, conservative viewpoints and social beliefs tend to impact providers' decision making and create barriers for women to access services that may be viewed as "personal women's issues."

44 <https://www.opendemocracy.net/en/5050/ukrainian-women-mis-led-abortion/>

45 <https://www.opendemocracy.net/en/odr/the-pains-and-perils-of-childbirth-in-ukraine/>

Section 2: **Findings**



2.1 Findings on availability and barriers to GBV service

Eight months into the response, there is still an incomplete picture of the type and location of services available for GBV survivors. In the assessed areas, the type and coverage of available GBV services remains unclear. Information collected through this assessment indicates GBV survivors are facing significant challenges in accessing care, support, and assistance to address the harmful consequences of the violence they experience. This is true for survivors of domestic violence and sexual violence. Several intersecting factors create these limitations, including:

- Gaps in services, referral pathways and dissemination of information about services and how to access them;
- Lack of an enabling environment and/or funding to support safe reporting and help-seeking after GBV, including supportive and helpful information and messaging, entry points and capacities for safe disclosure, support, and referral; and
- Institutional and community barriers, including community beliefs and norms surrounding GBV that influence attitudes and behaviors of service providers. Stigma, fear of revictimization and lack of awareness of services are major barriers to accessing care.

Some of the challenges identified are linked to pre-existing issues, such as beliefs, attitudes and social norms surrounding GBV, that manifest in the survivor experiencing stigmatization and poor coordination between services in some locations. As reported by one informant “there are

cases where police officers didn’t know what to do and where to go with the GBV survivor. Even when they had a properly working shelter in their city.” Without clear, confidential and safe options for disclosure and referral, survivors may see the risk of reporting as outweighing the value of any

support they may receive. Other challenges are linked to the conflict and humanitarian response, such as the competing priorities and needs of affected people, lack of visibility and attention to domestic violence, challenges associated with service delivery, and coordination between different stakeholders in a dynamic and insecure conflict setting. Further detail on the challenges identified are set out below.



GBV service provision is inconsistent and uneven. There is an incomplete picture of GBV service coverage, according to information collected during fieldwork. It is clear there are significant gaps in availability and accessibility of services required to ensure GBV survivors can meet their immediate—let alone longer-term—health, psychosocial, safety and other priority support needs. While certain services may be available in one location, they are absent in others. As reported by one person interviewed, “there are these Village Councils who are often, if not always, led by men who decide on the social services that are needed, and they always say, ‘we do not have domestic violence here, we don’t need that [social services for women and children].’ And as the Village Council head, he is personally responsible for the community.”

In addition to support services, this inconsistency of availability is also true for clinical management of rape and other SRH services (see section 2.2 for more specific information on availability of GBV-related and other SRH services). Case management and other information, advocacy, and coordination to assist survivors are notably limited.

The incomplete picture of what GBV services are available and functioning, in which locations, makes it very difficult to establish holistic and coordinated care for GBV survivors in line with good practice. This also impacts help-seeking. As noted by one informant, “if someone traumatized will try to reach out for help and fails – this person will never try to reach out for help again. That is the worst-case scenario, but it’s really possible in this context of such weak GBV infrastructure.”

While service provision is limited, the need for GBV services is growing. It is difficult to obtain a clear picture on the nature and scope of GBV occurring in areas assessed due to underreporting of GBV and a focus on war crimes perpetrated by Russian forces, specifically conflict-related sexual violence (CRSV). It is unclear if and how this emphasis on CRSV perpetrated by enemy combatants is impacting willingness of other GBV survivors (for example, survivors of other forms of sexual violence and survivors of domestic violence) to come forward, and influencing wider perceptions on GBV trends and incidence. Key informants reported there is a rise in incidence of domestic violence, as well as sexual violence in the locations assessed. They also advised that access to care, support and protection services is lagging well-behind this increase in incidence. It is important to recognize that it is always challenging to ascertain the nature and scope of GBV in emergency contexts and establishing prevalence is not feasible or appropriate in humanitarian situations where the priority is to ensure the availability of services to promote survivor’s health, safety, and rights, and implement strategies to mitigate GBV risks.

While remote services are available, survivors are not using them. Several key informants from local organizations shared that while organizations in Ukraine have hotlines, messenger applications and chat-boards available for GBV survivors, survivors are not using them. More information is needed to understand why survivors are not accessing remote support via phone or digital applications, particularly in the absence of, or difficulties accessing, face-to-face services.

Despite efforts by GBV sub-cluster actors, **there are currently no clear local-level referral pathways or protocols in place.** Not having in place agreed

referral pathways and protocols for making and receiving GBV referrals between relevant services (including between those delivered by local and national women's and other civil society organizations and those delivered by international humanitarian organizations), is making it challenging to ensure survivors can receive timely support in a trauma-informed manner to manage the consequences, needs, and risks associated with GBV. It also hinders interagency information-sharing and relationship building, which are important for establishing an effective collaborative and holistic response to GBV at the local level.

There is a lack of implementation of GBV interventions in line with good practice. Good practice in GBV in emergencies includes adapting critical minimum interventions to prevent and respond to GBV. These include mechanisms to enable survivors to safely disclose GBV if they choose and receive survivor-centered responses; establishing safe spaces for women and girls to facilitate appropriate psychosocial and other support; and taking proactive steps to reduce GBV risks and improve women and girls' safety and protection across humanitarian sectors and services. There are some investments in training of health personnel and police on trauma-informed response to GBV, and teachers and social workers are receiving training on how to respond to GBV disclosure safely and effectively. However, there are still no clear entry points for survivors to make safe disclosures, including for those who do not wish to report to police or receive medical care. As one head of a WRO providing GBV services reported, "we started getting calls from volunteers of other shelters because they were never trained and had no experience with GBV."



Women and girls do not have good information on how to access GBV services and this is a barrier to help-seeking. Key informants and participants in FGDs advised that women and girls do not currently have access to reliable information about where and how GBV survivors can safely and confidently access care, support, and assistance, nor do they have good information about the benefits of seeking help, such as how case management might support their safety and recovery. One person interviewed stated, "referral pathways, especially in newly liberated areas/territories, do not exist, and while dignity kits are being distributed, they do not include updated referral information to accompany." Another informant reported that while "stigma still exists, mainly it is that women do not know where they can get help." Even where there are no formal referral pathways established, it is vitally important that women and girls have access to accurate information about where and how they can seek help.

Another significant barrier facing GBV survivors accessing care and support is that service delivery for GBV survivors, particularly domestic violence, has been de-prioritized by service providers due to competing demands. As initially identified in an earlier assessment,⁴⁶ responding to GBV cases, especially domestic violence, has been deprioritized by some service providers, including police. As reported by the head of a WRO that provides GBV services, "from the side of the police, domestic violence has been completely deprioritized because the war started. Now there are new problems [because the domestic violence cases were not addressed]. The consequence is that the next time, she will not call." In another example, it was shared by key informants that shelters that had previously been operating as safe houses for domestic violence survivors and their children have been repurposed and are now being used as IDP collective centers to house IDPs, reducing the availability of safety services for women escaping violence. Even when it is known that a woman is a survivor of domestic violence and has been in a shelter prior to the war to protect herself and their children, now "they are not seen as survivors" and therefore their needs are deprioritized. GBV experts interviewed for this assessment also reported a reduction in government funding for GBV services, with resources directed towards the war effort.

46 See VOICE and HIAS, May 2022

Compounding this, **GBV needs are perceived by women and the broader community to be subservient to other needs**, and GBV survivors are therefore not seeking help to address their GBV-related needs because the country is at war. During the assessment, it was apparent that survivors 'do not have the option' to focus on the violent incident or experiences they have had, as there are just too many other 'more important' needs to contend with. There is such a high level and scope of need among war-affected people in Ukraine that women were reported to feel guilty about asking for assistance and resources to meet their own needs. It was apparent from both interviews and FGDs that there is a seemingly overwhelming desire and expectation among displaced women to show gratitude for the aid and support that they are receiving, and as such asking for anything more would feel inappropriate in the current context.



Attitudes and social norms surrounding GBV are a barrier to care and may contribute to revictimization of survivors. Many informants interviewed for this assessment expressed that there is significant underreporting of GBV related, in part, to high levels of stigma associated with sexual violence. Several key informants shared that there is still a great deal of prejudice and stigma associated with being a survivor of violence and that revictimization by both medical staff and police remains a deterrent to reporting. As stated by one informant from a local NGO, "people don't talk about sexual and gender-based violence, they are greatly afraid of stigmatization and revictimization by police or others. Many still believe that those who are raped or assaulted are to blame, and as a result survivors feel shame and are reticent to report."

Despite the incredibly difficult circumstances, women's organizations are working extremely hard to continue to support GBV survivors. Women's organizations continue to work to their full capacity, increasing and expanding their programming to provide services to new populations in need, including IDPs and other vulnerable groups. They are also having to rapidly learn to navigate international humanitarian response mechanisms and systems. Their 'business as usual' work is continuing, while at the same time they are also rapidly scaling up service delivery, engaging in new partnerships and creating new networks and referral pathways to ensure timely and quality services to their beneficiaries, the number of which is increasing.

2.2 Findings on availability and barriers to SRH care

Similar to services for GBV survivors, across assessed areas there are significant challenges facing women and girls in accessing SRH services, including clinical management of rape. As noted in other recent reports,⁴⁷ and confirmed through this assessment, military attacks on medical facilities and health care settings, as well as serious disruptions in health-system functioning, are key challenges. These and other findings are discussed below.

Availability of SRH services is severely impacted by the conflict. Significant logistical, financial, and social factors are influencing availability of healthcare, including SRH. The logistical, financial and security factors are a direct consequence of the war, while pre-existing social factors, including social norms and attitudes towards sexual violence, contraception, abortion, and other SRH issues, are also playing a critical role in shaping service delivery and service use.

The health system is not only experiencing a surge in demand due to war-related injuries and mental health needs, but also reduced budgets, impaired access to essential supplies, and staffing challenges, as doctors relocate away from areas under attack. In areas where the army is

47 Regional Gender Task Force. Making the Invisible Visible. An evidence-based analysis of gender in the regional response to the war in Ukraine. October 2022, https://reproductiverights.org/wp-content/uploads/2022/10/RGTF_MakingTheInvisibleVisible_ENG.pdf



conducting combat operations, the local hospital is often commandeered to provide trauma services to wounded civilians and soldiers. According to one informant, patients with other health needs are often required to travel “an hour or more” on damaged or destroyed roads or in areas that still may have high levels of unexploded ordnance to access healthcare. In such a context, women participating in FGDs reported limiting their SRH service usage out of necessity.

Ukraine has in place a national guideline for clinical management of rape, however, **multiple factors – some pre-existing and others conflict-related – are limiting the availability of comprehensive post rape care in line with best practice.** This is making it extremely challenging for rape survivors to receive appropriate survivor-centred post-rape medical care and treatment within the public system. These factors include availability, competence, and attitudes of healthcare providers; treatment and referral protocols and processes that are not aligned with best practices; and recently implemented health reforms stipulating that require patients receive referrals from a care coordinator for specialized care, which creates an

added layer of complexity. Within the public health system, attitudes that view post-rape care as a legal matter and not a medical one, also create a barrier. Survivors are therefore not automatically offered medical care, creating a perception that care is not available.

Particularly in rural areas, the new health reforms have created significant challenges for regional health coordinators who state that finding primary care providers to come into the area has been more challenging than ever, as many healthcare providers relocated to larger cities that offer more opportunities for work and protection. If the sole healthcare provider in an area is private, poorer residents who rely on farming and low-income jobs to support their families are not able to access care. Even when costs are low, this additional expense is likely to be unaffordable for most. The only alternative is to commute to a larger city where a government provider exists who could provide post-rape care. Due to the lack of access to clinical management of rape services within the public health system, informants reported that NGOs supporting GBV survivors have contact lists of private gynecologists who are willing to treat

survivors of sexual assault. However, as in any privatized system, this is a fee-based service and not universally affordable.

In some areas, humanitarian organisations are supplementing government health service delivery to affected populations by offering mobile outreach clinics. No one interviewed for this assessment was able to clarify whether these outreach services include clinical management of rape services or what referral mechanisms are in place to ensure that survivors receive referral for appropriate care or follow-up services.

The level of access for treatment and prevention of HIV and other STIs reportedly varies by region. As there is no routine surveillance data available tracking STI services, it is difficult to report where services are and are not available. STI testing and treatment is not used as a prophylactic or preventative measure. It is only conducted if a patient presents with symptoms, or the individual specifically requests it. While a few organizations provide HIV testing and treatment, their scope generally does not cover other STIs such as syphilis, gonorrhoea, or chlamydia, and their ability to offer testing and resources has been significantly limited by the war. Additionally, there is a need for evidence-based recommendations to be widely and easily accessible for clinicians throughout Ukraine to ensure that treatment for STIs is conducted with known and evolving drug resistance patterns. Given that Ukraine now faces significant shortages of antibiotics, training and expertise should be widely and easily available to convey a 'good, better, best' approach when selecting appropriate treatment.

For newborn and maternal mortality, existing obstetric and gynaecological services in many areas of the country remain unaffected by the



war, while other areas experience extreme shortages of supplies and trained personnel. It is difficult to provide specific details on the supply and personnel shortages in particular areas as supply issues fluctuate. For example, at one point, Poltava lacked the necessary medications for treating premature newborns. However, one month later, the drugs were available and then again in short supply. It is critical to note that within Ukraine, there is currently only one neonatal critical care transport for preterm infants who require transportation to another facility. Metrics related to critical care transport are tracked and monitored by the Ministry of Health (MOH) but given the increase in attention to meeting war-related healthcare needs, the status of reporting on these statistics is unclear.

Like other components of SRH care, access to contraception is also dependent on location.

According to health worker interviewed, in urban areas, accessing contraception is relatively easy, while in rural areas, which tend to be more conservative, accessibility and acceptability of contraception is reported to be relatively low. Health providers interviewed reported accessing contraception in rural areas is a challenge, because providers in those areas tend to be more conservative, with one informant advising that providers don't want to deal with "sensitive women's issues." Before the war, women in rural areas were able to travel to urban areas to access contraception services, however this is now significantly more difficult due to fuel and money shortages, damaged roads, curfews, and insecurity. As noted earlier, women in Ukraine are not attending to their own health needs, and this includes contraception.

Ukraine had programs to address unintended pregnancies, including abortive services, however, in the current context, accessing these services is problematic. Abortion in Ukraine is legal within the first twelve weeks of pregnancy and typically is provided either by medication (misoprostol/mifepristone) or via vacuum assisted. Within Ukraine, abortion after 12 weeks is available in certain situations, however a major complication in the current healthcare state is that generally, after 16 weeks, a surgical abortion is required. This surgical procedure requires the same anaesthesia, operating room and sterile processing services that are required of larger surgeries, which is likely

to be unavailable or have significantly longer wait times given the increase in demand for surgical services throughout Ukraine because of the war. Additionally, as similar with clinical management of rape, it is reported that access is significantly limited to a select few providers who are willing to perform these services.

Even where clinical management of rape and SRH services are available, other factors are limiting access and use of these services. As noted above, **in areas assessed outside major urban centers patients needing clinical management of rape and other SRH care must travel long distances and endure long wait times, posing a significant barrier to sexual assault survivors and other women and girls needing SRH services.** Access to reliable transport, costs of transport and accommodation are inhibiting access to post-rape and other SRH services. Fuel shortages are endemic, and prices are skyrocketing as winter sets in; one assessment found that fuel was a top concern in 99% of surveyed regions.⁴⁸ While prior to the war it may have been possible to make the journey in a single day, road closures, checkpoints, damage to roads/bridges, ongoing fighting, rocket attacks and curfews all present challenges to local communities who need to commute for care.

Provider and community attitudes and social norms are a critical determinant of healthcare for sexual violence survivors. As in many parts of the world, health provider and community beliefs, attitudes and norms surrounding sexual violence impact service providers' willingness and capacity to discuss the topic with patients and provide survivor-centered care. During the assessment, all clinicians interviewed, including those trained in obstetrics and gynecological care, were uncomfortable discussing how to treat rape survivors. It was expressed that this type of care would best be handled by "someone else" with a more appropriate skill set and/or experience and that this is "not the job of our facility" and that patients would need to be seen elsewhere. A hospital administrator indicated that additional training was needed and that all providers should be capable of referring a patient for clinical care post-sexual assault.

The same harmful attitudes and norms also impact patients' willingness to disclose and seek services. Another informant reported that the hospital she works in as a doctor has seen hundreds of sexual violence survivors in recent months, yet survivors are not accessing post-assault assistance due to stigma surrounding sexual violence. This particular hospital can refer identified survivors to mental health and psychosocial support services (MHPSS), but survivors are reportedly declining services and expressing that they just want to "move on." The need to "break the silence" was highlighted by one informant, who went on to further explain that there is a need to transform harmful norms and stereotypes and that this goes beyond the war, and the stigma around VAWG is continuing to silence them.

2.3 Issues impacting women and girls' health, safety and protection

The assessment identified several other key issues concerning women and girls' safety, protection and well-being linked to the conflict and to the humanitarian response.

Lack of GBV risk mitigation across sectors is increasing protection concerns for women and girls.⁴⁹ The informal nature of aspects of the humanitarian response to the conflict, characterized by a non-humanitarian trained workforce and a volunteer-driven response, may inadvertently lead to GBV risks and impact women and girls' safety

49 GBV risk mitigation comprises a range of activities within humanitarian response that aim to first identify GBV risks and then take specific actions to reduce those risks. GBV-related risks can exist in the general environment, within families and communities, and in humanitarian service provision. In practical terms, GBV risk mitigation means taking actions to 1) Avoid causing or increasing the risk of GBV associated with humanitarian programming; 2) Facilitate and monitor vulnerable populations' safe access to and use of humanitarian services; 3) Identify and actively reduce the risks of GBV in the environment and programming/service delivery. The key global tool for supporting the integration of GBV risk mitigation actions in humanitarian programming is the 2015 Inter-agency Standing Committee (IASC) Guidelines for Integrating Gender-based Violence Interventions in Humanitarian Action (the "GBV Guidelines"). The purpose of the GBV Guidelines is to assist humanitarian actors and communities affected by armed conflict, natural disasters and other humanitarian emergencies to coordinate, plan, implement, monitor and evaluate essential actions for the prevention and mitigation of gender-based violence (GBV) across all sectors of humanitarian response. The Guidelines provide sector-specific recommendations for integrating GBV risk mitigation across each element of the program cycle.

48 REACH. "Ukraine: Humanitarian Situation Monitoring July 2022", <https://reliefweb.int/report/ukraine/ukraine-humanitarian-situation-monitoring-july-2022-enuk>

and protection. For example, the provision of shelter services for IDPs across Ukraine is mostly informal, staffed by volunteers and/or run by non-humanitarian trained professionals. As a result, these shelter services may potentially create protection issues for women and girls if they are not designed and delivered in line with good practice in GBV risk mitigation. This concern was raised by IDP women, experienced Ukrainian GBV workers, as well as by staff of INGOs and UN Cluster Coordinators. Both local and international NGO informants reported that shelter staff are not trained on protection risks, including sexual exploitation and abuse (SEA) and other forms of GBV, and as such are not equipped to provide information on or implement risk mitigation strategies, set up women and girls safe spaces where needed, implement safe and confidential case identification, or refer GBV cases and women and girls in need of SRH care.

Access to safe shelter remains a major concern of IDP women. Most of the focus group participants shared that they had been displaced multiple times, either since the start of the full-scale invasion in February 2022 or since 2014, and almost all women expressed concern about the shelters they passed through, especially those accommodating both men and women, with women reporting feeling very unsafe in mixed sex shelters. It was also shared by several key informants that there is no training on safe identification of survivors or referrals of survivors at IDP reception centers. While the focus in this assessment was not on shelter services, a lack of awareness of GBV and the importance of GBV risk mitigation across sectors will undoubtedly increase safety and protection risks for women and girls throughout different aspects of humanitarian assistance and services.

Women in Ukraine are currently experiencing elevated rates of violence, and the conflict will continue to significantly impact VAWG in Ukraine in the coming months and years. As has been the experience in Ukraine in the past and in other conflicts around the world, VAWG is likely to be exacerbated even after the war ends.⁵⁰

50 UNOHCHR. Women's human rights and gender-related concerns in situations of conflict and instability, <https://www.ohchr.org/en/women/womens-human-rights-and-gender-related-concerns-situations-conflict-and-instability>. For example, in Ukraine, domestic violence rates increased among women whose partners had fought in the 2014–2015 conflict. [For example, for women whose partners fought in previous conflicts in Ukraine were more

For example, in Ukraine, domestic violence rates increased among women whose partners had fought in the 2014–2015 conflict.⁵¹

There are concerns regarding the impact of the proliferation of small arms and normalization of violence on rates of VAWG in the short and long term. Several key informants shared that they are concerned about the long-term impacts of the war on the nature and scope of VAWG into the future, with a leader of a women's rights organization stating "when it comes to women and the violence they face...I am most worried about small arms, mental health and domestic violence...". Another Ukrainian women's rights and health expert reported that "domestic violence will be more widespread and it's likely we will see more aggressive forms of violence. We do not know what is happening now [in regards to DV and women, during displacement and as the war continues]."

Women face an increased care burden as caregivers of injured and disabled family members which will profoundly impact their health and well-being. Since February 2022, there have been nearly 9,000 documented injuries as a result of the war.⁵² War-related injuries are often catastrophic

likely (79%) to say they have experienced all forms of current partner violence than those whose current partner has not fought in an armed conflict (58%). Four in five women whose partners have fought in a previous armed conflict say they have experienced psychological violence, compared with 58% of those whose partners have not fought in an armed conflict. Lifetime current partner physical violence is indicated more than twice as often by those women whose partners have fought in an armed conflict (29%) than by those whose partners have not (13%). A similar pattern can be seen in regard to current partner sexual violence, where three times as many women whose current partners have fought in an armed conflict say they have experienced sexual violence at the hands of their partner (12%) compared to women whose partners have not fought in an armed conflict (4%), see OSCE 2019 for further detail.]

51 For example, for women whose partners fought in previous conflicts in Ukraine were more likely (79%) to say they have experienced all forms of current partner violence than those whose current partner has not fought in an armed conflict (58%). Four in five women whose partners have fought in a previous armed conflict say they have experienced psychological violence, compared with 58% of those whose partners have not fought in an armed conflict. Lifetime current partner physical violence is indicated more than twice as often by those women whose partners have fought in an armed conflict (29%) than by those whose partners have not (13%). A similar pattern can be seen in regard to current partner sexual violence, where three times as many women whose current partners have fought in an armed conflict say they have experienced sexual violence at the hands of their partner (12%) compared to women whose partners have not fought in an armed conflict (4%), see OSCE 2019 for further detail.

52 UNOHCHR. Ukraine Civilian Casualty Update, 26 September 2022, <https://www.ohchr.org/en/news/2022/09/ukraine-civilian-casualty-update-26-september-2022>

and include shrapnel injuries, burns and limb injuries that often require amputation, not to mention the psychological impact. This is particularly true for young soldiers on the front lines at increased risk of blast injuries and gunshot wounds. While the number of these injuries in Ukraine is new, what remains constant is that women will be expected to be caregivers and to shoulder the physical, emotional, psychological, and financial burden of caring for injured, disabled, and traumatized family members in the short and long-term.

These increased care responsibilities are likely to lead to decreased social mobility for female caregivers, limiting their earning capacity and ability to financially support themselves, those they are caring for and other family members. Women caregivers may find themselves unprepared to deliver the complex physical and psychological care often required by war-wounded individuals. This can, in turn, lead to physical and psychological harm to the carer. This care burden is anticipated to be a heavy responsibility for women. Caregiving for family members suffering the physical and psychological impacts of war is commonly a full-time job requiring specialist training and support, which are currently not available. While the Health Cluster has established a Trauma and Rehabilitation Technical Working Group to focus on rehabilitation needs of the war wounded, a country wide unified system does not yet exist. Moving forward, it will be critical that the centralized rehabilitation system is adequately supported, staffed, and funded over the coming months and years to reduce the care burden that will fall to wives, mothers, and other female family members.

Insufficient attention is being given to particularly vulnerable groups of women and girls.

There are groups of women and girls that experience higher levels of disadvantage, discrimination and/or marginalization. This includes elderly women left behind and living in homes that have been destroyed or damaged due to fighting in now-liberated cities. It also includes single mothers and women with less access to financial resources, Roma women and girls, women and girls with disabilities, and those living in rural, occupied or frontline areas.

While there are many Ukrainian organizations dedicated to working with vulnerable groups, they are

likely to be overwhelmed and under-resourced. It will be critical moving forward that humanitarian actors direct attention and resources towards ensuring the needs and experiences of these groups are made visible and that measures put in place to reduce their vulnerability and risk, including risk of GBV, and ensure their access to humanitarian services.

Humanitarian responders are not consulting with women and girls or centering their needs. It was apparent during the assessment that women and girls are not being routinely consulted—or even consulted at all—in the process of designing humanitarian services and the delivery of aid. This is relevant across sectors, from shelter services to NFI distributions and cash interventions. Even where women and girls are being included in assessments, it appears data is not adequately disaggregated by gender to enable informed decision-making about the provision of aid. As this was a rapid assessment, this issue was not explored in detail, and further attention should be given to understanding the extent of the problem and rectifying it.

Women's rights organizations are at the heart of the humanitarian response and must be better recognized and supported.









The humanitarian response is largely government-led, but most of the effort on the ground has been shouldered by CSOs and grassroots organizations, including WROs. As of October 2022, INGOs have not provided much direct assistance to IDPs due to the safety risk to staff, and inability to establish operations in a new context where they were not legally registered before the full-scale invasion. INGOs to date have mostly been unable to access the most affected areas due to active fighting, mines, and risk analyses that deem the security risks too high to deploy staff. Most INGOs had either left the country entirely or had relocated to western Ukraine, mostly congregated in Lviv. Through this process of INGO withdrawal, the burden of delivering aid and services has fallen to Ukrainian CSOs, volunteers, and everyday Ukrainian citizens. They continue carrying out the delivery of humanitarian aid throughout all regions of the country. Already vulnerable in a warzone, Ukrainian aid workers live in fear of cyber and physical threats, specifically in the eastern regions of Ukraine.

While the burden of service provision has fallen to local groups, they often lack resources, visibility, and capacity. In becoming frontline humanitarian responders, WROs are either pulled away from their core mission to instead work with IDPs, or they are straining to do both jobs at once. The majority are engaged in shelter and distribution of hygiene kits, food, clothing, and other basic necessities. They are also engaged in both advocacy and strategic activities as they respond to the humanitarian crisis and face daily danger to their lives in that work. Their work includes educating the judicial system on working with sexual violence survivors; psychological counseling for IDPs; adolescent girls' protection and empowerment; legal assistance to IDPs; employment services; campaigns against VAWG, including IPV, and LGBTQI+ rights; among others. Despite their experience and work across a wide range of issues economic empowerment, advocacy, housing, VAWG, women's rights etc., they are rarely being included in humanitarian decision-making, coordination and coordination with duty-bearers.

There have been a lot of assessments, but not enough shifting of resources and decision-making to local actors in line with localization commitments. Money is not the issue across the Ukraine response; however, Ukrainian NGOs are bearing the brunt of direct service provision but are not being provided with the resources and support they need. INGOs processes are slow and bureaucratic, and while some local NGOs have funds, they are not receiving other types of support they need such as timely advice on budget realignment processes and approval to be able to respond in a dynamic environment to changing needs. The short-term nature and restrictions on funding to local NGOs, which are often only for grants of 2-3 months, makes it incredibly difficult for local organizations to plan ahead, work sustainably and procure particular items to enable them to function, such as generators. In addition to lack of empowerment of local actors in programming, there is currently inadequate meaningful participation, engagement and shared decision-making in humanitarian coordination architecture and systems.

Section 2: **Recommendations**

As the purpose of this assessment was to inform HIAS and VOICE programming, the recommendations below (recommendations 1 - 5) are primarily intended to support the design and implementation of strategies within HIAS and VOICE GBV programming. Recognizing that responding to GBV is a shared responsibility across sectors and clusters, the recommendations are also intended to support HIAS and VOICE advocacy efforts to encourage other humanitarian stakeholders to invest attention and resources in these areas. The final two recommendations are aimed at all humanitarian actors and duty-bearers to foster greater attention to centering and empowering local actors in the immediate response and in longer term peace and recovery efforts. While the recommendations are relevant to all areas assessed, access to services is lowest in rural areas, occupied territories, and areas close to occupied territories, and there is therefore a pressing need to prioritize humanitarian response and scale up support to local actors in these locations.

ICON KEY			
 <p>United Nations (UN) Entities</p>	 <p>European Union (EU)</p>	 <p>Host Country Governments</p>	 <p>Government of Ukraine</p>
 <p>Feminist Philanthropy/ Feminist Funds</p>	 <p>Member State Donors</p>	 <p>LNGO (Local Non Governmental Organization)</p>	 <p>INGO (International Non Governmental Organization)</p>

- Resource and support local WROs to lead in interagency coordination efforts, including leading adaptation and implementation of referral pathways for GBV survivors at the local level.** Local and national women’s organizations were doing the work before the war, are frontline humanitarian responders and will continue to deliver, care, support, and assistance for GBV survivors when the war ends. It is the responsibility of international humanitarian actors to build on and support local actors and systems.



- 2. Facilitate the scale-up and outreach of survivor-centered services to meet the health, psychosocial, safety and legal needs of GBV survivors.** Focus on funding and capacity support to local organizations to establish entry points for safe disclosure, provision of information, referral and coordinated care, support, and assistance. Explore feasibility of different service delivery models to ensure accessibility issues can be addressed to reach survivors in different geographical locations and those marginalized through other circumstances. Explore the reasons why local hotlines are not being utilized and identify strategies to address those reasons. Provide sustained funding and other support to local organizations to deliver services.



- 3. Work with local women's organizations to develop targeted information campaigns so that women and girls in all their diversity know where they can safely and confidentially seek information about GBV and support in the current context.** Messaging should include a focus on the benefits of care.



- 4. Invest in developing longer-term multipronged communication strategies to address stigma, help raise awareness about GBV within the community and build demand for services.** Multipronged communication strategies should be developed and implemented by local organizations, drawing on good practice in communications to shift harmful beliefs, attitudes and social norms surrounding gender and GBV.



- 5. Strengthen health systems response to GBV.** Coordinate with Health Cluster actors to identify and address training needs of health workers on clinical management of rape. Ensure the training, in line with good practice, builds survivor-centered attitudes and behaviors; survivors cannot be expected to reach out for medical care post-assault when clinicians have a negative attitude toward survivors, or are resistant to treating them. Until survivor-centered health care is in place, resource local WROs and others providing GBV case management ser-



vices to accompany rape survivors who wish to obtain medical care to health services to provide them with support and advocacy during the process. Support mobile health teams that offer a full complement of care, including SRH and clinical management of rape. These teams need to offer consistent, reliable care that can help offset the burden on the Ukrainian health system and help prevent unnecessary hospitalizations. Community outreach programs will be essential in seeking out rural and remote communities who are often hesitant, or even just unable, to travel even short distances to receive preventative care. Implement widespread community advocacy and awareness campaigns to help reduce stigma, encourage accepting attitudes and help create the social awareness needed to support access to clinical care and support. Support WROs to participate in health-systems strengthening, including advocacy on policy and practice reform. For example, facilitate a WRO led-review of clinical management of rape guidelines and practices and advocacy for survivor-centered practices so that patients experiencing sexual trauma can access accurate information and survivor-centered care through a transparent and clear process.

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- 6. Support local frontline humanitarian actors to implement minimum GBV interventions in line with good practice standards.** Partner with and fund WROs to implement GBV-specialized interventions, including safe spaces, safety audits, mobile services, etc. At the same time, strengthen capacity for integration of GBV risk mitigation across humanitarian programming and sectors to improve women and girls' rights, safety, and protection.



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- 7. Fulfill commitments to localization by shifting power to WROs.** Localization became a formal part of the mainstream humanitarian reform agenda through its inclusion in the 2016 Grand Bargain, a major reform agreement between humanitarian actors. The localization agenda is focused on increasing local actors' access to international humanitarian funding, partnerships, coordination spaces, and capacity



building. Localization is one key to upholding the rights of women and girls in emergencies, as local women's responses are often more relevant and effective than external ones.⁵³

8. Center and resource WROs in recovery and peacebuilding. Learn from experience and act now to center women's needs and rights in recovery, peace and post-conflict reconstruction efforts. WROs need the space and resources to think about and inform recovery and reconstruction efforts, including how to build Ukraine back with the rights of women and girls at the center. If the focus is only on immediate humanitarian response and women's organizations are pulled away from their core business and not properly funded, women's rights will be deprioritized as yet another cost of the war. WROs need to think about and engage in both the peace process as well as reconstruction—linking to the nexus work. At present they are responding to the emergency and sidelined from these processes, or they simply do not have the space to engage.



53 Robillard, Sabina, et al. Localization: A Landscape Report. Feinstein International Center Publication, Tufts University, December 2021. <https://fic.tufts.edu/publication-item/localization-a-landscape-report/>.

Conclusion

This assessment identified that in Ukraine, as is common in humanitarian situations, pre-existing issues of GBV impacting women and girls' safety, dignity and well-being are compounded by the conflict, with the war exposing women and girls to even greater GBV-related risks and threats and disrupting services and responses for survivors. Information collected through this assessment indicates GBV survivors are facing significant challenges in accessing care, support, and assistance to address the harmful consequences of the violence they experience. Like broader services for GBV survivors, there are significant challenges facing women and girls in accessing SRH services, including clinical management of rape, in assessed areas. These challenges are linked to several intersecting factors, including lack of availability of services and referral; lack of helpful information and messaging about entry points and capacities for safe disclosure, support, and referral; and institutional and community barriers, including community beliefs and norms surrounding GBV that influence attitudes and behaviors of service providers. Some of the challenges identified are linked to pre-existing issues, such as beliefs, attitudes and social norms surrounding GBV.

Other challenges are linked to the conflict and humanitarian response, such as inadequate coordination with local actors and organizations in a dynamic and insecure conflict setting. Given the increase in GBV and pre-existing reluctance to report, there is a critical need to establish a minimum set of GBV interventions in line with minimum standards. This includes supporting non-GBV programs and services to implement good practice to promote women and girls' safety and enable safe and effective responses to disclosure, including through the many shelter locations where IDP women and girls are living.

While a consequence of the extremely challenging context, it will be vital moving forward to ensure full and meaningful engagement of all relevant actors providing GBV services in the development and implementation of shared systems and processes for referring and supporting GBV survivors in line with survivor-centered principles and practices. Further, while attention must be given to GBV mitigation and response measures to protect and support women and girls in the current context, attention and resources must also be directed towards addressing risk factors for violence post-conflict.

The assessment identified several other priority issues concerning women and girls' safety, protection and well-being, linked to the conflict and to the humanitarian response that need to be addressed by the wider humanitarian community. These include the need to give greater attention to particularly vulnerable groups of women and girls, ensure meaningful participation of women and girls across all aspects of humanitarian action to better address and center their needs and rights, and better recognize and support the work and role of women's organizations in the response. This will require humanitarian stakeholders to 'walk the talk' and start shifting of resources and decision-making to local actors in line with localization commitments.



AMPLIFYING WOMEN AND GIRLS IN CRISES
voice

HIAS
Welcome the stranger.
Protect the refugee.