Fountain in front of the Ministry of Health in Duhok, Kurdish Region of Iraq

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THTP COMPARATIVE COUNTRY STUDY

Analysis of the quality of health care for survivors of sexual and gender-based violence in Kosovo, Bosnia and Herzegovina, Afghanistan and the Kurdistan Region of Iraq

As part of *medica mondiale*'s Transnational Health Training Programme (THTP), a comparative study of the current situation of the quality of health care for survivors of sexualized and gender-based violence (SGBV) was conducted in Kosovo, Bosnia and Herzegovina, Afghanistan and the Autonomous Region of Kurdistan in Iraq (KRI). The purpose of the study was to analyse and to compare the structural obstacles and barriers that survivors of sexualized and gender-based violence face when they try to access health care services. The focus was the degree to which heath care services are offered to SGBV survivors in a stress- and trauma-sensitive way. This was done by comparing country studies conducted in each of the four countries. Based on this analysis, recommendations were made to promote the institutionalization of stress and trauma sensitivity in the health care services at country and at international level.

country contexts

Table 1: Comparison of the four country contexts[i]

Criterion	Kosovo	KRI (reported as Iraq in sources)	Afghanistan	Bosnia and Herzegovina (BiH)
Population	1.80 million (2018)	38.4 million (5.1 million for KRI[ii])	31.6 million (2018)	3.5 million (2018)
Annual GDP per capita	$ 4 194 (2018) = € 3 805.6	$ 5 510.8 (2018) = € 5 000.5	$ 563.8 (2018) = € 511.6	$ 6 056.2 (2018) = € 5 495.4
Unemployment rate	24.5% (Sept 2019)	14.8% (Dec 2017); (10.2% for KRI[ii])	8.8% (Dec 2018)	32.6% (Nov 2019)
Corruption rank[iii]	101	146	173	101
Main SGBV issues and prevalence	An estimated 20 000 women were raped during the Kosovo war[iv] In 2015, 68% of women reported that they had experienced some form of domestic violence in their lifetime[v].	The destabilisation of family life and close proximity of people in camps has led to an increase in SGBV. The Yazidi women who were held in captivity by the terrorist group 'Islamic State' were especially subjected to extreme levels of SGBV, and have been further affected by stigma and the hardship of their living conditions. 36% of married women in Iraq were exposed to at least one form of violence by their husband.[vi]	Gender-based violence is a pervasive problem in Afghanistan. It stems from complex inequalities and cultural practices which subordinate women to men and prevent them from acting on or receiving support. 87% of Afghan women experience at least one form of physical, sexual or psychological violence[vii]	Estimates of between 20 000 to 50 000 women were raped during the Bosnian war[viii] According to a 2013 survey of 3,300 BiH families (conducted by the BiH Gender Equality Agency[ix]), every second woman (50%) had experienced some form of gender-based violence during her adult life (after the age of 15).

country studies

The country studies used the "5A" model of access to health care[x]. This model distinguishes between five dimensions of access: availability, accessibility, affordability, acceptability and adequacy. The study used mixed methods (quantitative and qualitative data like surveys and interviews), engaging with 1427 respondents in total (1058 women, 291 health professionals, 51 decision makers and 27 staff from local organisations). The four country studies were done over a period of four years, from 2015 to 2019, and the approach and tools were refined along the way.

The key findings about the strengths and weaknesses of the four health systems are presented below in two ways: a summary of findings which are common in all countries, and a summary of findings differentiated by country. Recommendations are then given for the national and international level.

findings: strengths

Figure 1: Summary of strengths in accessing stress- and trauma-sensitive health care of women affected by SGBV

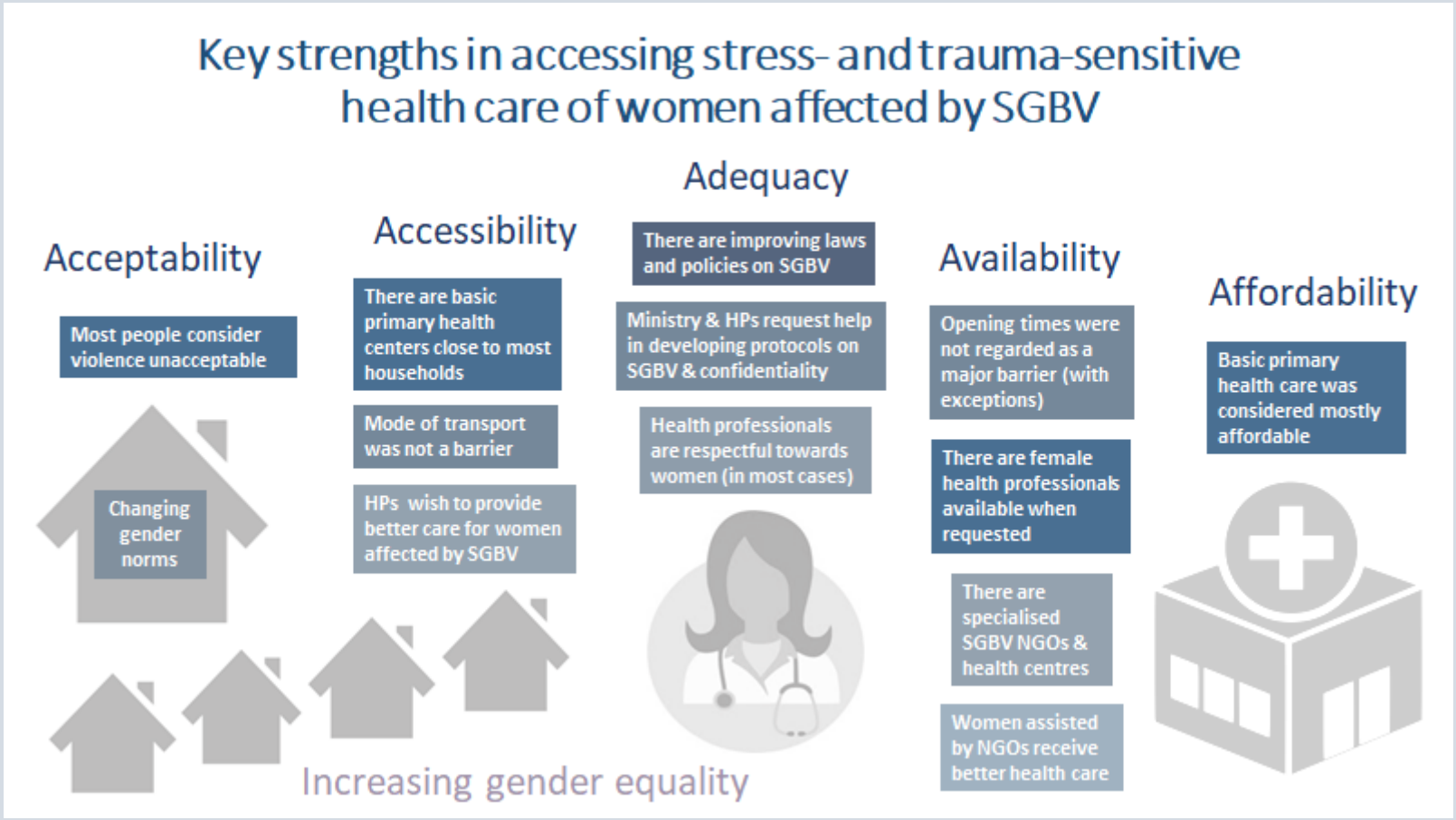

Table 2: Summary of main strengths to stress- and trauma-sensitive health care that are common to all four countries included in the study

Dimension	Strength
Availability	Opening times of health centres were generally not considered a barrier (with some exceptions)
	There are female health professionals available to assist when requested
	There are specialised non-governmental organisations (NGOs) and health centres assisting women affected by SGBV
	Women assisted by NGOs receive better health care
Accessibility	There are primary health care centres close to most households
	Mode of transport was not described as a barrier by women accessing health care
	Health professionals (HPs) expressed a wish to provide better care for women affected by SGBV
Affordability	Basic primary health care was considered mostly affordable by women
Acceptability	Most women, health professionals and ministry officials consider violence towards women as unacceptable
	Gender norms are reportedly changing, especially in urban areas
Adequacy	There are ongoing improvements to laws and policies on SGBV
	Ministry Officials and HPs requested assistance in developing policies and protocols on providing better health care to women affected by SGBV
	Health professionals were described as being respectful towards women accessing health care (with exceptions)

Table 3: Most Commonly Reported Strengths in Relation to Accessing Stress- and Trauma-Sensitive Health Care, differentiated by country

Dimension	Kosovo	KRI (Kurdish Region of Iraq)	Afghanistan	Bosnia and Herzegovina (BiH)
Availability	• 90% of women surveyed said that it is possible to see female health professionals if preferred	• 86% of women surveyed said that it is possible to see female health professionals if preferred • Gynaecologists in KRI are almost all female	• 86% of women interviewed agreed that there are female staff members available when preferred • 81% of patients agreed that the facility is always open and staff is present during its normal operating hours	• 76% of all health professionals in BiH are women

Dimension	Kosovo	KRI (Kurdish Region of Iraq)	Afghanistan	Bosnia and Herzegovina (BiH)
Accessibility	• Most women did not find it difficult to access health services in terms of geographical area and transport and there are health care facilities within 5km of every household in the country	• There are primary health care centres (PHC) close to most communities and women said they did not find them difficult to access PHC in terms of geographical area • Travel to PHC was available and not described as a barrier	• Most urban women did not find it difficult to access health services in terms of geographical area and transport and there are health facilities available in most areas	• Most women in urban areas did not find it difficult to access health services in terms of geographical area and transport and there are health care facilities available in most areas
Affordability	• Transport to basic primary health care is affordable • There are policies for some free health care assistance for war rape survivors (though not well known)	• The women described the primary health care initial consultations as affordable • Transport to basic primary health care is affordable	• Cost of travel was not spontaneously reported as a major barrier to health care	• Cost of travel was not spontaneously reported as a major barrier to health care • There are policies for free health care of war rape survivors (though not well known)
Acceptability	• 87% of women and 97% of health professionals expressed that violence in a marriage is unacceptable • Ministry officials expressed willingness to improve support for women affected by SGBV • The NGOs describe rapidly changing social norms toward gender equality, especially in larger urban areas	• 87% of women considered violence within marriage as unacceptable • The respondents describe rapidly changing social norms toward gender equality in KRI, especially in urban areas • Most health professionals felt that public awareness raising on prevention of SGBV was important • Several health professionals and Health Ministry officials wished to further develop the specialised centres for safely assisting women affected by SGBV • Most ministry officials were self-critical and eager to improve their services, and aware of the social and cultural barriers to women affected by SGBV accessing health care	• More health professionals than women thought that violence is unacceptable within marriage (though this figure is still low at 67%)	• Most health professionals regarded violence as unacceptable • Health professionals are conscious of unjustified stigmatization of survivors of SGBV • Being actively prevented from seeking healthcare by family members was not reported as a barrier for women in BiH • Women rated their safety as an average of '4 out of 5' for all health centres

Dimension	Kosovo	KRI (Kurdish Region of Iraq)	Afghanistan	Bosnia and Herzegovina (BiH)
Adequacy	• There are good laws and policies in place in Kosovo regarding supporting women affected by violence, with confidentiality • There are specialised NGOs providing holistic, confidential and non-stigmatising programmes for women affected by SGBV (and they are available to accept referrals) • There is good collaboration between service providers such as NGOs, places of safety, police and health professionals • Most women felt that the health services were respectful, culturally appropriate and that their details were kept confidential • The health professionals were eager to join *medica mondiale's* training program THTP	• There are good laws in place in KRI regarding reporting and addressing violence against women (in addition, respondents were self-critical of the degree of implementation of national and regional laws) • Ministry of health requested assistance developing and disseminating SGBV protocols • Several NGOs and two health centres provide specialised mental health services for families affected by violence (and are available to accept increasing referrals) • Most of the women reported that health professionals were kind, empathic and respectful towards them. They felt confident in the competence of the doctors and in their information being kept confidential • The health professionals felt that women's information was kept confidential (while acknowledging a need for clearer protocols around record keeping and systems for ensuring confidentiality) • The Ministry of Health officials were self-critical and eager to improve their services to women affected by SGBV, through the THTP	• 79% of the women felt that health professionals act in a respectful and professional manner towards them • 86% of patients surveyed agreed that they trust the people working at the facility • Health professionals scored high in terms of compassion satisfaction • 62% of health professionals said they would refer women affected by SGBV to a psychologist • The majority of health professionals (95%) indicated they would ask the client if she has ever been hurt, with 86% asking if she is currently in danger • Some health centres reportedly had a protocol for care for survivors of SGBV, which improved their quality of care • 71% of women felt they have a choice and 71% agreed that health professionals work with them rather than doing things for them or to them • 95% of women - at end of project - stated that over the past year they had become more satisfied with the services at the health facility	• Women rated health professionals with '4 out of 5' for politeness • Women are generally satisfied with the received medical treatment. They rated the quality of their medical examinations at an average of 3,9 out of 5 and general satisfaction at 4 out of 5 • Survivors of SGBV in principle trust the personnel of health institutions, rating their trust in the treatment given at '4 out of 5' on average • There is a good level of trust in confidentiality of women's direct doctors, with women giving an average rating of 4,1 out of 5 for trust in confidentiality • Women rarely described any ethnic or religious discrimination • There are some protocols in place for dealing with SGBV • Most professionals highly regarded the usefulness of the introduction of a stress and trauma-sensitive approach (STSA) training for health workers

findings: barriers

Figure 2: Key systemic barriers to access to stress- and trauma sensitive health care of women affected by SGBV

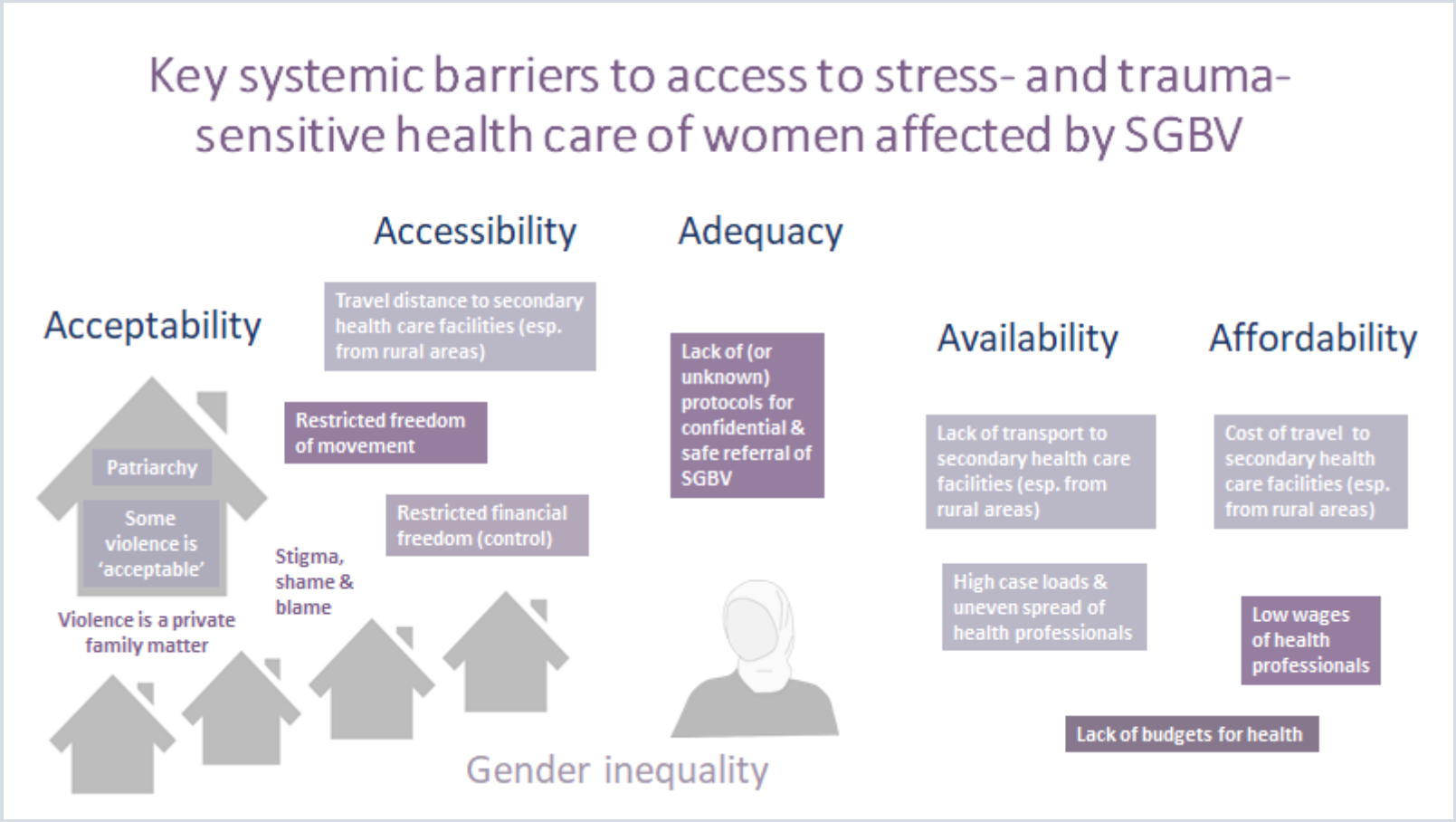

Table 4: Summary of main barriers to stress- and trauma-sensitive health care that are common to all four countries included in the study

Dimension	Barrier
Availability	Lack of specialist medicines and equipment
	Lack of local specialists (especially gynaecologists and psychologists)
Accessibility	Prevention of health-seeking by family members (in some cases 'imprisonment' of women in their homes, without access to unsupervised external communication)
	Accompaniment of family members into health consultations
Affordability	Underfunded health care systems and low salaries of health professionals
	Cost of specialist medicines and equipment
	Cost of travel to secondary health care
	Corruption (bribes, referrals to private health facilities, nepotism)
Acceptability	Social stigma
	Violence is considered a 'private family matter'
	Some violence is considered acceptable within marriage
	Negative attitudes towards young women seeking SRH care
Adequacy	Lack of institutionalisation and implementation of international policies, protocols and guidelines on standards of health care for women affected by SGBV
	Health professionals are not diagnosing and reporting SGBV
	Health professionals do not all know the protocols for reporting SGBV

Table 5 Summary of main barriers (and potential barriers) to stress- and trauma-sensitive health care across all four countries

Dimension	Barrier	Kosovo	KRI	Afghanistan	BiH
Availability	Lack of specialist medicines and equipment	YES	YES	YES	YES
	Lack of local specialists (especially gynaecologists and psychologists)	YES	YES	YES	YES
	High and uneven caseloads (especially in urban centres) – reported by health professionals		YES	YES	
	Lack of time spent with women (linked to dual role of HPs in private / public health services)	YES			
	Lack of private spaces for consulting women		YES	YES	YES
	Lack of availability of female health professionals			YES	
Accessibility	Restricted movement (women 'imprisoned' in their homes)		YES	YES	
	Prevention of health-seeking by family members	YES	YES	YES	Likely*
	Accompaniment of family members into health consultations	YES	YES	YES	Likely*
	Lack of safety for HPs in health centres (fear of family members)			YES	
	Limited opening hours	YES		Likely*	YES
	Lack of availability of government transport in certain rural areas				YES
Affordability	Underfunded health systems and low salaries of health professionals	YES	YES	YES	YES
	Cost of specialist medicines and equipment	YES	YES	YES	YES
	Cost of travel to secondary health care	YES	YES	YES	YES
	Corruption (bribes, referrals to private health facilities, nepotism)	YES	YES	Likely*	YES
	Economic restrictions on women (by family members)		YES	YES	
Acceptability	Social stigma	YES	YES	YES	YES
	Social stigma with danger of honour killings		YES	Likely*	
	Violence is considered a 'private family matter'	YES	YES	YES	Likely*
	Some violence is considered acceptable within marriage	YES	YES	YES	Likely*
	Fear that cases of SGBV won't be handled properly and confidentially			YES	YES
	Negative attitudes towards young women seeking SRH care	YES	YES	YES	YES
Adequacy	HPs are not diagnosing and reporting SGBV	YES	YES	YES	YES
	HPs don't agree with the definitions of SGBV and only report extreme cases of physical injury	YES	YES		
	HPs don't know the protocols for reporting SGBV		YES	YES	YES
	Women treated disrespectfully in some centres (e.g. maternity wards)	YES	YES		YES
	Discrimination on basis of economic status and race / ethnicity e.g. Roma	YES			YES

* This is likely to be the case, given the country context, but it was not reported on in the country study

Table 6 Main barriers (and potential barriers) to stress- and trauma-sensitive health care, differentiated by country

Dimension	Kosovo	KRI (Kurdish Region of Iraq)	Afghanistan	Bosnia and Herzegovina (BiH)
Availability	• Lack of time spent with women by health professionals, who felt rushed during consultations • Lack of specialised medical equipment and medicines • Lack of local gynaecologists and psychologists • Lack of completely private spaces for consulting women • Lack of strategy for employment of high numbers of qualified health professionals	• High case-loads carried by doctors in busy health centres (and uneven spread of patients and resources across health centres) • Lack of specialised medical equipment and medicines • Lack of sufficient privacy in consultations with women • Lack of availability of government transport and mobile clinics to assist rural women	• High case-loads carried by doctors affect availability of health care • Lack of availability of locally-situated gynaecologists • Lack of specialised medical equipment and medicines • Lack of sufficient privacy in consultations with women	• The length of the waiting time if women went without an appointment (the most common reason why women give up on services) • Lack of availability of locally-situated gynaecologists at certain times of day • Lack of specialised medical professionals, equipment and medicines • Lack of sufficient privacy in consultations with women
Affordability	77% of women found the cost of health care to be a big challenge, and only 23% did not find it a challenge. Affordability is one of the main barriers to accessing health care, especially: • The cost of medicines • The cost of specialised services and every aspect thereof • The cost of transport for specialised services at the bigger centres • One of the main structural issues is the low payment of health professionals and their dual roles in public and private health care centres, enabling corruption	72% of women said that the cost of healthcare is not a challenge, and 28% responded that it is a big challenge for them. Affordability was not described as a major barrier by women, and mainly described as a factor in relation to: • Economic restrictions placed on women by family members • The cost of medicines • The cost of specialised services (often only available in private clinics) • The cost of transport for specialised services at the bigger centres • Low payment of health professionals was described as a problem by ministry officials and NGOs	• 39% of women said that expenses for treatment, travel, and other health-related costs are the primary reason for not seeking treatment for health problems • 78% of women reported having to pay for medicines	• 70% of women in the project area and 76% of women in the control area reported that cost of health services is a barrier. The lack of money needed to pay for health services, as well as the cost of medicines, represents the most common reason due to which these are unavailable to the users • 12.5% of women in the project area and 54.8% in the more rural control area reported that transport costs are a barrier to healthcare • Corruption and "coercion" of patients to use private services was emphasized

Dimension	Kosovo	KRI (Kurdish Region of Iraq)	Afghanistan	Bosnia and Herzegovina (BiH)
Accessibility	• 43% of the women said they went to health care accompanied by a family member. Only 69% of health professionals said they would see a woman alone if they suspected violence. Given the high levels of social stigma, health professionals should be explained the importance and discuss practically how to consult women independently of family members • 20% of women reported having (at least sometimes) been prevented from seeking help by their family	• Restricted movement outside of the home (especially for women from traditional rural areas), even to access health care • Accompaniment of 64% women to health services by a family member (who may be a perpetrator or the family member of a perpetrator of violence) • Social stigma and shame of reporting violence • A belief that violence is a private family matter, rather than a cause for public concern and external intervention • A concern by some rural men that their wives and daughters may be seen by a male doctor if they access health care, which is against their religious beliefs	• Restrictions on women's mobility and autonomy delay and negatively impact their access to health services • 11% of patients reported that in the past year, there had been a time when they wanted to see a doctor, nurse, or other healthcare worker but were unable to because their family member/s didn't allow them to seek treatment • Health facility staff mostly reported a lack of physical and emotional safety caused especially by the presence of patient's relatives, some of whom were armed • 28% of rural women described travel time and cost as a barrier to accessing health care	• Lack of availability of government transport in certain rural areas affects accessibility

Dimension	Kosovo	KRI (Kurdish Region of Iraq)	Afghanistan	Bosnia and Herzegovina (BiH)
Adequacy	• Many health professionals are not diagnosing and reporting suspected violence. This is despite being aware of how to identify violence, knowing where to report it and what protocols to follow. They are reluctant to ask about violence and about a third deny the existence of violence in their areas of operation, due to social stigma and that the communities are small • The health professionals sometimes dealt with women patients superficially, without in-depth follow up or psychosocial support • The women do not seem to be greatly involved in the decisions affecting their wellbeing and the health professionals see their role more as dispensing diagnoses, medicines and referrals • Discrimination of some minority groups and socio-economically disadvantaged people like Roma was reported as a barrier to accessing health care	• Many health professionals are not diagnosing and reporting suspected violence. About a third deny, minimise or normalised SGBV. Others are afraid to intervene for the safety of women, themselves and the idea that it is inappropriate to intervene in 'family business' • There is a lack of educational materials about SGBV in the health centres • The health professionals are not aware of protocols for identifying and safely referring cases of SGBV. The ministry officials requested assistance in further developing and disseminating such protocols • Record keeping is ad hoc, and there is no centralised computer information management system • NGOs and ministry officials described incidents of rudeness by health professionals (while most women felt respected in how they were assisted) • Discrimination across religious and cultural groups does not seem to be a barrier, though family connections are given priority treatment at health centres	• 43% answered incorrectly to the statement 'health workers in government facilities are not required to report cases of intimate partner violence (IPV) to the police' • 81% of health professionals indicated they would ask women who report abuse to them what she may have done to be abused, implying that she had somehow asked for it • 38% of respondents did not know that the Ministry of Health has developed standards and protocols on management of sexual violence • 37% of women said that sometimes the healthcare facility services are not in line with cultural norms related to gender, religion, or society	• Only 28% of the health professionals from the project area said they had been in personal contact with at least one SGBV survivor, versus 7% of colleagues from the control area • Health professionals presented a lack of knowledge and occasional negative attitudes about SGBV, combined with unsupportive working conditions • Women who experienced SGBV and informed health professionals about the reasons for visiting a health institution, said that health professionals did not take the appropriate legal steps to report this. They said they did not inform the other referral institutions and did not refer the survivors to them • Only a portion of the professionals knows that their institution has a protocol for dealing with adult SGBV • In smaller communities, some of the women survivors of SGBV were not sure that the information they have shared will not "leak" outside of the health care institution

Dimension	Kosovo	KRI (Kurdish Region of Iraq)	Afghanistan	Bosnia and Herzegovina (BiH)
Acceptability	• The social stigma of reporting violence is a major barrier • Violence is regarded by 20% of health professionals as 'a private family matter' • There is social stigma about young women accessing sexual reproductive health services	• The social stigma and danger of reporting violence is a barrier • This stigma reportedly comes from within the family and the neighbourhood and in many cases can be literally life threatening in terms of honour killings. It seems to be a key factor in why health professionals are not asking about and reporting suspected violence • Violence was regarded by 73% of women and 33% of health professionals as 'a private family matter • Although gender norms and attitudes to violence are reportedly changing rapidly in KRI, there are still many people who express an attitude that GBV is acceptable. Only 58% of the health professionals were of the opinion that violence should never take place in a marriage	• 15% of health professionals think violence is a private family matter • 33% of health professionals agree that violence is a normal part of marriage • 28% of women surveyed agreed with some justification for SGBV • 19% of women agreed that if a woman is being abused by her husband, it is a private family matter and she should not seek help from public facilities • 45% of women agreed that they would feel offended if a health professional asked them about physical or sexual abuse • 66% of women are influenced by whether their family members and 24% by whether other people in the community approve of their seeking services • 40% fear the healthcare provider reporting their case to the authorities and 35% fear the healthcare provider telling their family about the treatment	• Although women directly affected by SGBV had confidence in the health professionals, qualitative data shows that the fear of stigmatization, as well as the feeling that there is no "real help / way out", prevent survivors to more often turn to health care institutions • They feel that the health professionals will medically provide for them, but that they will not take all necessary legal steps to protect them, and have the perpetrators punished • In smaller rural communities, stigmatization towards women affected by violence is greater, while the disclosure of information about experienced violence is considered shameful • There is social stigma about unmarried, young women accessing gynaecological services

Recommendations for the advocacy work at country level

Table 7 Main recommendations to addressing barriers to stress- and trauma-sensitive health care at country level

Dimension	Barrier	Recommended Action	Strategic Objective
Availability	Lack of availability and affordability of specialist medicines and equipment, linked to corruption and nepotism	Clarify the policies on the dual role of health professionals in private and public health care; Advocate for systems within the health centre to avoid preferential treatment of relatives and friends in the health care system (for example numbering and ticket systems)	The policies on dual role of health professionals in private and public health care are updated and implemented; Policies and systems to avoid preferential treatment are updated and monitored
	Lack of local specialists (especially gynaecologists, psychologists)	Advocate for more education and appointment of gynaecologists and mental health professionals at local primary health care centres (or mobile services)	Women affected by SGBV are referred for gynaecological and psychological support are able to access these specialists locally
Accessibility	Prevention of health-seeking by family members;	Develop awareness campaigns on the confidentiality measures which are undertaken when a woman affected by SGBV is assisted; Develop awareness campaigns on the role of specialised NGOs and health centres; Develop awareness campaigns that a woman accessing health care may request to be assisted by a female health professional; Facilitate media SGBV sensitisation training and monitoring; Discuss with decision makers the feasibility of home-based health visits to identify women severely affected by SGBV; Collaborate with UN Women, WHO and UNFPA to address the gap between existing international protocols, guidelines and handbooks for women affected by SGBV already accessing health care but not reaching out to women 'imprisoned' in their homes without access to unsupervised communication	Increase of referrals of women suspected of being exposed to SGBV to health centres and specialised centres; Increase in public knowledge that women may request to be assisted by a female health professional; Develop STSA media reporting criteria and increase awareness of media on how to report on SGBV sensitively (and develop into national policy?); Increased identification and referral strategies are developed for accessing women most severely affected by SGBV and unable to access health care; Increase focused attention and health programming on women who may be most severely affected by SGBV and who are excluded from access to health care
	Accompaniment of family members into health consultations	Develop country protocols and train health professionals to always separate family members in cases of suspected violence; Share strategies on how to consult women alone without risk to HPs or the women	International protocols such as WHO, UN Women and UNFPA Guidelines on health care for women who may be affected by SGBV are adopted and implemented
Affordability	Cost of specialist medicines and equipment	Advocate for free specialist medicines and health services (especially those commonly used by women affected by SGBV); Sensitise HPs and decision makers on the cost barrier as described by women	National policy is developed and implemented that medicines and services are available at no cost at public health centres when prescribed for women affected by SGBV
	Cost of travel to secondary health care	Advocate for mobile health services	Increased mobile health services to outlying area

Dimension	Barrier	Recommended Action	Strategic Objective
Acceptability	Violence is considered a 'private family matter' Some violence is considered acceptable within marriage	Develop awareness campaigns that all violence is unacceptable and is a matter of public concern, not a private family matter; Train health professionals that all forms of violence are unacceptable and must be addressed and develop protocols for this; Draw on local knowledge and strategies of HPs in how to educate other health professionals on types of violence and intervening; Support focal point persons (FPPs) employed by health care providers to target more resistant health professionals for training and awareness raising	Increase in public awareness that all violence is unacceptable and a point of public concern; HP training curricula and protocols specify all forms of SGBV and include mandatory reporting
Adequacy	HPs are not diagnosing and reporting SGBV; HPs do not all know the protocols for reporting SGBV	Develop and disseminate protocols for health professionals to identify and refer women suspected of SGBV: • Safely • Privately • Confidentially For holistic assistance (e.g. psychosocial support - PSS)	Development, dissemination and implementation (with monitoring) of protocols for health professionals to identify and refer women suspected of SGBV (eventually developed into legally binding policies); Increase in safe, confidential, structured identification and reporting of women affected by SGBV in health centres; Increase in clarity (and use) of referral pathways for holistic support of women (including PSS)
	Strength: women assisted by NGOs receive better STS health care	Advocate for formalised concessions and agreements; Lobby for funding for specialised NGOs and government women's health centres	Concessions and agreements between NGOs assisting women affected by SGBV and health centres are formalised; The role and value of specialist NGO and women's health centres is supported
	Lack of time spent in consultations with women during health care	Sensitise decision makers and health professionals to women's feedback that they would appreciate more time in consultations and that this is a core element of an STSA; Encourage decision makers to review caseloads of health centres	Increased time is spent with women by health professionals to do holistic health assessments; Policy on health professionals' workload and spread across health centres is revised and implemented
	Lack of institutionalisation and implementation of existing international policies, protocols and standards on health care for women affected by SGBV	Advocate for institutionalization and implementation of international policies, protocols and standards on health care for women affected by SGBV, beyond piloting and actively contribute to monitoring implementation; Collaborate with UN Women, WHO and UNFPA to contribute explicit sections to the existing clinical handbooks on their STSA, such as the importance of strengthening empowerment, choice and collaboration, although these are implicit in the reviewed guidelines; *medica mondiale* should contribute their expertise on self-care, not only of HPs providing services to women affected by SGBV, but creating a healthier organisational environment such that HPs are more enabled to offer STSA to all women	Institutionalisation and consistent, sustained implementation and monitoring of international policies, protocols and standards on health care for women affected by SGBV; All facets of a STSA, including empowerment, choice and collaboration are explicitly covered in international and nationally adopted policies, protocols and clinical handbooks; Organisational wellbeing is recognised as a key contributing factor to the provision of an STSA for all women accessing health care

Recommendations for the advocacy work at the international level

The findings of this study support the use of international protocols, guidelines and handbooks developed by WHO, UNFPA, UN Women and other partners, on strategies, standards and procedures for health care of women affected by SGBV. At an international level *medica mondiale* should challenge the international organisations who developed these guidelines to follow through on implementation, beyond pilot training initiatives and emergency support. *medica mondiale* could contribute to the development of such international policies and guidelines with a greater inclusion of women survivor's voices and meaningful participation in their monitoring and implementation.

A key point for international advocacy which has emerged from this study is the gap between general SGBV preventive strategies and specific assistance to women affected by violence who manage to access health care. For example, there is a lack of mention in these international guidelines of health systems reaching women who are reportedly 'imprisoned' in their homes, unable to access health care and who do not have access to any unsupervised external communications (such as calling 'hotlines' by telephone). *medica mondiale* is ideally placed to design and pilot safe and sensitive home-based health outreach interventions with its strategic partners, making recommendations for international policy and programme development. Further research on the prevalence of these most vulnerable cases is recommended, with sensitive thought to safe research design and implementation.

Information exchange with other organisations is recommended, in particular UNFPA and WHO, both of which have previously run training programmes with health professionals on health care for women affected by SGBV, but do not seem to be currently running training programmes (e.g. in Kosovo and KRI). They have expressed willingness to share their reflections and strategies. Ongoing networking with UN Women international and country offices and other national and local NGO networks is recommended to draw on local resources, especially for advocacy and development of strategies. Presenting THTP and networking at relevant international conferences was recommended.

Sincere thanks are expressed to all who participated in and supported this study, especially the women who contributed their voices to improve our understanding of their country situation.

[i] For consistency and comparability, all data is taken from https://tradingeconomics.com/ unless otherwise stated
[ii] UNFPA, Demographic Survey: Kurdistan Region of Iraq
[iii] "The Corruption Perceptions Index ranks countries and territories based on how corrupt their public sector is perceived to be", from https://tradingeconomics.com/
[iv] https://www.npr.org/sections/parallels/2018/04/06/598832041/in-kosovo-war-rape-survivors-can-now-receive-reparations-but-shame-endures-for-m
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