emma
EGYESÜLET

SUPPORTING WOMEN IN CRISIS

RESPONDING TO THE SEXUAL AND REPRODUCTIVE NEEDS OF WOMEN IN HUMANITARIAN CRISES

The EMMA Association is a cooperating partner of the International Planned Parenthood Federation (IPPF).

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INTRODUCTION

Background

All of Europe was shaken when Russia attacked Ukraine on 24th February 2022, escalating a conflict that had been going on since 2014. Millions of refugees crossed the borders of neighbouring countries, including Hungary, in a massive large-scale movement of forced displacement. While at the beginning, women, children, and men arrived from Ukraine, the soon-introduced military conscription for Ukrainian men aged 18-60 meant that later it was mainly women and children who arrived. Women and girls were, and are still, particularly affected by the humanitarian crisis (VOICE, HIAS, 2022).

The largest proportion of refugees in Hungary came from regions of Ukraine such as Kyiv and Transcarpathia (IOM, 2023). Transcarpathia is a region of Ukraine bordering Eastern Hungary, where the population of ethnic Hungarians was significant before the Russian invasion.[1] Geographical proximity, ethnicity, and language all contributed to many of them choosing Hungary as their destination. Although precise figures are not available, experience shows that Roma refugees who identify themselves as Hungarian also arrived in significant numbers from this region.

Hungary's civil society and volunteers responded with unprecedented solidarity since the beginning of the crisis (CRR, 2023). In parallel, with the mobilisation of considerable resources, serious efforts have been made to meet the needs of refugees. However, sexual and reproductive health care and support for victims of gender-based violence (including sexual and intimate partner violence) against women and girls have not been prioritised. The crisis has highlighted even more the lack of government commitment to funding and development of such services in Hungary and the surrounding Eastern European countries, exacerbated by inconsistencies in legal and policy regulation, stigmatisation, and restrictions on sexual and reproductive health and rights. As a result, refugees found limited access to professional, effective, and respectful healthcare.

Purpose and scope

This handbook is a compilation of knowledge and experiences drawn from EMMA's humanitarian programme 2022-2025. Our aim is to present a practical methodology for providing effective, respectful, and women-centred solutions to the sexual and

1 The last census in Ukraine was in 2001, when a little over 151,000 people declared themselves Hungarians.

reproductive health needs and rights of refugee women in humanitarian crisis management. It can also serve as a guide for the design and development of humanitarian programmes and projects that seek to address these needs and rights.

Our work is based on the fundamental belief that the free exercise of sexual and reproductive rights is a right for all people. We work to ensure that all women have access to safe and dignified gynaecological and obstetric care, antenatal care, contraception, and abortion.

The focus of the handbook is based on the experiences of professionals working in the field. We show how sexual and reproductive health services can be combined with mental health support and social work in the context of a humanitarian crisis response and highlight the aspects and principles that we have found to be essential for truly effective support and service delivery in this field. However, this manual is not intended to be a comprehensive methodological guide, nor does it cover the scientific and medical standards, guidelines, and aspects of sexual and reproductive health issues.

By presenting a feminist, women-centred and trauma-informed approach, the book seeks to highlight the shortcomings of humanitarian responses and how the current system often does not adequately serve women's interests. Practical examples and recommendations for practitioners and organisations aim to help them respond more sensitively, inclusively, and effectively to the needs of women in humanitarian settings.

Acknowledgements

We would like to thank all the programme staff for their commitment to supporting women and all the colleagues at EMMA Association for being there for each other during this challenging period. We thank the partner organisations for their cooperation and mutual learning opportunities, and the donor organisations for providing the financial means to work towards the sexual and reproductive health of vulnerable women.

Finally, we would like to express our gratitude to all the women with whom we have come into contact with throughout the programme's activities. We thank them for their trust, for sharing their difficult and joyful experiences with us, and for inspiring us with their strength and perseverance. Without their personal stories and courage, this handbook would not have been possible.

2 EMMA Association – Code of Conduct (See Appendix Chapter 5.4)

1.
CASE DESCRIPTIONS

Women are at the heart of our work: understanding their situation, identifying their needs, and working to meet those needs is the backbone of our activities. We want to demonstrate this approach by dedicating the first chapter of this handbook to women's stories. We invite everyone to „come close" to the women through reading, to get to know them and the challenges they have faced after fleeing their war-torn country.

The stories have been selected to showcase the wide range of activities that have been, and need to be, carried out to meet women's sexual and reproductive health needs. Most of the descriptions are about Hungarian-speaking, Roma women, from the Transcarpathian region of Ukraine, but some of the stories demonstrate our work done with Ukrainian-speaking clients too.

The case logs[3] kept during our work enabled us to reconstruct the stories as accurately as possible. We have tried to cover as many different situations as possible. The stories described here, and the different aspects of complex life circumstances and care situations, will be referred to in later chapters.

Names and identifying characteristics have been changed to protect the privacy of those depicted.

3 You can find a field log template in the Appendix (Chapter, 5.3) to illustrate the method for recording the interactions and procedures related to our clients.

NATASHA

Keywords: ***Ukrainian-speaking pregnant woman; partner living in Hungary; language barriers; lack of social network; abusive relationship; service gaps (safe house); police report; PTSD; inter-organisational cooperation***

We found out about Natasha through one of our partner organisations. We were approached to help support her into the prenatal care system. She was in the last trimester of her pregnancy, her Ukrainian medical records had been lost, and she had not yet been seen by a doctor in Hungary. Her housing was temporary and not suitable for a newborn baby. Natasha wanted to raise the child on her own, the father did not want to be involved. In cooperation with a partner organisation that referred her case to us, we arranged Natasha's medical care and psychosocial support, and the partner organisation worked on finding her a maternity housing programme. They quickly got back to us to say that such housing programmes can only take someone with a clear social security status. This was not the case for Natasha (and for many other refugee women), so she could not be placed in a subsidised shelter. Her housing had to be arranged through other channels. With our assistance, an international humanitarian organisation was able to arrange housing for Natasha in the short term.

Until birth, we supported Natasha by accompanying her to check-ups, childbirth education, and buying the necessary supplies. In addition, we provided her with a doula with whom she could prepare for the birth and who agreed to be with her during the hours of labour.

The birth went well, and Natasha gave birth to a healthy baby girl. Our plan at the time was to help her through the postpartum weeks: to connect her with the paediatrician and the health visitor; to help her get her birth certificate; and then to close the supporting relationship with her. However, the rapport with the paediatrician was not straightforward. The doctor was not helpful at all, completely refused to use the telephone interpreter line for health workers, only spoke to the caseworker, in Hungarian, and deliberately ignored the mother. He behaved in an impatient, offensive, and threatening manner towards Natasha, stating that she was unfit to become a parent. Therefore, we decided to support her more closely to prevent an unwarranted child protection intervention. Natasha became increasingly exhausted from all the sleepless nights and constant crying and began to accept more and more help from the father who would show up from time to time.

Later we found out that the father was emotionally abusive, so other NGOs with expertise in intimate partnership violence got involved in the case management. From the available options offered, Natasha was open to the supportive conversation, therapy, and to receive regular personal visits from support organisations. She was also

reassured by the fact that an “alert chain” had been set up and knew who to contact if he appeared again. In addition, she indicated that she would like to leave the country as soon as possible, so the baby’s birth certificate and citizenship status should be arranged as quickly as possible. This procedure started immediately.

Later, evidence of physical abuse also emerged, so further crisis intervention became necessary, including finding a new safe shelter and taking legal steps (filing a police report among others). Natasha needed psychiatric care as a result of the trauma and her deteriorating mental state.

The organisations involved in case management moved every stone to find a safe place with 24/7 support and professional supervision available. In addition to the scarcity of such available safe houses, she would have needed a clear social security record to get admitted (just like in the case of maternity housing programs). There was only one location with a few places for those without social security, but then her mental health history became the reason for exclusion, and also that place was not able to provide round-the-clock supervision. With no alternative, eventually she moved to a housing facility for Ukrainian refugees.

Due to the location of the accommodation, we were not able to provide Natasha with face-to-face support, but she could rely on our postnatal support (information on breastfeeding, childcare, and psychosocial support) both online and by phone. In addition, we could offer counselling and support to the housing organisation, and we provided them with donations to meet the basic hygiene needs of Natasha and her baby.

Before closing the supporting relationship with her, we helped her to obtain Ukrainian citizenship and a travel document for the baby. Natasha left the country soon afterwards with the child. We followed their story for nine months.

VANDA

Keywords: ***unaccompanied pregnant minor; Hungarian-speaking Roma refugee; partner living in Hungary; bureaucratic obstacles; guardianship administration***

We found out about Vanda from a volunteer working at a refugee shelter who called our phone line for Ukrainian refugee women. She told us that they were hosting a Roma girl, Vanda (soon reaching the age of majority), who was probably pregnant. They only provided accommodation, they did not have the capacity for case management, so Vanda was trying to get to medical check-ups on her own. However, as she was a minor and arrived

unaccompanied, she was denied care at the local clinic. She also visited a gynaecology clinic for minors, but their service had been discontinued. At this point, the staff at the shelter decided to refer Vanda to our humanitarian programme at EMMA.

One of our field workers then went to meet Vanda at the collective shelter, who was distrustful and reserved at first. During subsequent visits and time spent together, Vanda gradually opened up.

Vanda came over to Hungary alone. She didn't know anyone here, so immediately after arriving at the station, she called a young man whom she had known and who worked already in Hungary. He offered his place to stay for the night. Word quickly spread in their community, and they put pressure on them to commit to each other. Complying with the social norms of the community, they became a couple. A few months later, Vanda became pregnant.

When Vanda began case management with us, it was clear that in order to access health care, she first needed legal representation. As there were no other relatives or close friends of Vanda in Hungary, with the legal help of a partner organisation, her young partner became her guardian. Because of his employment, he could not accompany Vanda for prenatal visits, so Vanda's male partner signed a written statement to allow the health workers to perform all necessary examinations and authorised the EMMA field worker to accompany Vanda to the appointments. This meant that a field worker had to be personally present with Vanda at every step of the antenatal care. By the time the paperwork was sorted out and she finally had access to medical care, Vanda was three months pregnant, so it was necessary to act quickly and efficiently to make up for the overdue (and time-sensitive) tests within a few days.

Shortly after we contacted the antenatal care providers, the health visitor informed us that she would not allow the newborn baby to be returned to the collective accommodation where Vanda and her partner were living. It was therefore necessary to find a place for Vanda that meets the requirements set out by the health visitor. Vanda's field worker contacted humanitarian organisations who could provide accommodation, and they found a rental within a relatively short period of time, but they could not stay there long. For the remaining few months of her pregnancy, Vanda lived in several different places, and she had to sign up for a different health visitor at each location (the service area of health visitors is based on the place of residence). Vanda could always count on our staff to help her in contacting the new health visitor, as well as to book and accompany her to her gynaecological visits and screening tests. The frequent meetings provided an opportunity to develop a close, trusting relationship between the field worker and Vanda, thus psychosocial support was also constantly provided.

At the beginning, Vanda's gynaecologist showed no respect for her, communicated with her in a very condescending way, making offensive remarks about her ethnicity and life situation. He felt entitled to make statements such as, "*Why did you get pregnant? You are*

still a child!", "Why did you run away, there is no war in Transcarpathia!", *"It is irresponsible to have a child in wartime!"*. As a result of the intervention made by our field worker, communication improved over time, and the doctor became respectful to Vanda prior to the birth.

Upon the request of Vanda, her field worker was prepared to support her as a doula during labour and birth. Eventually the hospital staff only allowed one companion into the labour ward, so the father of the baby was there for the birth.

The baby was born without complications, but then due to bureaucratic difficulties, Vanda spent three weeks in hospital. Vanda needed both intensive emotional support and administrative management, in addition to postpartum help. The problem was that Vanda had given birth as a minor and therefore she could not become the legal guardian of the baby, and without which the hospital could not discharge the baby. A guardian had to be appointed as part of a guardianship procedure. This required the child's birth certificate, which was not automatically issued by the relevant office. In fact, Vanda was asked to prove her family status (in this case, her unmarried status) to clarify what surname the child would receive. This certificate of family status had to be obtained from the Ukrainian embassy. One complicating factor was that Vanda was only allowed to leave the hospital without the baby, but an even bigger problem was that the embassy issued this document in Ukrainian. Therefore, an accredited Hungarian translation had to be obtained, which took ten working days to process. Once the translation was in hand, the birth certificate was issued and delivered to the guardianship office, and a guardian was finally appointed for the baby. Only then, three weeks after giving birth, was Vanda able to leave the hospital with her baby. As an example of the lack of uniform procedures, in the same period, in the same city, a baby born to an underage unmarried refugee girl was automatically registered in the mother's name, without the certificate of family status, which shortened the procedure considerably and did not cause the new mother the psychological strain of a three-week hospital stay.

For four months following the birth, Vanda remained in our care, including receiving support with breastfeeding and childcare, as well as assistance in arranging the citizenship and travel documents for the infant. As Vanda was not planning to have another child in the near future, she also decided to get long-term contraception. After ten months, we closed the support process as Vanda had gained confidence in childcare, her baby had received mandatory vaccinations and personal identity documents. Occasionally, even after the end of the relationship, she contacted her EMMA support worker with questions about motherhood and childcare.

RENATA

Keywords: ***Hungarian-speaking Roma refugee woman; partner living in Hungary (temporarily working abroad); challenges of obstetric care; trauma; return to Ukraine; bureaucratic challenges; denied newborn care; livelihood difficulties; cooperation between partner organisations***

We got in contact with Renata upon the recommendation of another client, with a multiparous pregnancy. She was a resilient woman, skilfully navigating her way through the local healthcare system. When we met her for the first time, she already had her first check-up and had contacted the health visitor. She indicated to us that she needed emotional support rather than arranging prenatal care and accompanying her to examinations.

At the very first meeting, she shared with us the story of her previous births, including severe complications. The care provider for Renata told her that these traumatic birth experiences could have been avoided by performing a caesarean section. Consequently, she was adamant about having a caesarean section for this birth.

A later conversation revealed that the doctor who had confirmed her pregnancy at the local clinic had treated her with great disrespect, so she refused to return to him. She asked us to find another doctor for her, preferably a woman, and said that it would be important for her not to have a vaginal examination every single time. When we called the district clinic, it turned out that there was no female gynaecologist in the area. They suggested that we call the district hospital to see if we can find one.

A male doctor answered the phone at the hospital. When hearing that we were looking for a female gynaecologist, he asked, *"If she doesn't like men, how did she get pregnant?"*. It was clear from the conversation that there was no chance of finding a female doctor in the district, but we did not expect that getting access to decent, respectful care would be such a challenge.

During her pregnancy, there were several complications. She was very worried about her own and the baby's health, and needed constant emotional support, which we were able to provide. She was also finding it physically more and more challenging to cope, and after her husband went to work abroad, she could not share the chores of childcare and daily life either. The ob-gyn in charge of her care encouraged her to have a vaginal delivery because, in the absence of medical documentation of previous deliveries, he did not see any reason for an elective caesarean section. Renata was getting more and more anxious, fearing the severe health consequences of a vaginal birth. As the regulations only allowed free obstetric care at the local hospital, according to her place of residence, we sought a second opinion from doctors working in that hospital. Unfortunately, none of them

agreed to perform a caesarean section. She then decided to see her Ukrainian doctor, who confirmed that she could have a caesarean section in Ukraine without any problems. Renata then decided to travel home to Ukraine with her children.

Renata gave birth to a healthy baby and soon moved back to Hungary. The return was emotionally draining, it was tough for her to leave home for the second time. Renata's emotional state was further complicated by the fact that the baby was not breastfeeding and had to be given formula, which the Hungarian paediatrician refused to prescribe for administrative reasons. The donations of formula, as well as the emotional support we were able to give, was a great help to Renata.

Her newborn baby was denied healthcare for months due to an administrative mishap concerning the registration of her citizenship. In addition to not prescribing formula, the paediatrician did not attend to the baby when she was sick and did not administer the mandatory vaccinations either. After legal consultations and the involvement of an external social worker, eventually access to health care for both mother and baby could be sorted out.

The costs of returning to Ukraine and giving birth there, as well as her husband's exploitation at work (not getting paid for work done) put the family in such a dire financial situation immediately after the birth that we had to refer them to partner organisations for cash and food donations. Thanks to the support they received, they were able to keep going for a few months and, in time, regain a more stable financial footing.

We were in contact with Renata for 10 months, the last stage of her support was to help her with contraception.

VIKTORIIA

Keywords: ***Ukrainian-speaking single pregnant woman; victim of trafficking for prostitution; pregnant woman with disability; cooperation between partner organisations; gaps in care; lack of authority intervention; interruption of case management***

We found out about Viktoriia through an international humanitarian organisation. We had no language in common with her (she only spoke Ukrainian) and she arrived undocumented from a third country, where she was forced into prostitution. As she did not arrive directly from Ukraine, they wanted to expel her from Hungary. Her lawful stay in Hungary was assisted by human rights lawyers.

Viktoriia was pregnant by the time of our contact with her. We found out that one of our partner organisations had previously helped her access gynaecological care, where an invasive procedure was performed which was psychologically distressing for her. Following a psychological counselling session, intellectual disability was suspected. She was referred to further specialists to look into it further.

The interpreter, who had already supported her earlier, was present when we first met Viktoriia. We found out that Viktoriia did not have reliable accommodation and was reluctant to stay in an institutional setting (safe house). It was also likely that she had already given birth to a child who had been taken away from her and she was very much afraid of losing this child as well. Due to her history of sexual exploitation, she was advised to undergo an STI (sexually transmitted infection) screening.

At the first prenatal appointment with the health visitor, Viktoriia seemed very distrustful and disoriented. The interpreter was available only through phone. The misunderstandings and miscommunication during the visit caused severe distress to Viktoriia. After the visit, the health visitor informed us that if Viktoriia was diagnosed with an intellectual disability, the child would have to be placed in foster care. Unfortunately, Viktoriia had no relatives in Hungary, so it was not possible to appoint a close relative as her guardian. Due to the complexity of the case, an external expert was involved, who informed us that there are known cases in Hungary where a person with an intellectual disability could raise their child in an institutional setting. This was reassuring information and gave us reason for hope.

Unfortunately, our case management support for Viktoriia ended soon afterwards, as she was returned to the environment she previously had escaped. The man who had previously exploited her, appeared again, and coerced her to leave with him. Consequently, Viktoriia asked for help to get an abortion, but that was no longer an option at that gestational age. At this point, one of the organisations supporting Viktoriia contacted the police, but as Viktoriia had not been declared legally incapacitated, and left voluntarily, no authority intervention was made.

Later Viktoriia returned to Hungary, she spent days sleeping on the street. Eventually Viktoriia spent the last months of her pregnancy in a humanitarian shelter, under supervision. She was not able to keep her baby after giving birth, but she planned to build a relationship with the child.

SOPHIA

Keywords: ***pregnant woman with Ukrainian as her native language who also speaks Russian; partner living in Hungary; gaps in care; severe violation of patient rights; hysterectomy; employer abuse***

Sophia contacted one of our colleagues directly on the recommendation of a fellow refugee. At the time of her enquiry, our programme was running at maximum capacity, so we could only put Sophia on a waiting list. The waiting time was about 1-2 weeks and we knew that she would be assisted by our newly employed Russian-speaking staff member.

At the time of contact, Sophia was in the last trimester of her pregnancy. She contacted us because she had encountered obstacles in accessing medical care. She did not yet have a general practitioner, a gynaecologist, a health visitor, or a pregnancy record-keeping booklet. Our first step was to find out who the relevant health providers were and to book appointments with all of them. Sophia lived in an area of the country where we could not provide her with personal accompaniment, but we kept in touch with her by telephone. We provided her with all the relevant information, connected her to the appropriate health professionals and provided her with telephone interpretation during the check-ups and consultations. Later, she also needed legal aid, as she had been fired from her job in Hungary and thus her residence permit was terminated, so she wanted to apply for Temporary Protection status. In addition, she needed a family status certificate for the birth registration of her child. She could count on our support in preparing and arranging all of this.

During a visit to the general practitioner, when our colleague was interpreting between the doctor and Sophia, it was discovered that there was something unusual in the lab results, but the doctor did not want to tell us what exactly. He referred Sophia for further tests, where she went the next day and called our colleague from there. She did not get a diagnosis but was told that her husband should also visit the doctor the next day. Sophia was very desperate, not knowing what was happening and what to expect, afraid that something was seriously wrong.

On her next visit, when she was finally supposed to get some information from the doctor, the appointment was cancelled, so Sophia decided to call her previous doctor back home in Ukraine and ask what he thought the problem might be. The doctor reassured her that it was probably due to Chernobyl that one of her lab values was elevated, which had been the case with her previous pregnancy, and that there was no cause for concern. At the same time, she received a phone call from the Hungarian clinic telling her to show up for an injection the next day and make sure that she receives another dose 3 months later. She was not given a diagnosis at that time either, but it might have been an STI. Sophia was never informed about the diagnosis and the reason for getting the injection therapy.

At the onset of her labour, Sophia alerted our colleague first and asked her to call an ambulance. She even called our colleague from the delivery room for translation, and then she was not heard from for days. Four days after the birth, an exchange of messages revealed that a hysterectomy (surgical removal of the uterus) was performed on Sophia during the birth. The most striking point of the messages was that Sophia did not understand what had happened, why it was necessary, because she received no information whatsoever. After the birth, Sophia was in great need of emotional support to process what had happened, so our colleague visited her in person and continued to support her over the phone.

The postpartum period was made even more difficult by the workplace abuse of the baby's father. His employer threatened employees that if they quit, they would have to travel back to Ukraine for five days before they could work in Hungary again. Ukrainian men could not risk this because of the military conscription, leaving them at the mercy of the employer. Our colleague checked the accuracy of this information and confirmed that a regulation came into force stating that anyone who arrived from Ukraine before the war had to find another job within five days of termination of employment, or else return to Ukraine for at least five days or risk deportation. This has indeed given unprecedented power to employers.

In the months following the birth, Sophia also needed support to obtain Temporary Protection status for her newborn baby, access to the necessary paediatric examinations and vaccinations, and to arrange her baby's personal documents (birth certificate, recognition of Ukrainian citizenship). The administrative procedure was very lengthy, taking 14 weeks instead of the usual 3-4 weeks, as the birth certificate was issued incorrectly twice. With our help, Sophia also applied for the financial support she was entitled to after the birth. The supporting relationship was closed 7 months after we met.

ENIKŐ

Keywords: ***Hungarian-speaking Roma refugee woman of dual Ukrainian-Hungarian citizenship; partner living in Hungary; refusal of health care; endangerment; premature birth; advocacy; violation of patients' rights.***

Enikő, who was pregnant at the time, met our colleague by chance at the immigration office, where the field worker was helping another client to get her Temporary Protection status. The two women already knew each other, and Enikő asked our colleague if she could help her navigate the health system, as she had been in Hungary for over a month but had not yet received any care.

Enikő had dual Ukrainian-Hungarian citizenship. By then we had already been aware of the obstacles that dual citizens often face when trying to access medical care. As they are also Hungarian citizens, they could not apply for Temporary Protection status, but officially they have been entitled to free healthcare, if they were able to prove that they fled Ukraine because of the war. This should be evidenced by the date of crossing the border stamped in their passport, or a foreign (Ukrainian) address as their registered place of residence shown in their Hungarian address card. However, stamping at the border crossing – especially at the beginning of the large-scale refugee movement when many people arrived – was not common practice, and also dual nationals usually crossed the Hungarian border with their Hungarian passports, which are not stamped in such cases. Those who were unable to demonstrate the requirements set out in the regulation, could not access free medical care, despite having been forced to leave their country.

First, Enikő needed a gynaecological consultation and an ultrasound scan. As the local clinic had a 1-month waiting list, which is a long time for an unattended pregnancy, our colleague booked her an appointment with a private practitioner. At the examination, everything was found to be normal. Private care for the entire duration of the pregnancy would have been very expensive, so private health services were provided to women on a case-by-case basis, when absolutely necessary. We then supported them back into public healthcare as quickly as possible. We did the same for Enikő after the check-up at the private practice. As Enikő had not been able to access public care before, we knew that an accompanied, in-person appointment would be needed. By this time, we had already had several consultations with lawyers, so our colleague arrived at the appointment fully prepared.

More than half a year after the outbreak of war, many dual citizens – including Enikő – established permanent residency in Hungary. For many families, this was necessary to get by in Hungary. For example, to enrol their children in institutions (nursery, kindergarten, school) or to start paying social security contributions, which could be done after one year of permanent residence. However, these dual citizens, once they had a permanent Hungarian address, were no longer treated in the same way as their compatriots with Temporary Protection status and could not receive free health care unless their social security record was clear. On this ground, the clinic refused to attend them, disregarding the law guaranteeing free prenatal care to pregnant women of Hungarian nationality residing in Hungary. Our colleague, who accompanied Enikő to the clinic, explained this fact to the doctor. However, the doctor in charge refused to provide free care to Enikő and asked our colleague to leave the clinic and “keep reading the laws in the hallway”.

Our colleague did not let the case pass and made a complaint to the general director of the clinic and with the patients’ rights advocate. Although they both agreed with our field worker during the meeting, later in their written reply the clinic upheld the gynaecologist’s opinion (which was not in line with the relevant legislation) that Enikő was not entitled to

4 Act LXXIX of 1992 on the Protection of Fetal Life

free prenatal care. Following this, a quick reassessment was needed to ensure access to care, and we finally resolved the situation by helping Enikő to apply for a social security card, on the basis of social need. At the same time, we knew that refusing her care was a violation, so we filed a complaint to the Administrative Department of the National Public Health Centre to have Enikő's case reviewed.

In the meantime, we tried to arrange an ultrasound scan for Enikő at the local hospital, hoping that they would not question her eligibility for care. They attended her without any problems. The local health visitor did not refuse to see Enikő either. After her admission, the health visitor discovered that Enikő had a medical condition following the birth of her first child, that made the current pregnancy a high-risk one, and she should have been closely monitored during prenatal care. With this information, we tried once again to get Enikő an appointment at the local clinic, but she was still refused, so eventually the necessary tests needed to get done in a private laboratory.

The document entitling Enikő for free health care arrived 6 weeks after submitting the application – the same day she was hospitalised for premature birth. She soon gave birth without complications, and the kindness of the hospital staff was a positive experience for Enikő, especially after the previous rejections. After the health visitor made it clear that she would only authorise the baby's return home if the family bought certain equipment (e.g. a respiratory monitor), we shopped for all the supplies during their stay in the hospital.

Later, a response letter was received from the Public Health Centre confirming that Enikő would have been entitled to prenatal care regardless of social security record and condemning the clinic for denying her care. This was not only a positive outcome for the individual case, but also useful feedback on the systemic deficiencies in healthcare.

The baby was hospitalised shortly afterwards due to a respiratory infection. Enikő learnt that she also had a serious infection requiring immediate treatment, independent from the baby's health condition. Later we found out that the baby's final discharge report already contained this information, but Enikő was not informed. Enikő's condition deteriorated quickly, so she was taken to a specialist for treatment. The events highlighted that if she had received appropriate prenatal care, her treatment could have started sooner.

In the weeks after the baby was born, we supported Enikő with donations of hygienic and childcare supplies, helped her arrange her baby's documents, made sure she received the financial benefits she was eligible for, and supported her during the medical treatment. After the end of her postpartum period, Enikő also requested help in contraception, so we arranged access to medical consultations and the contraceptive method of her choice. We closed her support after eight months.

EVELIN

Keywords: ***Ukrainian-Hungarian dual citizenship, Hungarian-speaking Roma refugee woman; partner living in Hungary; abortion; time pressure; unexpected medical obstacles; substitution; failed contraception***

Evelin heard about our programme from a friend and contacted us by e-mail. She lived in the countryside, was a dual Ukrainian-Hungarian citizen and requested support in accessing abortion care. At the first consultation, we informed her about the procedure in Hungary and that the surgery should be performed before the 12th week of pregnancy. She already had an appointment for a pregnancy confirmation, so we asked her to report back after the examination had taken place.

When Evelin called us back, she had four weeks left to attend all the necessary consultations and tests required for pregnancy termination. In the cases where we received a request for an abortion, we had to consider which member of our team would be able to devote the necessary amount of time and energy within the short timeframe available. Although these cases required shorter periods of accompaniment than prenatal care, they meant a more intensive time commitment within that period and may have required occasional substitutions or "step-ins" by other staff members. Therefore, the commitment had to be considered at both individual and team level.

After contacting Evelin directly, our colleague tried to book an appointment with the Family Protection Service as soon as possible for an initial consultation. She called several places, but as they all had different days and different (rather tight) time slots for appointment booking, and it was summer vacation season, she was unsuccessful on the first day. The next day, her umpteenth phone call was successful, and she was able to schedule an appointment for Evelin five days later. This meant that a week had already passed out of the four she had available.

The aim of the first visit at the Family Protection Service, as stipulated by regulation, is to get the woman to keep her foetus (so she is told about the subsidies she can get; the possibility of adoption; and the dangers and risks of abortion). The health visitor was quite "delicate" with Evelin, and seeing that the decision had already been made, she tried to keep her mandatory explanation as short as possible. The mandatory waiting time between the first and second compulsory counselling session is a minimum of three days. The health visitor was able to set up the second consultation at relatively short notice (five days). In the meantime, our colleague accompanied Evelin to the hospital recommended by the health visitor and the pre-operative tests were started.

She had already been scheduled for surgery when our colleague received a call from the hospital saying that a medical condition was found that required further testing in another

hospital. Our colleague had to call several doctors and hospitals to ensure that Evelin received care. Evelin was finally given medication and there was a good chance that if her condition improved in a week, she could have an abortion in time before the 12-week deadline.

Evelin was a dual citizen with a foreign residence, so her care was not smooth at all, requiring extensive advocacy work. Further complicating matters was the fact that her health records were not available online, so all records and prescriptions had to be collected in person.

The second consultation went well, and Evelin received the abortion application form. At this stage, the Family Protection Service officially informs the relevant hospital that they have no objection to the operation. In the meantime, a week has passed, and a control lab test has been carried out. Evelin's lab results had unfortunately not improved, she was referred to another specialist and told that the operation would not be possible before the 12th week. However, Evelin was medically authorized to perform the surgery until the 16th gestational week, given that she had been delayed due to health reasons.

At this point, Evelin became very desperate. She feared that she would have to carry the baby to term, potentially suffering medical damage from the drugs she had taken. She also feared that she would soon feel the movement of the foetus, which would make her decision even more difficult. During these days, we provided her with intensive emotional support.

After about a week, good news came from the hospital: Evelin's condition improved significantly, and she was booked in for surgery. As this date was well beyond the originally planned timeframe and the annual leave of our colleague appointed for Evelin had started, a replacement had to be organised quickly. One of our team members took Evelin to the hospital in the morning, while three other field workers were on call so that one of them could take Evelin home after the operation. As soon as Evelin sent a message to the chat group that she was discharged from the hospital, someone went to pick her up and take home to her family.

After the abortion, Evelin expressed her desire to get long-term contraception, so we made an appointment for her with a gynaecologist, where it was discovered that the IUD cannot be inserted due to an active infection. Sadly, Evelin had to move soon afterwards, so accessing care became even more difficult. In the new accommodation, Evelin had a helper, but eventually she could not show up at the appointment. She was willing to travel in order to receive the IUD, but due to a family conflict she could not make it. We offered her another appointment, but as it turned out, her husband did not agree with getting an IUD, so the appointment was cancelled. We were in contact with Evelin for half a year.

ISABELLA

Keywords: ***underage pregnant woman; Hungarian-speaking Roma refugee; partner living in Hungary; abusive relationship; inter-organisational cooperation; obstetric violence***

Isabella was referred to us by a partner organisation, where Isabella and her family were already beneficiaries and had been supported by a social worker. The referral request came at a time when our programme was operating at reduced capacity, and we were not undertaking complex case management. We were able to take on Isabella's case because we knew that she received support from the other organisation as well.

At the time of the first meeting, it was suspected that Isabella might be pregnant. She wanted to keep the baby, but her mother had concerns because of her age and their life situation. In the first consultation, they were informed about pregnancy, prenatal care, and abortion, and also about the child protection system in view of Isabella being a minor.

After the visit, we booked an appointment for Isabella to see the health visitor and the local ob-gyn to get a medical confirmation of her pregnancy. However, the ob-gyn insisted on a pelvic exam and vaginal ultrasound, which Isabella wanted to avoid, so the doctor refused to provide the care, on the grounds of non-cooperation. In addition, he made derogatory, judgmental comments, so Isabella lost trust in him. It took some time to find a care provider with a respectful attitude in public healthcare, so in the meantime she was seen by a private practitioner to confirm pregnancy. By that time, she made the decision to continue the pregnancy.

At the same time, she and her mother regularly came to our drop-in day in our office, and they received psychosocial support in person as well as by phone. We also provided education on female anatomy, women's health and contraception, and they also attended childbirth education sessions. We were also in regular contact with the family's social worker in order to provide the best possible support for Isabella.

We were able to rely on this close cooperation even when the housing of the family became uncertain, and Isabella's partner abused her. With the involvement of an experienced staff member and the NGO supporting Isabella, we could secure a safe environment for her.

Getting close to her due date, Isabella was admitted to hospital due to suspected premature rupture of membranes, but because of disrespectful treatment and because the rupture of the membranes was not confirmed, a few days later Isabella left the hospital by her own decision (with the approval of her mother). Later examinations found the membranes intact. Isabella was advised to regularly visit the hospital for foetal heart rate monitoring and ultrasound scans until the birth.

When she returned to the hospital for the recommended check-up, she suffered severe rights abuses. The care providers did not respect her wishes with regards to the circumstances of the examination, performed an unauthorized examination without the presence of her legal guardian and caused injury. She was later admitted to another hospital, where she received supportive and respectful care, and eventually she gave birth there.

We also contacted a legal aid organisation because Isabella's mother wanted to take legal action because of the institutional abuse. The birth of the baby took the focus away from the legal case, but we assured them that they could count on our help when they were ready.

Isabella has already been given lots of information about contraception but has not yet received the device of her choice as it is difficult to get to a doctor's office with a newborn baby. We supported Isabella for 11 months.

2.
METHODOLOGICAL GUIDELINES FOR SUPPORT ORGANISATIONS IN ADDRESSING WOMEN'S SEXUAL AND REPRODUCTIVE NEEDS

2.1. INTRODUCTION TO THE METHODOLOGY

2.1.1. Principles of the methodology

In our humanitarian programme, we gained experience with a particularly vulnerable group of women and girls – members of the Roma community from the Transcarpathian region of Ukraine. Their disadvantaged situation is rooted in the complex impact of several factors, stemming from their social status on the one hand, and their individual life situations on the other. The combined effect of these factors is that they have limited access to a range of resources and are marginalised and stigmatised. These factors include: their ethnicity and the discrimination and racism targeted at them, their socio-economic situation, their refugee status, their low educational level, their deprived position in the community and in the family, the lack of information, knowledge, support systems and social networks, and the multiple barriers they face in asserting their rights. These negative factors do not simply add up but have a mutually reinforcing and compounding effect.

Our experience therefore comes mainly from working with members of this community. However, the following principles and methods are also highly recommended for organisations not only working exclusively with people from particularly vulnerable groups. A helping attitude that takes into account the complex interplay of multiple vulnerabilities will make all helping relationships more useful and more effective.

Women-centred approach

A women-centred approach to sexual and reproductive services means putting women's needs, experiences, and rights at the centre, ensuring that women have full information, autonomy and respect in decisions about their own bodies. A women-centred approach is characterised by empathy and respect, listening to women, taking into account their needs and personal preferences, recognising, acknowledging and empowering their agency, and supporting informed, autonomous decision-making. Communication with women is based on respect for human dignity and recognition of their lived realities and experiences in all circumstances. In the helping relationship, the client is not reduced to her problem, so the woman is seen as a whole human being, her personality and life situation are considered in their entirety: it is not only her health condition or the aspects of her life that cause difficulties that determine the attitude towards her. This approach supports not only women's physical health but also their emotional and psychological well-being.

Feminism

The feminist helping relationship puts women's rights, equality and autonomy at the centre and takes into account the social context: it looks critically at power relations, gender roles and social injustices, recognises and acknowledges power inequalities, oppressive structures, and different gender-based, socio-economic and other forms of discrimination present in the society. Taking into account, and being aware of, the wider social context helps, among other things, to avoid (erroneously) interpreting the vulnerable situation of some people in need of support as individual stories, accidental personal misfortunes or even self-inflicted. A feminist approach takes into account that social patterns and power dynamics based on group affiliation are very pronounced and concentrated in health and social care, that women's experiences may vary along different factors (e.g. ethnicity, social class), and emphasises the need to be mindful of the specific needs and challenges of members of marginalised groups (those experiencing social exclusion). The support worker creates an enabling environment that is free from stigma, judgement or shame and actively seeks to counteract the disadvantages of the social context, by, among other things, promoting informed decision-making, respectful communication and advocating for care that is appropriate and consistent with the decision made by the woman herself.

Peer support

The basic premise of peer support is that a person with shared experiences, belonging to the same community or living in similar circumstances, in this case a support worker sharing the experience of being a woman, can provide effective support in a relationship of trust and equality through her own lived experiences, supportive skills and knowledge. This type of relationship can have many benefits for emotional wellbeing: peers understand each other more easily because they have shared experiences allowing for a deeper level of empathy and support. It is important to note that peer support is not a substitute for professional help but can complement it.

It is worth being aware of and reflecting on, the fact that the helping relationship itself causes a shift in the power balance between the helper and the helped, as the helper has knowledge of the local context, a great amount of important information about health and other systems, and financial and other resources, which those helped often rely on. Efforts should be made to ensure that the support worker does not become an authority figure, a problem solver, as this can also reduce the helped women's sense of control. The priority of the EMMA humanitarian programme is to strengthen refugee women and girls' sense of autonomy and competencies, to empower, and to avoid patronising or over-helping, which, although often well-intentioned, also takes power and control away from the person being helped.

The power imbalances inherent in the helping relationship can be reduced with careful attention, delicate balancing, and ongoing reassessment, striving to create a safe environment that minimises hierarchical relationships and dependency as much as possible, and with a strong emphasis on solidarity and empathy based on shared experiences of womanhood and motherhood. It is important that the helper constantly reflects on the helping relationship in the process, and that the boundaries and transparency of the helping relationship are maintained alongside mutual trust, understanding and sincerity.

Providing evidence-based information to women

In the context of peer-to-peer support, knowledge sharing is less hierarchical. Information transfer is not a one-way, top-down process, but considers the knowledge and experience of the woman being supported. It is also important to focus on ensuring that up-to-date, evidence-based information that is relevant and important for decision-making is made available to the woman in a timely and easily understandable form. In the area of sexual and reproductive health and rights, the up-to-date and evidence-based information on specific procedures and practices can be assessed by looking at recent research, guidelines, and recommendations of international scientific and professional bodies. In addition, however, it is important to remember that helpers should not overstep their scope of practice in the field of health care advice.

Supporting informed and autonomous decision-making

Informed and autonomous decision-making is about giving the person concerned information about the care options, and risks and benefits related to their health condition or situation, in a clear, understandable, individualised and culturally sensitive way. It is important to strive for providing unbiased information, to ensure that neither the form nor the content is influenced by the opinions or beliefs of the person providing the information. The goal is to facilitate the supported person to consider both evidence-based information and her own life circumstances, needs and personal preferences when making a decision.

In supporting informed and autonomous decision-making for vulnerable groups, we also need to be aware of systemic barriers such as discrimination, racism, language difficulties or lack of trust in health institutions (see more in 2.2.2 Barriers to access to care). To mitigate and overcome these barriers, support workers strive to create an environment where women feel safe; their needs and feelings are listened to and respected; they can raise questions and receive meaningful and understandable answers, especially about pregnancy, childbirth, contraception, abortion, but also other, not health-related issues, if needed.

Informed decision-making is more than just consent (routinely called informed consent, but often lacking any information provided to the person supported, such as about the benefits and risks, to help them make an informed choice), which typically describes situations where the person can choose between giving or declining consent to an offered intervention or procedure. This rarely feels like a real choice, for example due to a lack of information or self-advocacy skills and opportunities, or perhaps due to pressure from the healthcare provider. Informed decision-making involves a broader sense of self-governance and autonomy, and the person's active participation in decisions about their own body and health; enabling this is not a one-time event, but requires ongoing information sharing, dialogue, and support.

Trauma awareness

Trauma is when a person has experienced or witnessed an event or has been informed of an event involving a close family member or friend, that resulted in actual or threatened death or serious injury, or endangerment to self or others (American Psychiatric Association, 2022).

A trauma-informed approach means that the peer helper or care provider (whether health or social care professional) is aware of the impact of trauma on individuals, families, and communities; is able to recognise its signs; and has the skills to approach the person, client or peer with understanding and attention. By incorporating knowledge of trauma into practice, the support worker or practitioner seeks to avoid re-traumatising the client. Trauma-informed care requires the creation of an environment that reduces the likelihood of further harm and, as far as possible, contributes to healing.

Distrust of authority figures, heightened stress reactions, difficulty regulating emotions and communicating needs are common among trauma survivors. These can prevent people from seeking or receiving care. The trauma experienced is therefore likely to affect physical and mental health and to have a profound impact on the extent to which people are likely to access health and social services and accept help from others.

Feeling disempowered, lacking the possibility of self-determination, is an inherent part of traumatic experiences. In health care, especially in the field of sexual and reproductive health, where crossing bodily boundaries is often part of routine health checks, these

issues are even more pronounced. Therefore, in providing such services, it is important to increase efforts to acknowledge women's own inner resources, to strengthen their sense of control in making decisions about their bodies and lives, to avoid re-traumatisation, and to reduce and counteract the effects of harms often present in healthcare.

The continuum of the sexual and reproductive life cycle

Women's sexual and reproductive health is not a series of isolated events, but a set of interrelated physical and mental processes that interact throughout the life course, from menstrual health, contraception, pregnancy, childbirth, miscarriage, and abortion, to menopause and beyond. Separating these events and treating them in isolation (without knowledge of what has happened before) overlooks the complex, multifaceted nature of women's health, which can lead to gaps in care, barriers in accessing services and unrecognised, and thus unaddressed, needs, with detrimental effects not only on the current health situation, but also on the long-term physical and mental health and quality of life of women and girls.

Resolving conflicts between principles

Keeping these principles in mind is essential for effective and ethical aid work. However, while we strive to implement each of these principles, in practice they can sometimes conflict and there may be situations where it is necessary to prioritise between them.

Access to (at least some) health care is the most basic need; it may be this priority that may cause other principles to take a back seat. This may be the case, for example, when a client is unable to choose the medically most advisable, evidence-based procedure for legal or financial reasons (such as medical abortion, which is not available in Hungary, or unaffordable foetal screening tests). In such cases, information may be provided, but the client's ability to make an informed decision is limited, as she can only choose from the options that are realistically available to her. There may be pressures, expectations and obstacles from the family or environment that also make autonomous decision-making impossible for the woman, or there may be such strong opposing forces that it is very difficult to decide how to put her own needs at the centre of support. If the woman expresses a desire that objectively serves the needs or interests of others rather than her own, it is difficult to apply the principle of woman-centredness. In such cases, in addition to the principle of providing evidence-based information, the support worker tries to reinforce the woman's sense of competence and support her in the decision she finally makes (regardless of the circumstances in which the decision was made).

It is a common problem that the deficiencies in the healthcare system result in a failure to provide the woman with trauma-informed care, and the helper is well aware that the healthcare service may be re-traumatising and may cause further psychological harm. However, the overriding consideration is that the provision of care is unavoidable and may be lifesaving. In such situations, it is also important to acknowledge to the client that they deserve better, and more attentive and respectful care. If the woman shares negative

experiences and feelings about the treatment she has received, the skills of mirroring and validation can be used. In resolving such conflicts of values, the fundamental aim is to focus on the needs of the woman seeking support and the realistic options available to her. This requires constant balancing, compromise, and reassessment of priorities. It is often necessary to accept that there is no perfect solution, but a good enough one; and to learn to appreciate that this solution is still much better than it would have been without.

2.1.2. Basic methodological tools

In the practice of women-centred peer support, there are a number of skills that enable the supportive relationship to enable empowerment, to be effective (achieve its purpose) and potentially even to contribute to healing in the broader sense, regardless of the specific purpose of the support situation.

Such skills include attentive listening, non-judgemental and respectful communication, and maintaining a safe space. This means that the behaviour of the helper towards the supported person is characterised in general by understanding, empathy and responsiveness. In this spirit, direct advice, ready answers to problems, and downplaying or minimizing the supported person's feelings or difficulties are avoided, as are positive, encouraging messages that are inappropriate to the situation and that may also come across as misunderstanding or may convey expectations (e.g. *"But at least you are alive!"*, *"Be strong!"* – use instead *"Thank you for sharing with me."*, *"This must be very difficult."*).

2.2. COMPLEX APPROACH TO CASE MANAGEMENT

2.2.1. On the vulnerability of the target group

The principles and methods of support that focus on the specific needs of vulnerable groups are ultimately beneficial and effective for all target groups: safety, trust, compassion, attention, and an approach that recognises and builds on the internal resources of the supported woman (client), in social, health and any other care, will mean better and more effective help for all.

> Respectful care that is accommodating to individual needs – at the level of systems, institutions and individual helping relationships – can create an environment where recovery is more effective, health indicators improve, the risk of re-traumatisation is reduced and the overall well-being of the clients supported increases in the longer term.

Refugee women from Ukraine, and especially Roma women and girls from Transcarpathia, are socially excluded and vulnerable due to several mutually reinforcing factors. These obstacles are not only cumulative and compounded, but the particular combinations of disadvantageous factors create additional, specific difficulties. They face the triple burden of gender inequalities, ethnic discrimination, and extreme poverty, compounded by the rights deprivation and the barriers to health care they experience as refugees.

Roma women often face prejudice and discrimination both in Ukraine and in Hungary because of their ethnicity. As women, they are also constrained by significant social expectations and structural barriers. Early marriage, strict gender roles and a sharply distinct division of labour in the family, as well as early dropping out of school and labour market, have the effect of making them economically vulnerable, making it even more difficult for them to lead independent lives or to overcome their dependence on institutions. Such vulnerability includes: being subjected to institutional harassment or coercion on the grounds of their socio-economic status, which may even result in children being taken into foster care; and dependence on state services and subsidies, which may mean that they endure abuse and unlawful treatment, as they have no other economic resources or social networks.

Intersectional discriminations are particularly pronounced in access to health care, where institutional racism, language and cultural barriers, financial difficulties, and the frequent disregard for the concerns and needs of female patients combine to create almost insurmountable barriers for these women. The Hungarian health system does not take into account the particularly vulnerable situation of Roma women as refugees. They are

usually unaware of the options available to them due to lack of information and support; having no access to digital and written information materials; and being treated in a discriminatory, humiliating, or dismissive manner by health workers.

> Negative perceptions about Roma attitudes towards sexuality, childbearing and family play a major role in the prejudices and stereotypes associated with Roma women, and this institutional discrimination has a particularly severe impact on sexual and reproductive health services, such as prenatal care or access to contraception, resulting in even deeper vulnerability in the long term.

The life story of refugee women and girls, regardless of ethnicity, is likely to include traumatic experiences: armed conflict, the threat of war, acute insecurity, fear of death, forced displacement, all of which expose individuals and communities to extreme stress, sudden and large-scale loss, and often direct violence.

At the community level, forced displacement causes a disruption of family and community ties. Family members are often separated (in the case of Ukraine, many men stayed in the country because of compulsory military service, while women and children crossed the border). They are removed from their familiar micro-environment, they are placed in a completely new environment. As a result, not only are the immediate relationships damaged, but the local, microsocial norms are not preserved and the people affected have to adapt to new roles and new tasks in the new living situation (e.g. women who had previously worked in the household have to become job seekers, breadwinners, or navigate the unfamiliar bureaucratic system of the host country, learn administrative procedures, find accommodation, etc.).

Adolescent girls and young women are particularly vulnerable in crisis situations such as these. They are at particular risk of sexual violence, violent expressions of stigma and discrimination, vulnerability resulting from limited opportunities for legal employment and work, and exposure to abuse or exploitation by a potential partner, (informal) employer or accommodation provider. Their situation is also affected by low access to quality health services, lack of material and other resources, deprivation of education and social services both in their country of origin and in the host country. Young women and girls are the most affected by fundamental changes in family roles and are more exposed to various forms of human right violations, while their ability to assert their rights is often lower.

The majority of Roma women coming from Ukraine have already had negative experiences of the attitudes of humanitarian responders when crossing the border, where they have been denied donations, legal assistance, or even basic information at a mere glance by officials and aid workers (Romaversitas, 2022). Many had also faced discrimination, racism, minimisation of their problems and disrespectful treatment during their previous health experiences (see the stories of Vanda and Isabella). These experiences understandably

made it difficult to develop trust in the helpers. And this mistrust, together with heightened stress reactions and reluctance to express their needs, makes it difficult for them to seek and receive care.

Countering these challenges and minimising their impact is (should be) the task of those involved in humanitarian crisis response. One of the most important skills of the support worker is to first understand and learn as much as possible about the life story of the person being supported, their personal needs and what they are trying to achieve: what drives them, what their goals are. This openness and genuine, sincere willingness to get to know the person is the absolute first step in the helping relationship and an indispensable prerequisite for effective, meaningful support. Without this personal engagement, support can easily become superficial, impersonal, ineffective, or even harmful.

The principle of "do no harm" is a guiding principle throughout the whole process of the helping relationship. Avoiding harm (such as alienation and disengagement from care, or "providing for" a perceived rather than an actual need) requires creating a safe and accepting atmosphere in which the client can, and feels able to, express their needs, so that they can receive personalised support and take an active and increasingly self-determined role in shaping their situation. This understanding is also necessary in order to enable the support worker to identify and present more precisely, and with flexibility, the steps and tools that best serve the client's interests in the given situation.

This type of understanding often requires the helper to work closely with the women being supported. This can lead to strong relationship of trust that our clients have with the helper, which could be likened to friendships, or sisterly or maternal relationships. Unfortunately, and regardless of the target group, many women and young girls do not have close, trusted, and supportive relationships where they really feel seen, so this experience can be significant in itself. In this situation, it is primarily the responsibility of the helper to ensure clear personal and professional boundaries are in place and upheld, and that the scope of the helping relationship is understood to the person being supported. This best ensures that the helper does not to contribute to potential illusions about the nature of the relationship, and to clarify what they can and cannot promise to help with.

It is this understanding and closeness that allows the helper to understand the resources of the women and girls being helped, which enable them to cope in difficult circumstances. As well as recognising and understanding their fragility and vulnerability, it is important to see their dignity and strength. Empathy is not pity. Being vulnerable in a situation does not mean being weak or helpless. Often the opposite is true: people in difficult situations are able to mobilise additional resources to find solutions even in the face of adversity, while acknowledging their own vulnerability.

It is also worth noting that the availability of external resources someone had access to when arriving in Hungary had a significant impact. Unfortunately, this has often been a haphazard process. It has often depended on luck (or even personal prejudices and

sympathies) as to how much and what kind of external assistance, financial support, accommodation, information, access to social workers, health, or other services, etc., that refugees have had.

Despite their multiple disadvantages, the majority of women and girls reached through our humanitarian programme have shown a high level of resilience and endurance in the face of adversity. The fact that they were able to deal with displacement, the losses caused by war, and the challenges they faced in a foreign country, is in itself an indication that their coping mechanisms were mostly successful and served them effectively. It is important to understand and acknowledge these resources, pointing them out and reinforcing the client's faith that she has them. True empowerment is not about bringing in a ready-made solution, but about recognising that the person being supported already has internal resources that she can, and does, rely on. The role of the helper is not to "fix" the other person's life from the outside, but to help her discover and mobilise the resources that are already present – be they inner strengths, coping strategies, experiences, or even a supportive network of relationships.

Part of this process involves building self-confidence and promoting gradual independence. Good support does not reinforce feelings of helplessness, but gives the person the opportunity to actively shape their own solutions. Awareness of resources, both in the helper and the helped, strengthens the person's autonomy and capacity to act in the longer term, not only to solve the problem at hand, but also to develop an inner confidence that she has the potential and the skills to manage her life competently beyond the helping relationship, after it has ended, and in other areas as well.

2.2.2. Barriers to access to care

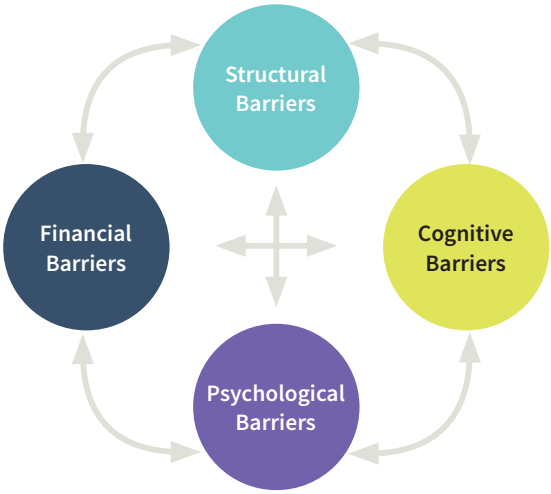
Due to economic inequalities, marginalised groups start out with basic health disadvantages. Even access to adequate housing and quality food is harder for them. Lack of these is associated with higher risks of chronic diseases (such as hypertension, asthma, diabetes) and has a direct impact on maternal and foetal health. Poor housing and nutritional deprivation increase the risk of complications, premature birth, and low birth weight (Hajdu et al, 2024; Jeffers, Grace, 2024). All of these have a significant impact on the long-term health and quality of life of those affected. In addition to starting out life from birth with lower life expectancy and worse health prognosis in general, several additional barriers compound the situation, making it difficult for marginalised groups to access health services later on and have a chance at better health outcomes.

Interlinked and mutually reinforcing socio-economic, human rights, cultural, and public health factors create complex barriers in accessing social, health, and other public services, which exacerbate the disadvantages and exclusion faced by affected groups.

Underlying social problems such as racism, gender role expectations, and economic inequalities are played out in multiple ways at the community and individual levels.

For example, gender roles in society, lack of quality educational institutions, and racism in schools, all contribute to the lack of access to education that women from marginalised groups face. This makes it almost impossible for women in deprived and underserved regions to work, leaving them financially dependent. In addition, the caregiving responsibilities expected in the family, geographical distances, lack of access to information, and lack of health literacy, both separately and in combination, further complicate their access to health services. The resulting decline in their health makes them even more isolated and vulnerable.

These complicating factors are constantly adding up, mutually reinforcing each other, acting as a complex set of barriers at each stage of access. We have used the HABPV (Health Care Access Barriers for Vulnerable Populations) model (George et al, 2018) to categorise the barriers to access. We do so, while aware of the limitations of the model and the fact that some of the factors could be classified into different or even multiple categories, exactly because of the overlapping nature of the barriers.



Structural barriers

Institutionalised or structural racism in healthcare is a systemic inequality that permeates healthcare institutions, policies, and practices, that causes disproportionate health disadvantages for different ethnic groups. Structural racism is distinct from individual or collective prejudices (although the latter certainly helps to perpetuate it). It is deeply embedded in the system and persists through the continuity of institutional norms, resulting in unequal access, poorer quality of care, and worse health outcomes for disadvantaged members of society. Below we review some aspects of structural racism – geographical, regulatory, labour, domestic, and bureaucratic barriers.

Due to the uneven regional distribution of health services and transport infrastructure, people living in rural areas, far from urban centres, are highly affected by *geographical and transport barriers,* as they have little or no access to health facilities without having a car. Some of the refugee families who arrived from Ukraine lived in accommodation that was very difficult to reach, and many were simply unable to get to the care they needed due to expensive and time-consuming travel and lack of infrastructure.

Legal and regulatory barriers are more severe for groups with precarious status, such as refugees or homeless people, who do not have all the official documents required for various benefits and services. Legislation and legal guidelines are often complex and difficult to understand, and are practically incomprehensible to people who are illiterate, have low levels of education, or do not speak the local language. In many cases, the legal conditions for access to health care are not clear (even for the providers of health and social services or other officers). This means that people may not obtain certain services at all or only for a fee, even if they are lawfully entitled to them, or may not even try to access services due to misinformation or the lack of information. Complicated and slow bureaucracy, and the limitations of advocacy opportunities (self-advocacy, but also fast, effective and accessible ways for complaints and legal remedies), tools and skills make it even harder for people to get the care they would otherwise be entitled to free of charge (see Enikő's story).

A related structural barrier is the *administrative requirements* and the *bureaucratic functioning* of the health system. Difficulty in booking appointments in advance, long waiting lists, and a complicated referral system, all contribute to the fact that many patients – even local citizens – do not even get to the point of care (see Sophia's story). Unclear referral pathways, shortages of specialists, and overworked health workers can exacerbate the situation. Patients often have to visit several places to get a single test or treatment. Both prenatal care and abortion care are complex, multi-actor processes, requiring women to interact with multiple providers in multiple locations, in a particular order and within very tight timeframes, without adequate guidance. Moreover, there is often a lack of information flow between the actors involved in care, with negative consequences for the patient.

Disadvantaged groups are acutely affected by *exploitation and workplace obligations,* as they often work unregistered, in low-prestige jobs, with no sick leave, and employers typically not being flexible about absences. As a result, many cannot afford to take time off work if they are unwell or have health problems, or to visit a doctor during working hours.

Household and caregiving responsibilities, such as looking after elderly people or young children in the family, can also be a barrier to accessing health services. Mothers who do not have a reliable, supportive environment often do not access health services because they cannot delegate caring for the children or the elderly. People in more stable financial situations may be able to get paid help, but this is not feasible here. Accessing sexual and reproductive health care is particularly difficult in this respect, as it is even less possible to bring a child to such appointments and examinations, and most people would also be uncomfortable taking their child/children. Caregiving responsibilities, especially for single parents, leave very little free time, so health care can be easily side-lined (see Isabella's story).

Financial barriers

Financial barriers are a major problem in accessing health services. Some health services are available only for a fee, or private providers are needed to perform the necessary examinations in a timely manner (during pregnancy and childbirth there are several time-sensitive tests to be completed in a short timeframe; or there may be external constraints that require the refugee woman to move, and not spend enough time in one place to wait out the long waiting list).

Another financial barrier is the *lack of health insurance,* in the light of the fact that it is especially difficult to obtain social security without a registered permanent job and that refugees are often employed informally. Although many health services in Hungary were (should have been) free of charge for refugees fleeing Ukraine, they were sometimes refused on the grounds of lack of proper social security records (see Enikő's story). A particular problem for children born in Hungary as the host country is that their social security status has remained unresolved for a long time due to delays in birth registration, citizenship, and other procedures, which has also led to denial of care (see Renata's story).

Households are often forced to *prioritise their expenditure* because of their limited financial resources, and health services are often considered less important or less urgent than meeting basic needs. In many households, travel costs have also become an insurmountable burden, not to mention paying for medicines, vitamins, or screening tests that are not available free of charge. In some cases, even the lack of basic hygiene products limits patients' options, for example, when they do not have personal hygiene items (shower gel, shampoo, detergent) and are therefore too embarrassed to visit a physician or are unable to leave their accommodation due to the lack of menstrual pads or disposable nappies. The lack of digital equipment such as a telephone or internet connection makes it impossible to book an appointment.

Cognitive barriers

The attitudes of health professionals and workers towards clients are also restricting factors. *Stigmatisation, judgement,* or fear of such behaviour can hinder or delay access to health services. Women are legitimately concerned about being judged and stigmatised by health or social service workers, or even by members of their own community or family, for almost anything related to their sexual and reproductive health. This is because menstrual health, active sexual life, having or not having children, being pregnant underage or unmarried, abortion, contraception, sexually transmitted diseases are all areas loaded with many prejudices, taboos, moral judgements, shame, guilt, and often previous traumatic experiences.

Trauma-informed, patient-centred, and woman-centred approaches to care are often lacking. Undignified, disrespectful treatment is common. These are compounded by *prejudice and discrimination* based on ethnicity and economic status. Members of vulnerable groups often experience discrimination in healthcare institutions. Women and girls supported under the EMMA humanitarian programme, both as Roma and as refugees, have often told us they experienced their complaints being taken less seriously, that they are not given adequate information, that they have to wait longer, that they are treated in a disrespectful and humiliating way, or that they are being denied care altogether. Bad experiences can discourage people from seeking help in the future. It is particularly common for marginalised and vulnerable groups to avoid accessing the care they need because of distrust of the health system and those in authority within it.

Lack of health literacy means that, due to lack of education and low levels of health awareness, many people are unable to find, understand and apply relevant information to make informed decisions about their own health. Difficulties can include navigating the health care system, understanding health insurance entitlements and care options, understanding medical advice and information sheets, appropriate use of medicines, and knowledge about healthy lifestyle choices and preventive measures (disease prevention, unwanted pregnancy, and prevention of sexually transmitted or other communicable diseases).

Lack of information on existing services can also be a major barrier. Many people are not aware of what services are available to them and where and how to access them. This is a particular problem for people who do not have easily accessible sources of information or who do not have the language and technical means to find information, meaning they would only encounter the information they need if it were directly delivered to them (this was the reason for our staff's field visits). Even if they do find the service they need, it is not evident that they will be able to use it. Excessive bureaucracy, unclear and incomprehensible information, which is typical of administrative procedures, and frequent and unclear referrals (and also diversions) can lead to patients getting lost in the system and then dropping out.

The *digital divide,* already mentioned above, also exacerbates the difficulties associated with the lack of information. Many health services now require online appointment booking, e-prescriptions, or digital customer service, which hinders those who do not have access to the internet, the right devices, and/or the digital skills to understand and navigate these platforms.

Language barriers can also be a significant barrier to accessing care. For people who do not speak the official language of the country, or who speak in a different dialect, or who do not understand medical terminology, using health services can be extremely difficult. The complexity of medical jargon is often a challenge even for people who speak the language but do not know the technical terms. In many cases, there are no interpreters available, or even if there are, the care system does not ensure that one is easily accessible and free of charge. Because of language difficulties and the lack of interpreters, many patients are unable to accurately explain their symptoms or understand the information they receive.

Cultural factors also play a major role. Certain cultural norms or beliefs can be barriers to accessing health care, especially in relation to sexual and reproductive health. Some women, out of modesty or for other reasons, are unable or unwilling to share their intimate complaints with a care provider, especially if the care provider is of the opposite sex (see Renata's story). Thus, women may prefer to avoid health facilities altogether if they can only be attended by a male professional. The lack of cultural sensitivity and openness of practitioners also hinders proper communication, which can lead to misdiagnosis and unrecognised problems.

Psychological barriers

Psychological barriers are mental and emotional factors that prevent people from accessing health care, even if it is available to them. *Fear and anxiety,* mistrust of the health system and the care providers who hold authority in it, and certain mental health conditions such as depression or post-traumatic stress disorder (PTSD) can also prevent people from seeking medical care. For people who have experienced trauma, especially related to sexual violence and obstetric violence, the hospital environment or certain procedures may trigger the re-experiencing of past traumatic memories (this is particularly common in sexual and reproductive health care), which may also lead to avoidance behaviour.

These barriers and limiting factors often combine to make access to health care for the most vulnerable people not only difficult, but almost impossible.

2.2.3. Complexity

Supporting women's sexual and reproductive health is a complex task. It involves not only information and knowledge sharing, the assertion of rights, and the promotion of physical health, but also support for emotional and mental well-being. The complexity of the necessary support in humanitarian crises is further compounded by the specific living conditions and needs of the people supported, barriers to access, and gaps in care. All these may require the introduction of new service elements over the course of the activity or project, additional training on new topics, and the involvement of expertise from other fields.

In our case, we started the programme with a perinatal (pregnancy and childbirth) focus, and then, based on field experience and to fill in the gaps in care left by other actors as they withdrew from service provision, we expanded to cover areas of women's reproductive life cycle such as menstrual health, contraception, and abortion. Thus our work became increasingly complex. Furthermore, given the specific needs of a vulnerable and precarious population, especially during pregnancy and the postpartum period, it became necessary to include social workers in case management alongside perinatal specialists.

Defining complexity in case management

Complexity of the specific case

In casework, we talk about the complexity of a specific case when there are multiple issues and concerns intertwined, all of which need to be considered when planning and implementing case management. This could be the situation where someone contacts us in relation to pregnancy or contraception, while at the same time being affected by intimate partnership violence or trafficking, or a housing crisis or mental illness (see the stories of Natasha and Viktoriia).

Coordinated professional support within the organisation

A case can be considered complex in the sense that the person concerned needs support in several areas, which require multifaceted and coordinated assistance. Such cases often require the joint effort of social workers, mental health and perinatal professionals employed by the organisation (see Renata's story).

Coordinated support with partner organisations

If a single organisation cannot cover all the different areas of support needed in a specific case, the cooperation with partner organisations, coordinated support from several actors, can be an example of complex case management. This includes, for example, cases where legal aid was needed to represent the interests of a client, or to assist an abused woman, or where psychologists and other specialists had to be involved (see the stories of Natasha, Isabella, Renata and Viktoriia).

Complexity in the form of prerequisites

Finally, the complexity of case management may also be reflected in the fact that the person cannot enter the programme and access the services offered by the organisation until she has received assistance with certain administrative tasks. This could be the case, for example, of arranging legal representation for a pregnant minor who has fled Ukraine unaccompanied to ensure her access to prenatal care, as she cannot be attended by the health institution without a guardian (see Vanda's story).

The above examples illustrate the ways in which a case can become complex and the ways in which effective management and support of such cases and life situations can become a multifaceted challenge. A further difficulty is when there is no partner organisation that can be involved in case management or to whom a client can be referred if the need arising is outside the scope of the organisation's core activities. Situations that are particularly stressful are when a partner organisation fails to provide the expected support for complex case management, or where, despite the best intentions of all involved, a situation cannot be resolved in a satisfactory manner. As organisations working in humanitarian crises, we must be aware that there will always be cases with a degree of complexity that cannot be anticipated and that cannot be managed effectively, even with the best of intentions and despite mobilising all available resources (see Viktoriia's story).

On the principles of complex case management

Support is always based on women's needs and is tailored to meet these needs in a flexible way. This means that a woman can receive different types of support (within the scope of the activities and project duration) according to her needs as they arise. This is the case when a woman joins the case management process needing prenatal care or requiring assistance in abortion, and later needs information about, and access to, contraception. A complex programme of support like this can be really useful if it does not rigidly adhere to preconceived plans, but builds on and adapts to the real needs that arise organically, and if the activities and services provided can be shaped accordingly. For example, following the onset of the crisis in Ukraine, both donors and service-providing organisations assumed that there would be a high demand for emergency contraception. However, experience has shown that there is a greater need for long-term contraception. Thus, it became pointless to focus on the difficulties in obtaining the former, and it was important to reallocate resources to the latter to meet the actual needs.

Support during case management should be considered in continuity. Field experience has shown that in the vast majority of cases, one-off information or a single referral does not suffice. Instead, multiple meetings and mutual engagement between the person supporting and the person being supported, and a longer-term commitment to case management are required. It understandably means a different duration of accompaniment and support for a client depending on their needs and circumstances. For example, clients who are towards the start of their pregnancy, client who are closer to the time of birth, or clients who need to terminate an early pregnancy may all need support for varied durations.

Given the sensitivity of the subject and the long-term cooperation, we should strive to provide each client with a dedicated support person, so that the relationship can remain continuous and stable, which is essential to build and maintain trust. In this trusting relationship, we devote space and time to getting to know the women, so that they have the opportunity and confidence to express their needs, experiences, and challenges, and to ask questions and get answers.

> The more time we take to get to know and understand where a woman is coming from (her family and partnership, her maternal experiences, her health history and background, her knowledge about women's health and any potential fears), the better and more personalised the support we can provide.

During case management, it is also important that women are made aware of the duration of support and the scope of the organisation's involvement. However, due to the nature of the support and the importance of long-term empowerment, the supporting relationship may be prolonged and at times the client may still require some form of follow-up support, encouragement, or occasional help. The ideal situation is to be able to offer this up to the point where those supported are able to manage their lives autonomously and confidently, with their own agency.

2.3. COOPERATION WITH PARTNER ORGANISATIONS AND INSTITUTIONS

In humanitarian crisis situations, horizontal cooperation between different actors is important to ensure that crisis response is rapid, flexible, and context-specific, and based on an understanding of local conditions and resources. Larger, hierarchical, centralised organisations often lack the flexibility to respond to needs due to lack of information or slower decision-making mechanisms, which can often be compensated through the mobilisation of local resources and the coordination and collaboration of network of organisations. Regular communication between smaller organisations, transparent information sharing, and joint problem solving can allow for more efficient operation and division of tasks, avoiding duplication of efforts where several organisations are trying to find a solution to the same problem simultaneously.

During the three years of the Ukraine crisis response, the range of actors changed considerably. International and local NGOs, municipalities, and self-organised groups entered the scene, and some of them stopped or reduced their humanitarian activities after a longer or shorter period. Tracking this and keeping in touch with those who remained active during the period is a major task, which also underlines the importance of continuous communication and regular participation in experience-sharing events.

Following the large-scale movement of refugees from Ukraine, many Hungarian NGOs who had previously worked with other vulnerable groups, joined in the humanitarian crisis response, so they were able to bring their expertise from various fields, such as housing poverty, reproductive health for women experiencing homelessness, or local Roma communities. Their direct services and fieldwork were well complemented by organisations that, for example, provided legal advice or collected and distributed donations, and by volunteers who offered occasional assistance such as interpretation, doula support as birth companions, or organising children's programmes. Knowledge from different fields can complement each other well when it comes to addressing the multiple and complex difficulties faced by refugees.

In terms of horizontal cooperation, we worked most directly with the operators of collective accommodation, as they typically also provided social work for their residents, and we needed concerted efforts in the context of case management (while also sharing knowledge and building a common level of understanding between us). This collaboration served to the mutual satisfaction of the organisations, as we took over some tasks from them, and they provided us with access to their collective shelters so we could follow up on needs and maintain contact with larger communities of women.

Other organisations and institutions that provided legal assistance, distributed donations or organised health-focused thematic events were involved on an individual basis, in connection with a specific case or event. In these collaborations, coordination of values and approaches was less of a crucial issue.

In working with church organisations, we had to consider that while we could rely on their supportive cooperation around services for pregnant women, there could be conflicts of values in other sexual and reproductive health activities. For many church organisations, the support of abortion care and certain contraceptive methods (e.g. IUDs, the morning-after pill) is unacceptable for conscientious reasons. Clients' trust can be easily shaken when they receive conflicting messages from two different aid organisations, so it is essential to have (sometimes mediated) discussions between organisations to achieve a common goal (client well-being and clients' expressed needs and priorities) and to establish clear protocols in advance for collaborative care (e.g. clarifying who is responsible for what service).

2.4. ABOUT CASE MANAGEMENT

Typically, there were two ways for women to enter the process of case management with us. One was to meet our colleagues in person during field visits (see Enikő's story) or at an event for refugees where we were representing EMMA Association. Another possible way to get involved in the programme was to contact us by e-mail or phone. These channels included both direct enquiries from refugees (see the stories of Sophia, Renata and Evelin) and referrals from other aid organisations and institutions (see the stories of Natasha, Vanda, Isabella and Viktoriia).

The programme was accessible to clients who fled Ukraine after the outbreak of the war, were pregnant or seeking our help with contraception or abortion, and lived in an area of the country where our services were available.

Typically, it was decided at the weekly meetings of EMMA's humanitarian team whether we could commit to an incoming request and, if so, which member of staff would contact the client. This depended largely on the nature of the enquiry, the staff's spare capacity, and the geographical location. Below we list the types of needs of refugee women that we could address.

2.4.1. Peer-to-peer mental and psychosocial support

EMMA Association has been providing direct psychosocial support to women for ten years, both through a telephone helpline (EMMA Helpline) and through informal women's groups (EMMA Hubs). In our humanitarian programme, we have relied on this professional and peer support experience, adopting the methodology and approach that we have successfully applied for a decade in our work for the mental and emotional well-being of women.

Basic concepts, skills and considerations

- **Supportive conversations:** These are conversations where women can freely share their positive and negative feelings and experiences about their life situation and reproductive health. The aim of the conversation is not to give advice, but to listen, and create and maintain a safe space where the supported person can experience compassion and understanding.
- **Empathetic attention:** This means being open and responsive to the woman's feelings, needs and experiences, alongside recognising her experiences as real and legitimate, and not questioning them. In addition to listening, this attentiveness helps women to understand their own feelings and needs more deeply and to express them with increasing confidence.

- **Attentive listening/active listening:** Being present and attentive is a way of ensuring that women feel genuinely listened to and understood. It also helps to develop a sense of security and gives them the freedom to express their feelings and needs. When listening, the facilitator tries to put aside his or her own feelings and thoughts in order to listen only to the other person – and only brings in his or her own feelings and thoughts (for example, having had experiences similar to the other person) to the extent that it supports being fully present and connected. The aim of listening is to really hear what they want to say to us. When we actively listen to someone, we give our full attention to the speaker and do not interrupt what they are saying, do not distract them from the originally intended content of their communication, and through our verbal and non-verbal communication (e.g. mirroring, relevant questions) make it clear to them that we are present, listening and hearing them.

- **Non-judgemental attitude:** The aim of our interaction with supported clients is to understand, not to evaluate, the stories shared (decisions, motivations, actions, needs) and, most importantly, not to pass any kind of judgement towards them. Women who are listened to in this way experience empathy, solidarity, and respect. This builds trust and has a positive impact on them and on relationship between the supporter and the supported person. Being non-judgmental also applies to the way information is conveyed and the questions asked. For example, when explaining different health procedures and options, and addressing questions to the person being supported, no value judgements are made that could influence her, or make her feel that she may be judged negatively by her choices or answers.

- **Peer support:** This is when the helper also has personal experience of challenges similar to those faced by the supported person. The helper is aware of this personal experience, and their experiences are reflected in the support process to express empathy and solidarity. This kind of peer-to-peer connection can build rapport and help prevent hierarchical imbalances between the person being supported and the person providing the support. It can also contribute greatly to the development of a trusting relationship. This is particularly important in relation to taboo-ridden, rarely discussed issues with others, such as reproductive and sexual health-related situations and conditions.

- **Boundary setting and self-reflection:** In trusting relationships based on empathy and solidarity, there can be over-involvement on the part of the person providing the support. Therefore, it is good to be periodically reminded of the risks associated with this, and to take preventive action. Boundary setting is an effective tool for prevention. One way of setting boundaries is to establish clear frameworks with the client so that roles and commitments are clear for both helper and helped. These boundaries can be reiterated by the support worker to themselves or to the supported person if the relationship starts to overstep the boundaries set. It is an important prerequisite that the helper is aware of his or her own emotional and professional boundaries. Supervision is an important means of doing this, providing a space for regular self-reflection, and

sharing of experiences with others, thus supporting helpers to remain aware of their own behaviours and actions, to maintain the necessary emotional distance, and to preserve their own emotional well-being.

Practical implementation

As part of EMMA Association's humanitarian programme, mental and psychosocial support were not only seen as a stand-alone programme element, but as a cross-cutting activity that was present throughout the entire supporting relationship. The conversations we had with refugee women all reflected this approach and made use of the skills mentioned above. However, they were not bound by the space and time constraints that usually characterise other forms of psychosocial counselling and to which even we, as service providers, are accustomed due to our social and economic background. Conversations were therefore not held in dedicated sessions, with fixed time frames, as a structured process with a given number of sessions. Instead, we created space and time to connect, share and listen, and thus to build trust by working together with the women we supported. In many cases, these conversations developed spontaneously between us and the women during visits at the shelters, in their homes, or while waiting, often for many hours, in health facilities. The organic development of such conversations is of course only possible if there is a common language that is spoken by both the support worker and the client.

In these conversations, the refugee women were always in charge, deciding what they wanted to share and how safe they felt in opening up to us. They talked about themselves, their children and their families, their previous birth experiences, the traumas of war, the abuses committed against them, their existential anxieties, but also their aspirations, joys and hopes. In the course of our work, we found on many occasions that this kind of organic space, in which we offered a genuine presence, helped women to connect with us and was more compatible with their complex life situations. Because, although they had a great need for psychosocial support, they had no experience of how to articulate this need. Also, oftentimes, their needs for social interaction and emotional support were neglected or side-lined due to the crisis situations and difficulties they were constantly facing to have their basic needs met. If we had required clients involved in case management to attend therapeutic sessions that were separated in space and time (which would have implied organising additional childcare, drop-offs, etc., and which would have been an unfamiliar setting to them), these important conversations would probably never have taken place.

As highlighted above, it was only in Hungarian that we were able to provide psychosocial support really effectively. For Ukrainian-speaking women, language barriers made this type of support difficult. We did not have a sufficient number of qualified interpreters available to be involved in case management. Until we had a staff member in the programme who spoke a common language with Ukrainian-speaking women, their psychological support was limited. Yet we did not give up on supporting these women. In communicating with them, we used interpreter apps, which undoubtedly limited our possibilities, but by adding non-verbal communication (compassionate glances, gestures, sometimes touch), they could sense that we were there for them and that they were not alone.

Our colleagues carried out interview-based research in autumn 2023, summarised in the report *"And Then We Reached the Border: There Were a Million Women!" Experiences of Roma Refugee Women from Ukraine with Sexual and Reproductive Healthcare in Hungary – in the Light of the EMMA Association's Humanitarian Programme* (Kupcsok et al, 2024). In the interviews, the women who had been involved our case management support also reported on how they experienced this kind of psychosocial support. The researchers summarised women's experiences with EMMA Association as follows:

"They believe that what makes the Association special is the empathy and care we show towards them. And the experience of womanhood, as a fundamental experience, connects the helper and the helped. Field workers not only provide professional assistance, but also build personal relationships, which provide women with significant emotional and psychological support. This is what the interviewees describe as special, as they have not received this type of support from any other helping professional."

And a few quotes from women who were interviewed:

> *"We can tell her everything. [...] She can give me advice on anything, and I can share anything [...] Well, I could stay with her all day. [...] We can talk, not just about the pregnancy, not just about the baby, but about anything."*
>
> *"I've grown very fond of her and it's very nice to be with her. I like talking to her because she listens to me. I don't have anyone to talk to anymore, only when I talk to her, and I can tell her everything. [...] No one has ever done anything so good to me, not even my mum. […] I was in the mouth of death [at birth], [...] but she was by my side."*
>
> *"She is a very good, blessed woman [...] And she can soothe a person's soul, and she is a very good person."*

2.4.2. Obstetric care

Regulation and care system in Hungary

Obstetric care in Hungary is very medicalised, which is reflected in the fact that providers see childbirth as a medical event, often as a potential health problem that needs to be monitored and controlled by medical interventions. In this approach, the autonomy of the woman giving birth is compromised and the natural process of childbirth is overshadowed. Prenatal care involves a high number of visits to specialists. A pregnant woman typically must see an obstetrician and a health visitor once a month, as well as undergo laboratory tests and ultrasound scans every three months. Being subject to all prenatal screenings and tests is not officially compulsory, but those who do not attend a sufficient number of visits, can lose financial support and be labelled as an "unattended pregnancy", which can lead to blame, criminalisation and even child protection consequences (on the grounds of endangering the child).

Obstetric units have a very high rate of interventions. Episiotomy is routinely performed in around 70% of vaginal birth, compared with the World Health Organisation (WHO) recommendation that they would only be absolutely necessary in about 10% of births. Caesarean section rates are over 40% and rising. Yet, decades of data that was reviewed concluded that increasing national caesarean section rates up to around 15% is associated with reductions in maternal and neonatal mortality. However, once caesarean section rates exceed 20%, the data found there to be no additional reduction in mortality (Ayres-de-Campos et al., 2024).

Globally, obstetric violence, which is the internationally accepted term for violence against women during pregnancy and childbirth by healthcare workers, is prevalent in maternity care. It is a multifaceted, complex violation of human rights and a public health issue with many negative health consequences.

> Obstetric violence can take many forms: verbal, physical, psychological, or sexual violence, social discrimination, stigma and prejudice, neglect, abandonment, violation of the right to privacy and self-determination, inappropriate use of procedures and technologies.

Women who are disadvantaged, on low-income, and deprived of a birth companion experience higher than average rates of obstetric violence (Hakimi et al, 2025).

From 2021, obstetric care is free of charge only in the designated local hospital, without being able to choose an attending midwife or doctor. The few privileged women who can afford it, in the hope of receiving better care and being treated with humanity and respect (which is not guaranteed anywhere), can see a private doctor during pregnancy and pay millions of forints in private hospitals. This allows them to be surrounded by professionals they at least know and trust, with whom they have prepared for 9 months for the birth. However, the majority of pregnant women, including women who have fled Ukraine, can only access free public care and give birth in the hospital designated based on their place of residence. They are at increased risk of all the harm inherent in the health care system.

In addition, ethnic discrimination, inequality, and systemic racism in the health care system have serious consequences for Roma women, making it difficult for them to access sexual and reproductive health services. Negative experiences have both short- and long-term effects on women's health, overall increasing their distrust of health care and health professionals, leading them to avoid health care services altogether, and delay in seeking professional help for their health problems.

Methodological considerations and skills

Supporting pregnant women is a very complex task, so involving the right professionals is key to its success. These professionals can be midwives, doulas, perinatal and lactation consultants. It is important that they are directly available within the organisation and can be involved in case management. This is also necessary because there are many concerns that arise in pregnant women that require a rapid response or reassurance, but are not necessarily medical competencies.

The abuse and harm present in obstetric care are symptoms of systemic problems, so eliminating them is not a realistic goal. Nevertheless, efforts can be made to reduce harm and to ensure that women are not left on their own in this dysfunctional system. When accompanying women to prenatal visits, both advocacy for access to care, and harm reduction from mistreatment, are needed. In some cases, this can be achieved simply by women not attending appointments alone. In other cases, advocacy and assertion of women's interests and patients' rights requires a strong, confident, active, and assertive stance. Understanding the power dynamics in the health system will help us to realistically assess how far we can go in an interaction and at what point speaking out could risk hurting the accompanied woman – most likely by being denied care in retaliation.

It is also important to be aware of patients' rights and advocacy options because there may be situations where serious rights violations occur. Knowing and mentioning these can be useful in acute advocacy communication, but it is particularly essential when it becomes necessary to initiate a formal complaints procedure (see Enikő's story). If this information is not available or difficult to access, it may be necessary to bring in an external expert.

Practical implementation

Supporting pregnant women has been a long-term task with a strong commitment. This process usually lasted several months and required continuous availability, as well as the arrangement of various check-ups and psychosocial support. Our organisation has ten years of experience in providing psychological support to pregnant women and mothers with young children, and we are well aware of the challenges and systemic problems that a woman may face in the maternity care system. This experience has enabled us to start assisting refugee pregnant women and mothers.

During our programme, we accompanied several pregnant minors. Roma women in Transcarpathia come from a more closed, traditional community where early marriage is still accepted and widespread (see the stories of Vanda and Isabella). Young women "marry"[5] as young as 15 years old, have their first child early in life, and raise it with the help of the wider family network. In the case of under-age pregnant girls, the need for guardianship procedure had to be also accounted for (see Vanda's story).

5 The reason for the quotation mark is that it does not typically involve a formal administrative marriage under family law but is considered by the community as a traditional marriage.

The access to maternity care for refugee women has been legally guaranteed, but in practice there were many obstacles. In Hungarian health care, all appointments need to be pre-booked, with long waiting lists. A particular challenge for refugee women was that it was very different from the Ukrainian system. Our clients were used to a health care system where anyone could get any medical procedure (including surgical, such as for an abortion or caesarean section) for money within a short time. The safety and medical justification of this approach is clearly questionable, but it is important background information that this is the health care system our clients were socialised in. Another difference in the system, which has caused difficulties for many refugee women (see Renata's story), is the very low proportion of female gynaecologists available in public care in our country. There are many areas where no female doctors are available at all.[6] Despite our efforts to accommodate women's needs and provide them with the care they need, we were often unable to do so. More women would have preferred to see a female doctor than we were able to find.

The obligation to book appointments has also proved to be often too challenging for refugee women. Even if they received help to know where and how to book an appointment, Ukrainian-speaking women could not do so by phone because of language barriers, and Hungarian-speaking Roma women could not because they did not have a phone with a SIM card. When they showed up in person for an appointment, their eligibility for care was often questioned and they were sent away. They could count on us to help them overcome these obstacles and advocate for their rights from the start. This activity is most poignantly reflected in the women's stories (see the stories of Vanda and Enikő) and in the interviews as quoted in the research report (Kupcsok et al, 2024): *"Before EMMA, I was turned away from the hospital, they were not authorized, they said. With EMMA, I received the care and they talked to me properly."* (Timi); *"When they hear that you come from a foundation, they have a different attitude. If somebody is there next to you, somebody is helping you, then they treat you differently. [...] Whenever we went, they welcomed us, they spoke nicely, normally. I didn't even get into the examination room when I went on my own."* (Kriszti).

Personal accompaniment to the visits had other benefits in addition to safeguarding their interests. In addition to access to care, the waiting time in the clinic, which often lasted several hours, was an opportunity for emotional support to reduce anxiety about health care (which was very common) and to have educational conversations about women's health.

In the examination room, we then facilitated doctor-patient communication and re-presented the interests of women: to help women understand what was happening to them and their babies; for them to be able to ask questions and have those questions answered; for the women to be directly involved in the decision-making about their bodies and health; and to reduce the likelihood of humiliating or disrespectful treatment and to mitigate the harms of such treatment (see Vanda's story).

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6 According to data from the Hungarian Medical Chamber, in 2020 there were a total of 1642 active OB/GYNs registered in Hungary, of whom 1440 were men and 202 women. Based on this, the proportion of female gynaecologists was about 12%.

PRACTICAL ADVICE FOR ACCOMPANYING A WOMAN TO A GYNAECOLOGICAL VISIT

If you accompany a woman to a gynaecological visit:

... if she has already stated in advance that she would rather see a female practitioner, keep this in mind when choosing the care provider.

… listen carefully if she would like to share her fears before the visit, what past experiences resurface, what situations she would like to avoid.

... based on this understanding, help to safeguard her interests during the visit.

... emphasise that she is free to ask questions and the practitioner needs to answer them in a way that she understands. There is always the possibility to ask further questions and to find out the purpose of the test/intervention, its risks, advantages, and disadvantages. Facilitate communication with the healthcare provider.

... it is important that the woman is aware that she can make decisions about her care and therefore has the right to refuse interventions.

... talk through what to expect and what could happen during the visit.

... an important question is, for example, whether there will be a pelvic exam, for which she has to undress. If this is too embarrassing for the woman you are accompanying, you can suggest that she wear a long skirt for the visit, which she should leave on and just pull up sitting on the gynaecological examination chair, to avoid having to walk about in the exam room with her lower body uncovered.

... discuss where she would like you to be during the examination (inside the exam room, next to her head, so that you can support her with your physical presence, eye contact, a hold of the hand if necessary; perhaps inside the exam room, but discreetly turning away; or even outside in the waiting room).

... make sure that if she ever wants you to leave the exam room, she can say so, you will not take it personally.

... do everything you can to ensure that the woman feels as safe as possible throughout the examination.

As the birth approached, we also held childbirth education sessions to help first-time parents be as equipped as possible for the birth of their baby, and to help all parents gain understanding, awareness and insight – even retrospectively – about what happened to them during their previous births.

The dilemma for us was whether our team members with experience as doulas should also accompany births, or whether we should hire doulas separately. In practical terms, it turned out that accompanying births was an overly demanding commitment and that being reachable and available during the on-call period was difficult to reconcile with day-to-day support tasks, so we decided to hire freelance doulas (see Natasha's story). To ensure continuity of care, the doulas were involved in the support activities as the birth approached, so that they could develop a relationship of trust with the clients, and they continued to visit the women with us for a few meetings after the birth, and only then did we part with them. This practice then worked to everyone's satisfaction.

After the birth, all women were offered the option of contraception, which the majority of women accepted, and in many cases the supportive relationship ended after the women received the contraception device of their choice (see the stories of Vanda, Renata and Enikő).

2.4.3. Unwanted pregnancy

Regulation and care system in Hungary

In most countries of the European Union, there are two options for early termination of pregnancy: medical abortion and surgical abortion. Medical abortion may be an appropriate option for most women in early pregnancy. This method means fewer days in hospital, less anaesthesia and surgery, and therefore fewer complications. However, in Hungary, only surgical abortion is legally available.

Termination of pregnancy[7] is possible up to the 12th week of pregnancy or the 18th week for those under 18, or later in certain circumstances (see Evelin's story). The consent of the father is not required for termination, but the consent of the legal guardian is required for minors. The fee for an abortion is 45 312 HUF (110 EUR) in 2025. If the pregnancy is the result of a criminal offense (sexual violence) or if there are medical reasons, there is no charge for the termination. A reduction of the fee may be requested under certain conditions. Termination of pregnancy can be requested in the case of a "serious crisis", defined by law as "a situation causing physical or mental disruption or social deprivation". The applicant determines what constitutes a serious crisis and no proof or justification is needed, although it may be discussed at the mandatory counselling session (see below). In the case of an applicant who is underage or legally incapacitated, the consent of the legal guardian is required.

7 Act LXXIX of 1992 on the Protection of Fetal Life

As pregnancy is typically detected at 4-6 weeks, there is a maximum of 6-8 weeks for the procedure to be completed. It is important that the necessary steps are taken as soon as possible, because it often takes several weeks to book a simple ultrasound scan. Given that the mandatory pre-operative consultations and tests also take 2-3 weeks, it is easy to run out of time.

The first step is always a gynaecological visit to confirm pregnancy. Since 2022, a decree has stipulated that the physician must present a "clearly identifiable indication of the functioning of the foetal vital functions" – by which ob-gyns typically mean listening to the foetal heartbeat (or more precisely, in the absence of a fully developed heart, the pulsation of the embryonic heart tube at this stage). It is therefore advisable to schedule the test for the 6-8th week of pregnancy, as the sound can usually be heard that time.

You must attend two counselling sessions with the Family Protection Service. There are no territory-based service areas, so patients can visit any of these offices in the country, regardless of where they live, but an appointment must be booked. The aim of the first counselling session is, as defined by law, to keep the foetus, so the role of the counsellor is to try to dissuade the woman from terminating her pregnancy. Research has shown that these sessions provide selective information about the risks of abortion as opposed to carrying the pregnancy to term, and use strategies that violate women's dignity and create guilt (Dés, Les, 2024). Based on personal experience and the accounts of the women concerned, it is difficult to book an appointment for counselling, as often only very short time slots of 30-60 minutes on weekdays are available for making the call for the appointment (see Evelin's story).

A record of the first counselling session will be issued by the Family Protection Service. This must be brought back for the next session. There is a mandatory three-day waiting period between the two sessions. The second counselling session is about the abortion itself: where, how and by what method. Family planning and post-operative contraception options are also discussed. Within 8 days of the second consultation, the woman will have to go to the hospital where further tests will be carried out (another gynaecological examination, laboratory tests, anaesthesia consultation) and an appointment for the operation will be made. The operation is performed under general anaesthesia and on an outpatient basis where the patient can go home on the day of the operation.

For refugees with a Temporary Protection status (TPS) and dual Ukrainian-Hungarian citizens who were under the same category as TPS holders, abortion was included among free health services.

Methodological considerations and skills

Getting someone through an abortion always requires complex support. It is essential to know the regulatory background and the steps of the process. Time pressure requires structured and coordinated work and prioritisation of tasks. The division of responsibilities between programme staff is particularly important, as the field worker needs to be able to

temporarily put on hold any other non-urgent issues with other clients. Substitution and caseload sharing can only be achieved through coordinated teamwork. To do this, it is good to prepare the ground in advance and introduce clients to the other team members who can temporarily fill in for them (see Evelin's story).

In addition to operational tasks, emotional support is a fundamental and central part of such case management. The emotional impact of abortion is very individual. Some people feel guilt and regret about their decision, some experience deep sadness, others feel relief – and these feelings can alternate. Emotional ups and downs, the stress of the process, and the treatment experienced during the care pathway, affect virtually everyone. In addition to the stressful medical and internal events, there can also be relationship conflicts and disagreements, which can make things even more difficult for the woman concerned. It is therefore crucial to provide an accommodating and supportive environment for all women affected, regardless of the background to their decision. Non-judgement and empathy are also key elements of support in these cases.

We should never forget that the decision to terminate a pregnancy should be a woman's personal choice. We can only contribute by ensuring that the client makes her decision in an informed way, but what she ultimately decides must be left entirely up to her.

> The harms of obstetric and gynaecological care, whether it is prenatal or maternity care or the termination of an unwanted pregnancy, are emotionally and mentally stressful not only for the women who are exposed directly, but also for the helpers, especially because of repeatedly witnessing similar situations.

Both the support worker and the organisation need to be aware of this (discussed in more detail in section 3.4.1. Personal safety), and it is important to provide opportunities and space for self-care and supervision to mitigate and prevent strain and harm.

Practical implementation

There was virtually no information available to refugee women about the abortion process (PATENT, 2023). In Ukraine, according to clients' testimonies, the system is quite different and more liberal, and therefore women were often at a loss as to what to do in Hungary. We heard from many women who decided to return to Ukraine for a medical abortion because of the unclear, complex, and strict regulations in Hungary and the lack of information available.

Enquiries about abortion have always been a priority because of the time pressure involved. This meant that when a request of this type came in, it was always followed by a quick capacity assessment within the team to see who could commit to the task.

It was also important here to assess (if we had not already known the client) what resources the clients could make use of and what their needs were. For example, if a woman needed help with transport, depending on the geographical location, it could be that only a team member with a car would be able to accompany her.

Since it had been regulated by a ministerial order that people with a Temporary Protection status could access healthcare services free of charge, the necessary visits and surgeries were carried out at public health institutions. Despite this, we had clients – mostly dual citizens who could not provide the requested evidence to prove their refugee status – who were charged for the cost of the intervention. We reimbursed these costs. We also covered the costs of care when, due to time pressure, an examination (e.g. pregnancy diagnosis, laboratory test) had to be performed in the private sector in order to speed up the process (and to adhere to strict timeframes) (see the stories of Enikő and Isabella).

The stigmatising, judgmental and disrespectful treatment often experienced in health care is even more prevalent in abortion care. In public services, although it is not possible to choose a physician (you can only access the physician in your location), it is possible to choose which Family Support Services (FSS) you can go to in any location in the country, so there is some freedom in choosing this service provider. In order not to expose women to unnecessary harm, we tried to book appointments with the family support health visitors we had already had good experiences with, because they treated women with humanity and respect.

Educational sessions were also part of the support for women seeking abortion. We had several clients who had more than one abortion, so we felt it was important to talk to them about contraception options. We were aware that in many cases their financial constraints prevented them from using a contraceptive method, so we offered all women who had had an abortion the opportunity to access a long-term contraceptive device after surgery (see Evelin's story).

PRACTICAL ADVICE FOR SUPPORTING WOMEN SEEKING ABORTION CARE

As this process may involve gynaecological visits and consultations, the information in the box of the previous section also applies.

- The first step is to book an appointment with the local gynaecologist to confirm the pregnancy and the gestational age.
- When booking an appointment, it should be stressed that it is a time-sensitive examination, in order to allow for an off-schedule appointment (usually there is an opening for urgent cases).

- It is important that the appointment is made at the earliest 6-8 weeks after the first day of the last menstrual period, so that the foetal vital signs can be identified and it is documented on the medical record that "the pregnant woman has been presented with a clearly identifiable indication of the foetal vital signs by the health care provider" (the Family Protection Service counsellor will only see the woman for the first consultation if this sentence is included on the medical record).
- If the woman also receives a referral for a laboratory test during the gynaecological visit, an appointment must be booked for this as well. (Sometimes the woman does not receive a referral, because the blood test is done in the hospital before the operation).
- As soon as the gynaecological appointment is scheduled, it is possible to know the earliest day on which the woman will be able to go to the Family Protection Service, so it is worth booking an appointment with this in mind (find out in advance the exact time intervals at which the Family Protection Service will take phone calls!).
- Usually, it is good to accompany the woman to the consultation, as they may need emotional support (if they wish to be accompanied).
- The second consultation can take place at the earliest three working days later. This is typically scheduled at the first consultation.
- If the woman has not changed her previous decision, she has 8 days after the second consultation to visit the hospital where surgery will take place (Family Protection Services can provide a list of facilities where abortion care is available).
- At the first visit to the hospital, the surgery is not yet performed, but a date is set and the necessary pre-operative tests (typically a laboratory test, a gynaecological examination, and an anaesthetic consultation) are scheduled.
- The operation is performed on an outpatient basis and takes about 15 minutes, but the patient must stay in hospital for a few hours (for observation).

2.4.4. Contraception

Regulation and care system in Hungary

According to the Contraception Policy Atlas Europe 2025[8], Hungary ranks second worst in terms of access to contraception among the European countries surveyed. Hungary lacks an easily accessible and understandable evidence-based, credible source of information on different contraceptive methods, and no contraceptive option is subsidised by the state. This makes access to safe and effective contraception very difficult or even impossible, especially for women from disadvantaged socio-economic backgrounds with limited financial resources. In addition, there are several contraceptive methods (e.g. the contraceptive patch, the implant, the vaginal ring) that are both difficult to access and for which very limited information is available. In the European Union, only Poland and Hungary require prescription for emergency contraception (the morning after pill).[9]

The most common contraceptive methods in Hungary are hormonal contraceptive pills and intrauterine devices (IUDs).

> Women are often misinformed both by their environment and health professionals about the benefits, risks, side effects, contraindications, and recommendations for use of these contraceptive methods. These misconceptions make it extremely difficult to make informed reproductive decisions about contraception.

The practice of IUD insertion is often not in line with the guidelines of the World Health Organisation (WHO, CCP, 2022) and other relevant international professional bodies. Women often have long delays in accessing devices because ob-gyns are ill-informed, follow outdated information or poor, non-evidence-based practices. For example, contrary to the common misbelief, a woman or girl who has not yet given birth can actually get an intrauterine device. The IUD can also be inserted immediately after giving birth (within 48 hours for vaginal births and caesarean sections) or at any stage of the menstrual cycle. It can also be inserted without waiting for the results of cytology test (cancer screening), as cytology sample can be collected at the same time as IUD insertion. It can also be inserted as part of sexually transmitted infection (STI) screenings.

International guidelines highlight the benefits of IUD insertion in a single visit. It is more cost-effective, saves the patient an additional office visit, increases the proportion of people using the device (and using effective contraception in general), and ultimately improves patient care (Bergin et al, 2012). To understand why time-consuming, unwarranted preconditions for initiating IUD use are not recommended, it is important to consider the

8 Contraception Policy Atlas Europe 2025

9 European Consortium For Emergency Contraception (2022): An update on access to emergency contraception in Europe; and in Poland, emergency contraception is available with pharmacy prescription (2024).

risks and costs of the increased chance of unplanned pregnancies that may result. Many women have partners who refuse to use other methods of contraception (such as condoms) until the IUD is inserted. In our experience, many women, especially vulnerable groups, are not able to return for a second visit for a number of reasons (financial and other logistical burdens of travelling for the service; arranging for supervision of young children; unsupportive behaviour of the partner, etc.). If the IUD insertion, which requires two or more visits, is ultimately unsuccessful, it not only takes up health care resources unnecessarily, but the woman must also deal with the emotional, physical, and health problems associated with an unplanned pregnancy. Considering the difficulties of making appointments for healthcare services in the country, the long waiting lists and waiting times, and the lack of respectful care, the mistreatment and negative experiences that discourage many patients from further visits, it would be in everyone's interest to ensure that anyone who wants an IUD can access it, after being properly informed, preferably with a single visit.

Under the national regulations, Temporary Protection status holders and Ukrainian-Hungarian dual citizens who were (in principle) treated in the same way, were entitled to free health care in the case of "urgent need". The most common gynaecological infections and contraceptive needs were considered by policy makers and care providers to fall outside this category, and were not available for free. This meant that refugee women who found themselves in dire financial straits or who had come from extreme poverty were prevented from accessing basic gynaecological examinations, screenings, and contraceptive care. However, they had access to free antenatal care, childbirth, and abortion.

Methodological considerations and tools

The first step to being able to provide contraception-related support is to get to know the woman. We need to understand what she knows about women's health and reproduction; what her current unmet needs are; what previous gynaecological (including contraceptive) experience and information she has; what her lifestyle is; and, how her partner (if any) is involved in contraception. With all this in mind – and continuing to work with and engage the woman in a personalised way – effective help can be delivered.

In addition to getting to know the woman, we need to have basic, evidence-based knowledge about women's health and reproduction; what contraceptive options are available and which ones are accessible; and, what the indications and contraindications are according to current scientific standards, so that we can provide accurate information and answer questions that arise. At the same time, we need to be mindful of the limits of our competence and knowledge – where our ability and obligation to share this knowledge end, and where the scope of practice of healthcare providers begins. The key point here is that it is the physician's role and responsibility to make and communicate a diagnosis, even if we understand the possible cause of complaints and test results.

In addition to knowledge about reproductive health, we also need to be aware of patients' rights guaranteed by the Health Act[10], in particular, the rights to human dignity, self-determination and informed decision-making. According to the law, "*Patients have the right to receive information in a way that they can understand, taking into account their age, education, knowledge, mental state, their wishes in this regard and to be provided with an interpreter or sign language interpreter if necessary and possible*". However, this information is often not provided at all or not in this manner, by the institution or the practitioner (see the stories of Sophia and Enikő). Therefore, it is the field worker who can support informed decision-making where the woman is given the information she needs in a way that she can understand, so she is able to make informed decisions about her own health.

Communication and advocacy skills are also needed. Medical visits usually do not allow enough time for the woman's situation to be mapped out, and care often has an assembly-line approach. Our knowledge of the woman and her individual needs can complement the physician's work – as long as the physician is open to partnership. For example, at relevant moments, we can ensure that the practitioner addresses questions that we know are important to the woman, or that relevant information from her medical history is presented to the care provider. At the same time, we do not take control. We treat the woman as a competent person and are aware of our role as a communicator. In other words, we do not speak for the woman or over her head, but support her to communicate with the practitioner and assert her rights.

In public care, we are limited by territory-based area of service, and do not have the freedom to choose a practitioner. In private care, it is worth seeking out and collaborating with health care providers who work in line with our principles and approach (trauma-informed, women-centred and evidence-based care, respect for human dignity, non-judgemental attitude).

Practical implementation

Contraception-related support usually started with educational talks. The trusting relationship we built with the women in the first place played a crucial role in enabling us to talk to Roma women about issues that were so intimate and taboo in their communities. Many times, other female relatives and friends would sit with us, and we would discuss these topics together. Many of them had not had the opportunity to learn about how the female body works, what happens during menstruation, how a foetus is conceived and exactly how contraceptives work (many of which they already had some knowledge of). We have tried to explain these as simply and clearly as possible, avoiding foreign words and medical jargon.

There were very few requests for emergency contraception, although we initially expected more in the context of the humanitarian crisis. The few incoming enquiries were from the humanitarian programme's helpline, not directly from women utilising case management.

10 Act CLIV of 1997 on Health Care

All related inquiries were requests for information, not for obtaining a prescription or financial assistance.

As mentioned before, hormonal contraceptive pills and IUDs are the most common methods of contraception in our country. Roma refugee women had little prior experience of the contraceptive pill, as most of them did not find its regular and more rigorous intake schedules compatible with their lifestyle. However, they had previous experience of IUDs and were happy to use them as a contraceptive method.

The selection of private care providers was made in line with our principles and core values, as mentioned above. A summary of trauma-informed care was sent to private clinics prior to the first visit. It was also important to work with practitioners who are non-judgemental, socially sensitive and have a good understanding of the complex life situations of vulnerable groups of women. For example, it was important for the practitioner/care provider to be understanding of the many ways in which attending examinations could be hindered (no money for travel, no one to leave the children with, etc. – see Evelin's story); or how flexible and responsive they had to be in cases where someone urgently needed contraception after childbirth or abortion, because the male partners' cooperation in contraception was unlikely and there was a risk that the woman might soon become pregnant again.

The process of requesting an IUD followed a well-planned and timely schedule, typically with two (occasionally one) appointments: 1. consultation, cervical cancer screening and IUD insertion; 2. follow-up visit. Providing contraceptive assistance required a shorter-term commitment from staff, so team members who provided this kind of support were able to support more women than those who accompanied pregnant women.

PRACTICAL ADVICE FOR TALKING ABOUT CONTRACEPTION

If the woman has used contraception before, give them the opportunity to tell you about their experience, what worked for them, what considerations played a role when choosing a contraceptive.

It's good to talk to the woman…

...about the process of conception – preferably with the help of visuals and demonstration tools – and about the female reproductive system and how it works.

...about the different contraceptive methods, their advantages, and dis-advantages.

When an IUD is the preferred method of contraception, discuss...

... the two types of IUDs (hormonal and hormone-free) and how they work, and how they can have a direct impact on everyday life.

… the symptoms that should be reported to a physician after the IUD is inserted (heavy bleeding, severe abdominal pain, fever).

…the importance of annual check-ups, the time range for safe use and the fact that they can change their minds and have the device removed at any time.

…what to expect during the medical examination (this may vary from one practice/care provider to another).

With a view to minimising the risk of an unwanted pregnancy, IUD insertion should ideally follow these steps:

1. The ob-gyn takes the medical history.
2. Gives information about the device, which can be looked at, and questions can be asked.
3. Performs a vaginal ultrasound scan and checks if there are any obstacles to the insertion of the IUD.
4. If the woman does not have a negative cytology result within a year, the ob-gyn performs the cervical cancer screening. Collecting the sample during menstruation is not recommended, so if the device is inserted during the period, the cancer screening should take place later, after the insertion and after the menstrual bleeding has stopped. The device can be inserted at any time during the menstrual cycle, although it is usually easier to insert during menstruation.
5. Inserting the IUD usually takes only a few minutes. If there is no menstrual bleeding, the doctor will typically use a uterine sound (a medical instrument) to check the patency of the inner and outer cervix, the cervix is grasped with a surgical clamp if necessary (the most uncomfortable but still bearable part of the procedure) and insert the IUD.
6. Following insertion there may be mild discomfort (feeling light-headed, abdominal cramping), so it is best to lie still and wait for symptoms to ease.
7. The ob-gyn will do another ultrasound scan to check that the IUD is correctly positioned.
8. There may be bleeding, so it is useful to tell the woman in advance to bring a menstrual pad or you can bring one for her (private clinics usually provide one).
9. The doctor will provide aftercare instructions for the next 48 hours (avoid getting anything in the vagina – so no tampons, sex, or bathing) and when to schedule the follow-up visit.

Ensuring the in-person presence of the field worker is preferable for this service, and as these visits were always carried out in private care, access itself was not impeded by administrative or legal problems. However, at the personal level, women encountered many difficulties that could have prevented them from accessing care. Many of them could not get to the clinic on their own. This was due to different reasons – they were housed outside of residential areas or in a location that was difficult to reach by public transport; they could not find the location due to a lack of literacy and familiarity with the area; they had no one to leave their children with during the visit; or they could not afford transport or the service and the contraceptive device. With in-person accompaniment support for the women, all these obstacles could be removed. We were also able to arrange on-time attendance at scheduled appointments, which was an expectation of all private providers.

2.4.5. Administrative support

Context in Hungary

In the framework of humanitarian crisis response, there are a number of administrative steps that are crucial for the legal stay of the refugees, for accessing benefits (housing, health and social care, monetary support) and for starting integration. Information and practical guides on these procedures should be made easily accessible, as well as services through which professionals provide guidance or concrete assistance in the administration of the procedures. This is a governmental responsibility.

However, following the Europe-wide refugee crisis in 2015 which saw Hungary take in high numbers of refugees, the Hungarian state systematically began to dismantle the full range of refugee welfare and integration services (Juhász, Molnár, Zgut, 2017), leaving significant gaps in the system. This has also affected certain administrative procedures. For example, the post-arrival registration process was a well-communicated and clear procedure, whereby refugees with Ukrainian citizenship were first granted humanitarian residence permits and then Temporary Protection status. However, the procedures concerning, among other things, benefit entitlements for Ukrainian-Hungarian dual citizens or the registration of children born in the host country were not at all clear. As a result of these procedural shortcomings, many Ukrainian refugees encountered administrative difficulties, and many did not have access to services to help them overcome these obstacles.

Ukrainian-Hungarian dual citizens were not able to apply for Temporary Protection status. In the absence of a TPS card, it was difficult to demonstrate their legal status and their eligibility for free health care services. They would have had to prove that they had left Ukraine after the outbreak of the war by having a date stamp in their passports. However, stamping at the border crossing – especially at the beginning of the large-scale movement of refugees when many people started to cross the border – was not a routine practice, and dual citizens usually crossed the Ukrainian side of the border with their Ukrainian

passport, but crossed the Hungarian border with their Hungarian passport, where they did not automatically receive a stamp. In the absence of such a stamp, having a foreign (Ukrainian) address as the permanent registered address on their Hungarian address card was also acceptable evidence. If they did not have this, they were often advised (including by the authorities) to return to the country at war and bring back a proof of their registered address. This scheme has not worked in practice and has led to many anomalies. Health care providers often refused to provide free health care to dual citizens (see Enikő's story). In Hungary, citizenship is determined primarily on the basis of descent and not place of birth. So, if a child of foreign parents is born in Hungary, the child's citizenship depends on the citizenship of the parents. However, citizenship is not automatically granted to newborn babies. After birth, they are registered as having unknown citizenship and can apply for registration of Ukrainian citizenship in a separate procedure at the Embassy of Ukraine in Hungary. This is a rather complicated, multiphase, and costly procedure, for which little official information is available, and which has been a heavy financial burden for many refugee families.

There is one more important point in the birth registration procedure – the registration of the father as the parent. This requires a different procedure if the child is born into a marriage, a civil partnership, or if the mother is a single parent. Until the supporting documents are presented, the child cannot be registered, and its legal status cannot be settled. Information materials on the procedure and the documents required, that could be obtained already before the birth, are not available. This leads to cases where the registration of children is stalled, and they are left without personal documents for months. In addition, the procedures are not uniform and vary from one office to another, with different institutions not applying the same rules (see Vanda's story).

Considerations

In this care context and with these systemic barriers, it was out of the question for us to provide administrative support to the refugee women who came to us. All the more so because, early on in our programme, we encountered situations where we simply could not start supporting women until the bureaucratic obstacles they faced had been overcome. In addition, no referral pathways had been established to address these cases.

However, special consideration should be given when providing administrative assistance. It is worth bearing in mind that these processes are time-consuming, difficult to navigate and expensive, and can often require expertise that is not necessarily available within the organisation. It may therefore be necessary to involve additional professionals (in this case social workers) or to build partnerships and cooperation with organisations specialised in this field (e.g. lawyers, human right defenders, or other experts experienced in the refugee welfare system). All of these require a high degree of flexibility and adaptability from the organisation, so it is advisable to carefully consider whether this task can be responsibly undertaken.

Practical implementation

With this activity, we added a programme element to our services during the project period, which was not anticipated at the planning stage. However, the shortcomings in the administrative processes had an impact on our direct services and could not be ignored.

Initially, we provided support for the administrative tasks needed to help our clients access healthcare. For example, in the case of Vanda, an unaccompanied pregnant girl who was unable to access medical care until she was assigned a guardian, and who was unable to leave the maternity ward with her newborn baby until she had submitted the necessary documents for birth registration at the office. But we also count here all the cases of Ukrainian-Hungarian dual citizens who had their eligibility for free health care questioned (see the stories of Enikő and Evelin) and had to do some advocacy work to obtain it.

During complex case management, we also identified anomalies in access that we could only learn about by being out on the field, and which we then channelled into the experience-sharing sessions with other refugee support organisations. We found that Hungarian-speaking Roma faced serious discrimination at the Embassy of Ukraine in Hungary, due to their origin, socio-economic status and the fact that they did not speak Ukrainian. This meant that even if they had been provided with relevant information in advance, they were unable to complete their cases, as they did not receive any assistance on the procedure. They also could not fill in the necessary forms in Ukrainian, and often could not even get through the gate because they could not tell the intercom in Ukrainian the aim of their visit. They needed special interpretation, both because of the language barrier and their lack of literacy. It was not easy to find help for this job, because for interpreters, filling in forms was not a real interpretation task, and in addition, the atmosphere at the embassy where the work had to be done was very hostile to our Hungarian-speaking Roma clients. Over time, however, we managed to establish a stable cooperation with a socially sensitive, Ukrainian-speaking woman with whom we could always turn when we needed to deal with a case at the embassy.

In general, we needed legal advice and background support throughout the whole programme, as some of the procedures changed from time to time, so we needed to update the information we had already acquired and to incorporate new developments.

In parallel with administrative management, there has also been advocacy work, particularly in relation to problems of access for dual citizens. This was necessary because in some cases it was not sufficient to simply cite the relevant legislation and present it to the care provider in printed form, but it was also required to file a complaint with the relevant patient advocates, the head offices of the health facilities, the National Public Health Centre (see Enikő's story).

An important element of administrative support was to cover the substantial financial costs (administrative fees, accredited official translation costs). We have encountered more than one child whose citizenship had not been settled even six months after birth, for financial and/or bureaucratic reasons.

The support we provided for newborn registration has proved to be a gap-filling service, with a steady stream of enquiries from mothers outside our core client base. However, we had neither the capacity nor the funding to handle these cases, so this service was only available to women who received sexual and reproductive health-focused or psychosocial support as well.

2.4.6. Donation of supplies

When considering the sexual and reproductive health needs of women and girls, it is important to remember hygiene needs. Not only menstrual hygiene supplies (pads, tampons, etc.), but also basic hygiene products (shower gel, shampoo, toothbrush, tooth-paste, nappies, wet wipes, etc.) that are essential for women and newborn babies to ensure their health, dignity, and well-being. As these products can quickly improve the quality of life of those affected, they are typically the first items to be donated in a crisis (alongside food and clothing donations).

When distributing menstrual hygiene products, attention should also be paid to access to water and sanitation facilities and cultural practices. Sustainable and low-cost solutions (washable pads, menstrual panties) are not an appropriate choice, for example when refugee women are living in collective housing or in a location where basic sanitation cannot be provided. Donating washable products should also be avoided in cultural settings where menstruation is taboo and women seek the most invisible solutions when choosing a product.

Before the humanitarian programme, we had no experience in organising the distribution of supplies, and our donation practice was shaped directly by field experience. Below we outline some of the issues that arose in practice and that we feel are important to consider. It is always important to define the target group, who the intended beneficiaries of the donation are. We can decide to accommodate all appropriate requests (in our case from refugee women from Ukraine), but we can also decide to make the supplies accessible only to a narrower group. Our experience has shown that for people in difficult financial circumstances, the purchase of relatively higher value items (mainly nappies, infant formula, and menstrual pads) is a major help in their daily lives. At the same time, the demand for these products can reach such proportions that a complete, extensive, and continuous supply management scheme is required. A clear definition of the framework is therefore essential. In our case, the donation of supplies was an additional service within our complex case management. It was available to women who were supported in the

context of reproductive health. At the same time, there were public events organized by EMMA and other organisations for refugees where all participating women had access to a specific range of items (typically menstrual pads, pregnancy tests, and condoms), whether or not they were being supported by case management. The primary purpose of these events was not to distribute supplies, rather to identify acute needs for care of refugee women and to raise awareness of our services.

To ensure transparency in our supply distribution practices, it was necessary to communicate our donation principles clearly and unambiguously to our clients, both externally and internally, so that they were clear about what they could reasonably expect from us, what types of donations they could receive from us, and what we could not provide.

> Providing personalised supplies is a sustainable form of donation: by responding to specific needs that have already arisen, we can avoid the accumulation of an unnecessary inventory that may not be used later. However, it is necessary to know the recipient and to assess their real needs and preferences, and to make targeted purchases.

While this approach requires significantly more time and energy than bulk procurement and distribution, it avoids the challenges associated with stockpiling. In this case, the staff member serving the client can acquire the necessary items prior to the next meeting and deliver the supplies immediately.

Large-scale donation (for example, when a large donation package is delivered to a collective accommodation) is a less resource-intensive form of supply distribution and can be more cost-effective due to the bulk purchasing. However, as well as not necessarily responding to real needs and being less sustainable, it can also be misused and may not reach the target group. This includes harmful practices seen in the field, such as social workers giving mothers one nappy at a time from a donation package delivered to the collective shelter, or measuring out teaspoon portions of baby cream. This meant that mothers had to stand in line daily for the basic supplies needed for infants, rather than being given the whole package at one time and, for example, being supported on utilising the full package economically themselves (if this indeed was the concern held by social workers in justifying the practice of rationing for women, but there may well be other reasons behind this harmful practice). There have also been cases where large quantities of supplies were given to a shelter, assuming that they would be distributed among the women concerned, but instead were added to the storage stock and only given out on request. This stockpiling practice discouraged several women from accessing the supplies, mainly because in many cases they would have had to ask male social workers for sanitary and menstrual products.

Defining the scope of the donated items is also an important issue. It will certainly be of great help if it be provided basic hygiene products to women, taking into account their needs during pregnancy and the postpartum period, as well as those of newborn babies:

- **For newborns:** nappies, baby cream, wipes, formula, burp cloths, baby shampoo, pacifiers, bottles, disposable changing pads.
- **For women:** shower gel, shampoo, toothbrush, toothpaste, body lotion, deodorant, razor, intimate wipes, sanitary and menstrual pads, pregnancy test, condom, prenatal vitamin.
- **For childbirth:** postpartum maternity pad, disposable panties, robe, sleepwear, slippers, nursing bra, nursing pad.

It should be noted that in some cases, the needs identified in the field went well beyond basic hygiene products. The donor who funded the programme, supported the purchase of a wider range of products for the women engaged in the complex case management. This approach by the donor was instrumental in ensuring this needs-based supply distribution practice. Donated items, such as baby cots or car seats for newborn babies may not seem essential supplies, but there were cases where a maternity unit or a health visitor would only allow the mother and baby to leave the hospital if they had these items (see Enikő's story).

The availability of such supplies has undoubtedly been a source of great support for our clients, but we also had to recognise that supply management is a very resource-intensive and demanding activity, which also presented some major challenges in terms of record-keeping and administration. However, the clearly framed principles of support have served us well throughout the duration of the programme, especially at a time when refugee support programmes were becoming increasingly scarce, putting refugees in ever more difficult circumstances, and generating an even greater need for material donations.

3.
KEY POINTS FOR ORGANISATIONS AND INSTITUTIONS TO CONSIDER WHEN DESIGNING PROGRAMMES TO ADDRESS WOMEN'S SEXUAL AND REPRODUCTIVE NEEDS

3.1. CONTEXT 2022

3.1.1. The state of refugee welfare services in Hungary

During the forced displacement and movement of refugees in 2015, the Hungarian state significantly reduced its refugee welfare services and integration capacities, with a physical barrier at the southern border and a number of deterrents to keep refugees away from Hungary (changes in legislation, detention of asylum seekers in transit zones, expulsion and forced return, closure of reception centres and refugee shelters, suspension of almost all forms of integration assistance and care). Due to the change in the legal environment in February 2022, access to the asylum procedure was extremely limited, with a few exceptions. The letter of intent required as a prerequisite for asylum applications could not even be submitted in Hungary, but only at the embassy of the "nearest safe country" in Kiev (Ukraine) or Belgrade (Serbia). Reception centres were lacking, as well as institutions, social workers, and interpreters facilitating access to housing, employment, schooling, and other services (Tóth, Bernát, 2022).

There has also been strong anti-immigration communication since 2015, increasing anti-refugee attitudes in society. This changed significantly with the large-scale movement of refugees from Ukraine, with a greater emphasis on inclusion and solidarity. The European

Union Temporary Protection Directive (Directive 2001/55/EC)[11] recognised the legal basis for the admission of refugees from Ukraine and the Temporary Protection procedure for asylum seekers was finally put into practice. However, the application for asylum status could only be submitted in person at the immigration directorate, and during the processing time (45 days) applicants could not receive any financial support. The vast majority of applicants from Ukraine were women, children and the elderly, for whom going in-person to the office was often a problem.

On 11 March 2022, the Minister of Human Resources issued a special order on health care for persons coming from Ukraine[12], which stipulated the availability of a number of health services free of charge. This order also granted Hungarian citizens who fled from Ukraine (dual nationals) the same treatment as those with a Temporary Protection status.

The gaps in the state refugee support system, which had been completely dismantled, has been filled mainly by grassroots initiatives, NGOs and individual helpers. Initially, municipalities were also involved in humanitarian activities, mainly in the areas of housing, food, and material donations, and the UN's international aid agencies (UNHCR and IOM) also played an active role in the crisis response.

However, these initiatives could not completely compensate for the lack of a nation-wide, competent, organised asylum system. Due to the lack of financial resources, knowledge of the area and language skills, it was very difficult for newcomers to find even the most basic information that was a prerequisite for practical access to the services that were (legally) made available to them (Bernát, Tomka, 2025).

> In addition, Roma refugees from Transcarpathia experienced discrimination from humanitarian aid organisations and all other actors. They were often not properly informed about available opportunities, services, and support, and faced disadvantages in accessing accommodation and material donations. Thus, the most basic needs of Roma refugee women and girls were often left unserved.

11 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

12 Special Order No. 9/2022 (III.11.) of the Minister of Human Resources on health care for persons coming from Ukraine

3.1.2. The state of civil society in Hungary

It is well-documented that women's organizations from civil society worldwide have long been extremely underfunded and operate under difficult conditions. This is particularly true for organisations working on sexual and reproductive rights (CIVICUS, 2024; AWID, 2022). Demographic arguments are increasingly prominent in the global political discourse. Concerns about population decline, ageing, and labour shortages are driving policies to increase birth rates and initiatives to encourage childbearing. However, this pronatalist approach often clashes with gender roles and reproductive rights in society. Governments and policy-makers who prioritise raising the birth rate often introduce measures that have a negative impact on sexual and reproductive health and rights, leaving organisations working on these issues severely under-resourced and often working in a particularly hostile political environment.

In the last decade, as a result of a combination of political and structural reasons, organisations working for the protection, promotion, and advocacy of human rights, including sexual and reproductive rights, have had to face increasingly difficult conditions in Hungary (European Civic Forum, 2024). These women's organisations, which are mostly feminist (i.e. they strive to promote equality between women and men) and have low capacities in comparison to other country or regional contexts (such as western Europe or the US), and had (and still have) very limited access not only to national, but also to EU and international, resources.

The traditional areas of work for sexual and reproductive rights organisations are centred around the birth control, with a focus on sexuality education, family planning, contraception, and access to abortion.

> The human rights aspects of childbirth, obstetric care and the quality of maternity services have only recently been brought into the sexual and reproductive rights framework, and are therefore a relatively new area both in the women's rights movement and among trusts, foundations and organisations supporting women's organisations.

At the start of the forced displacement of refugee from Ukraine, EMMA Association focused its activities on promoting human rights related to childbirth and improving the quality of obstetric care through an evidence-based, women-centred approach. In February 2022, due to the above-mentioned circumstances, we had minimal operating capacity, with very limited financial and human resources. We relied primarily on our vast professional experience and organisational networks to respond to the enormous challenge ahead, and by temporarily reducing our core activities to a minimum.

3.2. PROGRAMME DESIGN

3.2.1. Early crisis response

In the period of the early crisis response (covering the first 6-9 months of our humanitarian work), we had to depart from our established programme design processes. The general design processes were primarily based on a systematic review and identification of needs to be addressed by the planned programme, and included the organisational development necessary for programme implementation (e.g. setting up, preparing and training the future team responsible for the different elements of the activity).

> However, in the case of the refuge crisis, there was less room for systematic and advance planning, as the situation was changing rapidly. Also, in the absence of a public refugee support infrastructure or any kind of coordination and structured communication across initiatives and institutions, access to up-to-date information was severely limited in the first months.

Thus, based on our previous experience and the scarce information available, we identified the likely reproductive health needs of displaced women. We then took stock of the resources that were already available or could be rapidly mobilised:

- The human resources, skills, expertise, and experience that existed within EMMA Association and that could be easily mobilised from the surrounding community;
- The organisational structures, units and core activities that could be involved or made more flexible according to needs;
- The financial resources that could be mobilised: resources that could be reallocated within the organisation, private donors and for-profit organisations willing to become involved;
- Hungarian partner organisations involved in the crisis response.

On this understanding, we identified and prioritised needs according to which we could respond immediately to and developed an action plan that could be implemented quickly and flexibly if additional funding is mobilised. From the onset, we sought to work in close partnership with women's organisations that have been involved in the crisis response.

Our humanitarian programme was launched at the end of March 2022 in partnership with PATENT Association, which, in addition to advocacy on violence against women, is engaged in advocacy and protection of sexual and reproductive rights, especially regarding abortion, in Hungary. Our programme aimed to promote access to reproductive health care for refugee women. The four main elements of the activities that both our organisations

provided expertise based on our respective missions (EMMA Association focused on access to maternity care and PATENT Association on access to contraception and abortion) were as follows:

- **Providing information** on sexual and reproductive health services available in Hungary;
- **Providing in-person support** in accessing health care, securing human resources for this purpose, developing a referral system;
- **Providing the necessary supplies** related to sexual and reproductive health;
- **Providing specialised guidance** to practitioners caring for refugee women on women-centred, trauma-informed care.

For the successful launch of the programme, we needed:

- Alignment of the core values from partner organisations;
- Mutual sharing of knowledge and experience in the organisation's areas of expertise;
- Coordinated programme design and fundraising;
- Regular, effective, and transparent communication between organisations;
- Harmonisation of the related operational processes of the organisations.

In the first six months, we were contacted by representatives of a number of international organisations who wanted to be involved in the crisis response, either as a donor or as a coordinating organisation. Most of these organisations had very little information about refugee support and health care services in Hungary, and also about the situation, the approach and the functioning of Hungarian civil society, including women's organisations. For most international organisations, understanding the limitations of the day-to-day reality of the public services and welfare systems in Hungary was initially a major challenge. Most women's organisations, including EMMA Association, had no previous experience and knowledge of the structure, functioning, language, constraints, and potential opportunities of the international humanitarian crisis response system.

In the initial months, through a series of face-to-face meetings, we sought to build mutual understanding, harmonise cooperation, establish equal partnership between international and local organisations and to develop two-way, open communication, with varying results. Relationships with those organisations with which we succeeded in building partnerships through mutual efforts have led to collaborations that have gone beyond the refugee crisis.

3.2.2. Planned crisis response

3.2.2.1. Continuous evaluation and development of programme activities

The ever-changing environment, time pressures, and lack of information and resources place a very heavy burden on organisations involved in humanitarian response with no prior experience in this area. This is because they must protect the integrity of the organisation while maintaining and, where possible, expanding, an inherently resource-intensive programme. This type of activity requires targeted expertise, preparedness, and responsiveness, while case management and health services (specifically in the private health sector) are associated with significant costs. In addition to the elements of the programme already in place, the simultaneous increase in the scope of activities and networking requires additional resources, which necessitates regular reassessment of priorities and continuous redesign.

NGOs have a strong internal drive to respond to urgent needs and are usually able and willing to adapt flexibly, but their situation is made even more difficult when they have to make rapid decisions on the basis of incomplete or unreliable information. Decisions must take into account the immediate needs of the those to be supported, the resources available, and the long-term sustainability of the organisation. During the crisis response, donor organisations regularly came up with expectations that exceeded the capacities and capabilities of local NGOs or that differed significantly from the local NGOs core activities. Constant evaluation is required to assess what is the feasible scope and direction of increasing activities and teams responsibly, even if a donor could (at that moment) provide the funding. However, if an organisation decides to become involved in an acute humanitarian crisis, even modest commitments and expansions more closely linked to the already existing activities may require rapid capacity building in the short term, as well as the development of referral pathways and ad hoc partnerships, balancing needs, opportunities, and organisational sustainability.

With services like those we provided, the complexity and resource-intensive nature of the work, and the limited number of women supported can be surprising to donors. These activities, because they do not result in mass outreach, may be less attractive to many funders and organisations with inadequate program design experience, where quantity-focused performance indicators similar to those in the for-profit sector are often applied.

> Therefore, it is important that the organisation and the financial donors reach a common understanding on the purpose of the activities, the expected outcomes, and the quantified indicators of these outcomes. This is to set realistic expectations for the short, medium and long-term with regards to evaluation and impact assessment, including programme indicators and outreach figures.

The development of appropriate monitoring and evaluation tools is also necessary to provide financial donors with a realistic picture of the work done, the costs and time required, and to ensure that the results can be properly measured – and communicated. Adapting and adjusting impact assessment processes on the go is a further challenge, which can be made more difficult if different donor organisations expect different indicators and use different criteria to evaluate the effectiveness of the programme. A further difficulty is that the results of complex case management are often difficult to quantify, and there has been no available, proven system of indicators for such activities that could quantitatively and qualitatively reflect the (almost incalculable) impact of the programme on the quality of life and longer-term well-being of the women supported. However, the attempts to record, document, and compile indicators and benchmarks are not only valuable externally. They are also important to capture and acknowledge achievements and the fruits of collective effort at an internal, organisational level.

3.2.2.2. Advocacy activities

Direct service-provision needs to be complemented from the beginning of the programme with advocacy activities to highlight systemic issues that affect the situation of refugee women in the area of sexual and reproductive health and rights.

> A complex approach to advocacy is needed. In addition to the gaps in legislation and barriers to the exercise of rights, socio-economic and cultural factors must be considered, with a particular focus on groups of women who are more likely to experience difficulties, discrimination or violence because of their ethnicity, life situation, physical/cognitive abilities or language skills.

In addition, close cooperation with other stakeholders, including other civil society organisations, human rights defenders, activists, professional groups, academic institutions, as well as methodical collection of information and the formulation of targeted recommendations, are of particular importance.

This will require organisations to:

- Communicate the complexity and diversity of women's experiences and needs through advocacy;
- Provide adequate resources for active participation in coordinated advocacy initiatives;
- Develop appropriate forms of case-related data collection and documentation of rights violations;
- Communicate regularly with other organisations.

In our humanitarian programme, our advocacy activities covered the following areas at the national, EU and international levels:

- We analysed the situation of the health care system and general practices in the field of obstetric and gynaecological services;
- We provided feedback on the shortcomings and challenges on the practical implementation of legislation for health care for refugees to the relevant State Secretariat, the Commissioner for Fundamental Rights and the Ombudsman for the Rights of Minorities, local governments, the UNHCR and its partner organisations, the United Nations Committee on the Elimination of Discrimination against Women (CEDAW), the European Parliament, the European Commission, the Commissioner for Human Rights of Council of Europe, and the Advisory Committee to the Framework Convention for the Protection of National Minorities (FCNM), under the auspices of the Council of Europe;
- We documented the violations observed and initiated complaint procedures;
- We formulated recommendations to improve regulations;
- We provided feedback on the situation of local NGOs involved in the humanitarian response and the factors and impacts affecting their operations, to the UNHCR and its partner organisations, the UN Committee on the Elimination of Discrimination against Women (CEDAW), the European Parliament, the European Commission, the Commissioner for Human Rights of Council of Europe.

At the national level, we worked primarily with the UN organisations and their partners playing a coordinating role in Hungary, and at the Central and Eastern European regional level with international organisations and partners active in the European Union. This coordinated cooperation enabled us to:

- Understand the structure and functioning of the international humanitarian system, the mandate, competences, and activities of the various organisations;
- Establish channels of communication and information;
- Share expertise and good practices between organisations;
- Share organisational capacities and coordinate activities at national and regional level;
- Engage in referral pathways between organisations to reach a wider range of stakeholders and beneficiaries in a targeted way;
- Raise awareness among decision-makers about the situation of women's organisations in the region and the systemic difficulties they face;
- Launch a medium-term joint strategic reflection task among women's organisations in the region.

Valuable tools for our advocacy were two studies based on our own data collection and analysis:

Between July 2022 and April 2023, we conducted fact-finding work with nine organisations in Hungary, Poland, Romania and Slovakia to examine the barriers faced by refugee women in accessing sexual and reproductive health care and services for victims of gender-based violence. In this report titled *"Care in Crisis"* (CRR, 2023), we analysed in detail the legal, financial, information and language barriers, the impact of low quality and inadequate capacity in care systems, and the consequences of discrimination and stigma. Threats, attacks, and risks to NGOs were also highlighted. We formulated detailed recommendations to international humanitarian organisations, the European Union, individual governments, and donor agencies on the problems raised.

The second study titled, *"And then we reached the border: there were a million women!"* (Kupcsok et al, 2024) presented in detail the experiences of Roma refugee women fleeing Ukraine focused on sexual and reproductive health care in Hungary, based on the experiences of EMMA Association's humanitarian programme.

3.2.2.3. Organisational development processes

The situation and needs of refugee women are extremely complex. The humanitarian system should ideally operate a coordinated system of services to provide appropriate support. In addition to public institutions, this system usually involves organisations that either have a specialised focus (e.g. assisting victims of trafficking, facilitating sexual and reproductive rights, supporting victims of domestic violence), have resources and structures to be able to provide general assistance to a large number of beneficiaries (e.g. church charities), or have a coordinating role (e.g. international organisations).

> In countries where the refugee support system is not adequately prepared or does not have sufficient capacity, organisations that are not essentially humanitarian in their scope become involved in the humanitarian crisis response.

In this situation, we believe that multi-directional information exchange, awareness raising, and capacity building are necessary to ensure that:

- Local organisations become familiar with the structure, functioning and expectations of the humanitarian system;
- Humanitarian organisations operating in the country or arriving in the country in the wake of the crisis learn about the local organisations' context, functioning and capacity;
- The expertise of the local organisation is recognised by the humanitarian system.

Wherever possible, it is important that international humanitarian organisations arriving new to a country during a crisis collect information in advance on relevant topics (e.g. local legislation on abortion). This way educating these humanitarian organisations will not add further burden to the already stretched capacities of local organisations in the form of information-gathering meetings and briefing papers.

Training and capacity building in three areas may need to be organised for local organisations: thematic extension of activities; organisation and documentation of operational and financial processes; and development of policies and protocols.

Before the launch of the humanitarian programme, the focus of our Association's activities was on childbirth and maternity care. Once the services of other organisations providing for other essential needs of refugee women were discontinued, we expanded our activities to include facilitating access to contraception and abortion, and providing support for other areas of women's reproductive health (e.g. menstrual health, menopause). To ensure a consistent, evidence-based, trauma-informed, and mission-oriented approach across all our services, we organised training not only for programme staff but for the whole organisation. As any team member could easily encounter people affected by intimate partnership violence among our beneficiaries (see the stories of Natasha and Isabella), we organised a specific training on this topic, with the help of our partner organisation with expertise in this area (NANE Association).

UNFPA provided comprehensive training to our Association on the principles, structure and functioning of the international humanitarian system, and the international methodology for humanitarian programme planning based on the Inter-Agency Field Manual on Reproductive Health in Humanitarian Settings.[13] The partner organisation in Romania, who provided the training, proved to be an excellent help in aligning the expectations of the international humanitarian system with the capacities of our Association. It would be extremely useful if this training could be made available online and free of charge.

Operational and financial procedures have been continuously improved throughout the implementation of the programme. Changes to protocols, their rationale and purpose should be communicated to team members in a timely and appropriate manner. The monitoring of implementation is reinforced if the organisation periodically reviews the practices with the involvement of staff and adjusts them where necessary.

13 IAWG: Inter-Agency Field Manual on Reproductive Health in Humanitarian Settings (2018)

The most frequently requested policies and protocols in the humanitarian response system

The legally prescribed policies in the country (in this case, Hungary):

- Statutes or articles of the Association
- Accounting policy
- Valuation policy
- Inventory and stocktaking policy
- Cash management policy
- Data management policy under the General Data Protection Regulation

Policies and standards that are not legally required in a given country (in our case Hungary) but are expected by international donors:

- Rules of organisation and operation
- Safeguarding policy and protocol
- Code of conduct, code of ethics
- Travel reimbursement and representations policy
- Indirect cost policy
- Financial reserves policy
- Policies on zero tolerance and effective processes to prevent and address: any form of discrimination; harassment and abuse; retaliation against whistle-blowers; fraud; corruption and bribery; modern slavery and human trafficking; conflict of interest.

The different financial regulatory frameworks of the different partners and donors can create a number of difficulties during cooperation. It is therefore recommended to consult with the donor organisation at the planning stage of the cooperation or before signing the contract to see if there are any potential differences in the legal obligations or internal rules between the partners that could cause problems.

Some critical areas to be aware of:

- Accounting of exchange rate gains and losses, determination of the exchange rate;
- The exact conditions for releasing the grant amount; the timing of payment instalments, and the conditions for disbursement; and review potential problems that may arise;
- Whether the donor organisation requires a financial audit of the programme and, if so, what information is requested from the organisation for the financial audit;
- The exact types of eligible costs;
- The formal requirements of timesheets;
- Whether sick leave and paid leave can be accounted for under the grant for staff working in the programme;
- The rules for accounting for indirect costs.

3.3. CHALLENGES OF FUNDING

3.3.1. Early crisis response

The financial resources needed to launch the programme were made possible by the crisis funds of international organisations that were the first to contact Hungarian NGOs and had short-term, limited resources, but they were resources they could mobilise rapidly with minimal structural conditions. These grants were allocated for 6 months and could only be used to finance activities directly related to the humanitarian crisis response. As such, they did not allow for medium-term planning. They did not allow for the programmatic strengthening of the humanitarian activities or of the organisations' infrastructure, nor did they cover the indirect costs of the organisation. However, at least they did not require a deep restructuring of the organisations' operational arrangements.

To access crisis grants under this grant structure, local organisation's needed sufficient financial reserves to cover indirect costs and general operating costs. In addition, in parallel with the implementation of the initial activities undertaken in the crisis response, it is necessary to be prepared to receive funding for the next phase of the crisis response and to consider how this can be most effectively and usefully integrated within the financial and operational structures already in place.

3.3.2. Planned crisis response

The range of activities included in the programme expanded rapidly since the early crisis response, and intensity significantly increased. During the peak of our humanitarian programme in 2023, the Association employed ten employees exclusively in this programme and provided complex support to an average of 40-50 severely disadvantaged and vulnerable women per month.

The programming period and the financial volume of the available grants gradually increased. In the early emergency phase, the average funding period and amount was 6 months and 25 000 EUR, while in the later phase where we could better plan our crisis response, the longest funding period was 19 months, and the maximum funding amount was around 285 000 EUR. The eligible types of costs were extended, allowing for targeted and effective assistance, the integration of advocacy activities, the improvement of working conditions, and for the development and capacity-building of the organisation as a whole. Organisations that have been involved in the humanitarian crisis response have also carried out advocacy towards donors. This has led to more predictable, viable and favourable conditions for funding in terms of best ensuring organisation's long-term stability, and sustainable operations after a period of intense growth.

In the beginning of the planned crisis response there was a relatively flexible amount of funding with fewer organisational requirements, but none of the individual grants could

cover the full cost of the programme, so a combination of funding sources was needed. During this period, therefore, in addition to running an intensively expanding humanitarian programme, we were also required to rapidly develop organisational procedures that would meet the various donor requirements for financial transparency, accountability, and administration. These requirements often did not consider the practical circumstances of the programme activities, the operational capacity of the organisation, and could change within the same funding period for the same donor organisation. The conditions for obtaining and accounting for the largest grants, which could fully finance the programme, altered the overall functioning of the organisation to such an extent that it affected the activities of other programme areas as well.

> Regardless of the amount of grants, what has been a constant challenge is that we still did not have sufficient unrestricted operating funds, that would have enabled us to manage the finances of the programme with the expected flexibility.

Consequently, the following factors caused problems proportionate to the expansion of the programme:

- The expected rapid absorption rate of funds, which did not take into account the difficulties of reaching and supporting women and the time required by health services and procedures;
- The restrictions of budget modification procedures, which did not take into account changing needs, circumstances. and the necessary adaptability;
- Ensuring cash flow, which did not take into account the inability of the organisation to pre-finance significant expenditures for months;
- Financial statement requirements that had not been determined in advance and the communication of accounting terms that was given retrospectively;
- The risks of exchange rate fluctuations were taken on unilaterally by the local implementing organisations.

Although we have been able to overcome the difficulties encountered through a solution-oriented approach, open communication, cooperation, a willingness to compromise, and perseverance, we believe that gradual and thorough preparation would be the best way to ensure that effective and lasting partnerships are established that do not overburden or jeopardise the local implementing organisation.

To this end, we consider it necessary that:

- During the programme design phase of the planned crisis response, local implementing organisations should assess what operational conditions are necessary for them to safely implement the programme:
  - plan for infrastructure improvements (e.g. tools, software);
  - mobilise human resources to provide administrative and financial support to projects, providing training, where necessary;
  - upgrade the financial administration system, where necessary;
  - involve external experts to assess financial risks, where necessary;
  - review internal financial policies and, if necessary, modify them on the basis of experience gained in early crisis response;
  - prepare a cash flow plan;
  - plan the financial audit of the programme.
- Donor organisations should respect the priorities and strategies of their local partners and contribute to the operational stability and sustainable growth of those local implementing organisations;
- Organisational and financial due diligence should take into account the functioning, working methods, infrastructure, and capacities of the local NGOs, and should also keep in mind the objective of making the partner organisation more stable and secure in its operations, while complying with the requirements;
- When signing the grant contract, the local NGO should have access to a legal expert who is familiar with international regulations and can represent the interests of the implementing organisation;
- The donor organisation should communicate in detail, in writing, in advance, the terms and conditions for the use of the grant, the administrative and reporting requirements, and show flexibility, taking into account the local partner organisation's capacity;
- Financial risk-sharing between both parties in the contract – donor and grantee – should be carried out in an equitable manner.

The above are also intended as policy recommendations to international donor organisations supporting humanitarian programmes.

3.4. ORGANISATIONAL INTEGRITY

While women's organisations are often among the first responders in humanitarian crises, filling gaps in critical areas such as access to sexual and reproductive health care or support for survivors of gender-based violence (including sexual and intimate partner violence), the perspectives of these organisations, including their values, their strategies and capacities, and the consequences of their social embeddedness, are given very limited consideration in the planning and decision-making processes of key actors in humanitarian crisis management (the state and international agencies and aid organisations).

This stark contrast was also strongly reflected in our experience. As described earlier, women's organisations in the field, with limited capacities, did not have adequate access to key information, material and financial resources, while at the same time faced the enormous challenge of continuing with their core activities and core functions (also designed to fill gaps in institutional shortcomings and to address the harms resulting from those shortcomings and abuses). This, alongside, maintaining and developing their humanitarian activities, developing their organisational structures, giving visibility to their activities and achievements, and seeking to raise funds to continue all this work. These conditions severely limit the safe functioning and development potential of organisations and exhausts their resources in the medium term.

> In the current structure of humanitarian crisis management, women's organisations are therefore taking a serious risk by getting involved in efforts to alleviate the suffering of displaced people.

The following are some of the aspects that can contribute to the security and integrity of organisations involved in humanitarian crisis management.

3.4.1. Individual safety

Working in the field of women's rights is extremely complex undertaking, requiring a wide range of competences and sensitive interpersonal skills. Staff members are engaged in this work with their whole selves. The phenomena of secondary (vicarious) trauma, compassion fatigue, and burnout among helping professionals and support workers, have been the subject of growing interest in recent decades, both in psychology and in management science and practice.[14] In particular, the problem of burnout has become increasingly important in civil society. However, the specificities of burnout stemming from the nature of activism, organisational culture, the structure and functioning of civil society, and the wider socio-political-economic context have remained relatively unexplored, and the discourse to date has largely focused on individual-level responsibility and the depoliticised notion of "self-care".

14 European Training Platform on Domestic Violence: Training module for the legal sector, Module 9: Self-care

Women's organisations have been pioneers in the political conceptualisation of burnout and have a deep theoretical knowledge and extensive experience in the linkages between individual safety and systemic impacts, prevention and recovery from violence against women, traumatisation and secondary traumatisation. However, the problem of burnout is still characterised by a certain level of taboo and many organisations lack the knowledge and resources to develop appropriate organisational strategies, with preventive or corrective interventions.

The question of balance between individual and organisational responsibility is a sensitive one, especially in organisations that uphold feminist values. Our experience shows that both individual awareness and commitment, and organisational preparedness, are needed to prevent burnout, but that organisational responsibility is more important in cases that lead to burnout. For this reason, this chapter focuses on the options available to organisations. The following, although based on direct experience in our humanitarian programme, are equally applicable and relevant to activities done with other target groups and other types of assistance.

In humanitarian work, team members are at an increased exposure to the potentially traumatising effects of working directly with women, and to organisational factors that can increase exhaustion and burnout. The most typical of these are:

- They regularly witness, directly or indirectly, serious human rights violations, violence, discrimination, prejudice and the resulting harm;
- They are working under significant time pressures and are often confronted with tasks and problems that go beyond their scope of competence and their capacity to help;
- They may regularly experience deep moral distress when faced with systemic problems and the suffering caused by the inadequacy of the resources available to them;
- The social and political environment surrounding the organisations is unsupportive or explicitly hostile, and team members are often themselves victims of prejudice, animosity and mistreatment directed against refugees;
- The results of their work are difficult to measure, successes are often limited and temporary, and individual contributions are not always clearly visible, which can give staff the impression that the effort they put in is "not worth it";
- The general overstretching of the organisation can damage the internal values, human relationships, and functions that constitute its most important resources;
- The management capacity of the organisation is limited or not sufficiently effective, which may increase the individual burden on employees;
- Wages are often inadequate, which can undermine their sense of personal, basic security and hinder their ability to take care of themselves and access certain well-being services (although humanitarian funding has enabled our Association to increase salaries compared to previous levels, the wages of field workers have not reached the national average gross wage);

- The conditions for the predictable functioning of the organisation are not always in place.

Many of these difficulties also apply to staff who are not or only rarely involved in direct service-provision and who are mainly involved in operational, coordination or administrative tasks, in particular senior managers. In their case, while they are less exposed to the direct experience of unfair treatment and suffering, the structural responsibility for the sustainability of the organisation and its activities can be a serious and less visible pressure. While the burden of the leadership role increases, the necessary management support is virtually unavailable; and the human connections and direct feedback on the usefulness of the work that direct support workers experience in their interactions with clients are lacking – all of which can lead to isolation and emotional exhaustion, and in the long term, to increased risk of burnout.

> The motivation of staff and support workers in the women's rights field often originates from personal experiences, which can affect their daily work and their ability to cope with the associated mental burden to various extents. In addition, there is a high level of commitment among team members of organisations not only to the women they support and the mission of the organisation, but also to each other.

In addition to traumatic experiences, the combined consequences of permanent or recurrent exposure to stressors need to be given increased attention by both the worker and the organisation. Symptoms can take many forms, depending on individual characteristics and vulnerability, and affect both the physical and psychological well-being of the individual, their human relationships, and the quality of their work. Adequate self-awareness is of paramount importance in helping staff to recognise and monitor their own condition and to seek support and help when needed. There is also an important role for immediate colleagues, who often notice the signs earlier than the person concerned. The importance of early symptoms should never be underestimated, nor should the extent of the damage that unaddressed, untreated effects of stress can cause over time, both at the level of the individual and the organisation.

As well as maintaining and nurturing mental health, it is also necessary to assess and prepare for risks to physical safety. In particular, when supporting women and girls involved in, or at higher risk of intimate partner violence and/or trafficking (see the stories of Natasha, Isabella and Viktoriia), team members are also at higher risk of assault, physical or verbal abuse.

It is the responsibility of the organisation to develop, as best it can, operational structures, processes, working conditions and forms of support that can effectively prevent and, where necessary, address problems, considering the individual needs and concerns of team members. We consider the following aspects to be of particular importance:

- As far as possible, define precisely and clearly the professional competences, tasks and responsibilities of staff;
- When defining job descriptions, take into account not only professional tasks but also administrative duties, time for personal development and self-reflection, unforeseen difficulties and setting reasonable performance expectations;
- When organising assignments, take into account the need for staff to share both professional responsibilities and emotional burdens;
- Ensure that staff have individual safety plans and procedures in place to report emergencies. Staff should receive training and support in risk identification and personal boundary management, so that they can refuse high-risk requests even under pressure, and use conflict management and de-escalation tools;
- Wherever possible, staff should work in pairs and ensure that their whereabouts are known, especially when visiting unfamiliar or high-risk locations. Use secure channels of communication and be mindful of what is posted on social media in relation to fieldwork, and ensure that personal data and contact details of both field workers and beneficiaries are protected;
- Regularly check in with staff in person about their workload, difficulties and physical and mental well-being;
- At the organisational level, create regular opportunities for feedback, for making results visible, for celebrating successes, and for dealing with the difficult feelings that come with failures and losses;
- Allow time for uninterrupted recovery, both on individual days off and on organisational retreats;
- Where possible, ensure that staff have access to good quality healthcare;
- Ensure that psychological safety and mental health issues are mainstreamed at organisational level, and that staff have a basic understanding of the issues and the support available;
- Consider the resources needed for the above when planning and budgeting programmes.

Regular group case conferences focusing on professional issues, dilemmas, and problems to be addressed and resolved, and providing personal supervision sessions focusing on emotional well-being based on individual needs, are considered good practice. Group case conferences held with suitable regularity create opportunities to discuss complex professional challenges and dilemmas, support mutual learning processes, and enhance effective information flow and team bonding. Ideally, several supervisors appointed by the organisation should be available for individual support. We consider it essential that

the supervisors have prior knowledge of the organisation's operations, circumstances and realities, and a good understanding and commitment to its values. In our experience, regular individual supervision benefits all team members, regardless of their current situation.

3.4.2. Group cohesion

Strengthening and maintaining team cohesion is also necessary to ensure organisational integrity. When teammates work well together, it has a positive impact on both service quality and employee satisfaction.

There are several ways to build team cohesion. It is essential that all team members involved in the programme are aware of the organisation's values, principles, and operating standards, and work to uphold them. The framework for this is set out in the organisation's code of ethics[15] which includes the objectives for which the organisation works, the core values and principles on which it is founded, and the ways in which it manages conflict. This can be complemented by a programme-level code of conduct, which provides the operating principles and clear guidelines for day-to-day work. This should include a detailed description of the structure, roles and responsibilities of the programme team, the day-to-day running of the programme, the regulation of work processes, internal communication and information flows, and financial management practices. Operational standards also include a data management and privacy policy, and a safeguarding policy and protocol (see Annex, chapters 5.5 and 5.6).

Opportunities to learn together and share knowledge are also important for strengthening team cohesion. When team members come together to learn a new skill, they get to know each other better, which strengthens the bond between them and helps build trust. Shared learning can also bring new approaches and ideas to the team, which can enrich the work later on, and help staff to become more committed to common goals. These learning opportunities can take the form of structured training or unstructured knowledge transfer.

15 EMMA Association – Code of Conduct (See Appendix Chapter 5.4)

STRUCTURED KNOWLEDGE TRANSFER – TRAINING SESSIONS

Two training sessions were organised during the programme. The first training took place six months after the onset of the crisis, when it became necessary *to increase the professional capacity of the existing programme staff.* For new team members and volunteers, we organised a training session in which, in cooperation with our partner organisation, we shared the key skills and approaches to our work. During the three-day training, we covered the following topics: feminism, contraception, abortion, prenatal care, skills for team members accompanying women and effective support, field experiences of working with vulnerable groups of women, intimate partner violence and sexual violence.

The second training took place when *we extended our range of services*. The entire staff of our Association came together for a five-day, 40-hour training course on menstruation, women's health, contraception and abortion.

LEARNING BY DOING – LEARNING AND KNOWLEDGE TRANSFER THROUGH PRACTICE

This form of learning was a constant feature throughout the programme, as there was always new, emerging information (e.g. changes in legislation) that we learned about during the field activities and had to incorporate into our general knowledge and practices. Networking events and knowledge-sharing sessions with other organisations and professionals working on the crisis were also important for this kind of knowledge exchange.

Alongside this, this form of learning was also available to staff who joined the team after the first or second training session. They would pick up the knowledge that the others had acquired during the training sessions by working in the field directly. A women-centred, feminist approach and experience of working with vulnerable, socio-economically disadvantaged groups was a prerequisite for all new recruits. This was complemented by the transfer of knowledge about the specific field of activity through on-the-job training, through a mentoring arrangement. New team members were always supported by a more experienced staff member, who trained and introduced them to the details of the role and the tasks, who helped answer any questions that arose, and who enabled the new person to gain direct experience of how to build and maintain a helping relationship with women through job shadowing.

We also want to highlight the mutual knowledge-sharing that took place between colleagues with experience in perinatal and mental health support and social workers, in order to combine their knowledge and skills to support the women who came to us as effectively as possible.

Meetings that encourage open communication, where everyone can feel safe and express their views, ask questions, and share feedback, experiences, and ideas about work, also play an important role in building cohesion. In our practice, this has been achieved through weekly staff meetings, where, in addition to addressing operational issues, we have also discussed and addressed individual cases of the women we supported, urgent difficulties and shared knowledge.

Informal social events and team-building activities (e.g. retreats, group gatherings), which offer an unstructured and casual opportunity to connect, also serve to build team cohesion. As well as fostering cohesion between team members, these occasions also promote a more open and effective dialogue between team members that facilitates collaboration. In our case, these occasions were also very necessary because of the physical distance between the members of the programme team (there was one team in the capital and one in Eastern Hungary). In order to ensure that no one felt left out or ignored, and to make sure that no one was overlooked, and that cohesion was strengthened among the whole team, we created occasional opportunities for in-person connections.

3.4.3. Integrating the programme into the organisation's operational framework

Integrating programme activities with significant and rapid expansion of capacity into day-to-day operations, presents a range of challenges. As noted above, the integration of such a significant change has implications for all areas of organisational functioning.

Decision-making, transformation of organisational structure

Changes in the size of the organisation and the number of people working there may require changes to workflows and decision-making mechanisms. What was adequate for the organisation's previous activities may no longer serve it well enough to operate effectively once the new programme area is introduced. Informed decision-making is important not only at the individual level but also at the organisational level, i.e. the decision-maker must have the necessary information on all relevant aspects: administrative and financial, as well as the potentially affected elements (and staff) of the various core activities and projects currently underway.

In a small, flat organisational structure with one or two core activities, it is easier to arrive at decisions democratically and by consensus, but as the organisation grows, this becomes increasingly difficult. In such circumstances, it may be necessary to develop more distributed (e.g. limiting the involvement of those directly participating in the activities concerned) or hierarchical decision-making methods. Time constraints and capacity overload also make it difficult to develop consensus solutions. In such contexts, team members are also relieved if they do not have to participate in every decision. However,

it is also counterproductive for those higher up in the management structure to be over-burdened by the constant pressure to make decisions. In some situations, delegating and decentralizing decisions, and flattening the decision-making structure may be the right solution.

Re-establishing the levels of decision making, matching the information available at each level and the associated responsibilities and tasks is a challenge for all members of the organisation, as time constraints mean that these changes are not necessarily planned in advance and team members have to adapt to the new structures at a faster pace than usual. This can lead to tension, uncertainty, and resistance during project implementation. Clear and transparent communication, open dialogue about the rationale and purpose of change, reinforcement of the shared vision and commitment in line with the organisational mission, acknowledgement and validation of team members' concerns and doubts, and the celebration of small daily successes together can help prevent conflicts from escalating. Planning the procedures to facilitate a seamless transition, and integrating these procedures into the daily routine is a major challenge and may not even be achieved during periods of intense change.

Knowledge management

The purpose of organisational knowledge management is to ensure that the right information is available to all team members at the right time and in the right form, thereby improving the overall performance of the organisation. Unfortunately, with increased workloads, it is not always possible to summarise, structure or make accessible existing knowledge. Another obstacle to good knowledge management is that, under time pressure, there may not be time and space to carefully consider exactly who needs, or may need, what information, when and where. The rush caused by circumstances may mean, among other things, that valuable experience is not utilised and that solutions must be sought again and again to situations and problems that have already been solved; or that there is a simultaneous overload of redundant information and a lack of information with regards to the specific, relevant knowledge for the given activity or task.

It is important to ensure the multi-directional flow of information within the organisation. This means, the transfer of organisational culture, attitudes and experience from previous activities to new team members; and also, the sharing of knowledge, experience and network of contacts generated in the new programme area in such a way that it can be integrated into the organisation's knowledge base and be used beyond the specific programme.

There are also several aspects to consider when designing internal communication processes:

- If donor communications, the preparation of financial and narrative reports, and the external communication of the programme is carried out by a team member who also has functions related to other programmes in the organisation, it is important to

establish appropriate information channels so that he or she is informed about the progress of the programme, the current challenges and achievements, without this taking too much time from anyone. For example: a 20-minute closing session could be included in the regular staff meetings, where only relevant staff members stay and go through specific questions to summarise the current situation.

- It is worth thinking about how much, and what, information the staff involved in the programme need to know about the content and expectations of the relevant grant. Some of this information will directly affect their responsibilities (e.g. administrative requirements or the types of eligible services or supplies), and it is important to pass this information on to all team members. However, there may be information that is not strictly necessary for the direct implementation of tasks, and sharing this information would only increase overload due to time constraints. Frequent repetition of information related to project requirements can also have an overwhelming effect.
- It strengthens the integrity of the organisation and team cohesion if the staff of the different programmes and projects of the organisation know each other and, more broadly, the activities of the other programmes. A reasonable amount of time should be devoted to this, and caution should be given that if this takes too much time and effort it can become a burden for both the organisation and the participants.

Change management and leadership support

In the life of civil society organisations, change is constant, and they have to continuously respond to external and internal challenges. Launching, running, and integrating a new programme is a major change that places a greater than usual burden on all members of the organisation. This can be alleviated if staff are able to reflect on the changes as much as possible and are able to re-evaluate processes and reallocate duties as necessary.

Managing change and supporting staff to embrace change is primarily a leadership exercise, but it requires specific skills as new challenges beyond standard operations arise daily. With the sudden growth of the organisation and changes in the decision-making system, some team members may be given new leadership roles and responsibilities, and there is not always sufficient time for preparation and gradual implementation. In our experience, under time pressure and with a sudden increase in workload, these individuals are usually not supported to navigate the changes in their roles and responsibilities, although often it would be helpful if they could exchange experiences with other leaders currently facing similar challenges or who have experienced such a large-scale change in roles or organisational transformation. Failure to recognise this can leave new leaders isolated, on their own, with the pressure of increased responsibilities and previously unknown decision-making situations, increasing the risk of burnout.

Where possible, it can be useful to provide some form of support to both leaders and staff to enable them to cope more effectively with the external and internal challenges of humanitarian crises. At the same time, it must be accepted that the nature of the situation

means that we will not be able to anticipate all changes and that many steps and elements of organisational integration cannot be planned or controlled. However, we can strive to manage the situation as best we can and to choose "good enough" solutions.

Discussing successful and unsuccessful handling of situations, reviewing good and not so good experiences, and identifying lessons learned is also an exercise that promotes integrity at both organisational and individual level. Although it is difficult to find time for this on a hectic schedule, it is certainly worth doing it when there is a less intense period during the implementation of the programme.

3.4.4. Cooperation with funding organisations

As a women's organisation dedicated to sexual and reproductive health and rights, the work of the EMMA Association is based on women's reality: recognising its complexity, its personal and social dimensions, and promotes both individual and social responsibility. Direct service-provision is based on a complex and personalised approach, seeks equal partnership with women and strengthens individual agency while addressing immediate needs, whereas advocacy activities targeting system-level dysfunctions support the fulfilment and enjoyment of the right to self-determination. This approach also shapes the functioning of the organisation. Hierarchical relationships within the organisation are minimal, the division of responsibilities supports autonomous action, and the cohesion of the organisation is ensured by relationships based on mutual care.

The integrity of the organisation is the symbol of the change we want to see in society and is therefore of paramount importance.

> One of the mottos of our Association is "We strive to treat each other as we would like society to treat women".

The success of collaborations with other organisations therefore depends to a large extent on how much adaptation is required by all those involved in the collaboration, and in which areas of work and operations, so that we can still uphold our values.

According to international organisations, which play a key coordinating role in humanitarian aid, the basic principles for working with implementing partner organisations in the area of sexual and reproductive rights and health are: to develop respectful, partnership-based cooperation; to mainstream sexual and reproductive rights in programme design; to share information and results; and to ensure due diligence, respect for human rights and financial transparency.

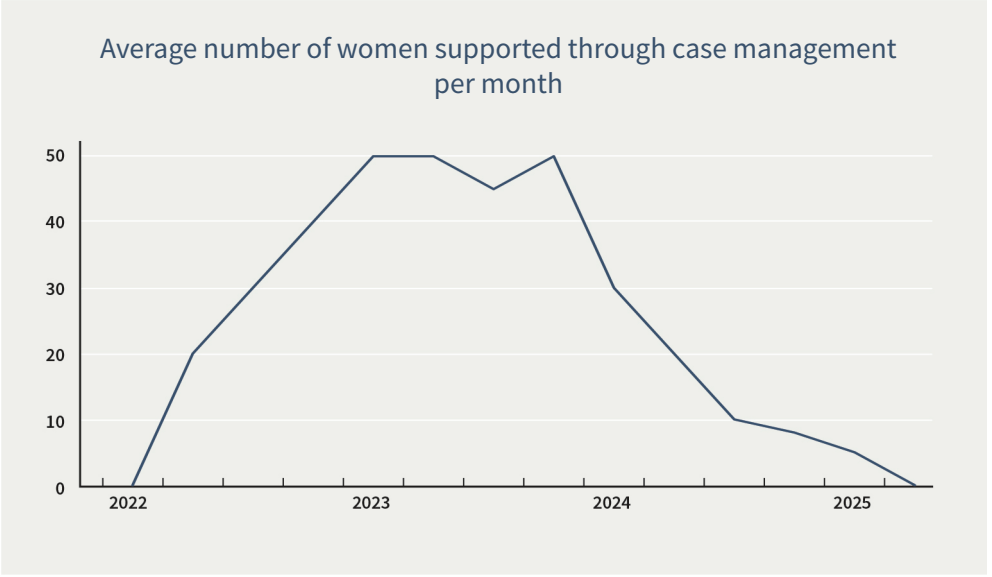
In the course of its humanitarian programme, EMMA Association worked with eight international donor organisations on 12 projects funded by grants from those donors.

Experience has shown that the following factors contribute to successful cooperation and the practical implementation of the above principles:

- The values that guide the professional work and operations of the partner organisations are in close alignment;
- The human rights and the social criticism aspects of the programme are consistently applied alongside the service-oriented approach of the humanitarian system;
- Programme activities are flexible and can be adapted to local conditions;
- Funding provides opportunities for advocacy;
- Funding provides opportunities for exchange of experience and strategic planning with regional organisations;
- Funding can be used for activities, tools and services to support individual and organisational safety and integrity;
- The structure and conditions of the funding do not hinder sound financial management, efficient working and flexibility, and contribute to the strengthening of the whole organisation;
- Indicators to measure results and the associated documentation required, as well as conditions for operational and financial transparency, will be defined during the programme design, in cooperation and mutual understanding;
- Partners communicate in a timely, regular and open manner;
- The donor organisation makes an in-person visit during the programme period;
- The donor fulfils its commitments in a transparent and accountable manner;
- Risk assessment is bilateral, not exclusively technical and takes into account the interests of all partners;
- The donor participates in the risk management of the programme.

4.
REVIEW AND CONCLUSION

If we were to visually depict the trajectory of the programme, we could draw a steep upward curve in the initial period, peaking at a high level at the end of the first year – with a high capacity of human resources, abundant financial resources, a wide range of services – and then operating at this maximum capacity level until the end of the second year. In the third year, with a substantial reduction in human and financial resources and the cessation of fieldwork, the curve became increasingly downward sloping.



The downsizing and imminent closure of the programme is the result of a complex process. The first two years of the programme have given us the opportunity to experience what real assistance and highly effective support for refugee women means: complex case management based on fieldwork. However, this type of activity is particularly demanding in terms of financial and human resources and can only be sustained in the long term if the organisation has the possibility of at least medium-term strategic and financial planning, which the current funding environment does not allow.

In addition to the depletion of financial resources, the very intensive period of operating at maximum capacity has also taken its toll on our human resources. It was often a challenge to maintain personal and professional boundaries in the face of new and emerging needs, while typically having nowhere else to refer women – there were no other organisations with whom to share the provision of services addressing sexual and reproductive health (and other) needs on a sustained, predictable basis. This was compounded by the fact that systemic barriers had not improved over time, and the daily grind of futile fighting drained our resources.

It is particularly painful that we are abandoning this activity in the absence of any systemic change, and that other NGOs involved in refugee support services, who have undertaken important public functions, are operating with shrinking capacities, so we cannot be reassured about the future and prospects for refugee women. All the more so because we receive daily feedback from them that, without the presence of a personal advocate, their access to reproductive health services remains hindered. Not to mention the psychosocial needs that they would continue to have due to the prolongation of the crisis and the day-to-day realities that make it difficult for them to cope (e.g. housing and financial insecurity, discrimination). The need for our services remains.

However, closing our programme and looking back also gives us the opportunity to take stock of our achievements and successes, and of all the positive things we can be thankful for. The programme has provided mental and psychosocial support and access to gynaecological and obstetric care for nearly a thousand women. We estimate that we have reached at least ten times as many people by providing new information, supplies or other indirect means. And in terms of the wider audience, we reached at least 100,000 people through raising awareness on the vulnerability of refugee women and the gaps in the system.

We are proud that women have shown their trust in us and made us a part of the most intimate events in their lives, that they have often given us positive feedback on our work and have recommended us to their female relatives and friends. We know from their feedback (Kupcsok et al, 2024) that we provided them with a sense of safety, and that it meant a lot to them, that we listened to them, we treated them as partners, we stood by them, we answered their questions, and that we were there for them and supported them when they felt most vulnerable and needed it most. Their understanding and awareness of their sexual and reproductive health increased. We have mutually enriched each other's lives through connections based on solidarity and empathy, which imply a deep relationship of trust. We have personally learned a lot about listening, caring, the challenges and joys of being a woman and a mother, and of humility and perseverance. We are also proud of our direct advocacy accomplishments – enabling access to health care for the women we served by providing accompaniment and a supportive presence. It means that we have prevented many health complications, legal difficulties, and have alleviated financial burdens faced by vulnerable women. We have helped many women reduce the risk of deeply traumatic birth experiences and the feeling of total abandonment and

vulnerability during their pregnancy, childbirth, and postpartum period. We helped many women to prevent unwanted pregnancies and forced deliveries, and the complications and hardships associated with these.

We have also gained a lot from this programme at an organisational level. Our network of contacts with humanitarian, international and national NGOs has been significantly expanded, and we have also diversified our networks by having the opportunity to develop partnerships with other civil society organisations in addition to women's rights organisations.

The programme has also brought about the need to broaden the scope of our services, to receive training on topics such as women's health, contraception, abortion, and to provide support on a wider spectrum of the reproductive cycle in addition to pregnancy and childbirth. This knowledge and experience have subsequently enriched our other programmes and we have been able to build on this foundation ever since.

First-hand, direct experience has added to our existing understanding of health care, administrative procedures, and the functioning of public authorities, the social welfare system and institutional services for women survivors of intimate-partner violence and domestic violence. Direct experience has given us greater insight and increased awareness of the experiences of vulnerable and marginalised groups, enabling us to better articulate their experiences and needs. We have also made a lot of progress in the background administrative work that supports the provision of client services.

Addressing women's sexual and reproductive health in humanitarian crises is vital not only at the individual level, but also at the community and societal levels. We encourage any organisation that would embark on a similar programme to do so, because women need this support in all circumstances. We trust that this handbook will provide the information and practical guidance needed to make an informed and responsible decision whether to undertake this challenge and, if undertaken, that it will provide useful guidance for its implementation.

5. ANNEXES

5.1. GLOSSARY

Case management: An ongoing, long-term, structured supportive relationship where the case worker meets regularly with the client to monitor and support their progress in a particular life situation. Case management involves personalised support, taking into account individual needs. The aim is to achieve the goals set with the active participation of the client and increase autonomy and agency.

Certificate of authentication (Apostille): In cases where a document issued by the Hungarian authorities (e.g. a birth certificate issued in Hungary) is used in a foreign country, the document must be authenticated in order to ensure that the foreign authority is sure that it is a genuine document. The international certificate of authentication (Apostille) is affixed to the original document.

Client: We are referring to the women we have supported through our humanitarian programme. Initially, our clients were women fleeing the Russian invasion who were either pregnant or had a child under 6 months old. As services expanded, we broadened our clientele to include women of reproductive age who were refugees from Ukraine seeking help with contraception or abortion.

Crisis response: This refers to the measures and support that organisations involved in the humanitarian assistance have taken to help refugees fleeing Ukraine following the Russian invasion of the country.

Donor organisation: These organisations are those that provide financial resources, material or technical support to individuals, groups or organisations to achieve their objectives. These fund providers can be governmental, non-governmental or private sector organisations that allocate funds to support specific initiatives in line with their mission, such as humanitarian aid, environment, health, education, human rights, and social justice, usually according to defined priorities and conditions.

Doula: A helper who provides physical, emotional, and informational support to women during pregnancy, childbirth, and the postnatal period. She helps the woman (and her partner) on the path to parenthood by providing experience and information about the physiology of childbirth. She is skilled in labour support, physical comfort measures, and pain reduction techniques during labour. She supports the natural course of labour by being continuously present. Doulas have no medical qualifications and are not involved in any way in the medical care of pregnant women. However, their mental health work throughout the perinatal period complements medical care.

Emergency contraception: A method of contraception used to prevent pregnancy following unprotected or inadequately protected sexual intercourse. In 2015, EllaOne emergency contraception was removed from the prescription-only category in the European Union, but it is still available by prescription in Hungary. There are several types of emergency contraceptive pills on the market, including those that can be taken within 72 hours and those that can be taken within 120 hours.

Family protection service: The Family Protection Service started their activities on 1 January 1993 with the aim of disseminating family planning information widely and reducing the number of abortions. Family protection health visitors work at the Family Protection Services. For abortion, attending two counselling sessions is compulsory. The first counselling session focuses on keeping the foetus: the health visitor informs the woman about her options for support if she carries the pregnancy to term and, if she chooses not to raise the child, about the options for adoption. It also provides information on the development of the foetus, the risks of abortion and its possible effects on the subsequent pregnancy. The second counselling session, which can take place at the earliest on the 3rd day after the first session, will discuss the abortion itself, family planning and post-operative contraception options. The counselling is free of charge for everyone, and women can go to any office of the Family Protection Service, regardless of where they live.

Field: This refers to the places where case workers have direct contact with clients. This includes places of accommodation, health facilities and locations of administrative procedures (embassies, immigration offices, guardianship offices, registry offices, etc.), as well as events where it was possible to meet refugee women.

Field worker: A professional (doula, social worker, mental health worker) working in the programme to assist refugee women, who supported the needs related to women's sexual and reproductive health and rights, as well as providing emotional and psychological support and administrative assistance to the individuals who contacted our Association.

Free health care: Access to medical care is not free. Those who pay their social security (social insurance) contributions each month (through their employer or by paying their own contributions) are entitled to medical care – without paying any extra fees. Refugees from Ukraine can become insured either by becoming employed or, if they are dual Ukrainian-Hungarian citizens and establish a permanent address in Hungary, they can start paying for themselves after one year. In the latter case, only a small number of people can become insured, and only after a long period of time. Refugees who are not employed (including pregnant women and women who work in the household) can only access a limited range of health care services without paying a fee[16]. These services are general practitioners and emergency care in outpatient and inpatient settings. They have to pay for all other care (e.g. treatment of gynaecological infections, contraception). However, prenatal care and obstetric care, as well as abortions, are included in the free care for refugees from Ukraine.

16 Special Order No. 9/2022 (III.11.) of the Minister of Human Resources on health care for persons coming from Ukraine

Health visitor: There are different types of health visitors (some of them work in kindergartens, schools, and hospital maternity wards), but in this handbook the term refers to health visitors involved in prenatal care and family protection services[17]. They are responsible for the care of pregnant women within their service area, in collaboration with the general practitioner, the obstetrician-gynaecologist and the midwife[18]. At the first appointment, they provide the pregnant woman with a Pregnancy Care Booklet, in which the examinations and clinical records are subsequently registered. Typically, the expectant mother will then come to the appointments every 4-6 weeks, where the health visitor will provide general prenatal counselling and carry out basic health checks such as blood pressure and weight measurements, urine tests and listening to the foetal heartbeat. Mental and emotional support is also part of the health visitor's work. As they are part of the child protection signalling system on the healthcare end, they also have an important role to play in identifying circumstances that may put children at risk. Therefore, if a health visitor does not find the housing and living conditions of a family suitable, they may prevent a newborn baby from being discharged from hospital.

Humanitarian crisis: A major emergency situation involving significant human suffering, mass casualties, fatalities and lack of basic services (food, water, shelter, health care). The humanitarian crisis affecting our clients is the result of the armed conflict between Russia and Ukraine, which has led nearly 7 million people to leave Ukraine and seek refuge in other countries.[19]

Intrauterine Contraceptive Device (also known as IUD, IUCD, coil): A long-acting, effective, intrauterine contraceptive device. There are two main types, one is the traditional hormone-free IUD, where a fine wire of copper, silver or gold is spirally wrapped around a plastic frame, and the other is the hormonal IUD. Hormone-releasing IUDs can significantly reduce the amount and length of menstrual bleeding, while hormone-free IUDs can increase the amount and duration of bleeding. They are recommended as a contraceptive in humanitarian crisis because they provide immediate, continuous, and long-term protection against unwanted pregnancy once inserted, and because they ideally require a single doctor's visit and a single cost.

Legal guardian (representative): A person who represents the interests and rights of another person in accordance with the law, who is responsible for protecting them and making decisions. In the context of guardianship administration, legal representatives include parents, guardians, and custodians, who represent the interests of minors or incapacitated persons.

17 See the term Family Protection Services in the Glossary

18 Order of the Ministry of Human Resources 26/2014 (IV. 8.) on prenatal care

19 According to UNHCR data from July 2024, approximately 6.74 million Ukrainians have been fleeing the war to seek asylum abroad, while a further 3.7 million have become internally displaced within the country.

Marginalized group: The term marginalized is used, along with vulnerable and disadvantaged, to describe people and communities who are socially and economically underprivileged, thus excluded from social structures and who have difficulties in integrating into society.

Medical abortion: An intervention that can be safely performed up to 12 weeks of pregnancy and is highly effective in terminating early pregnancies. A combination of two drugs is required to safely terminate a pregnancy. Both pills are included in the World Health Organization (WHO) Model List of Essential Medicines and are becoming more widely available and used around the world. This method of abortion is illegal in Hungary (PATENT, 2023).

Menstrual health: A state of complete physical, mental, and social well-being related to the menstrual cycle. This includes access to related information, menstrual supplies, adequate hygiene for the use of these supplies, health care, and an environment free from stigma and psychological stress (Erdey, Várnagy, 2022).

Mental health and psychosocial support (MHPSS): A form of assistance that addresses both the psychological and social needs of the individual. It aims to improve people's mental well-being, help them cope with stress, and support them in their social relationships and in the challenges of everyday life. Assistance can take the form of supportive conversations, counselling, but also providing information and referrals. In crisis situations, this kind of support is essential.

Non-governmental Organisation (NGO) or Civil Society Organisation (CSO): An organisation is considered to be a non-governmental organisation if it operates independently of the state and other institutions, is non-profit, i.e. its purpose is not to make a profit, and its activities are for the benefit of social good and community interests. These organisations are formed voluntarily, and their decisions do not depend on the will of other institutions. They typically rely on funding from grants and donations.

Obstetric violence: An internationally accepted term for institutional violence against women during pregnancy and childbirth. It is a multifactorial, complex violation of human rights, as well as a public health phenomenon with many negative health consequences. Obstetric violence can take many forms, including verbal, physical, psychological, or sexual violence, as well as social discrimination, stigma and prejudice, neglect, abandonment, violation of the right to privacy and self-determination, and inappropriate use of procedures and technologies. Women from disadvantaged backgrounds, with low incomes and deprived of chosen companions, suffer higher than average rates of obstetric violence.

Partner organisation: We refer to all the organisations we have worked with in our humanitarian programme, during collaborative case management, referrals, information, and experience sharing. We include national and foreign NGOs, social welfare and private health service providers, international aid agencies and church organisations.

Perinatal period: The period of childbearing, narrowly defined as the time from pregnancy to 6 weeks postpartum, and more broadly from the point the decision is made to try conceiving a child to 1 year postpartum.

Refugees: In this publication we refer to those persons who left Ukraine on or after 24th February 2022 as a result of the Russian invasion. This includes Ukrainian citizens, Ukrainian-Hungarian dual citizens and persons from third countries who were residing in Ukraine on a permanent basis before the outbreak of the war.

Sexual and Reproductive Health and Rights (SRHR): A state of physical, emotional, mental, and social well-being in relation to sexuality and the reproductive system, its functions, and processes. SRHR encompasses access to comprehensive health services, including contraception, safe abortion, prenatal care, obstetric care, prevention and treatment of sexually transmitted infections, the right to accurate information, sexuality education and bodily autonomy, and protection from gender-based violence, harmful practices and discrimination in health care settings. These rights are based on the human rights to equality and dignity. Sexual health requires a positive and respectful approach to gender and sexual relations, and the possibility of pleasurable and safe sexual experiences free from coercion, discrimination, and violence. To achieve and maintain sexual health, the sexual rights of all individuals must be respected, protected, and fulfilled[20]. Reproductive health includes the ability to have a satisfying and safe sex life, the ability to reproduce and the freedom to decide if, when, and how often to do so. Implicit in this last condition are the following – women and men to be informed of their rights; to have access to safe, effective, affordable and acceptable methods of family planning, including methods for regulation of fertility, which are not against the law; and the right of access to appropriate healthcare services to enable women to have a safe pregnancy and childbirth and provide couples with the best chance of having a healthy infant[21].

Surgical abortion: A procedure that can be safely completed in both the first trimester of pregnancy and in more advanced pregnancies and can be performed in a hospital with a gynaecological or obstetric ward by a trained doctor. It is most often performed under general anaesthesia or local anaesthesia. After dilating the cervix, the doctor uses a suction device (vacuum aspirator) to empty the contents of the uterus. The procedure takes about 15 minutes, after which the patient has to stay in hospital for a few hours for observation (PATENT, 2023).

Territory-based service provision: means that a health care provider is obliged to provide health care in a defined service area (geographical coverage) and that it cannot refuse to provide care to people living in that service area. In practice, this means, for example, that a pregnant woman living in a given municipality is obliged to receive care at the gynaecology clinic of the municipality's health centre.

20 The definition of sexual health by the European Institute for Gender Equality (EIGE)

21 The definition of reproductive health by the European Institute for Gender Equality (EIGE)

Temporary protection status (also known as Temporary Protection, TPS holder): a status offered by the countries of the European Union to people fleeing the war in Ukraine. Temporary Protection includes access to shelter, social benefits, medical care, education for children, and the possibility of working without a work permit.

Trusting relationship: A relationship between two or more people based on honesty and trustworthiness. The parties believe in each other's good intentions, can rely on each other, and feel secure in the relationship. It takes time and effort to build, but if successful, it creates a stable and supportive bond in the long term.

Unaccompanied minor: According to Section 2(f) of Act LXXX of 2007 on the Right of Asylum, an unaccompanied minor is „a foreign national under the age of eighteen who has entered Hungary without the presence of an adult person responsible for his/her supervision by law or custom, or who remains unaccompanied after entry until he/she is placed under the supervision of such person". Unaccompanied children are a highly vulnerable group and face various risks, such as becoming victims of criminal networks, violence, abuse, and exploitation[22].

Women's health: A broad term that covers health issues related to the specific biological, hormonal, and anatomical characteristics of the female body. Main areas covered:

- Reproductive and hormonal health (i.e. menstrual cycle, contraception and family planning, pregnancy and childbirth, infertility, menopause)
- Gynaecological health (i.e. vaginal infections, polycystic ovary syndrome, endometriosis, cervical cancer prevention, ovarian cysts, fibroids)
- Sexual health (i.e. sexually transmitted infections, sexual dysfunction, sexual education, and prevention)
- Mental health (i.e. anxiety and depression – especially related to hormonal changes, postpartum depression, body image disorders, eating disorders)
- General health and prevention

World Health Organization (WHO): an agency of the United Nations (UN) that acts as the coordinating authority for international public health. It aims to improve the quality of health care worldwide and to ensure the highest attainable standard of health for all.

22 European Parliament resolution of 11 March 2021 on children's rights in view of the EU Strategy on the rights of the child

5.2. FEMINIST AND CLIENT-CENTRED SOCIAL WORK

The following extract is written from the perspective of a social worker who has been directly involved in EMMA's humanitarian programme as a field worker and has experienced first-hand both the urgency of the needs and the key role of social work in addressing them. Anna Nada Péter's writing draws attention to the need for a feminist and client-centred rethinking of social work to effectively promote solidarity and justice in humanitarian crisis management, while reflecting on hierarchical relations, oppression and power inequalities (i.e. keeping them constantly and consciously in mind and seeking to mitigate their effects).

PÉTER ANNA NADA

SOCIAL WORK IN HUMANITARIAN CRISIS RESPONSE FOCUSING ON REPRODUCTIVE RIGHTS

(Extract)

EMMA Association has well-established knowledge, based on the experience of many women and its research, of the systemic sexist, violent, racist, paternalistic, bureaucratic, institution-centred practices in domestic obstetric care (EMMA Association 2014 et al.). (...) In the Humanitarian Programme, we carried out critical, women-centred social work with a focus on sexual and reproductive health. In Hungary, critical approaches in social work are marginal, with NGOs being the most prominent actors in demonstrating system-critical, micro-level good practices. One of the main obstacles to the widespread dissemination of critical practices is that most of the social workers are employed by institutions that are dependent on the ruling political-economic power, so they do not question the validity of their decisions even if they are against the interests of vulnerable social groups (Temesváry, 2020 cited in Ferguson 2009, Payne 2014: 82). (...)

In our opinion, the cumulated suffering of Roma women living in extreme poverty in Transcarpathia is the result of systemic oppressive practices, and the social work carried out in the field was also designed to counteract the discriminatory functioning of the system (...) We do not accept the general view, conveyed by the health, social and other institutions of power, that individual suffering is typically caused by individual causes and that interventions focused on changing the individual are therefore effective. (...)

Inefficient social and healthcare systems perpetuate and reproduce social inequalities. In line with a critical approach to the system, we have used advocacy and assertion skills in our work to achieve equal treatment. In our fieldwork, we have regularly encountered the problem of health workers and social welfare administrators being uninformed about refugees' entitlements – related to care – and the processes for accessing it. The protection services developed for the refugee crisis contained numerous missing components, for example, children with refugee status did not have access to all child welfare and protection services.

The principles and practices of critical feminist social work (...) specifically respond to the systemic manifestation of gendered suffering. They also challenge the approaches and techniques that are characterised by the standardisation and universalism of practices, and are best typified by professional structures organised along patriarchy and capitalist logics (...) The critical feminist perspective understands that women and members of other marginalised groups, not professionals, are the real experts in their own lives. The service recipient is therefore seen as the source of knowledge. Our guiding principle in our practice is to focus on the client's own narrative and reporting, which challenges authoritarian professionalism by allowing the purpose and framework of the help to be developed together by the social worker and the service recipient. (...).

Service recipients were not considered as vulnerable, dangerous, or inferior people. We worked in partnership and reciprocity and did not claim control over their lives. We believe that the field worker should engage in collaborative relationships in which the real imbalance of power, authority and access to resources that is perceived between different participants is made clear (Tew, 2006: 151). Communication between the social worker and the service recipient about these imbalances is necessary. This meant that we were present in the field using the essential aspect of partnership and mutuality. The experiences of the women in Transcarpathia, through the horizontal connection with them, have both enriched and shaped our professional and personal selves, as well as the principles and practices of our organisation. (...)

In individual case management, within the constraints of the programme and national support networks, we sought to help the service recipient to identify their needs and goals in relation to their sexual and reproductive health and related administrative procedures (e.g. birth registration). To the extent possible, we have worked on using empowerment and validation techniques to maximise their exercise of self-determination, awareness and control over their sexual and reproductive health and the health and well-being of their children in public and private spaces. (...)

Since its foundation, our Association has been committed to a systemic approach to the problems of social oppression and to reducing the suffering of discriminated social groups. Roma women in Transcarpathia experience racist, racialised[23] prejudice, discrimination, and violence in their daily lives in the forms of concrete social practices, patterns of behaviour, and structures. In addition to the confusing institutional interpretations of the legislation on refugee support, Roma women from Transcarpathia are regularly confronted with racist practices in the health care, social care and other social institutions, including obstruction or denial of care, low quality of care, or in other cases, lack of access to care. In several cases, they have experienced restrictions on their self-determination, repeated violations of their human dignity, and failure to provide adequate and understandable information about their own and their child's health in the course of their care. The employees of the Hungarian social and health care system are often blind to the systemic problems of the Hungarian Roma living in extreme poverty and also of the Roma refugees from Transcarpathia, and explain social, economic and political phenomena with racist beliefs and prejudices.[24] In our social work in the field with stigmatised and discriminated social groups, we have sought to reflect on social injustices (e.g. by advocacy, social sensitisation) and to reduce the suffering resulting from systemic oppressive practices (e.g. through meeting women's holistic needs). (...)

23 Racialisation and racial oppression are consistent and structural mechanisms that result in the group – in this case the Roma – being placed in an imagined hierarchical classification system based on their phenotypical, cultural, and social characteristics, and thus categorised as inferior (Angéla Kóczé, 2021).

24 One such example of these attitudes is the desire of the Roma woman to bring many children into the world. As opposed to the reality that women living in extreme poverty have virtually no access to any of the contraceptives on the market.

5.3. FIELD LOG TEMPLATE

Data

Identification code	Place of residence	Age	Citizensip
Temporary protection status (yes/no)	How we got in contact with the client first	Disability (yes/no)	Pregnancy / abortion / contraception
Date of giving birth / abortion / insertion of IUD	Method of contraception	Date of cervical screening, result	Name and contact info of ob-gyn
Name and contact info of health visitor	Hospital		

Contacts

Date	
Recorded by	
Contact	
Partner organisation (if PO is involved)	
Mode of contact	
Psychosocial support (yes/no)	
Topic of psychosocial support	
Contact	
SRH service (yes/no)	
SRH personal accompaniment (yes/no)	
Type of support in case of personal accompaniment	
Admin support (yes/no)	
Topic of admin support	
Notes (detailed logging)	
Referral related to SRH (yes/no)	
Referral related to other issue (yes/no)	
Donation of supplies (yes/no)	
Type of supplies	
Amount of donated supplies	
Costs of supplies (HUF)	
Number of invoice	
Duration of casework (in minutes)	

5.4. EMMA ASSOCIATION – CODE OF CONDUCT

The purpose of the Code of Conduct is to provide guidance to the members, staff, and volunteers (hereinafter referred to as "Staff") of the EMMA Public Benefit Association (hereinafter referred to as "Association") in the performance of their work. The guidelines also provide guidance in cases where they encounter a dilemma that raises a professional, ethical issue and where they are not bound by the law.

The Code of Conduct applies to both the behaviour and communication between the Association's Staff and clients who encounter the Association (hereinafter referred to as Client). It also contains guidelines relating to the values of universal ethics for staff not directly involved in providing support, and to the values of the helping profession for facilitators, counsellors and team leaders in their professional work. The Code of Conduct is not a substitute for the professional operating conditions of our work.

All representatives of the Association must be aware of the Association's principles and their responsibility for the safety of adults and children who come into contact with the Association and must sign and adhere to the Association's Code of Conduct, Safeguarding Policy and Protocol and a Data Protection Document.

All staff are responsible for encouraging and promoting the implementation of the Code of Conduct.

Mission Statement

EMMA Association is a national women's organization, which works for the fundamental rights and societal equality of women, paying special attention to gender-based oppression, violence against women during the childbearing and childrearing period, and sexual and reproductive health and rights (SRHR), on the individual, community, and social level, with a special focus on vulnerable groups of women.

We believe that childbirth is an opportunity for the development of both the individual and the society. The Association's mission is to support women in recognising and living this potential, bringing women's experience to the forefront and encouraging society to ensure equality and choice regardless of gender, class or social status. We also believe that the free exercise of sexual and reproductive rights is a right for all people, and we work to ensure that all women have access to safe and dignified gynaecological care, contraception, maternity care, and abortion.

All our staff and volunteers who work for the Association contribute to this goal.

Core Values

CREDIBILITY: An expression of feelings and thoughts that is in harmony with the inner experience and considers the outer world.

FREEDOM: To exist and function free from fear and constraint.

ACCEPTANCE: Considering, acknowledging, and respecting individual, family, group, and community differences without judgement.

JOY: A source of energy that provides emotional well-being.

Through living our values, we support and empower each other and our fellow women. In this way, we contribute to making sisterhood and solidarity between women (both vertically and horizontally) a resource for the development of society.

Principles

1. **Respect for personal autonomy as an expression of the value of FREEDOM.**

   Staff respect the value, will, dignity, uniqueness, and rights of all people. The Association will not tolerate any form of abuse of power, either within the organisation or between the organisation's Staff and its Clients or Partners.

   The Association's Staff shall not abuse their formal or informal position, nor shall they use their position in the Association for their own purposes, neither with their colleagues nor with Clients and Partners. In our work, we always strive to create an environment of partnership and security. Thus, in the course of our work, we do not set unrealistic expectations for our Staff or expectations that are not necessary for the performance of the work, we do not make excessive or unjustified demands, we do not create an intimidating working environment, and we do not tolerate humiliation or violent communication.

   The Association supports the health and safety of its Staff. The physical and mental health of our Staff is a priority in our work, so we consider individual life situations (especially those related to having and raising children) when defining responsibilities and tasks, and we provide regular supervision according to the extent of our resources.

2. **Justice, ACCEPTANCE free from all discrimination and politics.**

   The Association's mission is to ensure that all women are free to exercise their sexual and reproductive rights, and we hold non-discrimination and equality as core values. Staff members must not discriminate against any person or group of people, regardless of gender, sexual orientation, gender identity, age, social status, ethnicity, religion or belief, disability or health status, and must act without discrimination of any kind.

   The Association is committed to creating and maintaining a women-centred, mother- and child-friendly, breastfeeding-friendly workplace. In employing and providing working conditions for our employees, our policy is to ensure that motherhood and work are compatible for our employees. In all cases, we provide the opportunity for the

child to stay with the mother if the mother wishes to do so, and childcare is provided where necessary, depending on our resources.

The Association also takes into account the needs of staff working in rural areas. It selects the venues for its various programmes and events (training courses, retreats, meetings) to suit both colleagues in the Capital and those in Eastern Hungary and provides online access where necessary.

3. Taking care of our own physical and mental health and personal well-being, which gives us the ability to experience JOY in our work.

In the activities of the Association, all Staff members shall endeavour to ensure that their own physical and mental health does not prevent them from helping others or from carrying out their work. The Association offers supervision where possible, initiates encounter groups and pays special attention to the symptoms of burnout. Social/Support Workers have regular case meetings where they receive emotional and professional support and can report their work-related needs to their supervisors. The Association also provides, depending on its resources, recreational programmes, organisational development, and professional training to facilitate the smooth running of the work.

4. Professional principles and values that support the preservation of CREDIBILITY in our work.

Social reflection

In our work with vulnerable groups, we place particular focus on building partnerships, doing our best to establish an equal relationship with our clients. Our work is based on the principles of critical, anti-oppressive social work, considering existing social hierarchies.

Respecting the scope of competence

The professionals and volunteers who work in the Association as helpers, advisers and consultants take responsibility for their professional work. They are aware of the impact of their activities on the lives of their clients and therefore carry out their work to the best of their ability.

They are aware of the opportunities and limitations of their expertise. They only undertake tasks that are within their scope of competence, based on their studies and professional experience. Otherwise, they seek supervision or delegate their tasks to others. They may terminate the assisting relationship on professional grounds and/or in case of conflict of interest if they arrange for further professional assistance to the Client.

Where necessary, they will seek professional advice or refer the Client to an appropriate professional.

Do no harm, or the principle of beneficence

Our support workers' main ambition is to help others and avoid harm. In their work, they always have their clients' best interests at heart.

The Client decides

The cooperation between the client and the facilitator is based on trust, honesty, and respect for the client's autonomy. The facilitator relationship should aim to establish an equal, partner-like relationship with the client. In all cases, the client makes their own choices and decisions during the supportive conversation, whether it is about the process or about the life situation or the ways to solve the difficulty.

Tailored services

The counsellor or helper provides professional care that meets the specific needs and values of the individual. She provides information that is objective and does not reflect her own opinion, describing in detail the possible outcomes, consequences, advantages, and disadvantages of each option. The information provided must always consider the personal preferences and life situation of the client, which means that it must be personalised. This is explored through a thorough interview. The information provided must therefore be adequate to enable the client to make their own informed decision.

The work of the counsellor is based on scientific principles, up-to-date research findings and information.

The pace is up to the client, their boundaries and decisions must be respected, but we cannot support a decision that is against the law.

Offer an accompaniment

There should always be an opportunity for the client to reconnect with the professional or volunteer. The helper should respond to requests as soon as possible, within 24 hours on working days, depending on the helper's working hours, and if she is unavailable for any reason, such as holidays, she should inform the client in advance and indicate who to contact for help during this period.

Empowerment

The long-term goal of our work is to empower our beneficiaries to strengthen their own knowledge, capacity, and agency. We work to ensure that our beneficiaries gain new information and experience from engaging with the Association, which they can use after the end of our work together.

Creating a professional working group, team work

Staff members share their knowledge, practical experience, professional information and ethical dilemmas and discuss them together. They seek to cooperate with professionals in their own and related fields to best carry out their tasks. They shall initiate cooperation in cases where they recognise the limitations of their own academic or professional competence.

In their interactions with other professionals or colleagues, they respect their competences, their different opinions and working methods. Criticism is expressed only in a constructive and purposeful way, with recognition of strengths and involvement of the person concerned.

Self-training

Staff involved in helping relationships will call on the services of specialists, experts or consultants with specific knowledge, as necessary, if the task at hand is beyond their competence. At the same time, they are expected to continue their professional and ethical development in their respective fields. In their professional and educational activities, they will always endeavour to apply the most up-to-date professional practices. They keep up with the developments in their profession in order to maximise the opportunities offered by academic progress. Within the limits of its resources, the Association organises training courses for its staff when a working group indicates its need.

Quality assurance

The development of quality assurance is a long-term task for the Association.

Confidentiality

All activities are carried out with the maximum possible discretion, which is also our policy at events and in all forms of public communication.

The protection of personal data of Clients, Employees and donors and supporters (hereinafter referred to as „Donors") is also in line with the General Data Protection Principles of the European Union in force at the time, in accordance with the Association's Data Protection Statement. The identity of the Association's Staff and Donors will be disclosed only with their consent and in a manner acceptable to them.

Staff members working in the Association are bound by a strict confidentiality obligation. Confidentiality shall also apply in the relationship between the Association and the Client, the Association and the Co-worker, the Co-worker and the Client, and the Co-worker and the Co-worker.

Experts who provide individual counselling, facilitate peer support groups and participate in training are obliged to maintain confidentiality towards the Client. The only exceptions to this rule are cases of publication, participation in research, supervision, case conferences or training, where the Client has given their specific consent.

Public appearances, publications

Appearances and publications in the media, at conferences, in academic articles in connection with the activities of the Association may only be made in respect of the Association's core values and the Code of Conduct, with the Association's name, and in agreement with the Association's Management, the communications staff and the relevant project leader.

Our staff also undertake to follow the Association's core values, Safeguarding Policy and Code of Conduct in their public appearances outside the Association.

Guidelines on ethical issues and conflicts

Managing misconduct – Zero tolerance

Cooperation, trust and respect are fundamental values in the relationship between colleagues. The members, volunteers and staff of the Association actively and explicitly represent, at all levels, the fundamental rights and values of human freedom, dignity, and non-violence. Our core values are based on the principle of zero tolerance for discrimination, harassment, abuse of power, sexual abuse, emotional or physical violence and child abuse. Our position and procedures on these offences are detailed in our Safeguarding Policy and Protocol.

Conflict of interest

Staff members and volunteers shall refrain from using their official position or any information obtained during their work to secure personal gain or benefit for themselves.

Employees and staff members should put organizational goals and the best interests of the entire program before personal goals in their work related activities.

Conflict Prevention

The Association operates and takes decisions by consensus. It is our firm belief that a great deal of conflict of interest can be prevented as a result of the painstaking work of consensus building.

Conflict Resolution

The Association sees conflict as an opportunity for development. Accordingly, our basic aim in dealing with conflicts is not to shame and punish, but to restore balance between the parties involved.

In the event of conflict, the Association's Statutes, Mission Statement, Code of Conduct, Safeguarding Policy and the Safeguarding Protocol and the Strategic Plan approved by the General Assembly shall prevail. The principles of mediation are followed in the resolution of conflicts.

Any staff member of the Association who knowingly, unjustifiably and disproportionately obstructs the effective functioning of the Association, or who deliberately disregards or acts against the interests of the Association, shall be considered to have committed an ethical offence and shall be subject to ethical proceedings.

5.5. EMMA ASSOCIATION – SAFEGUARDING POLICY

on Misconduct related to Sexual Harassment, Exploitation & Abuse, and Child Abuse

Background

We at Emma Association recognise that all human beings are born free and equal. We are attentive to the moral and personal values, religion, customs, traditions and culture of the communities we serve. We do not violate human rights, and we are honest and fair with the people we seek to empower, our donors, our staff, our membership and partners, our government institutions and the public at large.

We reject any form of offence against human dignity, discrimination, harassment in the workplace or abuse of power in the work environment. The organisation aims to provide its employees and contractors with a safe working environment, free from abuse of power and harassment, based on mutual respect for human dignity. To this end, this Safeguarding Policy ensures that whistleblowers and those who make a complaint or report have an appropriate forum to seek and receive assistance. The Code of Conduct respects the principle of presumption of innocence and its rules are based on the fundamental constitutional right to due process.

Safeguarding is about promoting and safeguarding people's health, wellbeing and human rights, and preventing exploitation and abuse. This approach means that all throughout the activities of Emma Association, we identify and minimise the risk of harm to vulnerable children and adults from staff, representatives and partners, and includes responding appropriately to safeguarding concerns about children and vulnerable people in the communities where we work. This includes a wide range of policies, procedures and activities to address safety and wellbeing.

Purpose

The purpose of this policy is to protect people, particularly children, at-risk adults and beneficiaries of assistance, from any harm that may be caused due to their coming into contact with Emma Association. This includes harm arising from:

- The conduct of staff or personnel associated with Emma Association
- The design and implementation of Emma Association's programmes and activities

The policy lays out the commitments made by Emma Association and informs staff and associated personnel of their responsibilities in relation to safeguarding.

What is safeguarding?

The measures we take to prevent, report and respond to harm or abuse and to protect the health, well-being and human rights of anyone that comes into contact with Emma Association, whether it is Emma Association employees and related personnel, partners, program participants and communities.

This means that during our activities we identify and minimise the risk of harm to children and adults at risk from staff, representatives and partners, and includes responding appropriately to safeguarding concerns about children and adults at risk in the communities where we work. This covers a wide range of policies, procedures and activities to address safety and wellbeing.

Principles of safeguarding

Emma is dedicated to follow the principles of safeguarding in all settings, for all adults and children involved in or affected by the activities of Emma Association.

1. **Empowerment:** People being supported and encouraged to make their own decisions and informed consent.
2. **Prevention:** It is better to take action before harm occurs.
3. **Proportionality:** The least intrusive response appropriate to the risk presented.
4. **Protection:** Support and representation for those in greatest need.
5. **Partnership:** Local solutions through services working with their communities. Communities have a part to play in preventing, detecting and reporting neglect and abuse.
6. **Accountability:** Accountability and transparency in safeguarding practice.

Scope

This policy applies to all Emma Association employees and related personnel:

- All staff contracted by Emma Association
- Related personnel includes board members, volunteers, interns, visitors and international and local consultants, in addition to individual and corporate contractors of these entities and related personnel.

This policy is intended as a guide and commitment for Emma Association's employees and related personnel considering the standards set by local laws and regulations and the standards of inter-agency policies of humanitarian organizations, including the policies of the United Nations Standing Committee for protection from sexual exploitation and abuse in humanitarian response.

Policy Statement

Emma Association believes that everyone we come into contact with, regardless of age, gender identity, disability, sexual orientation or ethnic origin has the right to be protected from all forms of harm, abuse, neglect and exploitation. Emma Association will not tolerate abuse and exploitation by staff or associated personnel.

Emma Association recognises we have a responsibility to protect people we work with, and who work for us, and we will continuously strive to prevent sexual harassment, exploitation and abuse and child abuse from happening. We take seriously all reports of sexual harassment, exploitation and abuse, and child abuse.

Emma Association has a zero-tolerance approach toward sexual harassment, exploitation and abuse, and child abuse. We will carefully examine allegations and investigate, and take appropriate disciplinary action where this is needed, taking into consideration the rights and interests of the survivor. We make very clear that sexual harassment, exploitation and abuse, and child abuse in any form, perpetrated by our staff, partners or other related personnel, towards anyone, will not be tolerated.

Emma Association commits to addressing safeguarding throughout its work, through the three pillars of prevention, reporting, and response.

All employees of Emma Association and related personnel are aware of and act accordingly:

1. "Sexual exploitation and abuse by humanitarian workers constitute acts of gross misconduct and are therefore grounds for termination of employment.
2. Sexual activity with children (persons under the age of 18) is prohibited regardless of the age of majority or age of consent locally. Mistaken belief regarding the age of a child is not a defence.
3. Exchange of money, employment, goods, or services for sex, including sexual favours or other forms of humiliating, degrading or exploitative behaviour is prohibited. This includes exchange of assistance that is due to beneficiaries.
4. Any sexual relationship between those providing humanitarian assistance and protection and a person benefitting from such humanitarian assistance and protection that involves improper use of rank or position is prohibited. Such relationships undermine the credibility and integrity of humanitarian aid work.
5. Where a humanitarian worker develops concerns or suspicions regarding sexual abuse or exploitation by a fellow worker, whether in the same agency or not, he or she must report such concerns via established agency reporting mechanisms.
6. Humanitarian workers are obliged to create and maintain an environment which prevents sexual exploitation and abuse and promotes the implementation of their code of conduct. Managers at all levels have particular responsibilities to support and develop systems which maintain this environment" [25]

25 IASC Six Core Principles | IASC / PSEA interagencystandingcommittee.org

Responsibilities

Emma Association will:

- Make every effort to promote, create and maintain a safe organizational culture for all people who work for and with Emma Association, including our partners and the communities where Emma Association works.
- Develop organization-specific safeguarding strategies, with appropriate levels of dedicated capacity and allocated resources at all levels of the organization, to prevent and respond to sexual harassment, exploitation and abuse, and child abuse.
- Seek to employ staff who are aligned with our vision, mission and values, and, in compliance with applicable laws, prevent known perpetrators of sexual harassment, exploitation and abuse and child abuse from being (re)hired or (re)deployed.
- Ensure all staff have access to, are familiar with, and know their responsibilities within this policy.
- Design and undertake all its programmes and activities in a way that protects people from any risk of harm that may arise from their coming into contact with Emma Association. This includes the way in which information about individuals in our programmes is gathered and communicated.
- Ensure that multiple mechanisms for reporting sexual harassment, exploitation and abuse, and child abuse are accessible and sensitive to the differing needs of anyone wishing to report, including vulnerable adults and children most at risk of sexual harassment, exploitation and abuse, and child abuse, the communities we work with, our partners, and Emma employees and related personnel.
- Ensure staff receive training on safeguarding at a level commensurate with their role in the organization.
- Follow up on reports of safeguarding concerns promptly and according to due process.

As an Emma Association Employee or Related Personnel, I will not:

- Sexually harass, exploit or abuse anyone and understand that these behaviours constitute acts of gross misconduct and are therefore grounds for disciplinary and/or legal action, up to and including dismissal.
- Engage in any form of sexual activity or develop physical/sexual relationships with children (persons under the age of 18) regardless of the age of consent locally. I understand that ignorance or mistaken belief in the age of a child is not a defence. I acknowledge that regardless of the legal age under local laws, relationships of this nature with individuals under the age of 18 are contrary to the organization's image and accepted standards of conduct for humanitarian activists of international organizations.
- Exchange money, employment, goods, or services for sex, including sexual favours or other forms of humiliating, degrading or exploitative behaviour. I understand this means I must not buy sex from anyone at any time, or exchange assistance that is due to programme participants / beneficiaries for sex. I acknowledge that the need to refrain

from such behaviour is determined by the framework of generally accepted standards of conduct for humanitarian activists, as well as by the provisions of Hungarian criminal law.

- Engage in any sexual activity or sexual relationship with program participants. I am aware that such relationships are strictly discouraged. I understand that such relationships may be acknowledged as based on an improper use of my position and inherently unequal power dynamics and may undermine the credibility and integrity of Emma's work. I understand I must declare any doubts concerning an influence of previously existing relationships with programme participants to the Complaints Handling Committee (which includes the Program Director (as line manager) and the Executive Director (as employer); and if needed, another Board Member will be involved who is not involved in the Program).
- Request any service or sexual favour from participants of Emma programs, children or others in the communities in which Emma works, and will not engage in sexually harassing, exploitative or abusive relationships. I acknowledge that the need to refrain from such behaviour is determined by the framework of generally accepted standards of conduct for humanitarian activists, as well as by the provisions of Hungarian criminal law.
- Support or take part in any form of sexually exploitative or abusive activities, including, for example, child pornography, trafficking of human beings or child marriage.
- Hire children for domestic or other labour, which is inappropriate given their age or developmental stage, which interferes with their time available for education and recreational activities or which places them at significant risk of injury or exploitation.
- Use language or behaviour towards children that is inappropriate, harassing, abusive, sexually provocative, demeaning or culturally inappropriate.

Child safeguarding

Emma Association's staff and associated personnel must not:

- Engage in sexual activity with anyone under the age of 18,
- Sexually abuse or exploit children,
- Subject a child to physical, emotional or psychological abuse, or neglect,
- Engage in any commercially exploitative activities with children including child labour or trafficking.

Adult safeguarding

Emma Association's staff and associated personnel must not:

- Sexually abuse or exploit at risk adults,
- Subject an at-risk adult to physical, emotional or psychological abuse, or neglect.

Protection from sexual exploitation and abuse

Emma Association's staff and associated personnel must not:

- Exchange money, employment, goods or services for sexual activity. This includes any exchange of assistance that is due to beneficiaries of assistance.
- Engage in any sexual relationships with beneficiaries of assistance since they are based on inherently unequal power dynamics.

Additionally, Emma Association's staff and associated personnel are obliged to:

- Contribute to creating and maintaining an environment that prevents safeguarding violations and promotes the implementation of the Safeguarding Policy.
- Report any concerns or suspicions regarding safeguarding violations by an Emma Association's staff member or associated personnel to the appropriate staff member.

This Policy is consistent with existing national laws and protocols, in particular:

- Act XXXI of 1997 on child protection and guardianship administration (1997. évi XXXI. törvény a gyermekek védelméről és a gyámügyi igazgatásról)
- Act CXXV. of 22 December 2003 on equal treatment and promotion of equal opportunities (2003. évi CXXV. törvény az egyenlő bánásmódról és az esélyegyenlőség előmozdításáról)
- Act C of 2012 on the Criminal Code (2012. évi C. törvény a Büntető Törvénykönyvről), especially:
  - Act C of 2012, § 195: Coercion (2012. évi C törvény 195. §: Kényszerítés)
  - Act C of 2012, § 196: Sexual coercion (2012. évi C törvény 196. §: Szexuális kényszerítés)
  - Act C of 2012, § 197: Sexual violence (2012. évi C törvény 197. §: Szexuális erőszak)
  - Act C of 2012, § 198: Sexual abuse (2012. évi C törvény 198. §: Szexuális visszaélés)
  - Act C of 2012, § 200: Procuring (2012. évi C törvény 200. §: Kerítés)
  - Act C of 2012, § 201: Facilitating prostitution (2012. évi C törvény 201. §: Prostitúció elősegítése)
  - Act C of 2012, § 202: Living on the earnings of prostitution (2012. évi C törvény 202. §: Kitartottság)
  - Act C of 2012, § 203: Exploitation of child prostitution (2012. évi C törvény 203. §: Gyermekprostitúció kihasználása)
  - Act C of 2012, § 204: Offering, handing over, making available, making, placing on the market, trading in, or making accessible to a large audience a pornographic recording of a person who has not attained the age of eighteen years (2012. évi C törvény 204. §: Gyermekpornográfia)
  - Act C of 2012, § 222: Harassment (2012. évi C törvény 222. §: Zaklatás)

All employees of Emma Association and related personnel are obligated to always adhere to the policy, 24 hours a day, 7 days a week.

Enabling reports

Emma Association will ensure that safe, appropriate, accessible means of reporting safeguarding concerns are made available to staff and the communities we work with.

Emma Association will also accept complaints from external sources such as members of the public, partners and official bodies.

How to report a safeguarding concern

Staff members who have a complaint or concern relating to safeguarding should report it immediately to their Safeguarding Focal Point or line manager. If the staff member does not feel comfortable reporting to their Safeguarding Focal Point or line manager (for example if they feel that the report will not be taken seriously, or if that person is implicated in the concern) they may report to any other appropriate staff member. For example, this could be a senior manager.

If you have experienced any abuse (physical, sexual, emotional), harassment, discrimination or other concerning behaviour in relation to the work or operation of EMMA Association, or if you wish to provide any other feedback, you can report it anonymously through the following channels.

Phone/Viber/Whatsapp: +36 70 561 8006
Email: uzenet@emmaegyesulet.hu

Response

Emma Association's will follow up safeguarding reports and concerns according to policy and procedure, and legal and statutory obligations (see Procedures for reporting and response to safeguarding concerns in Associated Policies).

Emma Association will apply appropriate disciplinary measures to staff found in breach of policy.

Emma Association's will offer support to survivors of harm caused by staff or associated personnel, regardless of whether a formal internal response is carried out (such as an internal investigation). Decisions regarding support will be led by the survivor.

Confidentiality

It is essential that confidentiality is maintained at all stages of the process when dealing with safeguarding concerns. Information relating to the concern and subsequent case management should be shared on a need-to-know basis only and should be always kept secure.

Associated policies

- Code of Conduct
- Safeguarding Protocol – Procedures for reporting and response to safeguarding concerns

Glossary of Terms

1. A Child/Young Adult

A child/young adult is any individual under the age of 18, irrespective of local country definitions of when a child/young adult reaches age of majority.[26] Wherever and whenever this Policy refers to a child, it should also be understood to mean a young adult under the age of 18.

2. Adults experiencing vulnerability / Adults at-risk

Anyone 18 years or over who:

- is unable to take care of themselves/ protect themselves from harm or exploitation; or
- due to their gender, mental or physical health, disability, ethnicity, religious identity, sexual orientation, economic or social status, or as a result of disasters and conflicts, are deemed to be at risk;
- is in a situation of subordination and therefore experiencing a power differential putting them at risk.

3. Beneficiary of Assistance

Someone who directly receives goods or services from Emma Association's programme. Note that misuse of power can also apply to the wider community that the Emma Association serves, and also can include exploitation by giving the perception of being in a position of power.

4. Sexual Harassment[27]

Sexual harassment is any unwelcome sexual advance, request for sexual favour, verbal or physical conduct or gesture of a sexual nature, or any other behaviour of a sexual nature that might reasonably be expected or be perceived to cause offence or humiliation to another, when such conduct interferes with work, is made a condition of

26 Definition of child from the Inter-Agency Standing Committee (IASC) Guidelines to implement Minimum Operating Standards for Protection from Sexual Exploitation and Abuse by UN and non-UN Personnel, March 2013.

27 Definition of "sexual harassment" from the United Nations Secretary-General's bulletin: Prohibition of discrimination, harassment, including sexual harassment, and abuse of authority (ST/SGB/2008/5).

employment or creates an intimidating, hostile or offensive work environment. While typically involving a pattern of behaviour, it can take the form of a single incident.

5. Sexual Exploitation[28]

Sexual exploitation means any actual or attempted abuse of a position of vulnerability, differential power, or trust, for sexual purposes, including, but not limited to, profiting monetarily, socially or politically from the sexual exploitation of another.

6. Sexual Abuse

Sexual abuse means the actual or threatened physical intrusion of a sexual nature, whether by force or under unequal or coercive conditions..

7. Child Exploitation and Abuse (involves one or more of the following)

a. Physical abuse

Physical abuse occurs when a person purposefully injures or threatens to injure a child. This may for instance, take the form of slapping, hitting, punching, shaking, kicking, beating, burning, shoving or grabbing. Physical abuse can be a single or repeated act. It doesn't always leave visible marks or injuries.

b. Emotional abuse

Emotional abuse is inappropriate verbal or symbolic acts toward a child or a pattern of failure over time to provide a child with adequate non-physical nurture and emotional availability. Such acts have a high probability of damaging a child's self-esteem or social competence.

c. Neglect

Neglect is the failure to provide a child (where they are in a position to do so) with the conditions that are culturally accepted as being essential for their physical and emotional development and well-being.

d. Sexual Misconduct with a Child

Sexual Misconduct with a Child is any form of sexual activity with a child. It is evidenced by an activity between a child and an adult or another child who by age or development is in a relationship of responsibility, trust or power, the activity being intended to gratify or satisfy the needs of the other person. It may include, but is not limited to, contact or non-contact activities, the inducement or coercion of a child to engage in any sexual activity, the use of a child in prostitution or other sexual practices, or exposing a child to online sexual exploitation material, the use of children in pornographic performances and materials, or taking sexual exploitative images of children.

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28 Definitions of "sexual exploitation" and "sexual abuse" from the United Nations Secretary General's Bulletin: Special measures for protection from sexual exploitation and sexual abuse (ST/SGB/2003/13).

8. Grooming

a. Grooming generally refers to behaviour that makes it easier for an offender to procure a child or vulnerable adult for sexual activity. It often involves the act of building the trust of children and/or their carers or a vulnerable adult, to gain access to them in order to sexually abuse them. For example, grooming includes the provision of, or attention paid to a specific child or adult, providing gifts, money, drugs or alcohol to them, encouraging romantic feelings or exposing them to sexual concepts through conversation or exposure to pornography.

b. Online grooming is the act of sending an electronic message, series of messages or engaging over an online platform with content that may be of an indecent nature, with the intention of procuring the recipient to engage in or submit to sexual activity with another person, including but not necessarily the sender.

Both children and vulnerable adults can be victims of grooming and online grooming, with children being particularly targeted by online groomers.

9. Protection from Sexual Exploitation and Abuse (PSEA)

The term is used by the humanitarian and development community to refer to the prevention of sexual exploitation and abuse of affected populations by staff or associated personnel. The term derives from the United Nations Secretary General's Bulletin on Special Measures for Protection from Sexual Exploitation and Abuse (ST/SGB/2003/13).

10. Safeguarding

The measures we take to prevent, report and respond to harm or abuse and to protect the health, well-being and human rights of anyone that comes into contact with Emma Association, whether it is Emma Association Employees and Related Personnel, partners, program participants and communities.

Safeguarding means taking all reasonable steps to prevent harm, particularly sexual exploitation, abuse and harassment from occurring; to protect people, especially vulnerable adults and children, from that harm; and to respond appropriately when harm does occur.

This definition draws from our values and principles and shapes our culture. It pays specific attention to preventing and responding to harm from any potential, actual or attempted abuse of power, trust, or vulnerability, especially for sexual purposes.

Safeguarding applies consistently and without exception across our programmes, partners and staff. It requires proactively identifying, preventing and guarding against all risks of harm, exploitation and abuse and having mature, accountable and transparent systems for response, reporting and learning when risks materialise. Those systems must be survivor-centred and also protect those accused until proven guilty.

Safeguarding puts beneficiaries and affected persons at the centre of all we do.

11. Survivor

The person who has been abused or exploited. The term “survivor” is often used in preference to “victim” as it implies strength, resilience and the capacity to survive, however it is the individual’s choice how they wish to identify themselves.

12. Volunteer

Persons from the local community where Emma Association is working and who undertake tasks for Emma Association on a voluntary nature.

13. Visitors

Refers to a range of persons who are visiting Emma Association offices or programs, including donor representatives, journalists, media, researchers, celebrities, family members.

5.6. EMMA ASSOCIATION – SAFEGUARDING PROTOCOL

on Misconduct related to Sexual Harassment, Exploitation & Abuse, and Child Abuse

Background

EMMA Association is a national women's organization, which works for the fundamental rights and societal equality of women, paying special attention to gender-based oppression, violence against women during the childbearing and childrearing period, and sexual and reproductive health and rights (SRHR), on the individual, community and social level, with a special focus on vulnerable groups of women.

Main activities of EMMA Association:

- **EMMA Helpline:** anonymous helpline service for women facing difficulties in maternity care and motherhood;
- **EMMA Hubs:** a safe space for women to promote social justice and solidarity;
- **Community Network of Female Companions:** providing support to Roma women with regards to sexual and reproductive health and rights, specifically to promote access to maternity care and contraception;
- **Women living in homelessness:** training professionals to provide trauma-informed care;
- **Social activism:** turning personal experiences into community-building and social activism;
- **Research:** promoting systemic change through research on women's experiences;
- **Humanitarian Program:** case management focusing on sexual and reproductive health and rights for refugee women and girls.

The employees and related personnel of EMMA Association are not child protection professionals, but we want to provide a framework and effective tools for the prevention of sexual harassment, exploitation, and abuse of children, to ensure that all employees and related personnel act and behave in the full spirit of this safeguarding protocol, and to be guided by this attitude in all aspects of their work.

Principles

1. **Support**
    - Support and promote the development and fulfilment of children and young people.
    - Ensure the right to safety and security.

2. **Prevention**
   - Reduce the risk of child abuse through awareness raising, good practice development and training, and taking all positive steps possible to protect children.
   - Ensure that all staff are aware of the steps and processes needed to protect children.
   - Respond appropriately to abuse of children.
3. **Support through training**
   - Ensure that all staff are aware of their obligations to comply with the requirements set out in the safeguarding policy, protocol and other relevant rules.
4. **Partnership**
   - EMMA Association works in partnership with its partner institutions, their professionals and other actors in the child protection system (in particular the child protection referral system), bearing in mind that reconciling different perspectives and thinking together helps to ensure the most effective management of cases.
5. **Compliance with laws and regulations**
   - Commitment to complying with all relevant international and national legislation
6. **Follow-up and review**
   - Monitor and regularly review protocols, policies and practices relating to children to identify and address any gaps and to comply with relevant legislative changes.
7. **Safe data management, and confidentiality**
   - Keep children's personal and all sensitive data confidential.
8. **Transparency**
   - All decisions and activities of EMMA Association are transparent to ensure the protection of children.
9. **Zero tolerance**
   - EMMA Association condemns and rejects all forms of child abuse, exploitation, harassment, bullying and mistreatment. It strives to create a safe environment and community in all of its activities.
10. **Enforcement guarantee**
    - All complaints received about violations of the rights of persons associated with the organisation will be investigated and appropriate action will be taken, which will be communicated transparently and clearly to the persons concerned.

Purpose

The purpose of this Safeguarding Protocol is to:

- Clarify what happens in case of a breach of the Safeguarding Policy: an allegation on a misconduct related to sexual harassment, exploitation or abuse perpetrated toward or by the Emma Association staff and/or the related personnel as defined by the Safeguarding Policy.

- Present the complaint mechanisms available for reporting and the investigation process and possible consequences.
- Sets out a list of safeguarding measures for the prevention, detection and identification of situations of vulnerability and the necessary steps to be taken

Scope

The Protocol applies to all Emma Association employees and the related personnel who are required to report any misconduct related to SHEA (please find the definitions and regulations in the Safeguarding Policy) they have experienced, witnessed or heard about, whether in EMMA or outside, regardless of when the incident occurred. Even suspicions or rumours have to be reported. All complaints will be reviewed and addressed, but not all will require a formal investigation process. During the entire process, legal obligations will be considered according to the local laws. False or malicious complaints will be treated with the same resolution as factual and genuine dispositions. For the reports that are found to be malicious, the complainant will have to face the same consequences (a potential disciplinary action), as subjects of complaint found guilty of their misconduct.

The Reporting & Investigation Process

- **Feedback Focal Person:** This EMMA staff member will receive all complaints/feedback. She records the feedback in the central feedback database, classifies them according to the feedback category, refers them to the designated staff member and monitors the progress until a response is provided and the entry is closed. She will attend all the relevant training sessions provided by CARE.
- **Safeguarding Focal Person:** She will be responsible for all sensitive concerns and reports and handles them in accordance with relevant SOP. She will attend all the relevant training sessions provided by CARE and be responsible for organizing training sessions for all staff members.
- **Complaints Handling Committee (CHC):** The CHC includes the Program Director (as line manager) and the Executive Director (as employer). If needed, another Board Member will be involved (who is not involved in the Program). Following the investigation of complaints, the CHC decides on the appropriate actions.
- **Investigation Team:** The investigation team is responsible for managing sensitive issues and includes the Safeguarding Focal Person and the Executive Director. Based on the nature of the complaint other specialized team members or external experts may be included in responding to sensitive issues.

Feedback and complaints are categorized based on the level of response required, their urgency and who will be responsible for processing it.

Level	Category	Description	Forwarded to & CC'ed	Response and closing time frame
1	Expression of gratitude.	A positive expression or appreciation about the assistance received.	Recorded in the database.	Acknowledge within four weeks and shared in the accountability report.
E.g. A young woman sends a "thank you" message through Viber after receiving an assistance.				
2	Suggestion for improvement.	An idea or plan put forward for consideration on how to improve a service and/or activity.	Program Director	Acknowledge and respond within six to eight weeks.
E.g. A woman suggests through VIBER to include some supplies into our supply list.				
3	Request for information.	A question asked to the organization to get more information about available services.	Program Director	Acknowledge and respond within two weeks.
E.g. A woman asks about access to dentistry.				
4	Request for assistance.	Someone expresses a need for support from the organization.	Program Director	Acknowledge and respond within four to six weeks.
E.g. A beneficiary requests for filing a complaint against a health institution.				
5	Minor dissatisfaction with services/ aid providers.	An expression of discontent that does not have serious implications or long-term consequences for a person or group of people.	Program Director	Acknowledge and respond within four weeks.
E.g. Beneficiary reported that she is not satisfied with the hygiene supplies.				
6	Major dissatisfaction with services/ aid provided and security issues.	Expression of discontent or report of a situation that can have serious negative impact, pose safety threats or generate serious longer-term consequences for a person or group of people.	Program Director	Acknowledge and respond within two weeks.
E.g. Some beneficiaries noted aggressive behaviour during supply distribution.				
7	Report of violence, protection concern.	An allegation or suspicion of violence, intimidation or protection issue that occurred within the community we work in; not involving EMMA staff or volunteers.	Program Director	Acknowledge and respond within two weeks, depending on sensitivity of report.
E.g. Report that a teacher has used corporal punishment towards a student who came late to class.				
8	Sensitive concerns.	An allegation of misconduct by EMMA staff including sexual harassment, exploitation and abuse, fraud, corruption and other breaches of Code of Conduct.	Complainants Handling Committee. Safeguarding focal point.	Acknowledge within three days maximum, respond/update every two weeks until conclusion.
E.g. A community member reported that a social worker threatened her withdrawing support if the woman terminates her pregnancy.				

0	Out of scope.	Feedback or requests for assistance that falls outside the activities of EMMA or where EMMA can realistically intervene. Feedback regarding other NGOs should be accepted and systematically referred. Where no possible referral path exists, this should be explained and regularly reinforced.	Program Manager	Acknowledge within four weeks; referral if appropriate.
E.g. A man was looking for a recruitment agency.				

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