Gender-based violence

Women fleeing the war:

Access to sexual and reproductive healthcare in the EU under the Temporary Protection Directive

European Institute
for Gender Equality

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Country Codes

BE	Belgium
BG	Bulgaria
CZ	Czechia
DK	Denmark
DE	Germany
EE	Estonia
IE	Ireland
EL	Greece
ES	Spain
FR	France
HR	Croatia
IT	Italy
CY	Cyprus
LV	Latvia
LT	Lithuania
LU	Luxembourg
HU	Hungary
MT	Malta
NL	Netherlands
AT	Austria
PL	Poland
PT	Portugal
RO	Romania
SI	Slovenia
SK	Slovakia
FI	Finland
SE	Sweden

Abbreviations

CEDAW	Committee on the Elimination of Discrimination against Women
CRSV	conflict-related sexual violence
EU	European Union
IASC	Inter-Agency Standing Committee
ICTY	International Criminal Tribunal for the former Yugoslavia
ICTR	International Criminal Tribunal for Rwanda
ICCPR	International Convention on Civil and Political Rights
ICPD	International Conference on Population and Development
IHL	international humanitarian law
NGO	non-governmental organisation
OHCHR	Office of the High Commissioner for Human Rights
PEP	post-exposure prophylaxis
SRH	sexual and reproductive healthcare
STI	sexually transmitted infection
TPD	Council Directive 2001/55/EC of 20 July 2001 on minimum standards for giving temporary protection in the event of a mass influx of displaced persons and on measures promoting a balance of efforts between Member States in receiving such persons and bearing the consequences thereof (temporary protection directive)
UNCAT	United Nations Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment
WPS	women, peace and security agenda
WHO	World Health Organization

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Glossary

Accessibility of healthcare services: aspects of health services or health facilities that enhance the ability of people to reach a health professional, in terms of location, time and ease of approach (WHO, 2019).

Asylum seeker: a non-EU country national or stateless person who has made an application for protection under the Geneva Convention relating to the Status of Refugees of 28 July 1951, as amended by the New York Protocol of 31 January 1967, in respect of which a final decision has not yet been taken. In the context of the EU, this term is often understood as a synonym of 'applicant for international protection' (European Commission, 2023).

Conflict-related sexual violence: rape, sexual slavery, forced prostitution, forced pregnancy, forced abortion, forced sterilisation, forced marriage, trafficking in persons when committed in situations of conflict for the purpose of sexual violence/exploitation and any other form of sexual violence of comparable gravity perpetrated against women, men, girls or boys that is directly or indirectly linked to a conflict (UN, 2022).

Discrimination against women: any distinction, exclusion or restriction made on the basis of sex and gender that has the effect or purpose of impairing or nullifying the recognition, enjoyment or exercise by women, irrespective of their marital status, and on a basis of equality between women and men, of human rights and fundamental freedoms in the political, economic, social, cultural, civil or any other field (Committee on the Elimination of Discrimination Against Women, 2010).

Emergency contraception: methods of contraception that can be used to prevent pregnancy following unprotected sexual intercourse. In cases of rape, emergency contraception is advised to be administered as soon as possible, up to 5 days after the forced sexual intercourse (WHO, 2014).

Gender-based violence against women: violence that is directed against a woman because she is a woman or that affects women disproportionately (Council of Europe, 2011).

International protection: the protection that is accorded by the international community to individuals or groups who are outside their own country and are unable to return home because their return would infringe upon the principle of *non-refoulement*, and their country is unable or unwilling to protect them (Directive 2011/95/EU (recast qualification directive)).

Obstetric gynaecological care: a branch of medicine that specialises in the care of women during pregnancy, childbirth and in the diagnosis and treatment of diseases of the female reproductive organs.

Refugee: a person 'who is unable or unwilling to return to their country of origin owing to a well-founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group, or political opinion' (Geneva Convention relating to the Status of Refugees of 28 July 1951, as amended by the New York Protocol of 31 January 1967). In the EU, this term may be applicable to non-EU country nationals or stateless persons, in accordance with relevant provisions of Directive 2011/95/EU (recast qualification directive).

Reproductive health: a state of complete physical, mental and social well-being, not merely the absence of disease or infirmity, in all matters relating to the reproductive system and to its functions and processes (UN, 1995).

Safe abortion and post-abortion care: procedure of pregnancy termination that is appropriate to the gestational age and carried out under the care of a qualified abortion provider in an environment that conforms to minimal medical standards in line with the guidelines recommended by the World Health Organization (WHO, 2021).

Post-abortion care involves the provision of services, clinical examinations, treatment and care following an abortion procedure, such as emergency treatment for complications related to abortions (WHO, 2022a).

Sexual health: a state of physical, emotional, mental and social well-being in relation to sexuality; it is not merely the absence of disease, dysfunction or infirmity. Sexual health requires a positive and respectful approach to sexuality and sexual relationships, along with the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination and violence. For sexual health to be attained and maintained, the sexual rights of all persons must be respected, protected and fulfilled (WHO, 2006). Sexual health is a necessary condition for the achievement of reproductive health (WHO, 2010).

Sexually transmitted infections (also called '**sexually transmitted diseases**'): infections spread predominantly by unprotected sexual contact. They can also be transmitted during pregnancy, childbirth, breastfeeding and through infected blood or blood products (WHO, 2022a).

Sexual violence: any sexual act performed on the victim without consent (European Institute for Gender Equality (EIGE), 2017).

Short-term and long-term psychological counselling: psychological health services whereby a counselling psychologist supports individuals in understanding their psychological difficulties in order to reduce psychological distress and promote well-being. Support should be provided to victims from the earliest possible moment after the assault, irrespective of whether it was reported, and may be required for an appropriate period thereafter, depending on the victim's individual needs (European Commission, 2013).

Temporary protection: a procedure of exceptional nature to provide, in the event of a mass influx or imminent mass influx of displaced persons from non-EU countries who are unable to return to their country of origin, immediate and temporary protection to such persons, in particular if there is also a risk that the asylum system will be unable to process this influx without adverse effects for its efficient operation, in the interests of the persons concerned and other persons requesting protection (temporary protection directive (Directive 2001/55/EC)).

Undocumented migrant: a person who does not fulfil the requirements established by the country of destination to enter, stay or exercise an economic activity (UN, 1994).

Victim: 'a natural person who has suffered harm, including physical, mental or emotional harm or economic loss which was directly caused by a criminal offence; and family members of a person whose death was directly caused by a criminal offence and who have suffered harm as a result of that person's death' pursuant to the victims' rights directive, which establishes minimum standards on the rights, support and protection of victims of crime in the EU (victims' rights directive (2012/29/EU)).

Executive summary

This report presents the findings of a study launched following Russia's war of aggression against Ukraine on 24 February 2022, which led to a displacement of an unprecedented scale and forced over 8 million people – mostly women and children – to flee Ukraine and seek refuge and protection across Europe (United Nations High Commissioner for Refugees (UNHCR) data, as of 9 May 2023).

The overarching objective of this report is to assess the availability of specialised services available in the European Union for victims of conflict-related sexual violence (CRSV). More specifically, the report aims to identify gaps in the provision of sexual and reproductive health (SRH) services and offers recommendations to ensure that victims of CRSV enjoy immediate access to them.

Invoked for the first time on 4 March 2022, in response to Russia's unprovoked invasion of Ukraine, the temporary protection directive (TPD) sets minimum standards for Member States regarding the provision of necessary medical assistance to victims of sexual violence. In this report, the accessibility, availability, acceptability and quality of six specialised healthcare services that play a key role in the clinical management of sexual violence are assessed. The six services reviewed include emergency contraception; sexually transmitted infection (STI) prevention and treatment; obstetric and gynaecological care; short- and long-term psychological counselling; and safe abortion and post-abortion care.

This three-phase study comprised desk research, an EU-wide questionnaire completed by 26 experts representing EU Member States and 12 follow-up interviews with representatives of relevant NGOs and public bodies conducted in four of the Member States: Czechia, Germany, Poland and Slovakia.

The first phase served to gather an overview of relevant international and EU legal and policy instruments on CRSV and sexual and reproductive rights. The EU-wide questionnaire was used to explore Member States' provision of sexual and reproductive health services. Interviews in the four Member States aimed to complement and further explore the findings of the questionnaire.

Key findings

EU Member States reacted swiftly to the Council of the European Union's decision to trigger the TPD. However, a lack of clarity on the scope of the necessary healthcare services in the directive created ambiguity regarding the extent of service provision in Member States.

- EU Member States introduced specific legal and policy instruments to regulate access to healthcare services for persons under temporary protection. However, due to the diverse interpretations of the directive and a variety of national frameworks, not all Member States granted access to all the SRH services analysed in this study. Consequently, the provision of services for women and girls under temporary protection varies across Member States.

Legal requirements on parental consent mark a significant barrier preventing minors' access to SRH services.

- In several Member States, minors are legally required to present parental consent to access all the specialised SRH services analysed in this study. This can delay the provision of time-sensitive services and prevent unaccompanied minors from seeking help.

Language barriers, cost of services, geographical distribution of facilities, and long waiting times restrict access to SRH services for women and girls under temporary protection. Restrictive legislation on SHR services further hinders access to services required by victims of sexual violence.

- In 13 Member States, only selected SRH services are free of charge. A total of 14 Member States do not provide interpretation services to facilitate communication between patients and healthcare professionals. Only 7 Member States indicate that it is mandatory to assign a female professional providing SRH services if requested by a woman or girl. In 10 Member States, facilities providing certain SRH services are geographically distributed to major cities only. Restrictive legislation on abortion and other SRH services, mandatory consultations or reflection periods prior to procedures prove to be further barriers in accessing SRH services.

Member States made insufficient efforts to establish guidelines outlining the responsibility of professionals and the referral process that should occur on first contact with victims of (conflict-related) sexual violence.

- Most Member States have referral mechanisms in place for victims of sexual violence. However, a lack of coordination between the police, healthcare and other professionals was highlighted. Moreover, in 12 Member States, national guidelines on the provision of SRH services were identified.

The healthcare sector lacks guidelines and specialised training on how to respond to the specific needs of victims of (conflict-related) sexual violence. Rape crisis centres, women's non-governmental organisations (NGOs) and other NGOs bear the main responsibility in providing a holistic approach to victims.

- Healthcare professionals are not trained nor sufficiently experienced to deal with (conflict-related) sexual violence. The provision of all SRH services except for safe abortion and post-abortion care is often complemented by rape crisis centres, women's NGOs and other NGOs. However, only 13 Member States have established rape crisis centres. Authorities in states without these centres were called upon by research participants to establish holistic support systems for victims of (conflict-related) sexual violence.

Key recommendations for EU institutions

- Implement the Istanbul Convention to ensure coherence across EU Member States in preventing and combating violence against women, and support Member States in ensuring specialised services for victims of all acts of violence covered by the convention.

- Adopt the proposed directive on combating violence against women and domestic violence to enshrine minimum standards in EU law and Member States for ensuring, among other things, protection and support for victims and coordination between relevant services ([1]).

- Adopt the revision of the Victims' Rights Directive and ensure that victims of (conflict-related) sexual violence have easy access to targeted and integrated specialist support services, and a possibility to rely on free of charge psychological support for as long as necessary.

- Clarify the scope of necessary healthcare for victims of (conflict-related) sexual violence in the TPD, to guide Member States in ensuring service provision so that victims can exercise their SRH rights in each Member State on an equal basis.

- Provide guidelines on the correct implementation of EU rules on temporary protection and victims' rights, and support Member States in developing or improving existing needs assessments and referral mechanisms for victims of (conflict-related) sexual violence.

- Disseminate existing international guidelines on how healthcare providers should respond to sexual violence, for example, through the development of an online training course reinforcing the need for ethical standards, and trauma-informed and gender-sensitive responses.

([1]) On 6 February 2024 the European Parliament and the Council reached a provisional agreement on the Commission's proposal for a Directive on combating violence against women and domestic violence from March 2022.

Key recommendations for Member States

- Ensure that women and girls under temporary protection are fully eligible to access specialised SRH services.
- Establish mechanisms addressing the vulnerability of unaccompanied minors to ensure that their age or lack of parental consent do not limit their access to SRH services.
- Ensure that the provision of SRH services is affordable, provided in a timely manner and geographically accessible. Interpreters and female healthcare professionals should be available to assist women and girls, if requested.
- Introduce national guidelines outlining the responsibilities of the police, healthcare and social care sectors in responding to victims of (conflict-related) sexual violence and improve referral mechanisms and needs assessments among these sectors.
- Establish accessible rape crisis centres that provide specialised and immediate support to ensure the holistic, victim-centred, and gender and culturally sensitive provision of SRH services.

1. Introduction

1.1. Aim and scope of the study

Since the onset of Russia's war of aggression against Ukraine on 22 February 2022, human rights violations and violence have become the new harrowing reality of Ukraine, with growing evidence of mass atrocities and crimes of sexual violence and torture committed against civilians in the territories occupied by Russia's armed forces ([2]). Over 8 million persons – mostly women and children, since martial law prevents men from leaving the country – fled Ukraine and sought refuge and protection across Europe (UNHCR data, as of 9 May 2023) ([3]).

Previous studies have found that women and girls are exposed to conflict-related sexual violence (CRSV) at every stage of their journey, in the territories of conflict, in the transitioning stages of displacement and when they arrive in the asylum country (UNHCR, 2003). In addition, CRSV has devastating physical, psychological and social consequences for victims, such as sexually transmitted infections (STIs) – with HIV being the most prevalent one in conflict settings. Further consequences can include different types of genital trauma; depression; stress; anxiety; post-traumatic stress disorder; self-harm; suicide attempts; stigma; social exclusion and discrimination (WHO, 2002, 2012). Women and girls have been found to face an additional layer of negative outcomes concerning their reproductive health, namely forced pregnancy, pregnancy complications, induced abortions, gynaecological problems and miscarriages (WHO, 2012).

Therefore, women and girls affected by CRSV require specialised sexual and reproductive healthcare (SRH) services that are victim-centred, trauma-informed and aligned with international standards of care. Such services should respond to the specific needs of women and girls and be respectful towards individuals, minorities and communities with different ethnic and cultural backgrounds.

Having regard to these established facts and concerns related to emerging reports of sexual violence perpetrated in relation to Russia's war of aggression against Ukraine, this study was undertaken. It focuses on women and girls who fled Ukraine and are benefiting from Directive 2001/55/EC – also known as the temporary protection directive (TPD). The objective is to assess the accessibility, availability, acceptability and quality of the following specialised SRH services which are essential in the clinical management of sexual violence:

- emergency contraception,
- STI prevention and treatment,
- obstetric and gynaecological care,
- short-term psychological counselling,
- long-term psychological counselling,
- safe abortion and post-abortion care.

Potential challenges and gaps in the provision of SRH services are also explored to inform policy recommendations.

1.2. Overview of methodology

This study draws on a range of methods to address its research objectives. These include **desk research** and primary data collection through an **EU-wide questionnaire** distributed to all 27 Member States, which was conducted

([2]) From 24 February 2022 to 31 January 2023, the Office of the High Commissioner for Human Rights (OHCHR) documented 133 cases of conflict-related sexual violence committed against men, women and girls aged between 4 and over 80 (OHCHR, 2023)

([3]) It is important to note that the ongoing conflict makes reporting and investigating allegations of sexual violence challenging and that documented cases may not accurately reflect the extent of the phenomenon.

online and resulted in 26 responses (one per EU Member State) ([4]). In addition, 12 **interviews** were conducted in four Member States, selected among the EU Member States receiving the highest number of persons fleeing Ukraine. The data collection period was October 2022 to July 2023.

Desk research involved a review of relevant EU and international legislation and policy instruments on women's sexual and reproductive health and rights in the context of CRSV. The desk research also covered national instruments adopted in Member States to ensure healthcare access in their implementation of the TPD. The information was gathered in October 2022.

The EU-wide questionnaire was undertaken between November and April 2023 and served to assess the provision of specialised SRH services in Member States. The questionnaire inquired about the general availability of services in the country, the legal eligibility at the Member State level and formal requirements to obtain healthcare under the TPD, and any other legal restrictions and existence of guidelines or referral systems facilitating victims' access to these services.

Drawing on the questionnaire's results, **12 interviews** (three per country) **with relevant NGOs and public bodies** in Czechia, Germany, Poland and Slovakia were carried out between January and March 2023 to complement and further explore the findings of the online questionnaire. Interviewees were selected among organisations / public institutions directly involved in supporting victims of sexual violence or ensuring women's access to SRH services.

Detailed information on the methodology, including the questionnaire responses received, the selection criteria for the country interviews, and limitations, can be found in Annex 1.

1.3. Report structure

This report is structured as follows.

- Section 2 contains an overview of the theoretical framework and the key legal and policy frameworks adopted at the international and EU levels in relation to CRSV against women and girls and their sexual and reproductive health.
- Section 3 presents the findings of the EU-wide questionnaire conducted to assess the selected specialised SRH services for victims of CRSV arriving in the EU, complemented by findings from interviews conducted in four EU Member States selected for an in-depth analysis.
- Conclusions are outlined in Section 4.
- Policy recommendations are set out in Section 5.
- Further information can be found in the report's annexes.

([4]) BE, BG, CZ, DK, DE, EE, IE, EL, ES, FR, HR, IT, CY, LV, LT, HU, MT, NL, AT, PL, PT, RO, SI, SK, FI, SE. Denmark, while not obliged to follow the TPD, provided information on national measures offering protection to those displaced by Russia's war of aggression against Ukraine (equivalent to the TPD). Representatives of Luxembourg informed that they could not complete the questionnaire due to a lack of data.

2. Addressing conflict-related sexual violence against women and girls

This chapter provides an overview of the theoretical framework of CRSV against women and girls. This section also highlights international and EU key legal and policy instruments adopted to address this phenomenon and to adequately respond to the needs of victims of CRSV.

2.1. Understanding causes, risks and consequences

Although sexual violence in conflict settings has been present throughout history, it is only in the 1990s that it started receiving widespread attention, specifically following the outbreak of the war in former Yugoslavia (1992–1995) and the genocide in Rwanda (1994), which were marked by horrific acts of mass rape. The cases of former Yugoslavia and Rwanda led to a strong consensus that sexual violence can be used systematically as a weapon of war and that an accurate understanding of it requires a gendered analysis of the war context (Skjelsbæk, 2012).

To date, the most acknowledged theory of CRSV is the one Skjelsbæk (2012) refers to as social constructionist, a conceptualisation wherein the intersection between power and gender – here limited to the binary of masculinity and femininity – contributes to the understanding of both men and women's victimisation. According to the social constructionist framework, gender is not inherently defined by one's sex, rather masculinity and femininity are performative and context-situated (Bohan, 1997). Given that society in times of peace is far from being gender equal, when conflicts arise, pre-existing patriarchal gender relations and inequalities become exacerbated, thus making women particularly vulnerable (Skjelsbæk, 2012). Warfare increases the polarisation between the genders, in that men become militaristic men, where their masculine identity is accentuated together with the social attributes attached to it, such as power and domination (Skjelsbæk, 2012). At the same time, femininity remains within the socially ascribed attributes of passivity and vulnerability. When, for instance, sexual violence is committed against men, it becomes a symbolic act that reinforces perpetrators' masculinity and, therefore, their power, and feminises victims to a submissive role (Scarce, 1997). In addition, the symbolic effect of CRSV is not limited to the notions of power and gender, rather it intersects with other social categories as the violence is aimed at targeting the victim's identity, such as their ethnicity and religion (Skjelsbæk, 2012). Consequently, through this gender asymmetry, the ethnic, political, religious and other identities of perpetrators and victims become empowered and subjugated, thus creating a hierarchy of domination (Scarce, 1997).

For what concerns women's victimisation, CRSV has different effects. With men gone off to the war zone as combatants, women make up the majority of the civilian population and become easy targets of violence (Skjelsbæk, 2012). The use of CRSV against women may serve as a strategy for ethnic cleansing, in that it instils fear and induces civilians to flee from a given territory (Bernard, 1994). CRSV may also be used to target women's procreative abilities. For instance, forced pregnancies may be perpetrated to destroy the biological basis of a given nation (Skjelsbæk, 2012). Indeed, attacks on women are not only aimed at the individual, but also at the collective. As women bear the next generation, sexual violence becomes an attempt at cultural erasure and a symbolic humiliation against the male counterpart, who failed to protect their women, and, therefore, their nation (Seifert, 1994).

During conflict, women and girls may be abused by persons in authority or parties taking an active part in conflict and be exposed to sexual violence, including rape, sexual bartering and forced pregnancies (UNHCR, 2003). They are vulnerable to sexual attacks perpetrated by bandits and border guards in transit facilities. Upon arrival in the country of destination, women and girls may be

exposed to survival sex / forced prostitution and sexual violence by persons in authority (UNHCR, 2003). While the evidence on sexual violence against persons fleeing war across the EU is rather limited and assessing the prevalence faces numerous challenges (De Schrijver et al., 2018), existing studies confirm refugees, asylum seekers and undocumented migrants' extreme vulnerability to sexual violence. For example, a study conducted in Belgium and the Netherlands revealed that more than half of the participants (57 %) reported experiencing some form of sexual violence since their arrival in the EU. The reported violence reflects worrisome gender dynamics – women were victimised significantly more often than men (respectively 69 % versus 29 %), with violence being inflicted by men in 74 % of cases and 8 % by women (Keygnaert et al., 2012).

2.2. Strengthening international and EU legal frameworks

2.2.1. International legal framework

The international legal framework concerning CRSV encompasses the following key areas of law: international humanitarian law (IHL), international criminal law and international human rights law.

International humanitarian law is a set of rules laying out the responsibilities of state and non-state armed groups to limit the effects of armed conflicts. It is based on the 1949 IV Geneva Convention relative to the Protection of Civilians in Time of War and the additional protocols of 1977 and 2005. IHL contains general legal provisions protecting civilians, along with special ones afforded to women, recognising their vulnerability to specific forms of violence, such as sexual violence. As set out in Article 27 of the convention: 'women shall be especially protected against any attack of their honour, in particular against rape, enforced prostitution, or any form of indecent assault'.

Since the adoption of the Rome Statute of the International Criminal Court in 1998, sexual violence against women and girls in armed conflict may also amount to violations of **international criminal law**. Built upon the practice of the International Criminal Tribunal for the former Yugoslavia (ICTY), the International Criminal Tribunal for Rwanda (ICTR) and their precedents, the Rome Statute of the International Criminal Court recognised rape, sexual slavery, enforced prostitution, forced pregnancy, enforced sterilisation, or any other form of sexual violence of comparable gravity' (Article 7, point (g)) as crimes against humanity or war crimes.

International human rights law involves a set of international instruments on the protection and promotion of human rights. In 1993, the United Nations Commission on Human Rights condemned 'all acts of violence and violations of human rights directed specifically against women including those in situations of armed conflict' (UN, 1993a). The UN Commission also elaborated that states' parties have human rights obligations under the 1966 International Covenant on Civil and Political Rights (ICCPR) and the 1984 Convention against Torture and Other Forms of Cruel, Inhuman or Degrading Treatment or Punishment (UNCAT) to prevent and protect women from violence. Moreover, no exceptional circumstances, even a state of war or a threat of war, internal political instability, or any other public emergency, can serve to justify torture (under Article 2(2), UNCAT).

The impact that conflict has on women and girls was also recognised by the women, peace and security (WPS) agenda. Between 2000 and 2019, the UN Security Council adopted 10 resolutions on WPS, which include violence as a key focus area for discussions on conflict, peace and security (UN Security Council Resolution (UNSCR) 1325); recognise that sexual violence can be used as a weapon and tactic of war and can constitute a war crime, a crime against humanity or a constitutive act with respect to genocide (UNSCR 1820, 2008); and call for a survivor-centred approach in preventing and responding to sexual violence in conflict and post-conflict situations (UNSCR 2467, 2019).

Human rights obligations with respect to CRSV go far beyond the mere prohibition of violence.

States are required to allocate adequate resources and adopt effective measures to ensure that victims of gender-based violence, in particular sexual violence, have access to comprehensive medical treatment, mental healthcare and psychosocial support. States must also establish operating procedures, referral pathways and one-stop facilities offering medical, legal and psychosocial services for victims of sexual violence (UN Committee on the Elimination of Discrimination Against Women, 2013; Council of Europe, 2017).

Since the adoption of the International Conference on Population and Development (ICPD) Programme of Action ([5]) in 1994, the elimination of all forms of gender-based violence and the provision of assistance to victims were linked with the recognition of SRH as a human rights issue. The ICPD Programme of Action set out the concept of autonomy and laid foundations for the first holistic framework on sexual and reproductive health (Keygnaert et al., 2014). This obliges states to ensure that women and girls can make decisions concerning the sphere of sexuality and reproduction in an atmosphere free from discrimination, coercion and violence. It also allowed human rights bodies and institutions to further define states' obligations in this area and note that sexual and reproductive rights of women cover, inter alia, the right to life, the right to physical integrity, the right to health, the right to privacy, and the prohibition of discrimination (UN, 2014).

Therefore, a lack of respect for reproductive and sexual rights can constitute a violation of numerous provisions of human rights treaties. Violations of sexual and reproductive rights may involve, as identified by the UN Committee on the Elimination of Discrimination Against Women (CEDAW), limiting women's reproductive choices (e.g. criminalising health services that only women need), failing to provide maternal health services that can put women's life at risk, requiring spousal authorisation for certain reproductive health procedures or providing limited legal entitlement to services for refugee women (Shalev, 1998). Moreover, UNCAT monitoring activities revealed several violations of this kind which may amount to torture, inhumane or degrading treatment. These include instances of abuse against women in reproductive health facilities (UNCAT, 2013b), denial of access to emergency contraception to rape victims (UNCAT, 2013), denying access to and putting in place restrictions on legal abortion (UNCAT, 2011), denying access to abortion in cases of sexual violence and non-viability of foetus (UNCAT, 2011), requirements of third part authorisation (UNCAT, 2013c) unregulated conscientious objection (UNCAT, 2013d), complete bans on abortion (UNCAT, 2009), and denial of access to post-abortion care (UNCAT, 2011).

2.2.2. European legal framework

The EU considers violence against women and girls a breach of one of its key values ([6]) – equality between women and men – and a violation of several of the rights enshrined in the Charter of Fundamental Rights of the European Union, such as the right to human dignity (Article 1), the right to life (Article 2), the right to the integrity of the person (Article 3), the prohibition of torture and inhuman or degrading treatment (Article 4), the principle of non-discrimination, including on the grounds of sex (Article 21), the right to equality between women and men (Article 23) and the right to access justice (Article 47).

On 1 October 2023, the Istanbul Convention entered into force in the European Union. The Council of the EU is also negotiating with the European Parliament on the adoption of the proposed directive on combating violence against women and domestic violence (COM/2022/105 final) to complement already existing EU instruments, such as the victims' rights directive

([5]) The ICPD Programme of Action linked fundamental 'consensus documents' – such as guarantees enshrined in the Universal Declaration of Human Rights (UN, 1948) and the Vienna Declaration and Programme of Action of the World Conference on Human Rights (UN, 1993b) – with human rights treaties like the International Covenant on Economic, Social and Cultural Rights and the ICCPR (1966), the Convention on the Elimination of Discrimination against Women (1979) and UNCAT (1984).

([6]) Primary EU law acknowledges equality between women and men as a fundamental value and objective of its initiatives and policies, formulated in Article 2 (value) and Article 3 (objective) of the Treaty on European Union. Articles 8, 10, 19 and 157 of the Treaty on the Functioning of the European Union confer it power to address and combat discrimination based on sex (Art. 19(1)) and to mainstream gender-sensitive considerations in its policies.

(2012/29/EU) ([7]) (applicable to all victims of all crimes, currently under revision), the anti-trafficking directive (2011/36/EU), and the legal instruments constituting the common European asylum system ([8]).

Ensuring the proper implementation of all parts of the WPS agenda remains an important commitment of the European Union and its Member States. The EU's priorities were laid down in the 2019–2024 EU action plan on WPS (annexed to Council document 15086/18) and has six objectives: participation; gender mainstreaming; leading by example; prevention; protection; and relief and recovery. Action needed to achieve these objectives require from EU institutions and Member States continuous efforts, including, among other things, the adoption of a national plan for the implementation of UNSCR 1325. This measure should support all victims of CRSV in accessing reparations and restorative justice, promote the provision of medical, psychosocial, legal and safety support, and ensure victims, access to comprehensive healthcare information.

At the EU level, public health is a competence shared between the European Union and its Member States, as set out in Article 168 of the Treaty on the Functioning of the European Union (TFEU). Moreover, Article 35 of the Charter of Fundamental Rights of the European Union – which ensures the right of access to preventive healthcare and the right to benefit from medical treatments under the conditions established by national laws and practices – assigns Member States primary responsibility for shaping their health systems. The EU complements Member States' efforts to ensure public health via EU-level policy instruments, in line with the principle of subsidiarity. However, this results in different levels of healthcare provided across the EU. Member States seem to interpret the provision of the EU Charter of Fundamental Rights rather restrictively, leaving vulnerable groups in a difficult position where their legal status heavily influences their access to healthcare (Keygnaert, 2015).

On 4 March 2022, following Russia's invasion of Ukraine, the European Union activated, for the first time ever, Council Directive 2001/55/EC of 20 July 2001 on minimum standards for giving temporary protection in the event of a mass influx of displaced persons and on measures promoting a balance of efforts between Member States in receiving such persons and bearing the consequences thereof – also known as the TPD ([9]). The TPD obliges Member States to provide persons under temporary protection with, at a minimum, emergency care and essential treatment of illness, and to 'provide necessary medical or other assistance to persons enjoying temporary protection who have special needs, such as unaccompanied minors or persons who have undergone torture, rape or other serious forms of psychological, physical or sexual violence' (Article 13(4)).

It is also important to note that the issue of women's reproductive rights recently gathered significant attention at the EU level. In 2021, the European Parliament adopted the resolution of 24 June 2021 about sexual and reproductive health and rights in the EU, in the frame of women's health (2020/2215/(INI)) and called for the EU to step up the fight against the use of rape as a weapon of war, and to guarantee victims of rape access to SRH services. In June 2021, the European Parliament urged Member States to decriminalise and combat obstacles to safe and legal abortion. Moreover, members of Parliament prompted Member States to ensure

([7]) The victims' rights directive (2012/29/EU) aims to ensure that victims of crime receive appropriate information, support and protection, and may participate in criminal proceedings. In particular, it requires 'targeted and integrated support for victims with specific needs, such as victims of sexual violence' (Article 9(3)b) regardless of their legal status. The victims' rights directive ensures access to general and specialised support services for victims of crimes and imposes obligations on Member States in facilitating access to these services (Articles 8 and 9). Under the directive, the services must be confidential, free of charge and victim-centred; victims of sexual violence are considered particularly vulnerable to subsequent harm; therefore, specialised support services must take into account their special needs.

([8]) The European Common Asylum System (Directive 2011/95/EU; Directive 2013/32/EU; Directive 2013/33/EU) considers victims of rape or other forms of physical, psychological or sexual violence, human trafficking and female genital mutilation as 'vulnerable persons that need specific protection' and launches a comprehensive and gender-sensitive set of EU-wide guidelines to migration and asylum policy.

([9]) The TPD was formally activated in response to the mass influx of persons from Ukraine by Council Implementing Decision (2022/382), which was adopted on 4 March 2022, and which defined categories of displaced persons from Ukraine to whom temporary protection shall apply.

universal access to SRH services and urged the Commission to support Member States in this action in the framework of the 2021–2027 EU4health programme (resolution of June 9 2022, 2022/2665(RSP)).

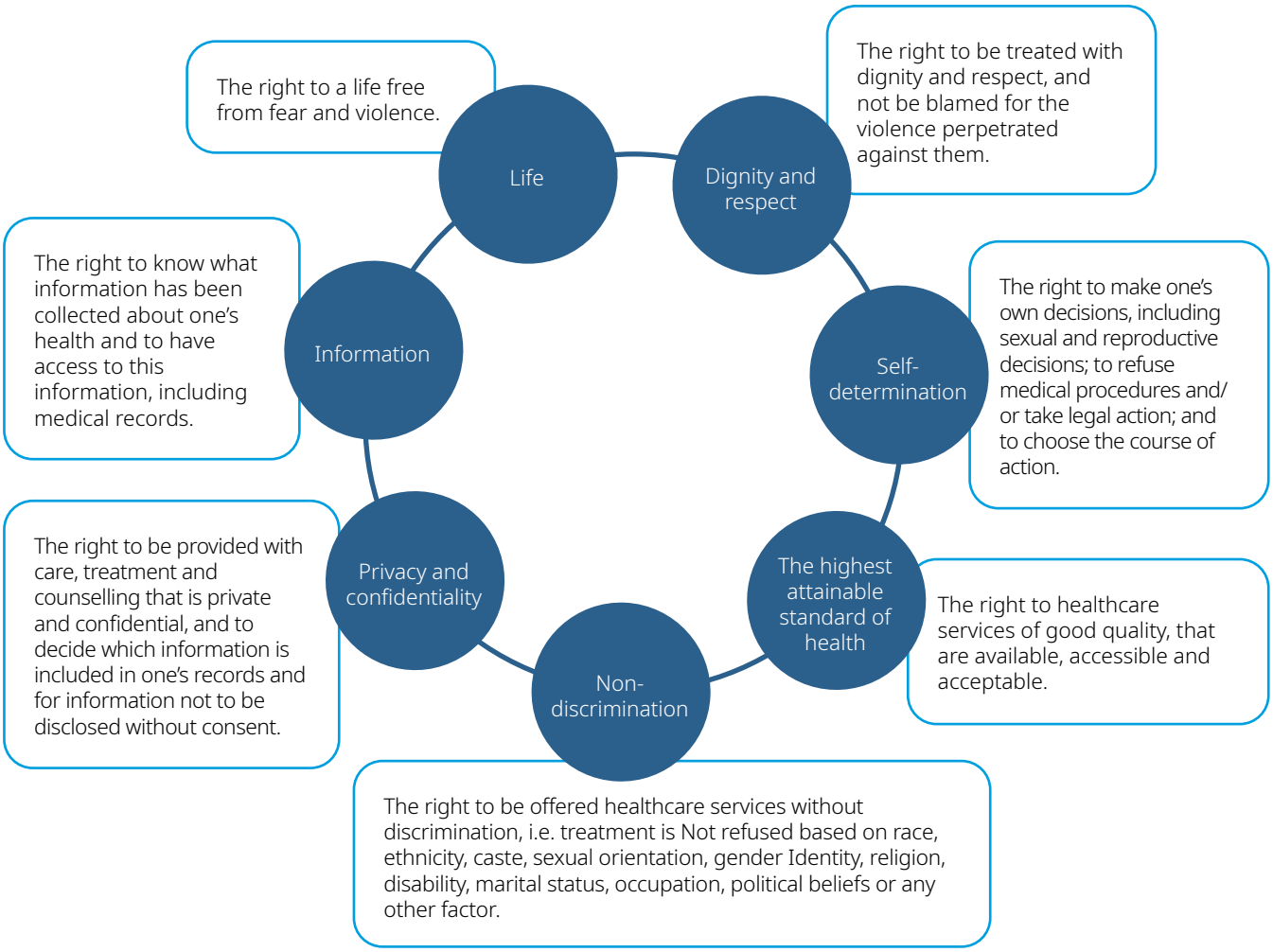
2.3. Ensuring holistic and gender-sensitive care for victims

CRSV has devastating physical, psychological and social consequences for victims, such as STIs, different types of genital trauma, depression, stress, anxiety, post-traumatic stress disorder (PTSD), self-harm, suicide attempts, stigma, social exclusion and discrimination (WHO, 2002, 2012). Women and girls are also exposed to forced pregnancy, pregnancy complications, induced abortions, gynaecological problems and miscarriages (WHO, 2012). The results of a study conducted by Medica Zenica and Medica Mondiale in 2014 confirm these alarming consequences. At the time of the study, 57 % of participants – who were female victims of CRSV from Bosnia and Herzegovina – were suffering from clinical PTSD symptoms and 70 % stated that their experiences of sexual violence continued to affect their daily life (Medica Zenica and medica mondiale e.V., 2014). The study also found an alarming frequency of gynaecological problems, despite having received treatment, with more than 58 % of the women still suffering from frequent and uncontrollable urination (53 %), pain in the pelvic area (49 %), vaginism (44 %), difficulties in getting pregnant (20 %) and cancer (10 %) (Medica Zenica and medica mondiale e.V., 2014). The abovementioned study also highlights victims' distrust towards the government and institutions as they argue that essential support was only provided by NGOs (Medica Zenica and medica mondiale e.V., 2014).

To address these serious occurrences, collective effort is required from governments, institutions and NGOs to ensure that women and girls affected by CRSV receive specialised SRH care that can address their specific needs adequately. In this study, sexual and reproductive health is understood to describe a state of physical, emotional, mental and social well-being in all matters relating to sexuality and the reproductive system; it is not merely the absence of disease, dysfunction or infirmity. Specifically, sexual health requires a positive and respectful approach to sexuality and sexual relationships, along with the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination and violence. For sexual health to be attained and maintained, the sexual rights of all persons must be respected, protected and fulfilled (WHO, 2006). Sexual health is a necessary condition for the achievement of reproductive health (WHO, 2010).

International organisations regularly issue publications on standards for improving the provision of specialised SRH services for victims of sexual violence. For example, the WHO stresses the importance of providing **survivor-centred care**, namely, an approach that treats victim's rights, needs and wishes as an absolute priority (World Health Organization, United Nations Population Fund and United Nations High Commissioner for Refugees, 2020). The core principles of survivor-centred care are illustrated in Figure 1.

Figure 1. Guiding principles of survivor-centred care in the clinical management of rape and intimate partner violence survivors



Source: World Health Organization, United Nations Population Fund and United Nations High Commissioner for Refugees (2020), *Clinical management of rape and intimate partner violence survivors: developing protocols for use in humanitarian settings*.

Victims of sexual violence also require urgent medical care that is suited to the type of violence they suffered. International guidelines advise to follow a five-step approach called 'LIVES', which takes its name from the key elements: listen, inquire, validate, enhance safety and support. These elements are paramount for health professionals to consider when approached by a woman who discloses violence (World Health Organization, United Nations Population Fund and United Nations High Commissioner for Refugees, (2020)). The response of healthcare providers should always be empathetic, judgement free and informative, but most importantly victim-centred, that is to say guided by the victim's rights, needs and wishes. The clinical management of rape entails additional steps; after providing the initial three steps of the first-line support, health professionals are advised to obtain informed consent from the patient, record their medical history (general medical information, mental health assessment, gynaecological history and information on the rape incident) and perform physical and genital examinations. At this stage, it is also suggested to carry out forensic evidence collection. It is imperative that forensic examinations respect the dignity of the victim and be as minimally invasive as possible. Ideally, medical and forensic care should be provided at the same time to reduce the number of examinations. In line with the guiding principle of respecting victims' dignity, it is also advised to refrain from these procedures if victims do not consent to them and they then cannot be used for legal proceedings. The victim's choice needs to respected (World Health Organization, United Nations

Population Fund and United Nations High Commissioner for Refugees, (2020)).

WHO guidelines list the essential elements for the clinical management of rape and set clear timelines. Health professionals are recommended to adhere to the following steps, noting that the first four (presented below in bold) are a matter of priority and should be administered as soon as possible (Table 1). After completing the physical examination, healthcare providers should discuss the issue of enhancing safety, assess the presence of psychological and emotional difficulties, provide support and, if necessary, refer to other service providers. Scheduling follow-up visits 2 weeks, 1 month, 3 months and 6 months after the initial visit completes the clinical management of rape protocol. In humanitarian settings, healthcare providers should ensure that essential care is provided during the first visit and they should aim to have at least one follow-up visit within the following 3 months (World Health Organization, United Nations Population Fund and United Nations High Commissioner for Refugees, (2020)).

Table 1. Essential elements of the clinical management of rape, with post-rape treatment timelines

Treatment	Timelines
1. Treating physical injuries or referring the patient	• Immediately.
2. Preventing HIV by offering post-exposure prophylaxis (PEP) for HIV infection as soon as possible	• As soon as possible, not later than within 72 hours.
3. Preventing pregnancy by providing emergency contraception	• As soon as possible, up to 120 hours after the rape.
4. Preventing STIs by administering presumptive antibiotics to treat chlamydia, gonorrhoea and syphilis	• As soon as possible.
5. Preventing tetanus	• According to vaccination protocol.
6. Preventing hepatitis B treatment, particularly in high-prevalence settings	• According to vaccination protocol.
7. Managing an unwanted pregnancy by providing counselling and discussing available options, including termination, with a victim	• The patient's decision on this matter needs to be respected.

Source: World Health Organization, United Nations Population Fund and United Nations High Commissioner for Refugees (2020), *Clinical management of rape and intimate partner violence survivors: developing protocols for use in humanitarian settings*, World Health Organization.

Healthcare professionals play a key role in aiding victims, therefore they need to be adequately trained to offer services that are non-discriminatory and of high quality. The guidelines developed by the Inter-Agency Standing Committee (IASC) also suggest that healthcare services responding to victims of sexual violence should ensure standards of safety, confidentiality, sensitiveness, accessibility (both in terms of location and physical access) and high quality in the provision of clinical care (IASC, 2015). To guarantee a holistic provision of clinical care relating to sexual violence, healthcare facilities should ensure that services are delivered by same-sex, same-language healthcare professionals, and, when possible, provide translators and sign language interpreters who are trained in guiding principles of victim care (IASC, 2015). To address the fear and stigma which may prevent victims from seeking help, a directory of services and emergency lines should be disseminated via the local community. If possible, services for victims should be open 24/7, cost-free, and provided in different forms – as part of existing facilities and as standalone centres or mobile centres (IASC, 2015). The IASC guidelines emphasise the need to approach the disclosure of sexual violence with respect, sympathy and confidentiality, as only these kinds of services can facilitate victims' access to specialised healthcare and initiate their recovery process (IASC, 2015).

3. Assessing specialised sexual and reproductive healthcare services: findings

This chapter presents an analysis of the data gathered from the questionnaire distributed online among all EU Member States. The analysis is informed by responses received from 26 individuals representing their respective Member States, and focuses on key aspects relating to the **accessibility, availability, acceptability and quality of specialised SRH services for women and girls protected under the TPD**. The analysis covers six SRH services, shown in Figure 2.

Figure 2. SRH services analyzed within a study

Source: Prepared by authors.

In addition, **12 semi-structured interviews** were conducted with experts representing **four Member States** that were among those receiving the largest number of persons displaced by the war in Ukraine: Czechia, Germany, Poland and Slovakia (three interviews per country). Although the number of interviews were limited, the objective was to engage with experts from each of the four countries to gather additional insights and identify key gaps and challenges in receiving SRH care. A more detailed description of the criteria informing the selection of interviewees is presented in Annex 1.

3.1. Accessibility

Access to healthcare services for persons protected under the TPD is regulated by specific legal frameworks ([10]) or policy instruments ([11]) introduced by EU Member States following the Council of the European Union's conclusions on Ukraine in March 2022 ([12]). The extraordinary nature of this type of protection, activated only in specific circumstances of 'mass influx of displaced persons' arriving in the EU, requires ensuring that access to temporary protection is immediate, with administrative formalities 'reduced to a minimum'. This is particularly important to avoid the risk of the EU asylum system being unable to process high numbers of applications (European Commission, 2022/C 126 I/01). Once the eligibility for protection under the TPD is established, EU Member States are obliged to offer 'necessary medical or other assistance' to persons in particularly vulnerable states, such as unaccompanied minors and those who have experienced 'torture, rape or other serious forms of psychological, physical or sexual violence' (Article 13(4) of the TPD).

([10]) CZ, HR, IT, CY HU, LT, LV, AT, PL, SI.
([11]) EL, PT.
([12]) Additional results from survey concerning these legal instruments are available in Annex 3.

Table 2. Documents required by Member States for access to healthcare for women and girls fleeing the war who are protected under the TPD by type of document (N=26), 2023

COUNTRIES	TYPE OF DOCUMENT									
	None required	Application for TPD	Residence Card / Document confirming TPD	Refugee / asylum seeker status	Passport with biometric data	Passport without biometric data	ID card	Visa	Personal identification number	Other
BE		✓	✓		✓	✓	✓			
BG		✓		✓						
CZ			✓					✓		✓
DK	✓									
DE		✓	✓							
EE			✓			✓	✓			
IE			✓							
EL					✓	✓				✓
ES		✓		✓	✓	✓				
FR		✓								
HR			✓							
IT		✓	✓	✓						
CY				✓						
LV					✓			✓		
LT		✓	✓	✓						
HU		✓	✓	✓						
MT		✓	✓							
NL			✓						✓	
AT	✓									
PL									✓	✓
PT		✓		✓						
RO				✓	✓			✓		
SI		✓		✓						
SK				✓	✓	✓	✓			
FI		✓	✓	✓		✓				
SE	✓									
Total	3	12	12	11	6	6	3	3	2	3

Question: What is required in your Member State for women and girls fleeing the war who are protected under Directive 2001/55/EC to access healthcare (by type of document)?
Source: Prepared by authors.

Results indicate that only three Member States ([13]) grant immediate access to healthcare without prior presentation of documents. The remaining 23 Member States require some form of documentation to grant access to healthcare. These Member States are flexible in accepting various documents such as, for example, an application for temporary protection status ([14]) (12 Member States), a residence card or a document confirming temporary protection status ([15]) (12 Member States), or an application for international protection or refugee status ([16]) (11 Member States).

([13]) DK, AT, SE.
([14]) BE, BG, DE, ES FR, IT, LT, HU, MT, PT, SI, FI.
([15]) BE, CZ, DE, EE, IE, HR, IT, LT, HU, MT, NL, FI.
([16]) BG, ES, CY, IT, LT, HU, PT, RO, SI, SK, FI.

Moreover, Member States accept passports, both with ([17]) or without biometric data ([18]) (six Member States), identity cards ([19]) (three Member States), visas ([20]) (three Member States) or personal identification numbers ([21]) (two Member States). Other acceptable options in specific Member States included: a police note offered upon arrival in Greece, a substitute insurance card in Czechia or a 'declaration of honour' in Poland. Documents accepted by Member States for access to healthcare are shown in Table 2.

Women and girls under temporary protection are eligible to access all six specialised SRH services analysed in 17 EU Member States ([22]). In the nine remaining Member States ([23]), the scope of services offered to beneficiaries of the TPD is more limited.

For example, Cyprus, Lithuania and Austria declared that women and girls under temporary protection are not legally entitled to emergency contraception as this service is 'generally not a benefit of the statutory health insurance and is only covered if it is medically necessary' ([24]) or 'is not provided in the framework of National Health Service' ([25]). The respondent from Bulgaria was not able to confirm whether this service is covered for persons under the TPD. Moreover, women and girls under temporary protection are not legally entitled to long-term psychological counselling in Sweden. Representatives of Bulgaria, Greece and the Netherlands could not confirm whether their countries cover this service ([26]). In Austria, STI prevention is not included in the scope of the statutory health service provision; only STI treatment is. Safe abortion and post-abortion care is not available in Malta due to a legal ban on abortion. In Lithuania, this service is only covered for minors and disabled women. Romania was not able to confirm whether safe abortion and post-abortion care is included in their scope of service provision. Detailed findings regarding legal entitlements to the six analysed services are available in Table 3.

([17]) BE, EL, ES, LV, RO, SK.
([18]) BE, EE, EL, ES, SK, FI.
([19]) BE, EE, SK.
([20]) CZ, LV, RO.
([21]) NL, PL.
([22]) BE, CZ, DK, DE, EE, IE, ES, FR, HR, IT, LV, HU, PL, PT, SI, SK, FI.
([23]) BG, EL, CY, LT, MT, NL, AT, RO, SE.
([24]) AT.
([25]) CY.
([26]) Sweden and Bulgaria could not confirm whether women and girls under temporary protection are legally entitled to short-term psychological counselling.

Table 3. Legal entitlement of women and girls fleeing the war, protected under the TPD, to the following specialised healthcare services. (N=26), 2023

Specialised service:		BE	BG	CZ	DK	DE	EE	IE	EL	ES	FR	HR	IT	CY	LV	LT	HU	MT	NL	AT	PL	PT	RO	SI	SK	FI	SE
Emergency contraception	Yes	X		X	X	X	X	X	X	X	X	X	X		X		X	X	X		X	X	X	X	X	X	X
	Partly																										
	No – not legally entitled													X		X				X							
	No – not available																										
	Don't know		X																								
STI prevention and treatment	Yes	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X		X	X	X	X	X	X	X
	Partly																			X							
	No – not legally entitled																										
	No – not available																										
	Don't know																										
Obstetric and gynaecological care	Yes	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
	Partly																										
	No – not legally entitled																										
	No – not available																										
	Don't know																										
Short-term psychological support	Yes	X		X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	
	Partly																										
	No – not legally entitled																										
	No – not available																										
	Don't know		X																								X
Long-term psychological support	Yes	X		X	X	X	X	X		X	X	X	X	X	X	X	X	X		X	X	X	X	X	X	X	
	Partly																										
	No – not legally entitled																										X
	No – not available																										
	Don't know		X						X										X								
Safe abortion and post-abortion care	Yes	X	X	X	X	X	X	X	X	X	X	X	X	X	X		X		X	X	X	X		X	X	X	X
	Partly															X											
	No – not legally entitled																										
	No – not available																	X									
	Don't know																						X				

NB: The response from Member State authorities is marked with X. Dark blue indicates restrictions on eligibility; grey indicates 'do not know', orange indicates partial eligibility.
Question: Are women and girls fleeing the war, protected under Directive 2001/55/EC, legally entitled to the following specialised healthcare services? (N=26)
Source: Prepared by authors.

In Czechia, Germany, Poland and Slovakia, the expert interviews conducted raised additional concerns regarding the provision of SRH services to persons fleeing war. The experts highlighted that there had been insufficient governmental efforts to address the needs of women and girls arriving from Ukraine and legal ambiguities relating to the implementation of the TPD. Initiatives advocating for urgent changes were identified in Germany, Poland and Slovakia, to facilitate access to these services (in particular to abortion) and to clarify the scope of services available to women. However, none of these had been successful at the time of analysis. For example, in Slovakia, an interviewee recalled a non-governmental initiative to issue an interpretive opinion that would confirm whether the temporary protection status guarantees women fleeing Ukraine access to abortion services, although this effort was also unsuccessful.

In Czechia, efforts were made to improve information dissemination: the Czech Ministry of Health clarified legal ambiguities in an official statement and confirmed that access to healthcare under the TPD also covers abortion procedures. Moreover, the ministry published various guides for healthcare providers clarifying the specific rights and processes applying to people fleeing from Ukraine. The ministry also prepared information leaflets (and information portals) about services available for people fleeing Ukraine. In this context, the interviewees also stressed the need for more guidance in applying and interpreting the directive.

The questionnaire responses identify various legal requirements that may hinder access to specialised SRH services, in particular when it comes to minors. For obstetric and gynaecological care, 11 Member States ([27]) require parental consent; in Czechia, parental consent is not needed if professionals believe that the minor shows reasonable understanding and maturity. France and Malta ([28]) require adult accompaniment. There are no restrictions in the remaining 12 Member States ([29]).

Emergency contraception is provided to minors without restrictions in 13 Member States ([30]). Seven Member States ([31]) require parental consent, with Poland also requiring a prescription. A prescription is further requested in Malta for minors between 16 and 18 years of age and in Czechia for minors under 16. Respondents from Bulgaria and Lithuania did not know about restrictions related to age in their countries. Cyprus and Austria did not provide a response to this question.

In relation to STI prevention and treatment, parental consent is required in 10 Member States ([32]). In Czechia, parental consent is not needed if professionals believe that the minor shows reasonable understanding and maturity. In France, minors need to be accompanied by an adult to access this service. Austria did not provide any information and in the remaining 13 Member States ([33]) there are no restrictions for minors.

Parental consent is also required to access short- and long-term psychological counselling in 10 Member States ([34]). In Czechia, parental consent is not needed if professionals believe that the minor shows reasonable understanding and maturity. Malta also requires adult accompaniment. There are no restrictions in nine ([35]) Member States for short-term psychological counselling and eight ([36]) Member States for long-term psychological counselling. In the remaining Member States, respondents did not know about

([27]) BG, DK, IE, HR, IT, CY, HU, PL, PT, RO,SK.
([28]) In Malta this applies for minors under 16.
([29]) BE, DE, EE, EL, ES, LV, LT, NL, AT, SI, FI, SE.
([30]) BE, DE, DK, EE, EL, ES, FR, LV, NL, PT, SI, FI, SE.
([31]) IE, HR, IT, HU, PL, RO, SK.
([32]) BG, IE, EL, HR, IT, CY, HU, PL, RO, SK.
([33]) BE, DK, DE, EE, ES, LV, LT, MT, NL, PT, SI, FI, SE.
([34]) DK, IE, HR, IT, CY, HU, MT, PL, PT, RO.
([35]) BE, DE, EE, ES, LT, AT, SI, SK, FI.
([36]) DE, EE, ES, LT, AT, SI, SK, FI.

restrictions related to age (respectively, six ([37]) and seven ([38]) Member States).

More restrictions apply in relation to safe abortion and post-abortion care, in comparison to other services analysed. Only six Member States ([39]) have no age restrictions for the provision of safe abortion and post-abortion care, whereas parental consent is required in 14 Member States ([40]). In Czechia, minors under 16 years of age and minors between the ages of 16 and 18 do not need parental consent; however, the healthcare provider must inform the parents / legal guardian that the procedure occurred. In Denmark, there is the possibility of dispensing with parental consent, and in France adult accompaniment is required. In Malta, this service is not available as abortion is illegal. Ireland, Lithuania, Austria and Finland did not provide a response to this question.

([37]) BG, EL, FR, LV, NL, SE.
([38]) BE, BG, EL, FR, LV, NL, SE.
([39]) BE, DE, LV, NL, SI, SE. Belgium requires parental consent only if the abortion is carried out under anesthesia.
([40]) BG, CZ, DK, EE, EL, ES, HR, IT, CY, HU, PL, PT, RO, SK.

Table 4. Number of Member States referring to any other legal restrictions for specialised services, by type of restriction (N=26), 2023

Specialised service		BE	BG	CZ	DK	DE	EE	IE	EL	ES	FR	HR	IT	CY	LV	LT	HU	MT	NL	AT	PL	PT	RO	SI	SK	FI	SE
Emergency contraception	No restriction	X			X	X	X		X	X	X				X				X			X		X		X	X
	Parental consent							X				X	X				X				X		X		X		
	Prescription			X														X			X						
	Don't know		X													X											
	No response													X						X							
STI prevention and treatment	No restriction	X			X	X	X			X					X	X		X	X			X		X		X	X
	Parental consent		X					X	X			X	X	X			X				X		X		X		
	Adult accompaniment										X																
	Reasonable understanding/maturity			x																							
	No response																			X							
Obstetric and gynaecological care	No restriction	X				X	X		X	X					X	X			X	X				X		X	X
	Parental consent		X		X			X				X	X	X			X				X	X	X		X		
	Adult accompaniment										X							X										
	Reasonable understanding/maturity			X																							
Short-term psychological support	No restriction	X				X	X			X						X				X				X	X	X	
	Parental consent				X			X				X	X	X			X	X			X	X	X				
	Reasonable understanding/maturity			X																							
	Adult accompaniment																	X									
	Don't know		X						X		X				X				X								X
Long-term psychological support	No restriction					X	X			X						X				X				X	X	X	
	Parental consent				X			X				X	X	X			X	X			X	X	X				
	Reasonable understanding/maturity			X																							
	Adult accompaniment																	X									
	Don't know	X	X						X		X				X				X								X
Safe abortion care and post-abortion care	No restriction	X				X									X			n/a	X					X			X
	Parental consent		X	X	X		X		X	X		X	X				X	n/a			X	X	X		X		
	Adult accompaniment										X							n/a										
	No response							X								X		n/a		X						X	

NB: The response from Member State authorities is marked with X.
Grey indicates that the question is not applicable because there this service is not available in the Member State.
Survey Question 2A-2F: Number of Member States referring to any other legal restrictions for specialised services, by type of restriction (age, prescription needed, parental consent, other) (N=26)
Source: Prepared by authors.

Several challenges were highlighted concerning the accessibility of SRH services for women and girls fleeing the war in Ukraine who have experienced sexual violence. According to the interviewees from Germany, Poland and Slovakia, the availability of services is also severely affected by strict national legislation concerning sexual and reproductive health. Barriers and difficulties concerned nearly all SRH services analysed within this report.

In Slovakia and Poland, obtaining emergency contraception (an essential component of healthcare concerning sexual violence that should be administered as soon as possible) can be challenging for victims due to regulations permitting refusal to provide SRH services on the grounds of conscience. In Slovakia, it was noted that pharmacists are not legally obliged to inform women and girls as to where they can obtain emergency contraception. In Poland, a medical prescription is required, which can cause delays despite the time-sensitive nature of this medical care. Delays are also caused by a lack of products in pharmacies and waiting times to see gynaecologists (although this does not require a referral). Further, in Poland there is a lack of awareness as to how to obtain emergency contraception, and this drives individuals to seek illegal surgical abortions or go abroad.

Regarding STI treatment and prevention, particular challenges were noted in Slovakia and Czechia. HIV treatment and access to preventive medication is hindered because of supply issues and the need for a prescription. Moreover, in Slovakia, there is a scarcity of PEP, and victims have to see a licensed virologist for a prescription. Therefore, in most cases, the critical 72-hour window to receive medication – as recommended by international guidelines of clinical treatment of rape – is missed. In Slovakia, attention was drawn to the supply issues regarding PEP sets for paediatric cases, which need to be ordered abroad and often arrive late. To avoid these delays, the organisation buys them at their own expense to ensure availability. It was pointed out that despite Slovakia having a low number of HIV-positive persons, health services were being stretched by the increasing number of HIV-positive patients from Ukraine (where the prevalence is higher). This has placed further pressure on the provision of antiretroviral medication ([41]). In Czechia, no specialised provision of STI treatment and prevention for victims was reported.

The access to safe abortion and post-abortion care is particularly challenging, in Slovakia, Poland and Germany. Interviewees from Poland highlighted the country's restrictive legislation on abortion, which permits the termination of pregnancy only in cases of rape or when a woman's health or life is endangered. While this restriction affects all women and not only those from Ukraine, the additional requirement to obtain a prosecutor's certificate to terminate a pregnancy resulting from rape poses an additional burden for women who are not familiar with the Polish system.

In Slovakia, legislation restricts access to abortions for non-citizens. This situation has given rise to a legal ambiguity for those women who came from Ukraine into the country. Further challenges stem from Slovak legislation which prohibits medical abortions and permits only surgical ones. In addition, in advance of the abortion, women are required to wait for a period of 48 hours and to listen to compulsory information. This was described as applying 'psychological pressure on women' not to have an abortion. In addition, in both Poland and Slovakia the availability of safe abortion is further limited by providers who may refuse to provide abortion services on the grounds of their conscience.

In contrast, findings from Germany uncover fewer restrictions, however women seeking a safe abortion in this jurisdiction are required to participate in a multistep process. First, they attend a mandatory consultation organised in a separate facility to discuss contraception and their decision to obtain an abortion; then, they are obliged to wait 3 days before having one. While there are measures in place to bypass the consultation process

([41]) European Centre for Disease Prevention and Control and WHO Regional Office for Europe (2021), HIV/AIDS Surveillance in Europe 2021 – 2020 data (europa.eu).

for victims of rape, interviewees mentioned that these measures are underutilised.

Difficulties identifying suitable abortion providers were highlighted in Slovakia and Germany, as a result of legal restrictions on access to abortion. In Slovakia, women struggle to identify a provider as most healthcare websites have little to no information as to whether they provide abortions or not. In Slovakia, one participant noted, many doctors refuse to provide abortions (this figure was estimated at approximately 40 %). In Germany, one interviewee noted that doctors might refrain from performing abortions as they have a fear of repercussions and are concerned about compliance with the regulations.

These difficulties appear to generate severe consequences for women and force them to seek safe termination abroad, as noted by interviewees from Germany, Poland and Slovakia. Due to severe restrictions on abortion in Poland, interviewees in Slovakia noted that women had arrived from Poland to access abortion in their country. In these cases, Ukrainian women must deregister from temporary protection in Poland and re-register in Slovakia (which takes a few hours) to access abortion services. A similar situation occurs in Germany, where it was also noted that women travel from Poland to access abortion services. However, yet another issue is forcing women to travel abroad, and it concerns finance. Women travel from Slovakia to Austria to seek abortions and it appears that the reason they travel is due to the high cost of abortion in Slovakia. The following section outlines concerns related to the affordability of SRH services.

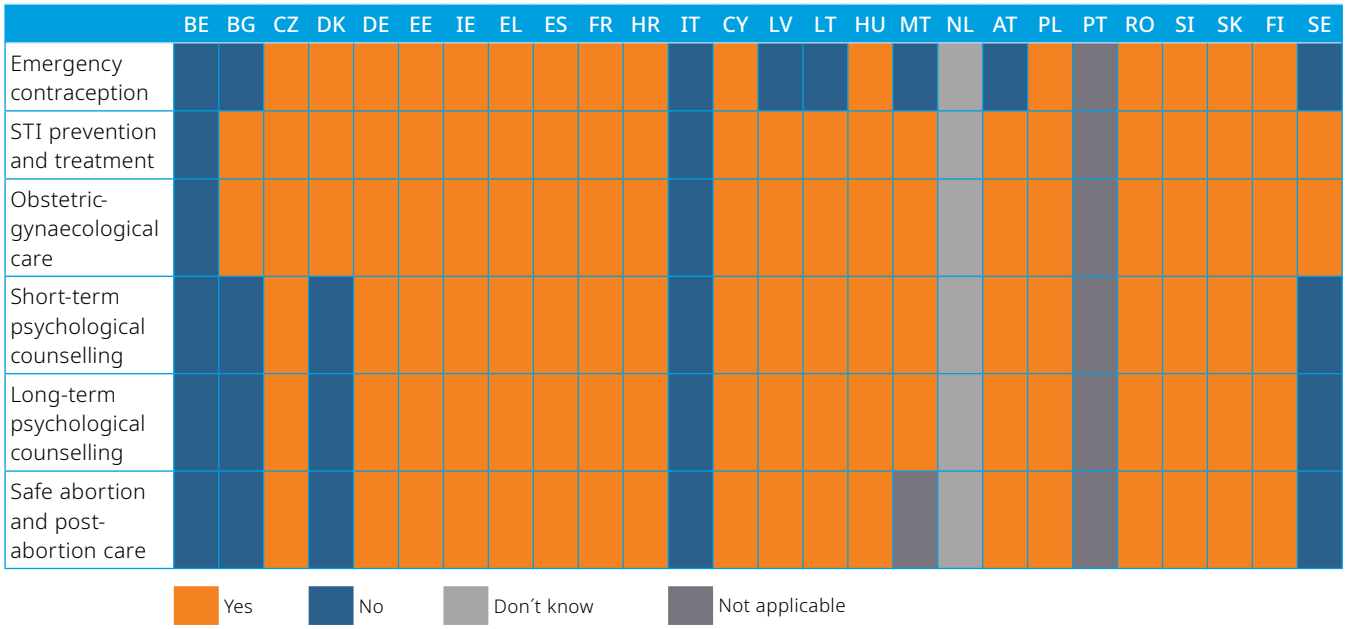
3.1.1. Economic accessibility

Affordability of SRH services is essential for ease of access. It is imperative that financial costs do not prevent women and girls from seeking care. This is particularly important for patients in refugee and migration contexts, as they may be in economically vulnerable positions. The questionnaire explored whether women and girls protected under the TPD can access the analysed SRH services free of charge.

All six SRH services are provided free of charge, in 13 Member States ([42]) according to questionnaire results. In the remaining 13 Member States ([43]), only selected SRH services are free of charge. The costs of emergency contraception, for example, are not covered in 10 EU Member States ([44]). In five Member States ([45]), payment for safe abortion and post-abortion care ([46]) is required. In Sweden and Bulgaria, short- and long-term psychological support are not available free of charge, whereas in Denmark they require part payment, as is standard for Danish citizens. In Belgium ([47]) and Italy, none of the SRH services reviewed are free of charge.

([42]) DE, EE, EL, ES, FR, HR, HU, PL, PT, SI, RO, SK, FI.
([43]) BE, BG, CZ, DK, IE, IT, CY, LV, LT, MT, NL, AT, SE.
([44]) BE, BG, CZ, IT, CY, LV, LT, MT, AT, SE.
([45]) BE, BG, CZ, IT, LT.
([46]) In Austria, emergency contraception, safe abortion and post-abortion care are only covered by the statutory health insurance funds if they are medically necessary, otherwise they are not benefits of the statutory health insurance fund, therefore not free of charge.
([47]) It should be also noted that, depending on the legal status one has, several schemes exist for (partial) reimbursement of costs. Belgium has recently improved its contraception policies, making it free for people aged under 25. People are also entitled to increased reimbursement and a tax decrease on contraceptive products. These measures are available for any person who has health insurance, so it also applies to people fleeing from Ukraine.

Table 5. Coverage of SRH services under the TPD by type of service (N=26), 2023



'Not applicable' indicates the lack of national insurance scheme (Portugal has universal access to healthcare) or that the service is illegal (Malta).
Question: Under insurance schemes (where applicable), can women and girls fleeing the war who are protected under Directive 2001/55/EC access these services free of charge?
Source: Prepared by authors.

Observations expressed in interviews on the costs of these services differ significantly from data obtained via the questionnaire. In all four EU Member States where interviews were conducted, the issue of costs associated with obtaining the services and the lack of insurance coverage were highlighted as significant obstacles for women and girls. In all four countries, for example, emergency contraceptives are not covered by insurance and must be purchased in pharmacies. This makes them less accessible for those from low-income groups. Insufficient awareness related to subsidies and cost support initiatives among professionals and individuals further exacerbates these challenges. For example, in Germany, there are initiatives to provide free emergency contraception for women under the age of 20, and some cities have special funds for women above this age to help cover costs; however, individuals and professionals are not always aware of these funds. A similar problem was noted by an expert in Germany in relation to PEP for potential exposure to HIV. These services are not always free. Victims may need to apply for and obtain insurance to access them.

Having to bear the financial costs for an abortion constitutes a major barrier as procedures are expensive, according to interviewees in Slovakia and Germany. In Slovakia, participants agreed that costs pose a particular challenge for women, given that some providers there add 'additional costs' which nearly double the total price of this health service, from EUR 248 to around EUR 414. According to one expert, these costs represent a heavy financial burden even for citizens of the country – this expert estimated that the cost of an abortion would amount to 60 % of the disposable income of a household with two adults and two children, in a given month. Similarly, in Germany abortions were described as expensive, with the cost of the procedure varying from EUR 500 to EUR 600.

Insufficient insurance coverage, with a limited scope of free services forces individuals to seek costly services offered by private providers. For instance, in Czechia, state-provided psychiatric care covered by insurance is limited, therefore victims must often cover the costs themselves, which can be expensive. On a similar note, the only available options in Slovakia are often private (psychotherapists that must be paid for privately).

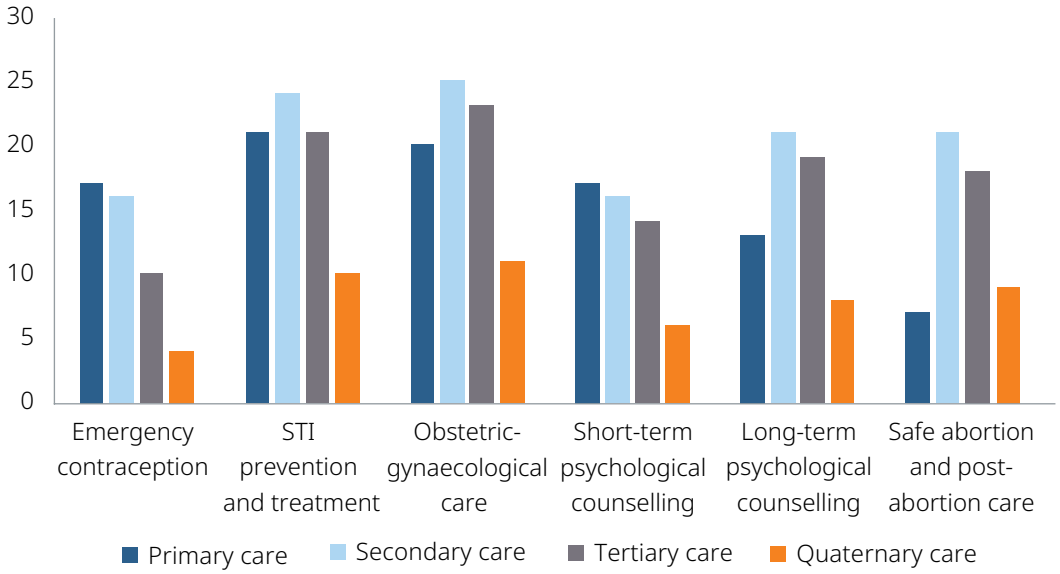
3.2. Availability

In the EU, specialised SRH services are distributed across different levels of patient care (WHO, 2022b).

- **Primary care.** Patients' first contact with a medical professional.
- **Secondary care.** Medical specialists, hospital care, acute care.
- **Tertiary care.** Highly specialised medical professionals.
- **Quaternary care.** More complex and specialised than tertiary care; it includes experimental treatment.

In relation to the availability of services, findings show that only two out of six analysed SRH services – emergency contraception and short-term psychological counselling, are most often provided at the primary care level – and these are usually delivered during the first contact with the medical professional. The remaining four SRH services are more often provided by health facilities classified as secondary care or even tertiary care, which – depending on the national framework – may require obtaining a referral from a primary care provider. This is particularly important in relation to STI prevention and treatment, and safe abortion or post-abortion care, due to the time-sensitive nature of these services. However, these are predominantly offered in secondary or tertiary care, with only seven Member States offering them on first contact with a medical professional ([48]).

Figure 3. Provision of SRH services by level of care (N=26), 2023



Question: In your Member State, which of the following specialised sexual and reproductive healthcare services are provided under primary, secondary, tertiary and quaternary care?
Source: Prepared by authors.

According to the questionnaire responses, the provision of all SRH services is organised either in healthcare centres and doctors' offices (or equivalent) or in hospital settings across all Member States. The provision of services is often complemented by women's organisations or other NGOs. The findings show that they provide a wide range of services, including emergency contraception ([49]) and obstetric and gynaecological care ([50]), yet their role is most prominent in the provision of

([48]) DE, IE, FR, HR, NL, SI, FI.
([49]) Provided by other NGOs in six Member States (BE, BG, DE, CY, LT, RO).
([50]) Provided by other NGOs in five Member States (DE, EL, CY, LT, RO).

STI prevention and treatment ([51]) and both short- ([52]) and long-term ([53]) psychological counselling. However, safe termination of pregnancy and post-termination care is provided only in healthcare centres, doctors' offices and hospitals in nearly all Member States. For example, only three Member States permit this procedure to take place in specialised abortion clinics ([54]) or sexual health centres ([55]).

It is important to note that only 13 Member States ([56]) **have established 'rape crisis centres',** which are highly specialised facilities designed to provide holistic care for victims of sexual violence, according to questionnaire responses. While the Istanbul Convention advises that they provide medical care and trauma support combined with immediate forensic examinations, responses suggest that these facilities are only able to offer selected SRH services. For example, only eight Member States provide emergency contraception ([57]), and six provide STI prevention and treatment ([58]). In addition, five states foresee specialised obstetric and gynaecological care ([59]). Further, 11 ([60]) Member States provide short-term psychological counselling, and six ([61]) provide long-term psychological counselling ([62]).

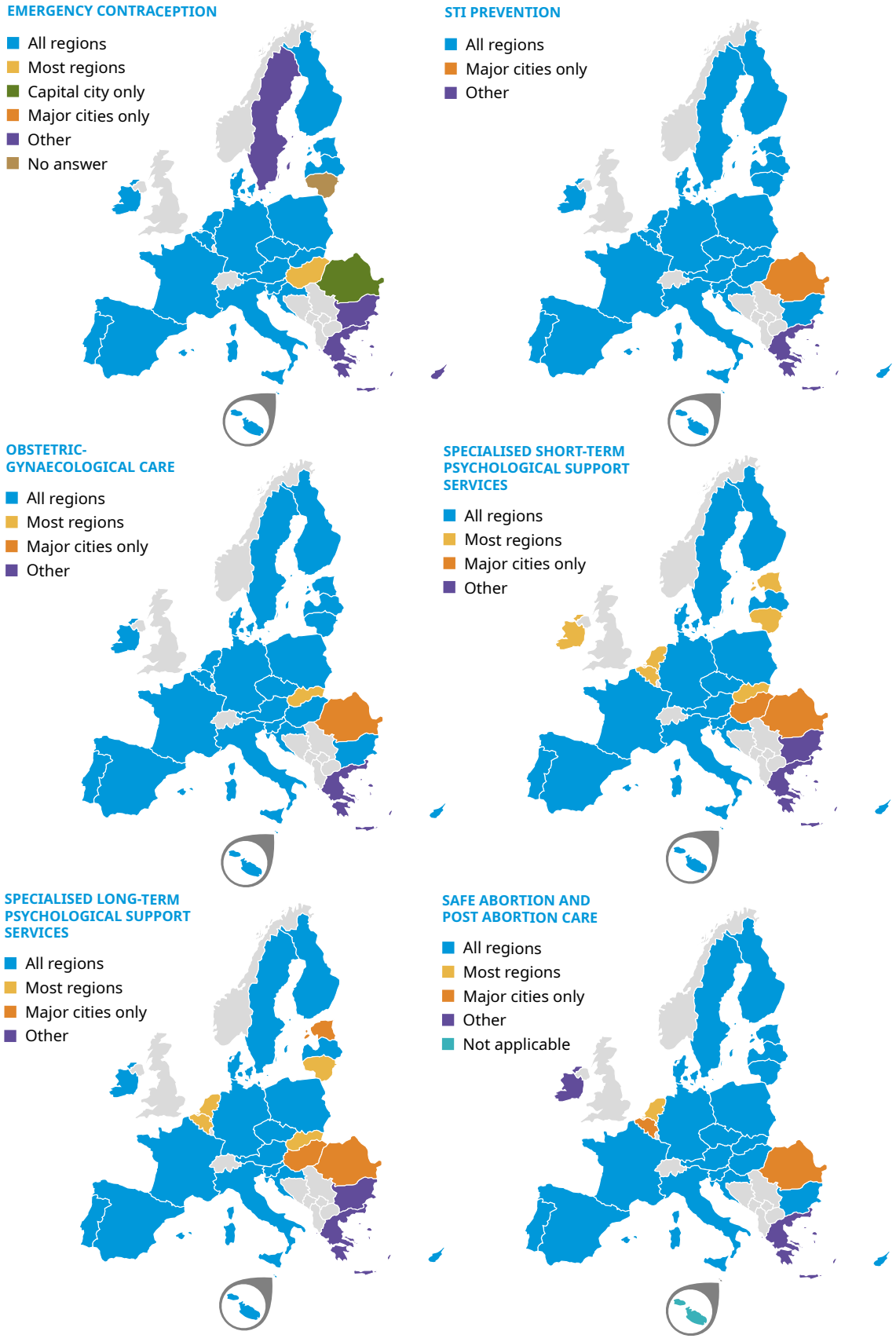
Regarding the geographical distribution of facilities that provide SRH services, 15 Member States ([63]) declare in the questionnaire that all six services are available in 'all regions (over 75 % of the regions)' within their state. However, in 10 EU Member States ([64]), access to certain SRH services may become more challenging as respondents argue they are provided only in major cities or selected regions.

To provide some examples: specialised short- and long-term psychological counselling for victims of CRSV is available in 'all regions (over 75 % of the regions)' in, respectively, 16 and 17 Member States, and in 'most regions (over 50 %)' or 'major cities only' in, respectively, 8 ([65]) and 7 ([66]) Member States. The respondent from Bulgaria indicated that specialised short- and long-term psychological counselling is only provided by NGOs. In Greece, there was no response in relation to this issue.

Responses from five Member States also stressed difficulties in accessing safe abortion and post-abortion care. These procedures are only available 'in most regions (over 50 %)' in the Netherlands, and only in major cities in Belgium and Romania, and they are not available in Malta, where pregnancy termination is illegal. The respondent from Ireland highlighted an uneven coverage of such services in rural counties, where very few primary care doctors provide safe abortion and post-abortion care.

([51]) Provided by other NGOs in eight Member States (BE, BG, CZ, DE, FR, CY, PT, SE).
([52]) Provided by women's rights organisation and other NGOs in respectively 8 (CZ, DE, EL, HR, LV, LT, HU, RO) and 12 (BG, CZ, DK, DE, EL, HR, CY, LV, LT, HU, MT, RO) Member States.
([53]) Provided by women's organisations and other NGOs in respectively 4 (HR, LV, LT, HU) and 10 (BG, CZ, DK, DE, HR, LV, LT, HU, MT, RO) Member States.
([54]) BE, NL.
([55]) FR.
([56]) BE, DE, DK, IE, EE, ES, LT, LV, HU, MT, NL, RO, FI.
([57]) BE, DK, EE, IE, LT, MT, RO, FI.
([58]) DE, DK, EE, IE, NL, FI.
([59]) BE, DK, LT, MT, RO.
([60]) BE, DE, DK, ES, LV, LT, HU.
([61]) BE, DE, DK, LV, LT, HU.
([62]) One explanation for discrepancies in this particular result might also stem from limited awareness about the scope of care provided in these types of facilities, since publicly available information on their scope of provision might differ.
([63]) CZ, DK, DE, ES, LV, IT, CY, FR, HR, AT, PL, PT, SI, FI, SE. Respondents from Cyprus and Sweden reported that emergency contraception is available in pharmacies.
([64]) BE, BG, EE, IE, LT, HU, MT, NL, RO, SK. The respondent from Greece did not provide specific information in relation to the geographical distribution of SRH services; instead, they highlighted that there are 7 regional health authorities spread around the country and around 102 public hospitals that offer such services.
([65]) BE, EE, IE, LT, HU, NL, RO, SK.
([66]) BE, EE, LT, HU, NL, RO, SK.

Figure 4. Geographical distribution of services (N=26), 2023



Question: What is the national distribution of the following specialised sexual and reproductive healthcare services in your Member State?
Source: Prepared by authors.

Key challenges regarding availability that were highlighted in interviews can be attributed to different factors linked to national contexts, such as general difficulties with the provision of healthcare: shortages of medical staff; unequal geographical distribution of health services; and an insufficient number of facilities with tailored support for victims.

In relation to short- and long-term psychological counselling, significant barriers due to a lack of provision were highlighted in interviews. The respondent from Poland pointed to the lack of state-led specialised services provided to victims of sexual violence and noted that these services are only available via a handful of NGOs. A lack of centres for people who require counselling specifically for sexual violence was stressed. Instead, women were only able to seek regular psychological counselling through health insurance schemes, which do not guarantee that counsellors are properly trained to assist patients who experienced sexual trauma. A similar challenge was noted by an interviewee from Czechia, who stated that specialist provision is limited, and women and girls fleeing the war in Ukraine can only rely on general healthcare services, which are difficult to access outside of cities.

In Slovakia, there is an overall lack of specialised counselling services targeting victims of sexual violence. The interviewee emphasised that there are two counselling centres in Bratislava that offer psychotherapeutic counselling to survivors of sexual violence and that there are two organisations that specialise in providing assistance to children. In the rest of the country, it was noted that there are only private providers.

The concern that insufficient provision leads to significant delays was expressed in three Member States. Challenges related to long waiting lists were identified by interviewees in Slovakia, Germany and Czechia. In Slovakia, victims may have to wait even half a year, noted one interviewee. In Germany, psychosocial centres for victims of violence fleeing war were developed in 2015 following the large arrival of Syrian refugees. However, victims covered by public health insurance (which includes individuals from Ukraine) encounter long waiting times, between 6 and 12 months, before a mental health professional can see them. This extended waiting period can exacerbate the mental health issues of Ukrainian victims of CRSV and may lead people to resort to unhealthy coping mechanisms, such as drugs and alcohol.

Czechia also has long waiting times, as experiences of violence are not a criterion for quicker access to psychological care, unless a person is identified as being high risk. The interviewee from Czechia shared that if a victim is found in a highly critical state (e.g. having suicidal thoughts) they can be referred to a crisis psychiatric centre, but even these are not specialised for victims of sexual violence.

3.3. Acceptability

The acceptability of SHR services in this study refers to several dimensions of their provision: whether services were provided in a gender- and diversity-sensitive manner, whether they were ethically and culturally appropriate and whether they were respectful of individuals, minorities and communities of different backgrounds. In addition, two dimensions of acceptability were examined: the availability of female staff to attend appointments with victims of CRSV and the availability of translators facilitating communication with medical professionals.

In relation to the acceptability of SHR services, findings suggest a limited awareness of measures in place for women and girls fleeing the war in Ukraine.

The availability of female staff is important for women to feel more comfortable when attending appointments related to the sexual violence they have been exposed to. However, only 7 out of 26 Member States consulted ([67]) declare that it is mandatory to have a female professional providing SRH services if requested by a woman or girl.

([67]) BE, CZ, CY, HU, LT, MT, FI.

In Czechia, the Act on Health Services provides this right ([68]). In Malta this is guaranteed by the sexual assault policy ([69]). However, nine respondents noted that the presence of female staff was not mandatory ([70]), another nine were not aware of any similar measure in place in their country ([71]), and the respondent from France did not provide an answer to this question.

Table 6. Mandatory provision of female healthcare professionals for SRH appointments (if requested) (N=26), 2023.

	BE	BG	CZ	DK	DE	EE	IE	EL	ES	FR	HR	IT	CY	LV	LT	HU	MT	NL	AT	PL	PT	RO	SI	SK	FI	SE
Yes	✓		✓							—			✓		✓	✓	✓								✓	
No		✓		✓		✓		✓		—	✓	✓										✓	✓			✓
Don't know					✓		✓		✓	—				✓				✓	✓	✓	✓			✓		

Question: Is it mandatory to provide a female staff member if requested by a woman or girl?
Symbol '—' represents the lack of answer.
Source: Prepared by authors.

Similar challenges were identified in relation to ensuring the linguistic comprehension of services, as only respondents from five Member States confirmed that English, Russian and Ukrainian interpreters are regularly available ([72]). In Portugal, this provision occurs via a telephone interpreting service, the 'National migrants support line', where patients can choose between 69 language options. Representatives of four Member States indicated that interpreters are available upon request, however, they did not specify the languages covered ([73]). In Spain, the provision is for English interpreters only. Respondents from Lithuania and Estonia explained that many healthcare professionals speak either Russian or English. Nine Member States ([74]) indicated that interpreters were not available. The respondents from Latvia and Austria did not know, and no answer to this issue was provided by the French representation (Table 7). The representative of Poland did not confirm the availability of interpretation services at SRH facilities. However, an application called LikarPL was launched to improve access to medical advice for Ukrainians in need of health consultations. The natural language processing of the application allows patients to share their medical history in Ukrainian, Russian and English, thus facilitating their communication with healthcare professionals.

According to the interviewees in Germany, Slovakia and Czechia, it was noted that language barriers make accessing services more difficult. Similarly, Czechia and Germany noted that persons arriving in their countries find it challenging to navigate the healthcare system due to its complex structure. Experts, however, shared the view that problems can be exacerbated for this group.

Findings from the interviews also stressed the crucial role that NGOs play in helping women arriving in the EU overcome language barriers and disseminating information on available services.

([68]) Act No 372/2011 Coll.
([69]) The respondent did not provide additional information on this or provide a source.
([70]) BG, DK, EE, EL, HR, IT, RO, SI, SE.
([71]) DE, IE, ES, LV, NL, AT, PL, PT, SK.
([72]) DK, IE, PT, FI, SE.
([73]) BE, HU, CY, MT.
([74]) BG, CZ, DE, EL, HR, IT, NL, RO, SK.

Table 7. Availability of translator services at SRH services by language (N=26), 2023.

	BE	BG	CZ	DK	DE	EE	IE	EL	ES	FR	HR	IT	CY	LV	LT	HU	MT	NL	AT	PL	PT	RO	SI	SK	FI	SE
English				✓			✓			—					✓						✓		✓		✓	✓
Ukrainian				✓			✓			—											✓		✓		✓	✓
Russian				✓			✓			—					✓						✓				✓	✓
Other	✓			✓		✓	✓		✓	—			✓			✓	✓			✓	✓					
Not available		✓	✓		✓			✓		—	✓	✓						✓				✓		✓		
Don't know										—				✓					✓							

Question: Are translators regularly available at the specialised sexual and reproductive healthcare services?
Symbol '—' represents the lack of answer.
Source: Prepared by authors.

With regard to the acceptability in terms of provision of services in a gender- and diversity-sensitive manner and whether the services were ethically and culturally appropriate and respectful of individuals, minorities and communities of different backgrounds, several issues surfaced. A lack of training and guidelines for professionals to ensure that their conduct is gender- and diversity sensitive, as well as victim-centred, was highlighted.

In Germany, one interviewee noted possible discriminatory treatment towards those perceived as migrants, which suggests an urgent need for diversity training. The level of understanding of victims' needs was described as dependant on the personal interest of the professional in the area of sexual violence. In Czechia, there are no recommended guidelines for doctors regarding the treatment of sexual violence victims, and there is also a scarcity of professionals appropriately trained to work with such victims, particularly among police and healthcare providers. Interviewees described how both police and healthcare workers who come into contact with victims are not properly trained on how to respond in a sensitive manner. Interviewees also stressed that wider change is needed in Czechia to address prejudice that women face when seeking help.

Responses to address the challenges identified focused on disseminating information to victims, particularly in Ukrainian. Organisations in Poland and Germany produced leaflets and brochures about how to access specific services and increased the availability of Ukrainian speakers for existing helplines. In Czechia, organisations have provided seminars for pregnant women from Ukraine, explaining the Czech healthcare system and how to register for insurance.

Expert interviewees mentioned concrete examples of specific projects and initiatives to respond to the crisis in Ukraine. For instance, Poland has a special programme called 'safe space' for Ukrainian women where they provide safe accommodation and social assistance for the women that arrive by helping them to register for Polish social services. A Slovak NGO deployed a team at the Ukrainian border, where it was active for 3 months. Furthermore, a clinic which employs Ukrainian healthcare staff was opened to provide health services in Ukrainian and help address backlogs in the health system. However, these staff work under the supervision of Slovak healthcare professionals, as Ukrainian staff still lack the necessary accreditation in Slovakia. The team also includes case managers who are able to refer a patient to a specialist (if required). The Slovak NGO also operates mobile teams across different regions of Slovakia to reach persons who do not have access to healthcare.

3.4. Quality

National standards or guidelines regarding the provision of specialised SRH services can help improve the quality of healthcare provided and ensure that victims receive a 'particularly sensitive response by trained and specialised staff', as is required by the Istanbul Convention. The benefits of

delivering the services in one place – either in accessible rape crisis centres or in coordinated care pathways, such as sexual violence referral centres, where women are swiftly referred from one institution to another – is also highlighted by the Istanbul Convention (Council of Europe, 2011).

To provide effective support, authorities and organisations coming into contact with victims need to establish referral mechanisms to quickly refer victims to specialised services. Questionnaire responses indicated that more than half of the consulted Member States have referral mechanisms in place to assist victims of sexual violence and to refer them to specialised SRH services (17 out of 25 states) ([75]).

For example, the respondent representing Greece highlighted a structured pathway that is supported by the government and is adjusted to the specific needs of Ukrainian victims of sexual assault who have arrived in Greece. The network of structures is staffed by expert psychologists, social workers and lawyers specialised in the counselling of women, and they offer counselling free of charge in Greek and in English. This service is available 24/7 via a nation-wide helpline (SOS 15900). Further, with the support of the UNHCR, a cultural mediator of Ukrainian origin has been recruited to provide interpretation (in Ukrainian and Russian) and to escort Ukrainian refugee women and ensure they are supported by the network of structures. Cultural mediators also facilitate awareness raising activities and focus group discussions. A pamphlet with the title 'We are here for you', available in three languages (English, Ukrainian and Russian), has been produced in cooperation with UNHCR and it is available at the entry points to Greece.

In Italy, a Decree (DPCM 24/11/2017), signed by the Council of Ministries, lays down nation-wide guidelines for health agencies and hospitals regarding the provision of assistance and support to women victims of violence and establishes a clear referral protocol. The document describes the diagnostic and therapeutic treatment offered to victims, the guidelines for forensic analysis and a codified risk assessment tool. In any case where risks of further violence are assessed as high, the medical staff is obliged to inform them about their rights and the relevant support services available ([76]).

Interview findings also suggest the need to urgently improve coordination and communication between professionals in the police, healthcare and social care sectors. For example, in Slovakia, specialised services were described to be overall very fragmented, noting that 'doctors treat the medical issues and psychologists focus on mental health'. Therefore, there is no concept of treating trauma as a complex issue requiring a multidisciplinary response. Similarly, in Poland, an interviewee described the system as 'very chaotic' and not designed for victims of sexual violence: victims must seek support from many different places for different services. This fragmentation ultimately hinders the process of referral between these institutions and the capacity of victims to access the range of services available.

In Czechia, referral pathways exist and are mainly provided by the police, however this is the same referral process used for victims of domestic violence. There is no system in place to respond in a more holistic way so that relevant healthcare workers can work in coordination with police. Similarly, Slovakia has no current referral pathways guaranteeing access to services in the country that the interviewees were aware of. In Poland, referral systems are more frequently available in larger urban cities than in smaller towns and rural areas. An interviewee noted that in the absence of official referral pathways, women have created informal support networks to refer and direct each other to available services. In Poland, in 2015, an organisation created a special procedure for the police to help them properly support victims of sexual violence and refer them to available healthcare services. While the procedure was adopted by the police, officers are largely

([75]) BG, CZ, DK, EE, IE, EL, ES, HR, IT, CY, HU, MT, NL, PT, RO, SI, SE.

([76]) Decreto del Presidente del Consiglio dei Ministri 24 novembre 2017 Linee guida nazionali per le Aziende sanitarie e le Aziende ospedaliere in tema di soccorso e assistenza socio-sanitaria alle donne vittime di violenza. (18A00520) (GU Serie Generale n.24 del 30.01.2018).

unaware of the procedure or are unfamiliar with how to apply it in their work. Moreover, changes in the country's political context have made it difficult to maintain communication and engagement with police officers and other stakeholders. In Germany, the situation is similar: there are no standardised referral pathways or evidence-based guidelines in place for providing care to victims of sexual violence at the national level, although some local pathways exist. The interviewee in Germany noted efforts undertaken by organisations to distribute the 2013 WHO guidelines on intimate partner violence and sexual violence (WHO, 2013), which are not widely used, to healthcare providers. Moreover, each state has a different referral system, and access is also dependent on the availability of specialised practitioners within different towns. This interviewee noted that '[r]eferral depends on the knowledge of the healthcare practitioner, the actions of the victim, the local context, and the availability of services at a given time', and this was evidenced by the responses in all the case study interviews. A more effective referral mechanism would rely on robust and adaptable systems with clear guidelines and procedures. Overall, in the four countries examined, referral systems are very limited, with referrals taking place on an ad hoc, case-by-case basis. To improve referral mechanisms in the EU, participants mentioned the need for common guidelines for professionals in the police, healthcare and social care sectors that work with victims of sexual violence and CRSV.

National standards or quality guidelines on the provision of SRH services were confirmed to be in place in just 12 Member States, according to questionnaire responses. Some practices ensuring high quality care for victims of sexual violence were identified in Belgium, Finland and Croatia. In Belgium, specialised SRH dealing with sexual assault is provided in sexual assault care centres, and national standardised guidelines and procedures are in place and issued at the federal level. In 2017, Belgium created the first three Sexual Assault Care Centres (SACCs) where victims of sexual violence could be provided with both acute and long-term medical, forensic and psychological care. Victims can also press charges at the SACCs. These centres are free of charge and accessible to refugees and undocumented migrants. By the end of 2023, each judicial district and province will have one SACC. With regard to specialised SRH provision outside sexual assault care centres, federal and regional guidelines apply. In addition, there are also regional organisations that provide certain types of SRH services (e.g. Luna abortion centres in Flanders and family planning centres in Wallonia).

Similarly, in Finland, the Finnish Institute for Health and Welfare has developed guidelines on the provision of specialised SRH on the basis of the HUS-Seri support centre model ([77]). Seri support centres for victims of sexual violence are support units for victims of sexual violence. They offer relevant healthcare services, such as psychological counselling and forensic examinations, from an interdisciplinary holistic perspective ([78]).

A further example was described by the respondent from Croatia, where in 2012 the Croatian government introduced a protocol on procedures in the case of sexual violence with the aim of providing standardised rules of conduct with victims of sexual violence, along with assistance and support from relevant institutions. The protocol describes the procedure for first examinations and the possible referral pathways: victims of sexual violence must be examined in general hospitals and clinical health institutions. While the protocol differs from the 'one-stop model', where victims receive help in one facility, it obliges healthcare institutions to provide trained and qualified personnel that are ready 24/7 to conduct examinations in cases of sexual violence. It also permits one or more persons to coordinate assistance provided to victims of sexual violence and provides for the availability of medications for sexually transmitted diseases and pregnancy prevention. In 2023, the protocol on procedures in cases of sexual violence was being updated.

([77]) Seksuaaliväkivallan uhrin hoitoketju: HUS Seri-tukikeskuksen malli Bildjuschkin, Katriina, Nipuli, Suvi; (2018) Seksuaaliväkivallan uhrin hoitoketju: HUS Seri-tukikeskuksen malli Seksuaaliväkivaltaa kokeneen psykososiaalisen tuen jatkohoito: HUS Seri-tukikeskuksen malli Bildjuschkin, Katriina; Hakkarainen, Pertti; Rajakaltio-Kiuru, Katja; Kiuru, Elina (2021) Seksuaaliväkivaltaa kokeneen psykososiaalisen tuen jatkohoito: HUS Seri-tukikeskuksen malli.

([78]) Seri-tukikeskus seksuaaliväkivallan uhreille.

However, the questionnaire revealed an important awareness gap, since respondents from 10 Member States were not aware of whether such standards or guidelines existed in their countries, and one did not provide any response in relation to this (France) (Table 8).

Table 8. National standards or guidelines in place on the provision of SRH services (N=26), 2023

	BE	BG	CZ	DK	DE	EE	IE	EL	ES	FR	HR	IT	CY	LV	LT	HU	MT	NL	AT	PL	PT	RO	SI	SK	FI	SE
Yes	✓	✓				✓	✓		✓	—	✓	✓	✓			✓	✓				✓				✓	
No				✓				✓		—													✓			
Don't know			✓		✓					—				✓	✓			✓	✓	✓		✓		✓		✓

Question: Are there national standards and guidelines in place that are primarily or exclusively focused on the provision of specialised sexual and reproductive healthcare services?
Symbol '—' represents the lack of answer.
Source: Prepared by authors.

Key challenges were outlined by the interviewees from Czechia, Germany, Poland and Slovakia regarding the lack of coordination and communication between professionals in the police, healthcare and social care sectors. Insufficient knowledge and training on essential components of obstetric-gynaecological healthcare provided to victims of sexual violence and their specific needs was reported.

In this regard, in Czechia, for example, interviewees argued that gynaecologists lack the necessary training to provide specialised services to victims beyond standard medical care. In Germany, victims of sexual violence, particularly CRSV, struggle to find a doctor that understands their distinct needs. This shows that there is not enough training for gynaecologists to understand the needs of victims of sexual violence, as it is not mandatory. Similarly, the interviewees in Poland and Czechia seemed to share this view, emphasising that current training provided to professionals working with victims of sexual violence (both conflict- and non-conflict related) is insufficient and reflects on the overall lack of systematic training outside of that provided by NGOs.

In Slovakia, an overall low awareness of the specific needs of victims of sexual violence was observed. One interviewee described how the healthcare sector lacked a standardised process for addressing the needs of victims of sexual violence up until the year prior to this study. The standardised process, once adopted, was described as a 'first step', and some concerns still remain about victim sensitivity and the extent to which it addressed prejudice. There is also no specialised training for doctors on how to implement this new procedure and raise awareness of its existence.

Several interviewees stated that they provide training to try to fill knowledge gaps and demonstrated this by providing examples of their initiatives. These focused on, among other things: improving healthcare and other professionals' ability to provide survivor-centred care and clinical management of rape victims from Ukraine; raising awareness about reproductive rights and gender-based violence among humanitarian organisations and healthcare providers; and more general training on gender-based violence for police officers and/or institutions responsible for social protection.

When asked about their recommendations to improve access to specialised services, experts formulated a wide range of initiatives, which seem to respond to issues they consider most pressing in their national contexts. In Poland, government action was needed to strengthen institutional responses, according to interviewees, but they did not consider this to be likely and, therefore, efforts should be focused on making changes at the local level, with more support and funding for NGOs. Other interviewees highlighted a range of initiatives that should be taken, including the

development of sexual assault care centres that would provide all the services needed by victims of sexual violence and CRSV. Another initiative would involve the provision of training through workshops to educate medical staff, police, social care workers and psychological workers. The revision of laws to improve access to abortion and contraception were also mentioned. In addition, interviewees suggested that reimbursement should be made available for those requiring emergency contraception. Finally, they also recommended a focus on raising awareness as to how, when and where to access legal abortion services in Poland.

In Germany, institutional responses would be strengthened by improved service provision and by introducing tailored services that recognise the specific trauma experienced by victims of CRSV, according to interviewees. In addition, the provision of round-the-clock centralised medical care and evidence collection were recommended. Furthermore, participants stressed the need for improved access to counselling and therapy for victims. They also indicated that the law permitting anonymous evidence collection without reporting the crime should be fully implemented. More effort was called for to address language barriers. It was proposed that insurance companies should employ translators in medical contexts to make services more accessible. In addition, German interviewees highlighted how health professionals should be sensitised to this topic and receive training in a standardised way. They also expressed the need for evidence-based national guidelines on standards for minimum care. They argued that the process of inter-agency cooperation and referrals could be improved by the provision of more information for professionals on how to make referrals. To overcome this issue, hospitals, police and other institutions should provide victims with lawyers to help them navigate the available support. Finally, they recommended improved data collection to increase the understanding of victims' needs and victims' ability to access services.

More training for key professions, such as the police and healthcare providers, was called for in Czechia. There is also a need for systematic change to challenge the prejudices that women can face when seeking help, and to address the narrow definition of rape in Czech legislation. In Slovakia, one interviewee stressed the need for government clarity on whether NGOs, which are accredited to provide social services for victims of domestic violence, can provide services to Ukrainian women as well. To date, these NGOs have not provided these services and some are hesitant to provide such services for fear that they will lose their accreditation. In Czechia, Germany, Poland and Slovakia, victims of sexual violence can struggle to find a doctor who understands their complex and distinct needs, as gynaecologists are not trained to provide tailored support for victims of sexual violence and CRSV. In Czechia, unless a victim first reports a crime to the police, she may not be able to receive specialised examination by a gynaecologist beyond standard medical care. In Slovakia, due to a shortage of specialists, women and girls may need to wait long periods before securing an appointment with a gynaecologist.

4. Conclusions

EU Member States reacted swiftly to the Council of the European Union's decision to trigger the TPD.

In response to the Council of the European Union's decision to activate the TPD, EU Member States introduced specific legal and policy instruments which regulate the access to healthcare services for persons benefiting from temporary protection in the EU. Member States significantly reduced the administrative burden in order to offer temporary protection to persons fleeing Russia's war of aggression against Ukraine without undue delay. Member States approach TPD requests flexibly, offering access to healthcare immediately (three Member States) or accepting various documents presented by persons fleeing war. Nevertheless, challenges were found in implementing the healthcare standards set in the TPD across Member States due to a lack of guidelines within the directive on the scope of services for victims of sexual violence, in particular SRH services.

Women and girls fleeing the war in Ukraine can access essential SRH services in the majority of EU Member States, but eligibility gaps under the TPD were identified.

In the majority of Member States, persons protected under the TPD can access healthcare services on equal footing with their respective citizens. While most Member States declare that women fleeing war can access all six sexual and reproductive health services, which form essential care for victims of sexual violence, several eligibility gaps in different Member States were uncovered. These most often concerned a lack of medical coverage for emergency contraception, or a limited provision of short- and long-term psychological counselling, and safe abortion and post-abortion care.

Women and girls fleeing war face several practical and financial access barriers which prevent them from obtaining the SRH services they urgently need.

Shortages of medical staff, the unequal geographical distribution of health services and the insufficient number of facilities with tailored support for victims all limit victims' access to holistic care. While the root causes of these challenges stem from prior conditions, rather than from the large number of persons arriving from Ukraine, women and girls face additional barriers, particularly because of language barriers and their lack of knowledge about healthcare systems.

In addition, limited medical coverage for SRH services creates obstacles for women and girls fleeing war in vulnerable economic and social circumstances. The procedures are expensive even for citizens. Alarming practices of some providers charging 'additional costs' make them even less affordable. More effort is needed to ensure that all SRH services are available for free for women and girls fleeing war.

The evidence points to restrictive legislation having severe effects on the sexual and reproductive rights of women and girls fleeing war.

The availability of services is also severely affected by existing strict national legislation concerning sexual and reproductive health, such as requiring a prescription for emergency contraception, the need for prior parental consent, and age limits set by national legislation. Access to SRH is encumbered due to mandatory consultations or a 'reflection period' before the procedures. In addition, further delays are caused by the requirement to obtain a prosecutor's certificate to terminate the pregnancy or when healthcare providers refuse to provide safe abortions and emergency contraception on grounds of conscientious objection.

Specialised safe abortion and post-abortion care bears more restrictions than other services analysed in this report. The evidence suggests that obtaining safe abortion and post-abortion care is available for women and girls fleeing war without any restrictions in only five Member States.

Secondary effects of legal restrictions on access to abortion include, among other things, challenges in identifying providers due to a limited number of doctors who decide to perform abortions. In the most extreme cases, women and girls fleeing the war in Ukraine who seek abortions need to travel abroad or back to Ukraine to obtain this service.

Legal requirements on parental consent mark a significant barrier preventing minors' access to SRH services, particularly in migration and refugee contexts.

Across the European Union, several Member States require minors to present parental consent to access specialised SRH services. When this practice is applied to unaccompanied girls in migration and refugee contexts, it not only exposes them to additional stress but may also hinder their progress or cause delays in accessing SRH services. This legal requirement is especially challenging with respect to the time-sensitive nature of certain SRH services, such as STI prevention and treatment, emergency contraception, and safe abortion and post-abortion care. Although the study identified some promising examples to ensure care for minors, a need for more systemic solutions to ensure confidential SRH care for minors was also highlighted.

Referral mechanisms for victims of CRSV are ad hoc and require better coordination.

Referral mechanisms are a crucial way for victims to access SHR services. However, only 17 Member States could confirm the existence of such mechanisms in their respective countries. Moreover, the findings highlight the urgent need to improve coordination and communication between professionals in the police, healthcare and social care sectors, since referrals often take place on an ad hoc, case-by-case basis.

The evidence further suggests that specialised services for victims are rather 'fragmented', and swift referral depends largely on the local context, the availability of services at a given time and the knowledge of the healthcare practitioner. As a result, in Member States where referral mechanisms are lacking, victims must seek support from different places for different services. This gap is characterised by the fact that the network of specialised sexual assault care centres providing holistic care for victims of sexual violence is underdeveloped across the EU – they are only available in less than half of the Member States (13). The evidence highlights in particular free 'one-stop' sexual assault care centres, accessible to refugees and undocumented migrants, where victims receive short- and long-term medical, forensic and psychological care in one facility.

National standards and specialised training on how to respond to the specific needs of victims of CRSV are lacking.

National standards or guidelines regarding the provision of specialised SRH services can help improve the quality of healthcare provided. However, just under half of the surveyed Member States (12) indicated having knowledge of the standards or quality guidelines in place.

The evidence highlights, however, that action taken by Member States to develop specialised guidelines serves as an important step towards interdisciplinary holistic care. The documents highlighted in this study describe, among other things, the diagnostic and therapeutic treatment offered to victims and the guidelines for forensic analysis, but often also contain a codified risk assessment tool. They also place emphasis on ensuring the round-the-clock availability of personnel ready to conduct examinations in the event of sexual violence, along with standardised training for healthcare professionals on how to effectively respond to the needs of victims in a sensitive and trauma-informed manner.

NGOs and women's rights organisations fill the gaps in the provision of SRH for victims, especially short- and long-term psychological counselling.

NGOs and women's rights organisations play a crucial role in providing specialised support for victims of sexual violence and complement services offered by medical facilities and hospitals. Their support is particularly prominent when it comes to short- and long-term psychological counselling, as the distribution of these two services over the different regions is less pronounced across the EU. Women's NGOs and other NGOs have a prominent role not only in providing SRH services, but also in undertaking various initiatives, such as training and sensitising healthcare professionals on the topic of sexual violence and facilitating access to healthcare services for women and girls from Ukraine.

5. Recommendations

This section outlines five recommendations for EU institutions and Member States to improve the provision of specialised SRH services for victims of CRSV. These recommendations are based on gaps and challenges identified throughout the study.

Access to specialised SRH services for victims of CRSV must be strengthened.

Recommendations for EU institutions

- Implement the Istanbul Convention to ensure coherence across Member States in preventing and combating violence against women, and support Member States in ensuring specialised services for victims of all acts of violence covered in the convention via dedicated funding.
- Adopt the proposed directive on combating violence against women and domestic violence to enshrine minimum standards in EU law and Member States for ensuring, among other things, protection and support for victims and coordination between relevant services.
- Adopt the revision of the Victims' Rights Directive and ensure that victims of (conflict-related) sexual violence have easy access to targeted and integrated specialist support services, and a possibility to rely on free of charge psychological support for as long as necessary.
- Clarify the scope of necessary healthcare for victims of (conflict-related) sexual violence in the TPD to guide Member States in ensuring the provision of services so that victims can exercise their SRH rights in each Member State on an equal basis. Introduce an exhaustive list of the necessary SRH services that victims of any form of sexual violence should be entitled to, regardless of their status, in accordance with international guidelines of care.
- Encourage Member States to establish and guarantee specialised and immediate support systems in rape crisis or sexual violence referral centres, to ensure that holistic, victim-centred and gender-sensitive care is provided. Allocate dedicated funding and facilitate the exchange of promising practices and information among Member States. This exchange should actively involve civil society and women's rights organisations.

Recommendations for Member States

- Ratify the Istanbul Convention and implement its legal standards in order to further develop a comprehensive framework for the protection of and provision of assistance to all victims of violence against women.
- Ensure that women and girls under temporary protection are fully eligible to access specialised SRH, including all services that are considered essential in the clinical management of sexual violence according to international guidelines.
- Introduce guidelines clarifying any ambiguities in applying the TPD, especially in relation to the scope of healthcare services available to victims of (conflict-related) sexual violence. Legal provisions include clear definitions and are consistently and easily interpreted by all stakeholders, such as insurance providers and service providers.
- Develop or further expand a network of specific and immediate support in rape crisis centres so victims can avoid delays. Ensure that the scope of services includes the key components of essential SRH for victims of (conflict-related) sexual violence and allows forensic examination, upon consent of the victim.

Mitigate legal restrictions related to age and establish mechanisms that ensure minors' access to SRH services.

Recommendations for EU institutions

- Continue to support Member States in ensuring the proper implementation of all parts of the TPD, particularly Article 13(4), which requires Member States to 'provide necessary medical or other assistance to persons enjoying temporary protection who have special needs, such as unaccompanied minors or persons who have undergone torture, rape or other serious forms of psychological, physical or sexual violence' and to ensure that the lack of a present legal guardian does not impede their access to medical or other assistance.

Recommendations for Member States

- Reduce, to the extent possible, the administrative burden of accessing SRH services, thereby allowing minors under temporary protection to avoid delays in the provision of time-sensitive services.

- Establish mechanisms to address the vulnerability of unaccompanied minors, to ensure that their age and/or the lack of parental consent does not limit their access to SRH services.

Ensure that language barriers, the cost of services, long waiting times and the geographical distribution of healthcare facilities do not prevent women and girls from accessing and receiving adequate SRH services.

Recommendation for EU institutions

- Support Member States in ensuring specialised services for victims are offered in 'adequate geographical distribution' and information on the availability of services is provided 'in a language they understand' – as set out in the Istanbul Convention – by providing targeted funding.

Recommendations for Member States

- Ensure that SRH services are affordable and, in this regard, consider women and girls in vulnerable positions, so as not to hinder those who are economically and socially disadvantaged from accessing the services needed in a timely manner.

- Strengthen the efforts to ensure that interpreters and female healthcare professionals are available to assist women and girls, if requested.

- Publish and widely disseminate information on entitlements to medical and other support services for victims of (conflict-related) sexual violence in different languages to make them more accessible for victims in migration and refugee contexts.

Introduce or strengthen existing guidelines and referral mechanisms tailored to responding to the needs of victims of (conflict-related) sexual violence and improve coordination among public services.

Recommendation for EU institutions

- Provide guidelines on the correct implementation of EU rules on temporary protection and victims' rights, and support Member States in developing or improving existing needs assessments and referral mechanisms for victims of (conflict-related) sexual violence.

Recommendations for Member States

- Assist victims in finding and addressing the competent authorities to avoid repeat referrals. Public services should work in a coordinated manner at the national, regional and local levels to ensure that victims receive the proper degree of assistance, support and protection.

- Introduce national guidelines outlining the responsibilities of the police, healthcare and social care sectors in responding to victims of (conflict-related) sexual violence, and improve

referral mechanisms and needs assessments among these sectors.

Introduce training for healthcare professionals on how to respond to the specific needs of victims of (conflict-related) sexual violence with the support of rape crisis centres and NGOs.

Recommendations for EU institutions

- Raise awareness on existing international guidelines on how healthcare providers should respond to sexual violence, for example through the development of an online training programme reinforcing the need for ethical standards, and trauma-informed and gender-sensitive responses.

- In line with Article 25 of the Istanbul Convention, the European Commission could encourage Member States and provide the funding needed to establish sufficient and easily accessible rape crisis centres with the means to carry out medical and forensic examinations, and provide trauma support and counselling for victims.

Recommendations for Member States

- To improve the institutional responses, establish accessible rape crisis centres that provide specialised and immediate support, ensuring the holistic, victim-centred, gender-sensitive and culturally sensitive provision of SRH services.

- In cooperation with the national governments and relevant local authorities encourage the establishment of regional and local working groups involving rape crisis centres, NGOs, healthcare providers and other professionals to facilitate the sharing of tools and best practices that can be used in responding to (conflict-related) sexual violence.

- Provide training for health professionals to ensure that victims of (conflict-related) sexual violence receive professional healthcare which is fully aligned with international recommendations on the clinical management of sexual violence.

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Annex 1. Methodology

This annex outlines the methodology of the desk research and the questionnaire administered to experts representing Member States, and the semi-structured interviews in the four case study countries.

A1.1. Desk research

Desk research was carried out to ensure a comprehensive understanding of the legal instruments and laws related to CRSV and access to healthcare, along with relevant legislative and policy texts. Table 8 details the scope and key elements of the study while Table 9 details the key words used to source relevant documents. The search engines used were Google, Bing and the research database EBSCO.

Table 9. Scope and key elements of the study

Element	Within scope
Geographic coverage	EU-27 Member States
Areas of public policy	Women's health and gender policies Victimology, specifically due to sexual violence
Areas of law covered (only legislation applicable during the timeframe)	Fundamental rights legislation, more specifically sexual and reproductive rights Anti-discrimination legislation, particularly with regards to discrimination against women and girls Migration law, more specifically the legislation guaranteeing access to healthcare International humanitarian law, more specifically with regards to sexual violence in wartime
Timeframe	Since Russia's invasion of Ukraine (24 February 2022) and covering the duration of the study
Stakeholders to be consulted	Institutions and actors providing short-term psychological support and specialised services to women and girl victims of CRSV in relation to reproductive and sexual health Non-governmental organisations or independent institutions monitoring access to SRH and/or providing specialised support for victims of violence against women

Table 10. Keywords

Research topic	Keywords	Anticipated outcomes
EU and international legislation and policy documents	'sexual rights', 'reproductive rights', 'right to healthcare', 'women and girls fleeing the war', 'Ukraine', 'EU', 'victims of conflict-related sexual violence', 'migrants in vulnerable situations', 'war crimes', 'temporary protection', 'international protection'	• Comprehensive mapping of key instruments of international, regional and EU legal frameworks • Refined level of legal obligations for Member States to protect reproductive and sexual rights • Identification (in part) of formal requirements for access to (specialised) healthcare for women and girl victims of CRSV
Risks of sexual violence for women and girls in times of conflict	'women and girls fleeing the war', 'Ukraine', 'EU', 'victims of conflict-related sexual violence', 'sexually transmitted infections', 'sexually transmitted diseases', 'human trafficking for sexual exploitation', 'migrants in vulnerable situations', 'war crimes'	• Estimation of the risk of sexual violence for women and girls in times of conflict • Comprehensive listing of factors increasing the risk of sexual violence for women and girls in times of conflict • Developing an overview of the impact of vulnerabilities on migrant women and girls' access to their reproductive and sexual rights

Research topic	Keywords	Anticipated outcomes
Roots and links to gender inequality	'anti-discrimination', 'discrimination', 'prejudice', 'access to specialised healthcare', 'women and girls fleeing the war', 'Ukraine', 'EU', 'victims of conflict-related sexual violence', 'accessibility of healthcare services for migrants'	• Assessment of the root causes of sexual violence against women and girls in times of conflict • Conceptualising links between sexual violence against women and girls in times of conflict, its roots and gender inequality • Gaining a deeper understanding of different levels of access to specialised healthcare for migrants, depending on gender
Scope of SRH services for victims of conflict-related sexual violence and new policies to guarantee access to this healthcare	'obstetric and gynaecological care', 'postnatal care' and 'puerperium', 'emergency contraception', 'prevention for sexually transmitted infections/diseases', 'treatment for sexually transmitted infections/diseases', 'safe abortion', 'post-abortion care', 'long- and short-term psychological counselling', 'medical coverage for migrants', 'free of charge', 'medical healthcare systems', 'all Member States', 'new policies', 'specific measures', 'migrants with special needs'	• Refined understanding of the scope of reproductive and sexual health services for women and girl victims of CRSV in each Member State • Preliminary understanding of the extent of medical coverage in Member States for women and girl victims of CRSV in each Member State • Preliminary listing of new policies • Gaining a preliminary understanding of the implementation of the TPD and specific measures guaranteeing medical or other assistance for persons who have undergone sexual violence

A1.2. Questionnaire

A1.2.1. Questionnaire: methods and responses

Given the focus on Member States' legal measures relating to the provision and access to SRH services for women and girls fleeing the war under the TPD, it was important that the target audience have the required knowledge to respond to the questions in the questionnaire. To this end, efforts were made to identify and contact relevant national-level representatives in all 27 Member States, with requests sent to health attachés from the permanent representations of Member States, and to deputy directors and heads of section in health ministries in all Member States. Where no response was received, representatives of academia were invited to participate in the questionnaire.

The questionnaire was provided in English ([79]) and had both closed (to collect quantitative data) and open-ended questions to capture complementary qualitative data. The EU-wide questionnaire was undertaken between November and April 2023.

The questionnaire was completed by 26 Member States. Luxembourg did not participate due to a lack of data on access to SRH services.

A1.2.2. Questionnaire limitations

As the questionnaire was administered in English, linguistic barriers need to be taken into account. Potential differences concerning healthcare systems across the EU must also be noted.

To maximise the number of responses received, the questionnaire link was sent to relevant contact points in the health ministries and it could have been, if necessary, passed along internally to a staff member. The questionnaire provided an option to record the job title of the person providing the information. However, while comprehensive measures were taken to ensure that the correct department and staff member were contacted to receive the request, there were some challenges in obtaining responses from all 27 Member States.

As a consequence, the results express the knowledge of individuals responding to the questionnaire, who may represent different sectors and roles, which could reflect various levels of knowledge about the specific services explored in the questionnaire. The responses were not cross-validated with available literature and policies.

([79]) Given the target audience of national-level representatives, providing the questionnaire in English was not anticipated to be a problem for respondents. However, some responses required translation.

Table 11. Questionnaire

Focus	Question	Response option
Job title	Please provide your job title and department within your ministry	[Open text box]
Member state	In which Member State are you located?	• Belgium • Bulgaria • Czechia • Denmark • Germany • Estonia • Ireland • Greece • Spain • France • Croatia • Italy • Cyprus • Latvia • Lithuania • Luxembourg • Hungary • Malta • Netherlands • Austria • Poland • Portugal • Romania • Slovenia • Slovakia • Finland • Sweden

Section 1. Provision of specialised sexual and reproductive healthcare services and national distribution of services
This section explores the provision of SRH services. Specialised services are designed and provided to meet the needs of victims of specific forms of violence against women and are not open to the general public. These may be government-funded or provided by the government or NGOs.

Question number and focus	Question	Type of question	Question statements	Response options
Q1 Legal entitlement to sexual and reproductive healthcare services	Are women and girls fleeing war, protected under Directive 2001/55/EC, legally entitled to the following specialised healthcare services? Please note this excludes any legal restrictions on eligibility due to the individual's age or whether they have health insurance.	Grid/matrix style Single choice	• Specialised obstetric and gynaecological care • Specialised emergency contraception • Specialised prevention and treatment of STIs • Specialised safe abortion and post-abortion care • Specialised long-term psychological support services • Specialised short-term psychological support services	• Yes – they are legally entitled to this service, on the same basis as citizens • Partly – they are legally entitled to this service but not on the same basis as citizens • No – they are not legally entitled to this service • No – they are not legally entitled to this service because it is not available (i.e. legal restrictions) • Don't know

Question number and focus	Question	Type of question	Question statements	Response options
Q1A [show if in Q1, 'Yes – they are legally entitled to this service, on the same basis as citizens' and/or 'Partly – they are legally entitled to this service but not on the same basis as citizens' is selected]	In the previous question, you responded that women and girls who are protected under Directive 2001/55/EC are legally entitled or partly entitled to the following specialised healthcare services. If possible, please provide evidence – for example, a link to a law or a policy.	Open text	• Specialised obstetric and gynaecological care • Specialised emergency contraception • Specialised prevention and treatment of STIs • Specialised safe abortion and post-abortion care • Specialised long-term psychological support services • Specialised short-term psychological support services	[Open text boxes for each statement]
Q1B [show if in Q1, 'Partly – they are legally entitled to this service but not on the same basis as citizens' is selected]	In the previous question, you responded that women and girls who are protected under Directive 2001/55/EC are legally partly entitled to the following specialised healthcare services. If possible, please explain the restrictions for these individuals in comparison to citizens.	Open text	• Specialised obstetric and gynaecological care • Specialised emergency contraception • Specialised prevention and treatment of STIs • Specialised safe abortion and post-abortion care • Specialised long-term psychological support services • Specialised short-term psychological support services	[open text boxes for each statement]
Q1C [show if in Q1, 'No – they are not legally entitled to this service' and/or 'No – they are not legally entitled to this service because it is not available' is selected]	In the previous question, you responded that women and girls who are protected under Directive 2001/55/EC are not legally entitled to the following specialised healthcare services. If possible, please explain what restrictions are in place.	Open box	• Specialised obstetric and gynaecological care • Specialised emergency contraception • Specialised prevention and treatment of STIs • Specialised safe abortion and post-abortion care • Specialised long-term psychological support services • Specialised short-term psychological support services	[open text boxes for each statement]

Question number and focus	Question	Type of question	Question statements	Response options
Q2 Legal restrictions	Are there any other legal restrictions in your Member State for the following specialised services? (Please do not include insurance requirements as this is covered in a separate question)	Multiple choice	• Specialised obstetric and gynaecological care	• Age • Parental consent • Other – please specify the nature of the legal restriction [open text box] • No restrictions • Don't know
		Multiple choice	• Specialised emergency contraception	• Age • Parental consent • Prescription needed • Other – please specify the nature of the legal restriction [open text box] • Restricted – no availability • No restrictions • Don't know
		Multiple choice	• Specialised prevention and treatment of STIs	• Age • Parental consent • Other – please specify the nature of the legal restriction [open text box] • No restrictions • Don't know
		Multiple choice	• Specialised safe abortion and post-abortion care	• Age • Parental consent • Other – please specify the nature of the legal restriction [open text box] • No restrictions • Don't know
		Multiple choice	• Specialised long-term psychological support services	• Age • Parental consent • Other – please specify the nature of the legal restriction [open text box] • No restrictions • Don't know
		Multiple choice	• Specialised short-term psychological support services	• Age • Parental consent • Other – please specify the nature of the legal restriction [open text box] • No restrictions • Don't know

Question number and focus	Question	Type of question	Question statements	Response options
Q3 Practical steps to obtaining access to healthcare	What is required in your Member State for access to healthcare for women and girls fleeing war who are protected under Directive 2001/55/EC? Please choose all that apply.	Multiple choice		• Refugee / asylum seeker status • Submitting an application for temporary protection status • Receiving a residence card / document confirming temporary protection status • Visa (over 90 days leave to remain) • Passport (with biometric data) • Passport (without biometric data) • Personal identification numbers • ID card • Driving license • Other official documents (e.g., bank cards, employment records) • None required • Don't know • Other – please specify [open text box] • None required because there is only access to emergency care
Q4A Access to specialised services: fees and insurance	Under insurance schemes (where applicable) can women and girls fleeing war who are protected under Directive 2001/55/EC access the following specialised services free of charge?	Grid/matrix style	• Specialised obstetric and gynaecological care	• Yes • No
			• Specialised emergency contraception	• Yes • No
			• Specialised prevention and treatment of STIs	• Yes • No
			• Specialised safe abortion and post-abortion care	• Yes • No
			• Specialised long-term psychological support services	• Yes • No
			• Specialised short-term psychological support services	• Yes • No

Question number and focus	Question	Type of question	Question statements	Response options
Q4B Access to Specialised Services: Fees and Insurance	Without insurance, can women and girls fleeing war and protected under Directive 2001/55/EC access specialised services listed below free of charge?	Grid/Matrix style	• Specialised obstetric and gynaecological care	• Yes • No
			• Specialised emergency contraception	• Yes • No
			• Specialised prevention and treatment of STIs	• Yes • No
			• Specialised safe abortion and post-abortion care	• Yes • No
			• Specialised long-term psychological support services	• Yes • No
			• Specialised short-term psychological support services	• Yes • No
Q4C	What access do women and girls fleeing war and recognised under Directive 2001/55/EC have to national health insurance schemes? If possible, please specify in the box below.	Open text		[Open text box]
Q5A Provision of services	In your Member State, what type of facilities provide specialised SRH? Select all that apply for each statement.	Grid/matrix style Multiple choice	• Specialised obstetric and gynaecological care	• Primary health centres / doctors' offices or equivalent (non-hospital settings) • Hospital • Rape crisis centre / sexual assault referral centre • Women's NGOs (i.e. women-only NGOs) • Other NGOs • Other [open text box]
			• Specialised emergency contraception	• Primary health centres / doctors' offices or equivalent (non-hospital settings) • Hospital • Rape crisis centre / sexual assault referral centre • Women's NGOs (i.e. women-only NGOs) • Other NGOs • Other [open text box]

Question number and focus	Question	Type of question	Question statements	Response options
Q5A Provision of services	In your Member State, what type of facilities provide specialised SRH? Select all that apply for each statement.	Grid/matrix style Multiple choice	• Specialised prevention and treatment of STIs	• Primary health centres / doctors' offices or equivalent (non-hospital settings) • Hospital • Rape crisis centre / sexual assault referral centre • Women's NGOs (i.e. women-only NGOs) • Other NGOs • Other [open text box]
			• Specialised safe abortion and post-abortion care	• Primary health centres / doctors' offices or equivalent (non-hospital settings) • Hospital • Rape crisis centre / sexual assault referral centre • Women's NGOs (i.e. women-only NGOs) • Other NGOs • Other [open text box]
			• Specialised long-term psychological support services	• Primary health centres / doctors' offices or equivalent (non-hospital settings) • Hospital • Rape crisis centre / sexual assault referral centre • Women's NGOs (i.e. women-only NGOs) • Other NGOs • Other [open text box]
			• Specialised short-term psychological support services	• Primary health centres / doctors' offices or equivalent (non-hospital settings) • Hospital • Rape crisis centre / Sexual assault referral centre • Women's NGOs (i.e. women-only NGOs) • Other NGOs • Other [open text box]

Question number and focus	Question	Type of question	Question statements	Response options
Q5B Provision of services	In your Member State, which of the following specialised SRH services are provided under primary, secondary, tertiary and quaternary care?	Grid/matrix style Multiple choice	• Primary care	• Obstetric and gynaecological care • Emergency contraception • Prevention and treatment of STIs • Safe abortion and post-abortion care • Long- and short-term psychological support services • Other [open text box]
			• Secondary care	• Obstetric and gynaecological care • Emergency contraception • Prevention and treatment of STIs • Safe abortion and post-abortion care • Long- and short-term psychological support services • Other [open text box]
			• Tertiary care	• Obstetric and gynaecological care • Emergency contraception • Prevention and treatment of STIs • Safe abortion and post-abortion care • Long- and short-term psychological support services • Other [open text box]
			• Quaternary care	• Obstetric and gynaecological care • Emergency contraception • Prevention and treatment of STIs • Safe abortion and post-abortion care • Long- and short-term psychological support services • Other [open text box]

Question number and focus	Question	Type of question	Question statements	Response options
Q6 National distribution of services	What is the availability of the following specialised SRH services in your Member State?	Grid/matrix style Single choice	• Specialised obstetric and gynaecological care	• All regions (over 75 %) • Most regions (over 50 %) • Just major cities • Capital city only • Other [open text box]
			• Specialised emergency contraception	• All regions (over 75 %) • Most regions (over 50 %) • Just major cities • Capital city only • Other [open text box]
			• Specialised prevention and treatment of STIs	• All regions (over 75 %) • Most regions (over 50 %) • Just major cities • Capital city only • Other [open text box]
			• Specialised safe abortion and post-abortion care	• All regions (over 75 %) • Most regions (over 50 %) • Just major cities • Capital city only • Other [open text box]
			• Specialised long-term psychological support services	• All regions (over 75 %) • Most regions (over 50 %) • Just major cities • Capital city only • Other [open text box]
			• Specialised short-term psychological support services	• All regions (over 75 %) • Most regions (over 50 %) • Just major cities • Capital city only • Other [open text box]

Section 2. Mechanism of referral to specialised services for victims of conflict-related sexual violence

Question number and focus	Question	Question style	Question statement	Response options
Q7	Are there any referral mechanisms in place to refer victims of sexual violence to specialised SRH services?	Single choice list		• Yes (please specify) • No • Don't know
Q8	What organisations are mandated to refer victims of sexual violence to specialised SRH services? Please select all that apply.	Multiple choice list		• Police • Immigration authorities • Healthcare providers (e.g., hospitals) • Education providers (e.g., schools) • Welfare or employment services • General victim support services (including helplines) • Embassies and consulates • NGOs • Other [open text box]

Question number and focus	Question	Question style	Question statement	Response options
Q9	Which of the below institutions most commonly refer victims of CRSV to specialised SRH services?	Grid/matrix style Single choice	• Police	• Very often refers • Often refers • Rarely refers • Very rarely refers • Never refers
			• Immigration authorities	• Very often refers • Often refers • Rarely refers • Very rarely refers • Never refers
			• Healthcare providers	• Very often refers • Often refers • Rarely refers • Very rarely refers • Never refers
			• Education providers	• Very often refers • Often refers • Rarely refers • Very rarely refers • Never refers
			• General victim support services (including helplines)	• Very often refers • Often refers • Rarely refers • Very rarely refers • Never refers
			• NGOs	• Very often refers • Often refers • Rarely refers • Very rarely refers • Never refers
			• Other, please specify in the box below [open text box]	• Very often refers • Often refers • Rarely refers • Very rarely refers • Never refers

Section 3. Standards relating to guidelines, access to female staff and translators for sexual and reproductive healthcare services for victims of conflict-related sexual violence

Question number and focus	Question	Question style	Response options
Q10 National standards	Are there national standards and guidelines in place that are primarily or exclusively focused on the provision of specialised SRH services? (i.e. to ensure these services are gender-sensitive, trauma-informed and victim-centred)	Single choice list	• Yes (Please provide a link to standards or guidelines) [open text box] • No • Don't know
Q11 Access to female staff	Is it mandatory to provide a female staff member for SRH services if requested by a woman or girl?	Single choice list	• Yes (please provide legal/policy source of the obligation) [open text box] • No • Don't know
Q12 Translators	Are translators for the following languages regularly available at specialised SRH services?	Multiple choice list	• Russian • Ukrainian • English • Other, please specify in the box below [open text box] • No

Section 4. Current and upcoming measures to improve the provision of and access to sexual and reproductive services			
Question number and focus	**Question**	**Question style**	**Response options**
Q13 Measures to improve provisions	Has your Member State taken any legal, policy or practical measures to improve the provision of, and access to, SRH services to victims of sexual violence? If yes, please specify whether they apply to women and girls fleeing war from Ukraine only or countries other than Ukraine as well	Single choice list	• Yes – please explain [open text box] • No • Don't know
Q14 Upcoming laws or policies	Are there any upcoming laws, policies or practical measures at national and/or regional levels to improve the provision of and access to SRH services to victims of sexual violence? If yes, please specify whether they apply to women and girls fleeing war from Ukraine only or countries other than Ukraine as well	Single choice list	• Yes – please explain [open text box] • No • Don't know
Section 5. Other remarks			
Question number & focus	**Question**		**Response options**
Q15 Other remarks	Do you have any other information to provide on the availability of specialised SRH services for victims of sexual violence in your Member State?		[Open text box]

1.2.3. Background of respondents

Table 12. Stakeholders surveyed

Country	Institution
BE	Institute for Equality of Women and Men
BG	Ministry of Health
CZ	Ministry of Health
DK	Representative of academia
DE	Ministry of Health
EE	Ministry of Social Affairs
IE	Representative of academia
EL	Ministry of Labour and Social Affairs
ES	Ministry of Health (response was complemented by the Ministry of Equality)
FR	Office of Gender Equality and Women's Rights
HR	Ministry of Health
IT	Ministry of Health
CY	Ministry of Health
LV	Ministry of Health
LT	Ministry of Health
HU	Ministry of Interior
MT	Ministry of Health
NL	Ministry of Health
AT	Federal Ministry of Social Affairs, Health, Care and Consumer Protection
PL	Ministry of Health
PT	Ministry of Health
RO	Gender Equality Body
SI	Ministry of Health

Country	Institution
SK	Department of Healthcare
FI	Finnish Institute for Health and Welfare
SE	Ministry of Health

A1.3. Four country interviews

Following on from the EU-wide survey, 12 interviews with relevant NGOs and public bodies in Czechia, Germany, Poland and Slovakia were carried out between January and March 2023.

A1.3.1. Criteria selection for interviews

The selection process for interviewees involved two key steps, listed below.

- **Step 1.** A list of potential interviewees was drawn up, listing organisations and institutions whose mandates cover eithe providing support to victims of sexual violence or monitoring access to / providing SRH services.

- **Step 2.** It was assessed whether the organisation identified in step 1 carried out support initiatives regarding persons fleeing Russia's war of aggression against Ukraine, to ensure that the interviewee demonstrates the required knowledge and practical experience.

Potential interviewees were identified through online searches and a review of key literature, such as Member States' baseline reports submitted to the Council of Europe's Group of Experts on Action against Violence against Women and Domestic Violence and grey literature. A snowball approach was used to identify further stakeholders by asking stakeholders for their recommendations of other relevant contacts ([80]).

A1.3.2. Interviews

The interviewees were first approached by national researchers via email/phone and provided with a European Institute for Gender Equality (EIGE) accreditation letter at the point of contact. The invitation emails also included embedded hyperlinks with the EIGE privacy notice statement and the ICF Consulting Services Limited privacy statement. To ensure the consent of participants with regard to using the transcripts, all participants were asked at the start of each interview if they consented to the interview being recorded and/or to sign an EIGE consent letter.

The interviews were conducted online via Microsoft Teams in English for Germany and Poland. The interviews with respondents from Czechia and Slovakia were carried out in Czech or Slovak, depending on the preference of the interviewee. Interviews were conducted between January and March 2023.

The interviews were semi-structured. The interview topic guide was developed thematically, with key focus areas for discussion, and analysed using thematic content analysis. This approach allowed the team to identify patterns in the interviews and to ensure the findings were coherent and clearly linked to the questions asked. The interview topic guide is available below (A.1.3.4.).

A1.3.3. Interviews' limitations

The interviews were conducted in Slovak, Czech and English, depending on the preference of the interviewee. In total, 12 interviews were conducted (three per Member State) in Czechia, Germany, Poland and Slovakia. The results express the knowledge and shared views or opinions of individuals who may represent different sectors and roles. Moreover, as far as the limitations of this phase of the study are concerned, apart from linguistic aspects, it should be noted that, due to the small number of interviews for certain

([80]) It was initially agreed to only interview NGOs because, as the first point of contact with victims, they often have a better understanding of practical challenges. However, in some case study countries, for example in Czechia, the response to women and girls fleeing war in Ukraine is provided by the national health system in place. Therefore, to capture the most relevant stakeholders, the criteria was expanded to include a public body.

categories of interviewees, the findings reported in this report only represent interviewees' knowledge, views or opinions shared during the interviews. As such, the findings may not be representative of the situation in each Member State. However, the findings offer individual perspectives of experts, who provide support to victims of sexual violence (SV) or monitor access to SRH services.

A1.3.4. Interview topic guide

1. What is your role at the organisation you represent?

2. What is your organisation's role, specifically related to women and girl victims of sexual violence?

3. What is your organisation's role, specifically related to women and girl victims of CRSV, including in the context of the influx from Ukraine?

4. Are you aware of the TPD under EU law? How has this affected the specialised SRH services your organisation provides, if at all? Effects can include the impact on the types or level of service provision you offer and on demand for services from victims.

5. Can you comment on how the TPD has affected specialised SRH services in your Member State?

6. Reflecting on the provision for specialised SRH services in your country for victims of sexual violence, please could you provide your thoughts (including any challenges and gaps you see) on the availability of and access to these services?

7. Are there referral pathways in your country, particularly for victims of CRSV/SV?

8. How effective do you find these referral mechanisms to be in ensuring women and girl victims of CRSV/SV can access the specialised SRH services they need?

9. What are the main challenges your organisation has experienced and/or observed in the sector, more broadly regarding CRSV/SV victims' access to specialised SRH services?

   Specialised sexual and reproductive health services include:

   a. long-term psychological counselling,

   b. short-term psychological counselling,

   c. obstetric gynaecological care,

   d. emergency contraception,

   e. STI prevention and treatment,

   f. safe abortion and post-abortion care.

10. Are the challenges you've identified specific to the mass influx of persons fleeing from Ukraine following the Russian invasion?

11. What is your organisation doing to address the challenges we've discussed?

12. Do staff at your organisation receive specialised training to support women and girl victims of sexual violence? Have staff received specialised training to support women and girl victims of CRSV? If so, please provide details of the training (e.g. who offers it, what it covers, the frequency of such training, if it was in response to the influx of people from Ukraine).

13. In your experience of the sector in your Member State, do staff at other general or specialised SRH services receive specialised training to support women and girl victims of CRSV/SV? Do you think this training is sufficient to meet the needs of such victims?

14. Has your organisation identified and/or received/adopted government measures that aim to improve CRSV/SV victims' access to specialised SRH services, in response to Russia's unprovoked invasion of Ukraine in February 2022?

15. If applicable, were you consulted and/or given the opportunity to contribute in any way?

16. To what extent have these government measures (if any) improved access to specialised SRH services for victims of CRSV protected under the TPD? What challenges remain?

17. In your view, what can be done to facilitate or improve CRSV victims' access to specialised SRH services?

18. Is there any other information related to accessing specialised SRH services that you would like to add?

Annex 2. Summary of interviews

A2.1. Czechia

In Czechia, persons fleeing Ukraine are granted full access to healthcare on par with Czech citizens. Following the triggering of the TPD, Czechia signed a law package known collectively as 'Lex Ukraine' on 17 March 2022, which sets out the scope of temporary protection and guarantees, among other things, public health insurance to holders of temporary protection from the date of entry into the territory of Czechia ([81]). Amendments to 'Lex Ukraine II' entered into force in June 2022, introducing important changes to health insurance coverage ([82]). Czechia's Ministry of Health undertook a number of measures aimed at improving access to healthcare for persons arriving from Ukraine, including the establishment of 'UA points' across major hospitals in the country, where translators are available ([83]), and the issuing of an interpretative opinion in March 2022, guaranteeing access to abortions for women benefiting from temporary protection in the country.

According to interviewees, systemic support tailored to victims of sexual violence seems to be largely lacking in the country. A Czech NGO is currently in the process of preparing to open the first ever complex centre focused on providing assistance to victims of sexual violence. Until February 2023, such a centre did not exist. Moreover, most existing referral mechanisms tackle domestic violence rather than sexual violence. There are also no approved national guidelines for the police and healthcare providers on how to respond to the specific needs of victims of sexual violence. Interviewees stressed that there is insufficient training for healthcare professionals on how to support victims of sexual violence.

The Czech system's response to sexual violence appears largely focused on the route of criminal prosecution. Unless a woman first reports a crime to the police, she may not be able to access further medical assistance. For example, for her to receive a more specialised examination by a gynaecologist, she may be asked to come with a police officer or to show proof that a crime has been reported. Otherwise, if she is not suffering from life threatening or serious injuries, a doctor is able to decline providing care.

The Ministry of Health swiftly issued an interpretive opinion in March 2022 granting women and girls under temporary protection full access to safe abortion on the same basis as Czech citizens.

Regarding access to specialised psychological counselling, only psychiatric care is covered by the Czech healthcare system and requires a diagnosis of a serious condition (e.g. suicidal tendencies) for someone to be admitted to a clinic, which would be a broader trauma centre not specialised for victims of sexual violence. There are no other mechanisms of referral to specialised psychiatric care for victims of sexual violence. Women may try to find a private counsellor, or they may turn to the help of dedicated NGOs. Yet, interviewees perceive that specialised and trauma-informed counselling for victims of sexual violence is rather limited in the country and only really found in main cities.

Despite how difficult it is for Czech women and girls to access specialised SRH services, interviewees argued that is even more challenging for women and girls from Ukraine due to the

([81]) https://ec.europa.eu/migrant-integration/library-document/czech-republic-lex-ukraine-law-package-enters-force_en

([82]) Except for children and the elderly, state health coverage is now ensured only for a maximum of 150 days, after which a person must pay for health insurance themselves, be employed or be registered with an employment office as a job seeker – see: https://ec.europa.eu/migrant-integration/news/czech-republic-amendment-laws-lex-ukraine-ii-enters-force_en

([83]) UA POINT – медичне обслуговування українських біженців – Ministerstvo zdravotnictví (mzcr.cz)

language barrier and the complexities of the Czech healthcare system, which requires patients to find their own healthcare providers. According to an interviewee, these challenges led many persons under temporary protection to seek help in emergency rooms, which created difficulties in service provision. To address this issue, the Ministry of Health introduced dedicated points for Ukrainian persons in major hospitals and a call centre where Ukrainian translators can provide information about the healthcare system. The Ministry of Health, together with the help of the WHO, also prepared patient leaflets explaining the Czech healthcare system and how to seek care in Ukrainian and Russian. With regard to initiatives targeted at women fleeing Ukraine, NGOs, with the help of Unicef, developed a programme aimed at helping pregnant women from Ukraine navigate the Czech healthcare system.

While women and girls under the TPD are ensured equal access to healthcare on par with Czech citizens, it is not guaranteed that they will be able to fully exercise their sexual and reproductive rights due to a lack of specialised services tailored to victims of sexual violence and difficulties in accessing healthcare services due to language barriers and the complexity of the Czech healthcare system.

A2.2. Germany

In Germany, citizens and legal residents are required to obtain statutory health insurance or private insurance. Initially, the German Asylum Seekers' Benefit Act facilitated medical care coverage for recipients of international temporary protection from Ukraine. As of 1 June 2022, Ukrainian refugees are entitled to statutory health insurance, giving them access to the full scope of the public health service ([84]). Victims of sexual violence in Germany can access healthcare services through general practitioners, specialised doctors (i.e. gynaecologists) and hospitals. SRH services are also provided through local pharmacies, which can give information on minor issues and recommend over-the-counter medicines. Specialised healthcare services can also be accessed through various non-governmental organisations in Germany. Research conducted by the Women Against Violence Europe (WAVE) Network found that there are approximately 183 rape crisis centres available for victims of SV in Germany. Additionally, victims can find support through 310 additional counselling services and the national women's helpline ([85]).

In Germany, there are no standardised national referral mechanisms as each federal state has a different referral system. Referral mechanisms also do not guarantee the immediate availability of the service needed; in fact, interviewees stress long waiting times. Language is noted as the major barrier hindering victims' access to SRH services.

Interviewees highlighted the difficulties of accessing long-term psychological counselling or psychotherapy for victims of sexual violence. Victims covered by public health insurance encounter long waiting times before they can be seen by a mental health professional (i.e. 6–12 months) ([86]). Moreover, even when victims can secure appointments, healthcare professionals are rarely trained to support victims of CRSV. In addition, while women and girls under the TPD are entitled to psychotherapy under statutory health insurance, language and economic affordability are a major access barrier, as insurance companies are not obligated to cover the costs of the interpretation services needed to facilitate counselling sessions.

([84]) Federal Office for Migration and Refugees (2022), 'Germany4Ukraine: Statutory health insurance'. Available at: https://www.germany4ukraine.de/hilfeportal-en/healthcare/statutory-health-insurance#:~:text=Due %20to %20the %20new %20regulation,social %20care %20insurance %20(cited %20in

([85]) Women Against Violence Europe (WAVE) (2021), *WAVE Country Report 2021 – Women's specialist support services in Europe and the impact of COVID-19 on their provision*, Vienna, Austria, December 2021. Available at: https://wave-network.org/wave-country-report-2021/

([86]) According to the Federal Chamber of Psychotherapists, the average waiting time for an initial interview with a psychotherapist is 20 weeks. German Federal Chamber of Psychotherapists (BPtK) (2018), 'Waiting times 2018'. Available at: https://www.pksh.de/aktuelles/2018/bptk-news-rund-20-wochen-wartezeit-auf-psychotherapeutische-behandlung

In terms of obstetric and gynaecological care**,** interview participants indicated that victims of sexual violence, particularly CRSV, can struggle to find a doctor who understands their distinct needs. Patients who have suffered from sexual violence can experience significant discomfort during the process of gynaecological care and may find it difficult to communicate it to medical practitioners. Poor understanding of the trauma experienced by victims and the long-lasting impact of existing trauma (i.e. anxiety, depression, PTSD) can cause greater harm to victims. As such, interviewees described the need for formal and regular training for gynaecologists on the provision of tailored support for victims of CRSV/SV. An interviewee from Germany also urged to consider and shed light on the complex needs of victims of sexual violence after sharing a case where a 17-year-old girl was turned away from evidence collection because she did not want to inform her parents of the sexual violence experienced.

In Germany, individuals are required to undergo mandatory consultations prior to an **abortion**, which needs to be certified before one can proceed to the termination 3 days later. According to an interviewee, there are measures in place which allow victims of rape to bypass the consultation process, but they are underutilised, as doctors performing abortions are punished if protocols are not properly observed. Interviewees stress that mandatory consultation can cause greater harm to victims and the time requirement can also affect their eligibility to undergo the procedure within 12 weeks of gestation.

In Germany, emergency contraception is accessible at pharmacies and gynaecological centres, and is free of charge for people under the age of 22 ([87]). However, people over the age of 22 are required to pay for it as this service is not covered by health insurance. According to interview participants, the high cost of emergency contraception is inaccessible for low-income groups.

Services relating to STI prevention and treatment are widely available in Germany. However, the procedural length and costs associated with these treatments can vary depending on the medical facility. Moreover, the bureaucratic procedures to access this service can be the lengthy. For instance, to receive full PEP treatment, victims must submit an application to their health insurance provider justifying the need for the treatment. According to interviewees, these requirements delay the treatment process, which should occur within 72 hours after exposure.

Respondents highlighted other broader challenges that shape victims' access to specialised healthcare services in Germany. First, due to the complexity of the federal system, the minimum standards for service provision can vary significantly among federal states. Second, there is a lack of coordination between professionals that work with victims in the police, healthcare and social care sectors. Furthermore, respondents stress that there are no minimum care guidelines for responding to sexual violence and that healthcare providers are not trained to support victims beyond standard medical care. To address these challenges, respondents highlighted the need for standardised national guidelines that outline each sector's responsibility to support victims of sexual violence, and the referral process that should occur after initial contact with service providers. Interviewees also shared various initiatives taken by NGOs to raise awareness on CRSV, such as their collective efforts in training and sensitising healthcare providers to such issues.

([87]) German Federal Centre for Health Education (2023), 'Die „Pille danach"'. Available at: https://www.familienplanung.de/verhuetung/verhuetungspannen/pille-danach/

A2.3. Poland

In the Polish healthcare system, persons protected under the TPD have full access to the range of healthcare services on equal terms with citizens ([88]). These provisions are covered by the new law on assistance to Ukrainian refugees passed on 12 March 2022 ([89]). Specialised SRH services in Poland are provided by primary care physicians and gynaecologists and through organisations that aim to improve the sexual and reproductive health rights of women and girls. However, women and girls in Poland face significant barriers to accessing sexual and reproductive health services, in particular legal abortions. Support mechanisms for SRH services are also not widespread. According to the WAVE Network, there are no support services for victims of sexual violence, such as rape crisis centres, sexual violence counselling centres, crisis and medical services or specialised helplines ([90]). Assistance is mainly provided by NGOs

While Poland simplified the process for accessing healthcare for Ukrainian women under temporary protection, interviewees described the Polish system as overburdened with limited access to support services, long waiting times, and larger institutional constraints. Access to SRH services is mostly limited to big cities, with insufficient referral mechanisms for victims of sexual violence and a lack of coordination between the police and the healthcare sector.

Women face many barriers to accessing SRH in Poland, especially with regards to **safe abortion and post-abortion care**. In 2020, a ruling by Poland's Constitutional Tribunal banned most legal routes to abortion. Safe abortion is permitted only to save a woman's life, and in the case of incest, rape and irreversible malformation of the foetus. Victims are required to report their experience of rape in order to obtain an official certificate from a prosecutor, which would allow to terminate the pregnancy. Consequently, respondents stress that access to safe abortions and post-abortion care is hindered due to restrictive abortion laws, stigma around this procedure, conscientious objection used by doctors, and the fact that doctors performing abortion may face criminal charges. Due to the strict abortion laws, victims may travel abroad to terminate a pregnancy. For example, respondents have encountered Ukrainian women who chose to migrate back to Ukraine to undergo an abortion procedure.

Similarly, interviews highlight that a key challenge of accessing **emergency contraception** is the obligation to obtain a medical prescription, which is also hindered by conscientious objection as gynaecologists and doctors may refuse to prescribe emergency contraception. Furthermore, emergency contraception is not always available in pharmacies and is not free of charge.

Interviewees also highlight a general lack of training and competence on how to support victims of sexual violence among professionals. For example, state-led **psychological counselling** tailored for victims of sexual violence does not exist, therefore victims can either access general psychological support covered through their health insurance plan or resort to private providers. **Obstetric and gynaecological care** is more widely available, however, gynaecologists may not be trained to respond to the specific needs of victims of sexual violence.

Interviewees stress the necessity of state-led and funded initiatives to support victims of sexual violence as NGOs bear the main responsibility in facilitating access to SRH services without support from the government. Among the various initiatives taken, NGOs have created leaflets on how to access SRH services for Ukrainian women, established a program providing them safe accommodation and social assistance, and

([88]) European Migration Network (2022), *Access to Services for Beneficiaries of Temporary Protection – EMN Inform*, November 2022, p. 10, available at: https://emn.ie/wp-content/uploads/2022/11/2022_EMN_INFORM_TPD_services.pdf

([89]) https://ec.europa.eu/migrant-integration/news/poland-parliament-adopts-law-assistance-ukrainian-refugees_en

([90]) Women Against Violence Europe (WAVE) (2021), *WAVE Country Report 2021 – Women's specialist support services in Europe and the impact of COVID-19 on their provision*, Vienna, Austria, December 2021. Available at: https://wave-network.org/wave-country-report-2021/

created guidelines for the police on how to support victims of sexual violence and improve the process of referral mechanisms.

A2.4. Slovakia

Slovakia grants persons under the TPD access to emergency medical care and 'necessary' medical care; however, the scope of services considered necessary is not legally defined ([91]). This grey legal area creates a context whereby the provision of services may be uneven as it relies upon the discretion of professionals. The context of Slovakia is peculiar in that the country is facing a shortage of general practitioners ([92]). Moreover, the country is increasingly restricting access to abortions, which has created barriers preventing Slovak women from exercising their sexual and reproductive rights ([93]). Consequently, women and girls arriving from Ukraine face the same barriers as Slovak women, including limited access to psychologists and other specialists. Women and girls from Ukraine are also further disadvantaged due to their unfamiliarity with the national healthcare system.

Interviewees highlight that access to SRH services in Slovakia has become increasingly restrictive in recent years, especially for what concerns safe abortion. The ambiguous status of women and girls from Ukraine under the TPD has hampered their right to access safe abortion. Interviewees highlight two legislative proposals put forward in April 2022 aiming to ban access to abortions for women without permanent residency in Slovakia. These proposals were interpreted by NGOs as attempting to limit the right to abortions for women coming from Ukraine. While these proposals were rejected, the Ministry of Health did not issue a definitive opinion clarifying whether women under temporary protection are guaranteed access to abortions, thus leaving healthcare providers room for interpretation. Interviewees argue that healthcare professionals may be less willing to provide services to Ukrainians as insurance companies are not fully reimbursing them for the treatments provided.

Respondents argue that access to safe abortions and emergency contraception is also hindered by the fact that healthcare providers and pharmacies can refuse the provision of these services on grounds of conscientious objection. Cost is an additional challenge, with providers reportedly charging up to double the amount of the average cost for surgical abortions (EUR 280–450). Furthermore, while emergency contraception is available, it is also quite expensive (EUR 30–40). Interviewees also stress the difficulties in finding abortion providers, especially in rural areas, which may require women to travel long distances.

In relation to obstetric and gynaecological care, respondents argue that there is a national shortage of specialists, meaning that women and girls may need to wait long periods before securing an appointment. Interviewees also stressed the challenges Slovakia is facing in providing treatment to HIV positive patients due to a lack of antiretroviral medicines and specialised virologists who can prescribe this treatment. Slovakia has a relatively low prevalence of HIV; therefore, its system is not prepared to deal with the increase in cases caused by persons arriving from Ukraine ([94]). As such, in most cases, the critical 72 hour window is missed.

There are two counselling centres in Bratislava (the capital) which are able to provide some psychotherapeutic counselling to survivors of sexual

([91]) https://ec.europa.eu/migrant-integration/news/slovakia-adopts-package-legislative-changes-facilitate-integration-those-fleeing-ukraine_en

([92]) https://eurohealthobservatory.who.int/countries/slovakia/

([93]) 'The situation regarding SRHR in Slovakia does not only meet required international standards, but it has worsened in the last two decades.' – European Parliament, Committee on Women's Rights and Gender Equality (2022), *Access to abortion services for women in the EU – Slovakia*, October 2022. https://www.europarl.europa.eu/RegData/etudes/IDAN/2020/659922/IPOL_IDA(2020)659922_EN.pdf.

([94]) According to one stakeholder, they already know of two persons from Ukraine who died from AIDS in Slovakia last year. It is not clear whether this was due to a lack of access to medication, fear of stigma, or other factors, but it points to a potentially life-threatening problem in the system. Moreover, besides the lack of PEP, Slovakia reportedly has no PEP for paediatric cases, which has to be ordered online, meaning the crucial 72 hour period when it can be administered is often missed.

violence; however, access to these centres may require 6 months waiting time. Therefore, women and girls can only access immediate psychological counselling through private providers. Interviewees also highlight that language remains an overarching barrier preventing access to counselling and other healthcare services.

Respondents point to an overall lack of healthcare and other professionals that are trained and sufficiently experienced to deal with gender-based and sexual violence beyond the context of domestic violence. This, coupled with the non-existence of referral pathways, point to systemic issues in responding effectively to the needs of victims of sexual violence. In 2022, the healthcare sector introduced some information and guidelines on sexual violence; however, there is no training for professionals on how to implement these and it is not clear whether the guidelines have been adopted among providers.

Given the overall challenges that the Slovak healthcare system is facing, some NGOs report that Ukrainian women and girls sometimes prefer to travel back to western Ukraine (e.g. Uzhhorod) for their medical check-ups and to access SRH services, rather than try to navigate the Slovak system.

Nonetheless, respondents highlighted important initiatives and efforts undertaken by NGOs to support Ukrainian people and improve professionals' response to victims of sexual violence. For instance, they set up a clinic for Ukrainian people where they are assisted by Ukrainian healthcare professionals who work under the supervision of Slovak doctors. NGOs also operate mobile teams across different regions of Slovakia to reach persons that do not have access to healthcare. Another significant initiative is the launch of a training programme for healthcare and other professionals on the clinical management of rape and how to provide survivor-centred care.

Annex 3. Key legal and policy instruments

Table 13. Summary of the relevant EU and international law and policy measures

	International/regional
Humanitarian law	Geneva Convention I, II, III and IV. Geneva Conventions Protocol I Protocol II UN Security Council Resolution 2457 UN Security Council Resolution 2122 UN Security Council Resolution 1325 UN Security Council Resolution 1820 UN Security Council Resolution 1888 UN Security Council Resolution 1889 UN Security Council Resolution 1960 UN Security Council Resolution 2106 UN Security Council Resolution 2242 UN Security Council Resolution 2467 UN Security Council Resolution 2493 ICTY, The Prosecutor v Dragoljub Kunarac, Radomir Kovac and Zoran Vukovic, IT-96-23 and IT-96-23/1, Appeals Chamber, Judgement, 12 June 2002.
Criminal law	Rome Statute of the International Criminal Court ICTY, Delalič case, Judgment §§ 688, 731 ICTR, Akayesu case, Judgment
Human rights law (including asylum law)	International Covenant on Civil and Political Rights International Covenant on Economic, Social and Cultural Rights Convention against Torture and Other Cruel, Inhuman, or Degrading Treatment or Punishment Convention on the Elimination of All Forms of Discrimination against Women General recommendation No 28 on the core obligations of states parties under Article 2 of the Convention on the Elimination of All Forms of Discrimination against Women General recommendation No 30 on women in conflict prevention, conflict and post-conflict situations General recommendation No 35 on gender-based violence against women, updating general recommendation No 19 Istanbul Convention European Convention on Human Rights M.C. v Bulgaria, Judgement; Charter of Fundamental Rights of the European Union Directive 2013/33 Recitals 40 and 46, Articles 3, 9, 20 and 30 of Directive 2011/95 Directive 2001/55 Council Implementing Decision 2022/382 (Directive 2012/29 EU strategy on victims' rights (2020–2025) Gender equality strategy 2020–2025 ESC Committee General comment No 22 (2016) on the right to sexual and reproductive health Beijing Platform for Action Pararaph 6 of the European Commission's 10-point plan for stronger European coordination on welcoming people fleeing the war from Ukraine Pararaphs D, F, J, K, M, O, Q, T, U, 6, 7, 8 and 11 of the European Parliament resolution 2022/2633 Pararaph 6 of the Commission communication on operational guidelines for the implementation of Council implementing decision 2022/382

Annex 4. Additional information from the questionnaire

This annex outlines the results of the questionnaire conducted with 26 Member State expert individuals, as part of this study. The data is presented by question in a table.

Table 14. Overview of the legal entitlement for SRH services under the TPD (by country), 2023

Country	Legal entitlement
BE	Access to all specialised SRH on the same basis as citizens.
BG	Access to specialised STI prevention and treatment, obstetric gynaecological care, safe abortion and post-abortion care on the same basis as citizens. No data regarding emergency contraception, specialised short- and long-term psychological support.
CZ	Access to all specialised SRH on the same basis as citizens.
DK	Access to all specialised SRH on the same basis as citizens.
DE	Access to all specialised SRH on the same basis as citizens.
EE	Access to all specialised SRH on the same basis as citizens.
IE	Access to all specialised SRH on the same basis as citizens.
EL	Access to all specialised SRH on the same basis as citizens. There is no data on short-term psychological support.
ES	Access to all specialised SRH on the same basis as citizens.
FR	Access to all specialised SRH on the same basis as citizens.
HR	Access to all specialised SRH on the same basis as citizens.
IT	Access to all specialised SRH on the same basis as citizens.
CY	Access to all specialised SRH on the same basis as citizens apart from specialised emergency contraception.
LV	Access to all specialised SRH on the same basis as citizens.
LT	Access to essential services (emergency medical services, pregnancy care, antenatal care, necessary I, II and III level personal healthcare services that, if not provided, could worsen a person's medical condition) on the same basis as citizens. No entitlement to emergency contraception. Access to abortion care but not on the same basis as citizens.
HU	Access to all specialised SRH on the same basis as citizens.
MT	Access to all specialised SRH on the same basis as citizens except for specialised safe abortion and post-abortion care (there is a total ban on abortion).
NL	Access to specialised emergency contraception, specialised STI prevention and treatment, obstetric gynaecological care, short-term psychological counselling, safe abortion and post-abortion care on the same basis as citizens. No data regarding long-term psychological counselling.
AT	Access to specialised STI prevention and treatment, obstetric gynaecological care, short-term psychological counselling, safe abortion and post-abortion care on the same basis as citizens. Emergency contraception is generally not a benefit of the statutory health insurance and is only covered if it is medically necessary. Specialised safe abortions are only covered by the statutory health insurance if they are medically necessary, otherwise they are not benefits of the statutory health insurance fund.
PL	Access to all specialised SRH on the same basis as citizens.
PT	Access to all specialised SRH on the same basis as citizens.
SI	Access to all specialised SRH on the same basis as citizens except for specialised STI prevention and treatment, obstetric gynaecological care, long-term psychological counselling.
SK	Access to all specialised SRH on the same basis as citizens.
FI	Access to all services on the same basis as citizens.
SE	Access to all services on the same term as citizens except long-term specialised psychological support services. No data recorded for short-term psychological support services.

Table 15. Legal instruments related to specialised healthcare services, 2023

Country	Legal instruments
Czechia	• Lex Ukraine IV (fourth version of the law CZ initially adopted to help Czechia implement TPD at the national level • Zákon č. 65/2022 Sb., tzv. Lex Ukrajina IV Zákon č. 372/2011 Sb., o zdravotních službách a podmínkách jejich poskytování (zákon o zdravotních službách) Zákon č. 48/1997 Sb., o veřejném zdravotním pojištění a o změně a doplnění některých souvisejících zákonů. • Law on abortion and post-abortion care: Zákon č. 48/1997 Sb., o veřejném zdravotním pojištění a o změně a doplnění některých souvisejících zákonů. Zákon č. 66/1986 Sb., o umělém přerušení těhotenství Vyhláška č. 75/1986 Sb., kterou se provádí zákon České národní rady č. 66/1986 Sb., o umělém přerušení těhotenství.
Spain	• Royal Decree 220/2022, of 29 March, approving the regulation governing the reception system for international protection. • Royal Decree Law 7/2018, of 27 July, regarding the universal access to the national health system. • Law 12/2009 of 30 October, regulating the right of asylum and subsidiary protection. • Royal Decree 1325/2003 of 24 October, approving the regulation on the regime of temporary protection in the event of mass influx of displaced persons.
Croatia	• Healthcare of foreigners in the Republic of Croatia is regulated by the Law on Mandatory Health Insurance and Health Care for Foreigners in the Republic of Croatia (Official Gazette No 80/13, No 15/18, No 26/21 and No 46/22 – https://www.zakon.hr/z/634/Zakon-o-obveznom-zdravstvenomosiguranju-i-zdravstvenoj-za %C5 %A1titi-stranaca-u-Republici-Hrvatskoj-)
Italy	• Access to specialised healthcare services for foreigners is included in law DPCM 28/03/2022 and DPCM 12/01/2017/ • Access to specialised emergency contraception is granted by the Circular of the Ministry of Health, 12.08.2020 • Law 194/1978 relates to specialised abortion and post-abortion care
Cyprus	• Women and girls fleeing war and recognised under Directive 2001/55/EC have full access to the national health system. The service providers are limited to the governmental medical institutions. However, if the required service is not available, women and girls fleeing war and recognised under Directive 2001/55/EC are forwarded to private service providers and the cost is covered by the Ministry of Health. • The right to abortion has been legalised but has not yet been included among the provisions of the healthcare system and there is no provision of universal free-of-charge, safe abortion. Free-of-charge abortion is provided in certain cases, such as in cases of unwanted pregnancies after rape, or induced abortions because of medical reasons related to the mother or the foetus.
Latvia	• Latvia adopted the Law on Assistance to Ukrainian Civilians on 3 March 2022 https://ec.europa.eu/migrant-integration/news/latvia-new-law-assistance-people-ukraine_en#:~:text=The%20law%20stipulates%20that%20Ukrainian%20civilians%20are%20entitled,190%20EUR%20to%20all%20minors%20arriving%20from%20Ukraine.
Lithuania	• Health insurance law of the Republic of Lithuania (as last amended on 17 November 2011 – No XI-1670) https://e-seimas.lrs.lt/portal/legalAct/lt/TAD/256642c2efd811e3abf5c17841df37a3. • Resolution on the provision of temporary protection in the Republic of Lithuania to foreigners.
Hungary	• Act LXXX of 2007 on Asylum implementing Government Decree No 301/2007 (XI. 9.) of Act LXXX on Asylum – Hungarian–Soviet agreement promulgated by Act 16 of 1963 (and the decree on its execution (MüM, i.e. Labour Ministry decree No 7/1964. VIII. 30.)). • Government Decree No 56/2022. (II. 24.) on the differed implementation of transitional rules in the asylum procedure (granting temporary protection). • Government Decree No 86/2022. (III. 7.) Korm. rendelet (emergency rules for temporary protection) https://health.ec.europa.eu/system/files/2022-08/soc-det_tpd-rr-report_en.pdf
Austria	• Paragraph 1 Z 21 of the Ordinance on the implementation of health insurance persuant to paragraph 9 ASVG (BGBl. Nr. 420/1969 idgF))
Portugal	• Resolution of the Council of Ministers No 29-A/2022, of 1 March • Resolution of the Council of Ministers No 29-D/2022, of 11 March • Order No 25360/2001 (2nd series), of 12 December

Country	Legal instruments
Poland	• Support for Ukrainian citizens, including access to the public healthcare system, on the same terms as Polish citizens, is guaranteed by the Act of 12 March 2022 on assistance to Ukrainian citizens in connection with an armed conflict in the territory of that country (Journal of Laws, item 583, as amended). In accordance with the above-mentioned act, persons who have refugee status in connection with the war in Ukraine are entitled to all psychiatric and addiction healthcare services – including services provided by psychologists. • Healthcare also includes access to abortion procedures, which – in cases specified in the act of 7 January 1993 on family planning, protection of the human foetus and conditions for the admissibility of termination of pregnancy – belong to guaranteed services.
Slovenia	• Act on International Protection (Official Gazette of the Republic of Slovenia, No 16/17 – official consolidated text and No 54/21)

Table 16. Types of facilities that provide specialised SRH in Member States (N=26), 2023

Specialised service		BE	BG	CZ	DK	DE	EE	IE	EL	ES	FR	HR	IT	CY	LV	LT	HU	MT	NL	AT	PL	PT	RO	SI	SK	FI	SE
Emergency contraception	Primarily health centres, doctors' offices or equivalent (non-hospital settings)	X		X	X	X	X	X	X		X	X	X	X	X			X	X		X	X	X	X	X	X	X
	Hospital	X			X	X	X	X	X	X	X	X	X	X			X		X	X	X	X	X	X	X		
	Rape crisis centre / sexual assault referral centre	X			X		X	X								X		X					X			X	
	Women's NGOs (i.e. women-only NGOs)					X										X							X				
	Other NGOs	X	X			X								X		X							X				
	Other				X		X	X			X																
STI prevention and treatment	Primarily health centres, doctors' offices or equivalent (non-hospital settings)	X	X	X	X	X	X	X		X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
	Hospital	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X		X		X	X	X	X	X	X		
	Rape crisis centre / sexual assault referral centre				X	X	X	X											X							X	
	Women's NGOs (i.e. women-only NGOs)					X																					
	Other NGOs	X	X	X		X			X		X			X								X					X
	Other				X		X	X			X								X								

Specialised service		BE	BG	CZ	DK	DE	EE	IE	EL	ES	FR	HR	IT	CY	LV	LT	HU	MT	NL	AT	PL	PT	RO	SI	SK	FI	SE
Obstetric gynaecological care	Primarily health centres, doctors' offices or equivalent (non-hospital settings)	X	X	X		X	X	X		X	X	X	X	X	X	X	X	X			X		X	X	X		X
	Hospital	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	
	Rape crisis centre / sexual assault referral centre	X			X											X		X					X				
	Women's NGOs (i.e. women-only NGOs)					X										X							X				
	Other NGOs					X			X					X		X							X				
	Other				X		X				X																
Short-term psychological support	Primarily health centres, doctors' offices or equivalent (non-hospital settings)			X	X			X		X	X	X	X	X	X	X				X		X	X	X	X	X	X
	Hospital			X	X		X	X			X	X	X	X	X	X				X		X	X	X	X	X	
	Rape crisis centre / sexual assault referral centre				X			X							X	X	X	X					X			X	
	Women's NGOs (i.e. women-only NGOs)			X					X			X				X	X						X				
	Other NGOs		X	X	X				X			X		X		X	X	X					X				
	Other	X			X				X																		

Specialised service		BE	BG	CZ	DK	DE	EE	IE	EL	ES	FR	HR	IT	CY	LV	LT	HU	MT	NL	AT	PL	PT	RO	SI	SK	FI	SE
Long-term psychological support	Primarily health centres, doctors' offices or equivalent (non-hospital settings)	X		X		X		X	X	X	X	X	X	X	X	X		X	X	X	X	X	X	X	X	X	X
	Hospital	X		X	X	X	X	X	X		X	X	X		X	X					X	X	X	X	X	X	
	Rape crisis centre / sexual assault referral centre	X			X	X									X	X	X		X	X							
	Women's NGOs (i.e. women-only NGOs)			X		X						X			X	X	X						X				
	Other NGOs		X	X	X	X						X			X	X	X						X				
	Other				X														X								
Safe abortion and post-abortion care	Primarily health centres, doctors' offices or equivalent (non-hospital settings)	X				X				X	X			X	X	X			X	X	X	X	X	X	X	X	
	Hospital	X	X	X	XX	X	X		X	X	X	X	X	X	X	X	X		X	X	X	X	X	X	X	X	X
	Rape crisis centre / sexual assault referral centre																										
	Women's NGOs (i.e. women-only NGOs)																										
	Other NGOs																										
	Other	X																	X								

Question 5A. In your Member State, what type of facilities provide specialised sexual and reproductive healthcare?

Table 17. SRH services provided under primary, secondary, tertiary and quaternary care (N=26), 2023.

Specialised service		BE	BG	CZ	DK	DE	EE	IE	EL	ES	FR	HR	IT	CY	LV	LT	HU	MT	NL	AT	PL	PT	RO	SI	SK	FI	SE
Primary care	Emergency contraception	X		X	X	X	X	X	X		X	X				X	X		X		X	X	X	X		X	
	STI prevention and treatment	X	X	X	X	X		X		X	X	X	X	X		X	X		X		X	X	X	X	X	X	X
	Obstetric gynaecological care		X	X		X	X	X	X	X	X	X	X	X		X	X	X			X		X	X	X	X	X
	Short-term psychological support	X			X	X		X	X	X	X	X		X		X			X			X	X	X		X	X
	Long-term psychological support					X		X		X	X	X	X	X		X		X				X		X		X	X
	Safe abortion and post-abortion care					X		X			X	X							X					X		X	
	Other				X						X																
	Don't know																										
Secondary care	Emergency contraception	X		X	X	X	X	X		X	X	X	X				X		X	X	X	X			X		
	STI prevention and treatment	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X		X	X	X	X	X	X		X
	Obstetric gynaecological care	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X		X
	Short-term psychological support	X		X	X		X	X	X	X		X	X	X			X			X	X	X		X	X		
	Long-term psychological support	X		X	X	X	X	X		X	X	X	X	X		X	X		X	X	X	X	X	X	X	X	
	Safe abortion and post-abortion care	X		X	X	X		X	X	X	X	X	X		X	X	X		X	X	X	X	X	X	X	X	X
	Other							X																			
	Don't know																										

Specialised service		BE	BG	CZ	DK	DE	EE	IE	EL	ES	FR	HR	IT	CY	LV	LT	HU	MT	NL	AT	PL	PT	RO	SI	SK	FI	SE
Tertiary care	Emergency contraception	X				X	X	X		X		X					X		n/a			X			X		
	STI prevention and treatment	X	X		X	X	X	X	X	X		X		X	X	X	X		n/a		X	X	X	X	X		X
	Obstetric gynaecological care	X	X		X	X	X	X	X	X	X	X	X	X	X	X	X		n/a	X	X	X	X	X	X	X	X
	Short-term psychological support				X	X	X	X	X	X		X		X			X		n/a		X	X		X	X		
	Long-term psychological support	X			X	X	X	X	X	X	X	X		X		X	X		n/a		X	X	X	X	X	X	
	Safe abortion and post-abortion care	X	X		X	X	X	X	X	X		X		X	X	X	X		n/a		X	X	X		X	X	
	Other																										
	Don't know																										
Quaternary care	Emergency contraception					X	X			n/a		X							n/a						X		
	STI prevention and treatment		X		X	X	X			n/a		X		X	X				n/a		X		X		X		
	Obstetric gynaecological care	X	X		X	X	X			n/a		X	X	X					n/a	X	X		X		X		
	Short-term psychological support					X	X			n/a		X		X			X		n/a		X				X		
	Long-term psychological support				X	X	X			n/a		X		X			X		n/a		X		X		X		
	Safe abortion and post-abortion care		X			X	X			n/a		X		X	X				n/a		X		X		X		
	Other									n/a									n/a			X		X			
	Don't know									n/a	X								n/a								

Table 18. National distribution of specialised SRH services by Member States (N=26), 2023

Specialised service		BE	BG	CZ	DK	DE	EE	IE	EL	ES	FR	HR	IT	CY	LV	LT	HU	MT	NL	AT	PL	PT	RO	SI	SK	FI	SE
Emergency contraception	All regions (over 75 %)	X		X	X	X	X	X		X	X	X	X		X	-		X	X	X	X	X		X	X	X	
	Most regions (over 50 %)															-	X										
	Major cities only															-											
	Capital city only															-							X				
	Other		X											X		-											X
	Don't know								X							-											
STI prevention and treatment	All regions (over 75 %)	X	X	X	X	X	X	X		X	X	X	X	X	X	X	X	X	X	X	X	X		X	X	X	X
	Most regions (over 50 %)																										
	Major cities only																						X				
	Capital city only																										
	Other																										
	Don't know								X																		
Obstetric gynaecological care	All regions (over 75 %)	X	X	X	X	X	X			X	X	X	X	X	X	X	X	X	X	X	X	X		X		X	X
	Most regions (over 50 %)																								X		
	Major cities only																						X				
	Capital city only																										
	Other		X																								
	Don't know								X																		
Short-term psychological support	All regions (over 75 %)			X		X				X	X		X	X	X			X		X	X	X		X		X	X
	Most regions (over 50 %)	X					X	X								X			X						X		
	Major cities only																X				X						
	Capital city only																										
	Other																										
	Don't know								X																		

Specialised service		BE	BG	CZ	DK	DE	EE	IE	EL	ES	FR	HR	IT	CY	LV	LT	HU	MT	NL	AT	PL	PT	RO	SI	SK	FI	SE
Long-term psychological support	All regions (over 75 %)			X	X	X		X		X	X		X	X	X			X		X	X	X		X		X	X
	Most regions (over 50 %)	X														X			X						X		
	Major cities only						X										X						X				
	Capital city only																										
	Other		X																								
	Don't know								X			X															
Abortion care	All regions (over 75 %)		X	X	X	X	X	X		X	X	X	X	X	X	X	X				X	X		X	X	X	X
	Most regions (over 50 %)																		X								
	Major cities only	X																		X			X				
	Capital city only																										
	Other																										
	Don't know								X																		

Question 6. What is the national distribution of the following specialised sexual and reproductive healthcare services in your Member State?

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