STANDARD OPERATING PROCEDURES FOR GBV INTERVENTIONS IN HUMANITARIAN SETTINGS

POLAND

Developed collaboratively among GBV sub-working group members

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SECTION 1: INTRODUCTION

These Gender Based Violence Standard Operating Procedures (GBV SOPs) have been developed to facilitate collaborative action to respond to, mitigate and prevent GBV against all GBV survivors in Poland.

These GBV SOPs, were developed through a collaborative process among representatives of various actors involved in the response including UN agencies, international and national non-governmental organisations (INGOs, NNGOs), women-led and women rights organisations (WLO, WRO).

These GBV SOPs, are intended to serve as preliminary SOPS and will be updated in 6 months to reflect changes in the context and needs and will be expanded to more comprehensive SOPs.

The purpose of these SOPs is to improve the quality and consistency of services across the country for survivors of GBV including sexual violence; standardize the response to GBV, sexual violence, and violence against children, older persons, persons with disabilities, and other vulnerable or at-risk groups. It aims to improve coordination, partnership and effective cooperation between government, national and international NGOs, as well as other key stakeholders. They are designed for actors to be able to hold each other accountable for addressing the needs of GBV survivors, to be used together with established guidelines and other good- practice materials related to the response to and mitigation and prevention of GBV. The SOPs apply to both specialized GBV actors as well as non-specialized GBV actors. The different roles, responsibilities and guidance for GBV specialized and non-specialized actors will be indicated throughout.

1.1 Context

Since 24 February 2022, Poland has recorded over 3 million entries from Ukraine, of whom over 90% are women and children. Poland has committed to receiving refugees from Ukraine, including at facilities near the border and in cities. Nevertheless, the speed and scale of arrivals have strained systems, as refugees disperse to urban centers across the country. The refugee population consists of women-head of households, single women, adolescent girls, children, older women, Roma women, stateless, third country nationals and LGBTI persons who are at heightened risk of GBV; in addition to men who do not fall under the conscription criteria.

People fleeing from conflicts are at higher risk of conflict-related sexual violence, sexual exploitation and abuse by humanitarian actors, and trafficking for the purpose of sexual exploitation. Additionally, risks of GBV are exacerbated in the context of informal shelter, reception and transit facilities, refugee accommodation centers, private arrangements for accommodation and transportation from the border, and movement to other countries. Compared to initial arrivals, newer arrivals are less resourced and without an onward plan. On arrival, refugees cite information needs, and there is a critical need for identification and referral of persons with specific protection needs (PSN). Additionally, rapid border processing from the onset resulted in limited data for profiling, monitoring, and PSN identification as the population dispersed into cities and onward countries.

Despite a lack of evidence, there is a high risk of GBV due to a lack of security measures to prevent these incidents, and many women and girls are taking shelter with strangers[1][1]. UNHCR has warned of the dangers of not registering volunteers. Predators and criminal networks may pretend to be volunteers and attempt to exploit refugees by luring them with promises of free transport, accommodation, employment, or other forms of assistance[2][2]. Many volunteers also lack the training to identify signs of sexual abuse and the risks of exploitation and trafficking in persons.

While many civil society organizations (CSOs) are active in providing GBV services, there is an ongoing national and political debate on Poland's withdrawal from the Council of Europe's (CoE) Convention on preventing and combating violence against women and domestic violence (the 'Istanbul Convention'). Reportedly, the general GBV response environment in Poland is weak. The availability and accessibility of appropriate GBV services for refugees remain a significant concern.

1.2 Settings and Persons of Concern

The SOPs should be applied equally, without discrimination, to all persons of concern and affected host communities, regardless of age, gender identity, sexual orientation, religion, ethnicity, employment status, or any other factors. The SOPs apply to both adult and child survivors of GBV.

These GBV SOPs have been developed for use in the following settings:

Location	Type of Setting	Persons of Concern
The Republic of Poland	All locations where refugees and other persons of concern are in transit, residing, or located. Persons of concern located temporarily or permanently in a setting are equally included. Settings may include, but are not limited to, host community locations, Refugee Accommodation Centers (RAC), and transit locations such as border control points (BCP) and transport hubs.	-Asylum seekers -Host community -Migrants (including all migratory statuses, both regular and irregular) - Refugees[3] (from Ukraine, Third Country Nationals-TCN, and any other refugees of other country origins located in the Republic of Poland). - Stateless persons.

[1][1] CARE and UN Women https://www.unwomen.org/sites/default/files/2022-05/Rapid-Gender-Analysis-of-Ukraine-en.pdf ; HRW 29/04/2022
[2][2] https://data.unhcr.org/en/documents/details/92011
[3] Note that for the purposes of the SOPs Ukrainian and TCN fleeing from Ukraine from the 24th of February 2022 are referred to as refugees irrespective of whether they have applied for/been officially granted refugee status, equally irrespective of their current visa/migratory status, be it regular or irregular.

1.3 Terms

1.3.1 General Terms

An extensive but non-exhaustive list of general terms is included in Definitions.

Actor(s): Refers to individuals, groups, organisations, and institutions involved in responding to, mitigating, and preventing gender-based violence. Actors may be refugees/internally displaced persons, stateless persons, local populations, employees, or volunteers of UN and all other agencies and organisations, NGOs, host government institutions, donors, and other members of the international community.

Adolescence: Defined as the period between ages 10 and 19 years old. It is a continuum of development in a person's physical, cognitive, behavioral and psychosocial spheres.

Adolescent: Any person between the ages of 10-19 years old. Adolescence can be broken down into the following sub-group: pre-adolescence (9–10), early adolescence (10–14), middle adolescence (15–17) and late adolescence (18–19)[4].

Adult: Any person 18 years and older.

Asylum seekers: Persons whose refugee status has not yet been determined by the authorities but whose asylum application entitles them to protection on the basis that they could be refugees.

Caseworker: This term describes an individual working within a service-providing agency who has been tasked with the responsibility of providing case management services to clients. This means that caseworkers are trained appropriately on client-centered case management; they are supervised by senior program staff and adhere to a specific set of systems and guiding principles designed to promote health, hope, and healing for their clients. Caseworkers are also commonly referred to as social workers and case managers, among other terms.

Child: Any person under the age of 18. Children have evolving capacities depending on their age, maturity and developmental stage and specific needs. In working with children, it is critical to understand these stages, as it will determine the method of communication with individual children. It will also allow the caseworker to establish an individual child's level of understanding and their ability to make decisions about their care.

Conflict Related Sexual Violence (CRSV) - The term "conflict-related sexual violence" refers to rape, sexual slavery, forced prostitution, forced pregnancy, forced abortion, enforced sterilization, forced marriage and any other form of sexual violence of comparable gravity perpetrated against women, men, girls or boys that is directly or indirectly linked to a conflict. That link may be evident in the profile of the perpetrator, who is often affiliated with a State or non-State armed group, which includes terrorist entities; the profile of the victim, who is frequently an actual or perceived member of a political, ethnic or religious minority group or targeted on the basis of actual or perceived sexual orientation or gender identity; the climate of impunity, which is generally associated with State collapse, cross-border consequences such as displacement or trafficking, and/or violations of a ceasefire agreement. The term also encompasses trafficking in persons for the purpose of sexual violence or exploitation, when committed in situations of conflict.

[4] Age 18 is the legal age for a person to be responsible for their actions; it is possible to be a 'late adolescent' in terms of development and an 'adult' according to international guidance.

Denial of resources, opportunities or services: Denial of rightful access to economic resources/assets or livelihoods opportunities, education, health or other social services. Examples include a widow prevented from receiving an inheritance, earnings forcibly taken by an intimate partner or family member, a woman prevented from using contraceptives, a girl prevented from attending school, etc. Some acts of confinement may also fall under this category.

Disclosure: The process of revealing information. Disclosure in the context of this document refers to a survivor voluntarily sharing with someone that she has experienced or is experiencing gender-based violence.

Disability: An evolving concept that results from the interactions between persons with impairments and attitudinal and environmental barriers that hinder their full and effective participation in society on an equal basis with others.

Domestic violence (DV): Although DV and intimate partner violence (IPV) are sometimes used interchangeably, there are important distinctions between them. 'Domestic violence' is a term used to describe violence that takes place within the home or family between intimate partners as well as between other family members. 'Intimate partner violence' applies specifically to violence occurring between intimate partners (married, cohabiting, boyfriend/girlfriend or other close relationships), and is defined by WHO as behaviour by an intimate partner or ex-partner that causes physical, sexual or psychological harm, including physical aggression, sexual coercion, psychological abuse and controlling behaviours. This type of violence may also include the denial of resources, opportunities or services.

Emergency: An event or series of events that represents a critical threat to the health, safety, security or wellbeing of a community or other large group of people, usually over a wide area.[5]

Emotional abuse (also referred to as psychological abuse): Infliction of mental or emotional pain or injury. Examples include: threats of physical or sexual violence, intimidation, humiliation, forced isolation, social exclusion, stalking, verbal harassment, unwanted attention, remarks, gestures or written words of a sexual and/or menacing nature, destruction of cherished things, etc. 'Sexual harassment' is included in this category of GBV.

Empowerment of women: The empowerment of women concerns women gaining power and control over their own lives. It involves awareness-raising, building self-confidence, expansion of choices, increased access to and control over resources, and actions to transform the structures and institutions that reinforce and perpetuate gender discrimination and inequality.

Forced marriage and child (also referred to as early) marriage: Forced marriage is the marriage of an individual against her or his will. Child marriage is a formal marriage or informal union before age 18. Even though some countries permit marriage before age 18, international human rights standards classify these as forced marriages because those under age 18 are unable to give informed consent for these actions. Therefore, child marriage is a form of forced marriage as children are not legally competent to agree to such unions.

Gender: Refers to the social attributes and opportunities associated with being male and female and the relationships between women and men and girls and boys, as well as the relations between women and those between men. These attributes, opportunities and relationships are socially constructed and are learned through socialization processes. They are context- and time-specific and changeable. Gender determines what is expected, allowed

[5] Humanitarian Coalition. https://www.humanitariancoalition.ca/what-is-a-humanitarian-emergency, last accessed April 18, 2022.

and valued in a woman or a man in a given context. In most societies there are differences and inequalities between women and men in responsibilities assigned, activities undertaken, access to and control over resources, as well as decision-making opportunities and power relations Gender is part of the broader socio-cultural context.

Gender-based Violence (GBV) case management: GBV case management, which is based on social work case management, is a structured method for providing help to a survivor. It involves one organization, usually a psychosocial support or social services actor, taking responsibility for making sure that survivors are informed of all the options available to them and that issues and problems facing a survivor and her/his family are identified and followed up in a coordinated way, and providing the survivor with emotional support throughout the process. GBV case management services require specialized intervention from a range of service providers to meet a survivor's immediate needs and support long-term recovery. Effective GBV case management ensures adherence to the GBV Guiding Principles. Case management for child survivors will be guided by the best interests of the child.

Gender equality: Refers to the equal rights, responsibilities and opportunities of women and men and girls and boys. Equality does not mean that women and men will become the same but that women's and men's rights, responsibilities and opportunities will not depend on whether they are born male or female. Gender equality implies that the interests, needs and priorities of both women and men are taken into consideration, recognizing the diversity of different groups of women and men. Gender equality is not a women's issue but should concern and fully engage men as well as women. Equality between women and men is seen both as a human rights issue and as a precondition for, and indicator of, sustainable people-centred development.

Gender mainstreaming: A strategy that aims to bring about gender equality and advance women's rights by building gender capacity and accountability in all aspects of an organization's policies and activities, thereby contributing to a profound organizational transformation. It involves making gender perspectives – what women and men do and the resources and decision-making processes they have access to – more central to all policy development, research, advocacy, development, implementation and monitoring of norms and standards, and planning, implementation and monitoring of projects.

GBV Coordination Group: An umbrella term to describe a group of actors implementing or involved in supporting GBV programming. Examples include Sub-Cluster, Sub-Sector, Area of Responsibility or Working Group.

GBV Coordination Leads: GBV specialized actors who lead GBV coordination efforts. This may be a sub-cluster/sub-sector coordinator(s) or other leads of the relevant coordination mechanism.

GBV specialized service providers: Refers to all actors, including UN, NGO and governmental actors, providing services that are specialized GBV.

Harmful traditional practices: Cultural, social and religious customs and traditions that can be harmful to a person's mental or physical health. Every social grouping in the world has specific traditional cultural practices and beliefs, some of which are beneficial to all members, while others are harmful to a specific group, such as women and girls. These harmful traditional practices may include female genital mutilation/cutting (FGM/C); forced feeding of women; child marriage; the various taboos or practices that prevent women from controlling their own fertility; nutritional taboos and traditional birth practices; son preference and its implications for the status of the girl child; female infanticide; early pregnancy; and dowry price. Other harmful traditional practices include binding, scarring, burning, branding, violent initiation rites,

fattening, forced marriage, killings in the name of honor, dowry-related violence, exorcism or 'witchcraft'.

Host community: Persons in the location to which refugees, asylum seekers, returnees, IDPs and migrants have arrived.

Informed assent: The expressed willingness to participate in services, for children under the age of 15 years, requires the same sharing of information (in a child-friendly format) on services and potential risks

Informed consent: The voluntary agreement of an individual who has the legal capacity to give consent. To provide informed consent the individual must have the capacity and maturity to know about and understand the services being offered and be legally able to give their consent. Free and informed consent is given based upon a clear appreciation and understanding of the facts, implications and future consequences of an action. In order to give informed consent, the individual concerned must have all adequate relevant facts at the time consent is given and be able to evaluate and understand the consequences of an action. They also must be aware of and have the power to exercise their right to refuse to engage in an action and/or to not be coerced (i.e. being persuaded based on force or threats).

Interagency GBV Standard Operating Procedures (GBV SOPs): Specific procedures and agreements among organizations in a particular context that reinforce the GBV Guiding Principles and standards for ethical, safe, and coordinated multisectoral service delivery and outline the roles and responsibilities of each actor in the response to, risk mitigation and prevention of GBV.

Intimate partner violence (IPV): Although IPV and domestic violence (DV) are sometimes used interchangeably, there are important distinctions between them. 'Intimate partner violence' applies specifically to violence occurring between intimate partners (married, cohabiting, boyfriend/girlfriend or other close relationships), and is defined by WHO as behaviour by an intimate partner or ex-partner that causes physical, sexual or psychological harm, including physical aggression, sexual coercion, psychological abuse and controlling behaviours. This type of violence may also include the denial of resources, opportunities or services. 'Domestic violence' is a term used to describe violence that takes place within the home or family between intimate partners as well as between other family members.

Mandatory reporting: This refers to state laws and policies that mandate certain agencies and/or persons in helping professions (teachers, social workers, health staff, etc.) to report actual or suspected forms of interpersonal violence (e.g., physical, sexual, neglect, emotional and psychological abuse, unlawful sexual intercourse). Mandatory reporting may also be applied in cases where a person is a threat to themselves or another person. Mandatory reporting is a responsibility for humanitarian actors who hear about and/or receive a report of sexual exploitation or abuse committed by a humanitarian actor against a member of the affected population.

Mental Health and Psychosocial Support (MHPSS): Support that aims to protect or promote psychosocial well-being and/or prevent or treat mental disorders. An MHPSS approach is a way to engage with and analyse a situation, and provide a response, taking into account both psychological and social elements. This may include support interventions in the health sector, education, community services, protection and other sectors.

Migrants: Persons or groups of persons who move away from their place of usual residence, whether within a country or across an international border, temporarily or permanently, and for a variety of reasons. The term includes a number of well-defined legal categories of people,

such as migrant workers; persons whose particular types of movements are legally defined, such as smuggled migrants; as well as those whose status or means of movement are not specifically defined under international law, such as international students.

Perpetrator: Person, group or institution that directly inflicts or otherwise supports violence or other abuse inflicted on another against his/her will.

Physical assault: An act of physical violence that is not sexual in nature. Examples include: hitting, slapping, choking, cutting, shoving, burning, shooting or use of any weapons, acid attacks or any other act that results in pain, discomfort or injury.

Prevention: Actions that prevent GBV from occurring by addressing its root causes, namely gender inequality, systemic discrimination and unequal power relations between women and men, as well as people with diverse sexual orientations and gender identities.

Protection from sexual exploitation and abuse (PSEA): This term is used by the United Nations and the wider humanitarian community to refer to measures taken to protect vulnerable people from sexual exploitation and abuse by their own staff and associated personnel[6].

Rape[7]: Physically forced or otherwise coerced penetration, even if slight, of the vagina, anus or mouth with a penis or other body part. It also includes penetration of the vagina or anus with an object. Rape includes marital rape and anal rape/sodomy. The attempt to do so is known as attempted rape.[8] Rape of a person by two or more perpetrators is known as gang rape.[9]

Refugee: Any person who owing to a well-founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group, or political opinion, or because a conflict, generalized violence or other circumstances that have seriously disturbed public order, is outside the country of her or his nationality, and is unable to or, owing to such fear, is unwilling to avail herself or himself of the protection of that country. This person, as a result, require international protection.

Response: Response refers to immediate interventions that address survivors' physical safety, health concerns, psychosocial needs, and access to justice, in line with the survivor-centred approach and the GBV Guiding Principles. The provision of multi-sectoral services and assistance to all survivors of GBV contributes to ensuring people's safety, improving physical, mental, sexual and reproductive health, and facilitating access to justice. All survivors of GBV, including survivors of SEA perpetrated by humanitarian workers, have the right to immediate life-saving protection and GBV services. Survivors of SEA should be treated equally as survivors of other forms of GBV. Working with perpetrators of GBV is not the responsibility of GBV response programming.

Risk mitigation: Refers to a process and specific interventions to mitigate risks in all phases of humanitarian programming. It includes actions that are taken in each humanitarian sector and area of work to reduce risks and exposure to GBV and improve safety as part of an agency-

[6] Inter-Agency Standing Committee: Global Report on Protection from Sexual Exploitation and Abuse and Sexual Harassment: https://psea.interagencystandingcommittee.org/sites/default/files/2022-01/IASCExternalReview_GlobalReportPSEAH_2021_web.pdf
[7] This definition of rape is consistent with the IASC GBV Guidelines. The GBV Information Management System (GBVIMS), however, defines rape as "non-consensual penetration (however slight) of the vagina, anus or mouth with a penis or other body part. Also includes penetration of the vagina or anus with an object." These are the two definitions used by GBV specialized actors, whereas Health actors might use a World Health Organization definition. Please see Section 1.3.2.1 for the GBVIMS Incident Type definitions.
[8] In the GBV Information Management System (GBVIMS), attempted rape is included under "Sexual Assault".
[9] IASC GBV Guidelines, p. 322.

wide mainstreaming approach. Cross-sectoral coordination is essential to ensure a comprehensive approach.

Sexual abuse: The actual or threatened physical intrusion of a sexual nature, including both actual and attempted abuse, whether by force or under unequal or coercive conditions. All sexual activity with a person under 18 years-old is considered sexual abuse.

Sexual assault: Any form of non-consensual sexual contact that does not result in or include penetration. Examples include attempted rape, as well as unwanted kissing, fondling, or touching of genitalia and buttocks.

Sexual exploitation: Any actual or attempted abuse of a position of power, trust or vulnerability, for sexual purposes, including, but not limited to profiting monetarily, socially or politically from the sexual exploitation of another person, withholding due services or blackmailing for sex, hiring sex workers or threats of sexual exploitation. Using the position as a humanitarian worker to receive any sort of sexual favour is sexual exploitation.

Sexual exploitation and abuse (SEA): A common acronym used in the humanitarian sector, referring to acts of sexual exploitation and l abuse committed by United Nations, national and international NGOs, volunteers, government personnel or anyone involved in a humanitarian response effort, against the affected population[10].

Sexual harassment: Unwelcome sexual advances, requests for sexual favours, and other verbal or physical conduct of a sexual nature. In the context of SEA, sexual harassment can also include other forms of GBV if conducted in a work environment or co-worker relationship. Examples include touching, kissing or speaking in a sexual inappropriate manner to a colleague at work; obscene gestures; intrusive behavior such as stalking, spying, pestering for sex etc.

Sexual violence: For the purposes of these guidelines, sexual violence includes, at least, rape/attempted rape, sexual abuse and sexual exploitation. Sexual violence is "any sexual act, attempt to obtain a sexual act, unwanted sexual comments or advances, or acts to traffic a person's sexuality, using coercion, threats of harm or physical force, by any person regardless or relationship to the victim, in any setting, including but not limited to home and work." Sexual violence takes many forms, including rape, sexual slavery and/or trafficking, forced pregnancy, sexual harassment, sexual exploitation and/or abuse, and forced abortion.
Survivor (see also 'Victim'): A person who has experienced gender-based violence. The terms 'victim' and 'survivor' can be used interchangeably. 'Victim' is a term often used in the legal and medical sectors. 'Survivor' is the term generally preferred in the psychological and social support sectors because it implies resiliency.

Trafficking in persons "...the recruitment, transportation, transfer, harbouring or receipt of persons, by means of the threat or use of force or other forms of coercion, of abduction, of fraud, of deception, of the abuse of power or of a position of vulnerability or of the giving or receiving of payments or benefits to achieve the consent of a person having control over another person, for the purpose of exploitation. Exploitation shall include, at a minimum, the exploitation of the prostitution of others or other forms of sexual exploitation, forced labour or services, slavery or practices similar to slavery, servitude or the removal of organs."[11]

Victim (see also 'Survivor'): A person who has experienced gender-based violence. The term recognizes that a violation against one's human rights has occurred. The terms 'victim' and 'survivor' can be used interchangeably. 'Victim' is a term often used in the legal and medical

[10] IASC GBV Guidelines, p. 322.
[11] IASC GBV Guidelines 2015, p. 323, citing United Nations. 2000. Protocol to Prevent, Suppress and Punish Trafficking in Persons, Especially Women and Children, www.osce.org/odihr/19223? download=true.

sectors. 'Survivor' is the term generally preferred in the psychological and social support sectors because it implies resiliency.

1.3.2 Gender-based Violence Terms

Gender-based violence[12] is an umbrella term for any harmful act that is perpetrated against a person's will, and that is based on socially ascribed (gender) differences between males and females. It includes acts that inflict physical, sexual or mental harm or suffering, threats of such acts, coercion and other deprivations of liberty. These acts can occur in public or in private. Acts of GBV violate a number of universal human rights protected by international instruments and conventions. Many – but not all – forms of GBV are illegal and criminal acts in national laws and policies.

Around the world, GBV has a greater impact on women and girls than on men and boys. The term "gender-based violence" is often used interchangeably with the term "violence against women and girls". The term "gender-based violence" highlights the gender dimension of these types of acts; in other words, the relationship between females' subordinate status in society and their increased vulnerability to violence. It is important to note, however, that men and boys may also be victims of gender-based violence, especially sexual violence.

The nature and extent of specific types of GBV vary across cultures, countries, and regions. Examples of GBV include but are not limited to sexual violence, including sexual exploitation and abuse, intimate partner violence, trafficking in persons, forced marriage, harmful traditional practices such as female genital mutilation, widow inheritance, and others.

The term "GBV" is most commonly used to underscore how systemic inequality between male and female persons, which exists in every society in the world, acts as a unifying and foundational characteristic of most forms of violence perpetrated against women and girls. The term "gender-based violence" also includes sexual violence committed with the explicit purpose of reinforcing gender inequitable norms of masculinity and femininity.

1.3.2.1 GBV Incident Type Definitions

Gender-based violence encompasses many different types of violence. When each GBV actor has a different understanding of how a type of GBV is defined, challenges in communication and analysis can arise. Differing definitions may cause inaccurate information to be reported about the scope and impact of GBV risks. To address this issue, the GBV Information Management System (GBVIMS) developed an incident classification system that helps to define and standardize different types of GBV for documentation and trend analysis.

The incident types/case definitions listed below reflect the current recommended good practice for classifying GBV incidents by the GBVIMS. Please see Annex 4 for the GBVIMS Classification Tool.

Note: Incident type definitions used in the context of GBV programming are not necessarily the legal definitions used in national laws and policies. Many forms of GBV may not be considered crimes in certain places and legal definitions and terms vary greatly across countries and regions.

[12] This definition of gender-based violence is used widely by the GBV Area of Responsibility and various UN agencies.

The six core GBV types were created for data collection and statistical analysis of GBV.[13] They should be used only in reference to GBV incidents, even though some of the definitions may be applicable to other forms of violence that are not gender-based.

- **Rape[14]**: non-consensual penetration (however slight) of the vagina, anus or mouth with a penis or other body part. Also includes penetration of the vagina or anus with an object.

- **Sexual Assault**: any form of non-consensual sexual contact that does not result in or include penetration. Examples include: attempted rape, as well as unwanted kissing, fondling, or touching of genitalia and buttocks. FGM/C is an act of violence that impacts sexual organs, and as such should be classified as sexual assault. This incident type does not include rape, i.e., where penetration has occurred.

- **Physical Assault**: an act of physical violence that is not sexual in nature. Examples include: hitting, slapping, choking, cutting, shoving, burning, shooting or use of any weapons, acid attacks or any other act that results in pain, discomfort or injury. This incident type does not include FGM/C.

- **Forced Marriage**: the marriage of an individual against her or his will.

- **Denial of Resources, Opportunities or Services**: denial of rightful access to economic resources/assets or livelihood opportunities, education, health or other social services. Examples include a widow prevented from receiving an inheritance, earnings forcibly taken by an intimate partner or family member, a woman prevented from using contraceptives, a girl prevented from attending school, etc. Reports of general poverty should not be recorded.

- **Psychological / Emotional Abuse**: infliction of mental or emotional pain or injury. Examples include: threats of physical or sexual violence, intimidation, humiliation, forced isolation, stalking, harassment, unwanted attention, remarks, gestures or written words of a sexual and/or menacing nature, destruction of cherished things, etc.

1.3.3 Regulation of GBV in the legislation of the Republic of Poland

Domestic violence: pursuant to Art. 2 clause 2 of the Polish Act of July 29th 2005, on Counteracting Domestic Violence (Journal of Laws No. 180, item 1493, as amended), it is a one-time or repeated intentional act or omission that violates the rights or personal rights of relatives (within the meaning of Art. 115 § 11 of the Criminal Code), as well as other people living together or running a business, in particular exposing these people to the risk of loss of life and health, violating their dignity, bodily inviolability, freedom, including sexual freedom, causing damage to their physical or mental health as well as causing suffering and moral harm to people affected by violence.

[13] GBV IMS data is collected by GBV case management organizations as a means to improve planning and delivery of care to survivors. Hence, collected data represents reported incidences associated with data sharing protocols. IMS data, when available, should not be confused as reflecting prevalence. See GBV Minimum Standards, Standard 14: Collection and Use of GBV Survivor Data.

[14] Rape is defined in the IASC GBV Guidelines (p. 322) as: “Physically forced or otherwise coerced penetration, even if slight, of the vagina, anus or mouth with a penis or other body part. It also includes penetration of the vagina or anus with an object. Rape includes marital rape and anal rape/sodomy. The attempt to do so is known as attempted rape. Rape of a person by two or more perpetrators is known as gang rape.”

Rape: On October 25th, 2012, the European Parliament and the European Council adopted a directive establishing minimum standards on the rights, support and protection of crime victims (Directive 2012/29 / EU). The directive defines 'rape' as gender-based violence that is discriminatory on the basis of gender, as the predominantly women are the victims of rape. Polish specific: The basic type of rape is mentioned in Art. 197 § 1 of the Criminal Code, which penalizes sexual intercourse by violence, an unlawful threat or deception of another person. Art. 197 § 2 of the CC defines the second form of rape, which consists in causing, by force, unlawful threat or deception, to submit to or perform another sexual activity.

Sexual harassment: it is not defined in criminal law. However, the scope of acts classified as sexual harassment may include: art. 216 of the Penal Code providing responsibility for insult; art. 217 of the Penal Code in cases of violation of bodily inviolability; art. 197 of the Penal Code in the case of rape; art. 199 of the Penal Code when abusing a dependency relationship or using a critical position; art. 202 of the Penal Code in connection with the public presentation of pornographic content in such a way that it may impose its reception on a person who does not wish to do so; art. 207 of the CC if sexual harassment takes the form of bullying; art. 203 of the Penal Code when sexual harassment, for example in the workplace, leads the victim to prostitution using a relationship of dependency or her critical position; art. 218 of the Penal Code if the sexual harassment takes the form of malicious or persistent violation of the employee's rights under the employment relationship or social insurance by a person performing activities in the field of labor law and social security.

SECTION 2: Guiding Principles for GBV Programming

2.1 GBV Guiding Principles and Approaches

All humanitarian aid programming, including GBV interventions, must adhere to these core principles:

- **Humanitarian principles:** The humanitarian principles of humanity, impartiality, independence and neutrality, are essential to maintaining access to affected populations and ensuring an effective humanitarian response.[15]

- **"Do no harm" approach:** A "do no harm" approach involves taking all measures necessary to avoid exposing people to further harm as a result of the actions of humanitarian actors.[16]

- **Accountability to Affected Populations[17]** (AAP) refers to the "commitments and mechanisms that humanitarian agencies have put in place to ensure that communities are meaningfully and continuously involved in decisions that directly impact their lives". Humanitarian actors have a duty to make sure that assistance generates the best possible outcomes for all groups who are affected by a crisis, including those who may be less visible.[18]

[15] See, e.g. https://www.unocha.org/sites/dms/Documents/OOM-humanitarianprinciples_eng_June12.pdf.
[16] See, e.g. GBV Minimum Standards.
[17] The 'P' in AAP may also refer to 'People'.
[18] AAP focuses on the rights, dignity, and protection of an affected community in its entirety. AAP is about meaningful engagement, working with communities, and to actively seek and put forward the voices from the most vulnerable. It requires humanitarian actors to identify and address the needs and vulnerabilities of members of affected communities, and it equally requires them to recognise and harness the capacities, knowledge, and aspirations of those communities. Community members must be engaged and empowered throughout all stages of the humanitarian programme cycle not only to be a part of decision making, but to be equal partners helping to drive the process. Humanitarian actors are aiming to achieve this by taking account, giving account, and being held to account.

- **Centrality of Protection** This statement affirms the commitment of the IASC Principals to ensuring the centrality of protection in humanitarian action and the role of Humanitarian Coordinators, Humanitarian Country Teams and Clusters to implement this commitment in all aspects of humanitarian action. It is part of a number of measures that will be adopted by IASC to ensure more effective protection of people in humanitarian crises

The Guiding Principles and approaches outlined in the following section apply to all GBV programming:

- **Survivor-centred approach[19]:** A survivor-centred approach creates a supportive environment in which survivors' rights and wishes are respected, their safety is ensured, and they are treated with dignity and respect. A survivor-centred approach is based on the following guiding principles:

    a. **Safety:** The safety and security of survivors and their children are the primary considerations.
    b. **Confidentiality:** Survivors have the right to choose to whom they will or will not tell their story, and any information about them should only be shared with their informed consent.[20]
    c. **Respect:** All actions taken should be guided by respect for the choices, wishes, rights and dignity of the survivor. The role of helpers is to facilitate recovery and provide resources to aid the survivor.
    d. **Non-discrimination:** Survivors should receive equal and fair treatment regardless of their age, disability, gender identity, religion, nationality, ethnicity, sexual orientation or any other characteristic.

- **Rights-based approach:** A rights-based approach seeks to analyse and address the root causes of discrimination and inequality, to ensure that everyone has the right to live with freedom and dignity, safe from violence, exploitation and abuse, in accordance with principles of human rights law.

- **Community-based approach:** A community-based approach ensures that affected populations are engaged actively as partners in developing strategies related to their protection and the provision of humanitarian assistance. This approach involves direct involvement of women, girls and other at-risk groups at all stages in the humanitarian response, to identify protection risks and solutions, and build on existing community-based protection mechanisms.

- **Age, Gender, Diversity (AGD)**:[21] Age, gender and diversity factors influence how forced displacement and statelessness impact people; understanding and analysing how these factors impact people's experience is necessary for an effective response. Effective and accountable humanitarian responses therefore require: (i) continuous and meaningful engagement with persons of concern; (ii) understanding their needs and protection risks; (iii) building on their capacities; and (iv) pursuing protection, assistance, and solutions that take into account their perspectives and priorities.

[19]The Inter-Agency Minimum Standards for Gender-Based Violence in Emergencies Programming https://www.unfpa.org/minimum-standards
[20] There are some limitations to confidentiality, including when there are concerns about the immediate physical safety of survivors or risk to others, or in the case of mandatory reporting requirements. See Section 3.3.3 on Mandatory Reporting for more information.
[21] UNHCR. UNHCR Policy on Age, Gender and Diversity, 2018, pgs. 5-6.

- **Child-centred approach**:[22] A child-centred approach creates a supportive environment in which children are involved in all matters that affect them. Child-centred and child-focused are synonymous terms.

    a. **Best interests of the child[23]**: The best interest of the child is one element of the child-centred approach. It means that child and adolescent girl and boy survivors of sexual abuse have the right to have their best interests assessed and determined and taken as a primary consideration in all decisions that affect them.

The above guiding principles and approaches are linked to the overarching humanitarian responsibility to provide protection and assistance to those affected by crises. They serve as the foundation for all humanitarian actors when planning and implementing GBV-related programming. Organizations should ensure that all staff are trained on these principles so that they are understood and can apply them without discrimination

2.2 Operationalizing the GBV Guiding Principles in This Setting

2.2.1 Guiding Principles for Safe and Coordinated GBV programming

b. Understand and adhere to the ethical and safety recommendations in the *WHO Ethical and Safety Recommendations for Researching, Documenting and Monitoring Sexual Violence in Emergencies* (WHO 2007).

c. Extend the fullest cooperation and assistance to each other in responding, mitigating and preventing GBV. This includes sharing situation analysis and assessment information to avoid duplication and maximise a shared understanding of the situation.

d. Establish and maintain carefully coordinated multisectoral and inter-organisational interventions for GBV response, mitigation and prevention.

e. Engage the community fully in understanding and promoting gender equality and power relations that protect and respect the rights of women and girls.

f. Ensure equal and active participation by women, girls, men and boys – including persons with disabilities and diverse gender identities and sexual orientations, among other groups who face barriers to access – in assessing, planning, implementing, monitoring, and evaluating programmes through the systematic use of participatory methods.[24]

g. Integrate and mainstream GBV interventions into all programmes and all sectors.

h. Integrate and mainstream gender considerations into all interventions and sectors.

i. All staff and volunteers involved in humanitarian interventions should understand, be trained on and sign a Code of Conduct that includes PSEA (see Annex 5 for a sample Code of Conduct).

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[22] UNHCR Best Interests Procedure Guidelines: Assessing and Determining the Best Interests of the Child https://www.refworld.org/docid/5c18d7254.html
[23] ibid.
[24] See, e.g. IASC Guidance on Localisation (IASC Guidance on Strengthening Participation, Representation and Leadership of Local and National Actors in IASC Humanitarian Coordination Mechanisms, 2021).

SECTION 3: GBV Response Programming

3.1 Overview

GBV survivors often need various types of care and support to help them recover, heal and be safe from further violence. Survivors of GBV have the right to access quality, confidential, age-appropriate, and compassionate services. All services for survivors of GBV should be delivered in a non-judgmental and non-discriminatory manner, that considers the survivor's sex, age, and specific needs.

Across all contexts and types of GBV incidents, health care for GBV survivors is the priority service. Adequate health services are vital to ensuring life-saving care for women, girls and other at-risk groups. Health-care providers are often the first and sometimes only point of contact for GBV survivors.

The quality of care and support that GBV survivors receive, including the way they are treated by the people they turn to for help, affects their safety, well-being and recovery. It also influences whether other survivors feel comfortable coming forward for help. Qualified staff and systems in organisations providing GBV case management services are essential to establishing and maintaining quality, survivor-centred care.

All GBV service providers should create a safe, supportive, confidential environment that allows survivors and/or their caregivers to disclose violence should they choose to do so. It often takes time to build trust for the survivor to disclose that they have experienced violence.

Entry points to services for survivors of GBV will be accessible, safe, private, confidential, and trustworthy.

3.2 Key Considerations for GBV Response Services

3.2.1 Disclosure

A survivor has the freedom and right to disclose a GBV incident to anyone. She may disclose her experience to a trusted family member or friend, seek help from a trusted individual or organisation in the community, or make an official report to a local, national or international humanitarian actor, including UN agencies and NGOs, police, or other local authority.

Anyone the survivor tells about her experience has a responsibility to give honest and complete information about the response services available, encourage her to seek help, and accompany her and support her through the process whenever possible and with her agreement. The suggested entry points for response services for survivors of GBV seeking help are the health and/or psychosocial support and/or case management actors.

The wishes of the survivor must always be respected as to where or from whom to seek help. She should not be urged into a particular course of action. It is necessary to maintain confidentiality of information at all times and only share based on consent of survivors and/or their caregivers, on a need-to-know

Special Considerations for Children

All actors and stakeholders, including community members, should not attempt to actively identify survivors of GBV as this can lead to stigma and put survivors and staff/volunteers at risk.

However, in the case of very young children, a more active identification approach is required. This approach should be discussed and agreed between GBV and Child Protection actors and align with Child Protection minimum standards.

See Section 3.4.3.2 on Child Protection

basis. Some exceptions will apply based on confidentiality and informed consent limitation, which are:

- When a survivor threatens his/her own life, threatens to harm another person
- When person is non-responsive (i.e. unconscious) or a person without capacity of discernment
- When child abuse and it is in the best interest of the child

3.2.1.1 Disclosure to Non-specialised GBV Service Providers

- Ensure frontline staff and volunteers are trained on (1) how to support a survivor safely and ethically in the event of a disclosure, including through psychological first aid[25] (PFA); and (2) how to relay information on available GBV services, including remote modalities, such as hotlines, if necessary.

- Non-specialised actors should ask the survivor's informed consent[26] to contact a primary focal point on the GBV referral pathway and facilitate the contact between service provider and survivor. If a survivor consents to share their information, the referral should be made by accompanying the survivor to the service provider, or by phone and documented by email using the inter-sector referral form. Referral forms should be sent password-protected, only to the relevant focal point of the service provider sharing information, on a need-to-know basis. The referral form template can be found in Annex 3. Emergency cases should be first referred by contacting the service provider via telephone.

- Non-specialized GBV actors <u>should not interview survivors or respond directly but rather refer them to GBV specialised actors</u>[27] (e.g. health, psychosocial support, case management, and protection).

In the case of alleged Sexual Exploitation and Abuse (SEA) by a humanitarian aid worker -also a form of GBV-, the person/organisation receiving the complaint, should also immediately report the case to their organisation's PSEA focal point. The PSEA focal point will then activate the PSEA Network's Referral Pathway, to relay the necessary information to the relevant organization and the Network Coordinator, should the survivor consents, for investigation. The information collected on the SEA allegation, must be sent to the indicated actors, on a need-to-know basis, following the established channels by the Network, based on the information initially shared by the Survivor, avoiding exposing them to further questioning and/or stigmatization. In whatever case, the priority should be to provide the survivor with the necessary medical, psychological and/or legal support, as needed.

3.2.2 Consent

3.2.2.1 <u>Informed Consent & Assent</u>[28]

Informed consent is the voluntary agreement of an individual who has the legal capacity to give consent. Consent should be obtained before a disclosure is made, if possible. Survivor is

[25] IASC 2015. IASC GBV Pocket Guide.
[26] Informed consent is the voluntary agreement of an individual who has the legal capacity to give consent (age 18+). It is a term that is widely used in health and social services and is intended to protect the rights of the survivor and ensure that they are fully aware of the limitations, risks (and benefits) of receiving services.
[27] IASC 2015. IASC GBV Pocket Guide.
[28] See Case Management Guidelines, Section 2.2, Engaging the Survivor in Services (2017).

informed about the course of action if mandatory reporting is required. Consent must be obtained again for every new action or referral. Consent to one action or referral by a service provider does not constitute consent for any other actions. Survivors have the right to revoke consent at any time. Consent will be obtained verbally from survivors. Service providers should be informed of survivor's consent to receive services.

The survivor should be given honest and complete information about possible referrals for services. If the survivor agrees and requests referrals, she must give her informed consent before any information is shared with others. She must be made aware of any risks or implications of sharing information about her situation. She has the right to place limitations on the type(s) of information to be shared, and to specify which organisations can and cannot be given the information. The survivor must also understand and consent to the sharing of non-identifying data about her case for data collection purposes.

To provide informed consent, the individual must have the capacity and maturity to understand the services being offered, be legally able to give their consent, and have the relevant information to understand the implications of the decision they make.

As part of developing this section of the GBV SOPs, **all actors and stakeholders should understand that, in many cases, survivors do not wish to pursue security or police action or any other referrals. Therefore, developing these GBV SOPs must involve emphasizing the GBV Guiding Principles and GBV survivors' right to control how information about their case is shared with other individuals or actors.**

To ensure consent is "informed", service providers must:

- Provide all possible information and options available to the person.
- Inform the person that the service provider may need to share the survivor's information with others who can provide additional services.
- Explain to the survivor what will happen as part of service provision.
- Explain the benefits and risks of services to the survivor.
- Explain to the survivor that she has the right to decline or refuse any of the services.
- Explain limits to confidentiality (e.g. mandatory reporting; see Section 3.2.3).
- Check the survivor's understanding of the case management process by asking her to share her understanding of the purpose, what she has agreed to and what the risks might be.
- If needed, rephrase the information shared as many times as required to ensure the survivor's understanding.

There is no consent when the agreement is obtained through:

- The use of threats, force or other forms of coercion, abduction, fraud, manipulation, deception, or misrepresentation.
- The use of a threat to withhold a benefit to which the person is already entitled; or
- A promise made to the person to provide a benefit.

Informed assent:[29] is the expressed willingness to participate in services, for children under the age of 15 years, requires the same sharing of information (in a child-friendly format) on services and potential risks

Children must be consulted and given all the information needed to make an informed decision using child-friendly techniques that encourage them to express themselves. Their ability to provide assent on the use of the information and the credibility of the information will depend on their age, maturity and ability to express themselves freely. (See also the GBV Guiding Principles in Section 2.1 and *Caring for Child Survivors of Sexual Abuse*).

A sample Consent for Release of Information Form[30]*, Consent for Service Form*[31] *and the GBVIMS Standard Intake and Assessment Form can be found in Annex 4*.

3.2.3 Mandatory Reporting

Survivors must be informed, before or immediately upon reporting an incident, when mandatory reporting procedures are in place. At a minimum, sharing information with the survivor about mandatory reporting must include explaining the reporting mechanism and what she can expect after the report is made. Service providers should not promise confidentiality when it cannot be maintained.

Each service provider must have documented procedures for mandatory reporting and train staff to:

- Inform survivors about the staff's duty to report certain incidents in accordance with laws or policies;
- Explain the reporting mechanism to the survivor; and
- Explain what the survivor can expect after the report is made.

Procedures for mandatory reporting requirements differ; therefore, it is important that each organization outline its mandatory reporting procedures. Each actor's mandatory reporting procedures should consider the following:

- How mandatory reporting policies are explained to survivors;
- When the caseworker should inform a supervisor of the mandatory reporting requirements;
- The responsibility of the supervisor;
- To whom (other than the supervisor) the mandatory report will be made; and
- What information will be needed if a mandatory report to an external entity is necessary.

In the Republic of Poland, pursuant to art. 240 of the Polish penal code certain crimes have to be reported, or the person having credible information about them faces a penalty of 3-year imprisonment. The crimes that are encompassed by mandatory reporting and are related to GBV include: rape with particular cruelty, group rape, sexual abuse of any kind of a minor under 15, rape towards a dependent family member, deprivation of liberty, causing serious damage to health, sexual exploitation of the helplessness or insanity of another

[29] CM Guidelines, p. 108.
[30] This form requires survivors to give their authorization for any of their information to be shared with other agencies or organizations. It is intended to ensure that the rights of the survivors to control their incident data are maintained and protected. This form is also available in the GBV Case Management Guidelines, pgs. 227-228.
[31] GBV Case Management Guidelines, p. 179.

person. In such cases, the nearest police station or prosecution office adequate for the site of crime should be informed in writing.

In addition, the Act of 29 July 2005 on counteracting domestic violence, introduced the mechanism of Blue Cards, which is a help mechanism in case of domestic violence and may be opened without the consent of the survivor, especially children. The blue card procedure may be opened by any of 5 services: police, social services, health providers, education or Municipal Commission for Solving Alcohol Problems. If other actors are informed about domestic violence, they may report it to the Police or Social Services. Opening the Blue Card procedure is not tantamount to filing a criminal complaint. The Blue Card procedure is an assistance-providing procedure, not a penal one.

In humanitarian settings, all organisations are mandated to have protocols in place for responding to and reporting on Sexual Exploitation and Abuse (SEA) by humanitarian workers (see also Section 5 on Protection from Sexual Exploitation and Abuse). Organisations need to be clear on the interagency protocol and inform the survivor as to whom the case would be reported, what information would be shared, and what the expectations would be regarding the survivor's involvement.

3.3 GBV Specialised Service Providers

The following sections will explain the role, function and services provided by each GBV specialized service provider in the setting's referral pathway.

3.3.1 Health Care for GBV Survivors

Health service delivery systems should be equipped to ensure clinical management of rape, intimate partner violence, and the consequences of other forms of GBV.[32]

Health care providers should also be able to address the health needs of survivors of early/forced marriage (e.g. high-risk pregnancy, health effects of forced sexual activity, fistula repair) and complications related to female genital mutilation/cutting (e.g. pain, bleeding, urinary and vaginal infections, menstrual problems, childbirth complications, etc.).

Male survivors have specific needs regarding treatment and care that should be addressed by health care providers who must be trained to identify indications of sexual violence in men and boys, and offer care that is survivor-centred, non-stigmatizing and non-discriminatory.

Information regarding the nearest specialist services is provided via

- a 24/7 hotline ***800 190 590***
- The following website (Polish only) https://terminyleczenia.nfz.gov.pl/#
- The following website (Ukrainian only) https://www.nfz.gov.pl/dla-pacjenta-z-ukrainy/

[32] This includes first-line support/psychological first aid, the provision of emergency contraception, HIV post-exposure prophylaxis, treatment of sexually transmitted infections, Hepatitis B immunization, identification and care of survivors of intimate partner violence (including assessing the risk of continued and more serious violence, treatment of injuries and other physical care needs), and assessment and management of mental health conditions such as depression, suicidal thoughts or attempts, and post-traumatic stress disorder. Health care providers and messaging should include menstrual hygiene management. See GBV Minimum Standards, p. 29.

Direct numbers for

- Psychology Services
  - *Adults 800 70 22 22 (Provided by Support Center for Adults in Crisis, available 24/7)*
  - *Children 800 12 12 12 (Provided by Ombudsman for Children, toll free, available 24/7)*
  - *Children 11 61 11 (available 24/7 (POL), Monday-Friday 14:00-18:00 (UKR, RUS)) operated by Empowering Children Foundation.*

- *Gynecological Services* for women and girls from Ukraine
  - *FEDERA (Monday- Friday 16:00 – 20:00) +48 22 635 93 93*
- Emergency Services
  - *Emergency Number 112*
  - *Emergency Medical / Ambulance Services 999*

Emergency medical services can be accessed without any prior registration / a PESEL number, some providers however might request that the latter is provided at a later stage.

To access routine medical services, a PESEL (Personal ID) number is required and information regarding the PESEL registration process can be found on the following website (Ukrainian, English & Polish) https://www.gov.pl/web/gov/uzyskaj-numer-pesel--usluga-dla-cudzoziemcow-en

Some routine specialist services also require a referral from a general practitioner / family doctor:

- To find the closest family doctor
  - Call the NFZ helpline 800 190 590 or 800 137 200 (additional out-of-hours)
  - Access the following website (Ukrainian) https://www.gov.pl/web/ua/derzhavna-medychna-dopomoha
- Once you have the contact details of your nearest family doctor, call the number to make an appointment.
- If your family doctor refers you to a specialist, you will be required to make an appointment yourself:
  - 24/7 hotline
  - Website (Polish only) https://terminyleczenia.nfz.gov.pl/#
- To book an appointment with and visit a specialist, the following are required:
  - PESEL number

- Referral document / referral number from the family doctor.

Medical services can be free of cost only if the medical service provider has an active agreement with *NFZ (Narodowy Fundusz Zdrowia)*.
In case of doubts, this ought to be checked with the service provider / registration staff prior to booking.

3.3.2 Psychosocial Support

The term 'psychosocial' emphasises how 'psychological' and 'social' aspects influence one another and recognizes that individual human beings are influenced and impacted by the environments in which they live. GBV psychosocial support includes programming geared towards all women and girls and specific services for survivors of GBV.[33] Psychosocial support (PSS) includes a variety of approaches delivered by different types of organisations, including community-based and women-led.

All psychosocial support providers must understand the consequences of GBV and be able to provide compassionate support to survivors whether or not survivors disclose. In emergencies, as health is often an entry point for other services, GBV programme actors can support healthcare providers to offer emotional support; understand the potential psychological, social and medical impacts of GBV; and refer survivors to appropriate services in a safe and timely manner.[34]

List all organisations providing psychosocial support, including information about community-based support provided by women-led organisations:

- **Centrum Praw Kobiet /Center for Women's Rights**
  Warsaw & Countrywide CPK's Centres: Warsaw, Krakow, Łódz, Poznań, Gdańsk, Wrocław Information, general and specialized support for all women who have experienced gender-based violence (GBV), including those who fled Ukraine. National hotline: +48 800 107 777, Monday–Friday 10:00-18:00 (UKR) +48 600 070 717, 24 h / 7 days a week (POL)

- **Feminoteka**
  Warsaw & Countrywide Hotline for women and adolescents who experience violence including sexual violence. Referrals for psychological, social support, and legal assistance. +48 888 88 79 88, Monday–Friday 14:00-17:00 (UKR, RUS) +48 888 883 388, Monday–Friday 11:00-19:00 (POL)

- **FEDERA**
  Warsaw & Countrywide
  Hotline for women and adolescents who experience violence including sexual violence.
  +48 22 635 93 92 Monday- Friday 16:00 – 20:00 (POL)

- **Polskie Forum Migracyjne/ Polish Migration Forum**
  Warsaw & Countrywide Hotline for women and adolescents who experience violence including sexual violence.

[33] Quality PSS services are survivor-centred, age-appropriate, build individual and community resilience, and support positive coping mechanisms. They should include opportunities for social networking and solidarity-building among women and girls. It is important that psychosocial support for women and girls is informed by an understanding of their experiences of violence and discrimination. See GBV Minimum Standards, p. 36.
[34]

Referrals for psychological, social support, and legal assistance. +48 888 887 988, Monday–Friday 14:00-17:00 (UKR, RUS) +48 888 883 388, Monday–Friday 11:00-19:00 (POL)

- **Niebieska Linia/ Blue Line**
  Warsaw & Countrywide Hotline managed by a team of psychologists, psychotherapists, psychiatrists, and lawyers. Provision of psychological short-term intervention and long-term therapies; legal aid and other forms of assistance +48 22 668 70 00, 7 days a week, 10:00-20:00 (POL, UKR)

- **Niebieska Linia/ Blue Line (domestic violence cases)**
  Warsaw & Countrywide Psychological support and legal counselling. +48 22 800 120 002, 24h/ 7 days a week (POL); Monday 18:00 -22:00 (ENG); Tuesday 18:00-22:00 (RUS)

- **Ukraiński Dom - Fundacja Nasz Wybór/ Ukrainian House - Our Choice Foundation** Warsaw & Countrywide
  Psychosocial support +48 727 805 764, Monday-Friday 9:00 -19:00 (UKR)

- **Fundacja dla Somalii/Foundation for Somalia**
  Warsaw & Countrywide
  Psychological counseling and legal assistance for persons who experienced gender-based violence (GBV) +48 736 380 203, Monday-Thursday 9:00-18:00 (UKR, RUS, POL) and Friday 9:00- 15:00 (UKR, RUS, POL)

- **LAMBDA**
  Warsaw & Countrywide
  Psychological counseling, legal assistance, and shelter for refugees from Ukraine who experience violence or discrimination based on their psychosexual orientation or gender identity +48 226285252, Monday Friday, 12:00-14:00 (POL) 16:00-18:00 (UKR, RUS)

- **Ośrodki Interwencji Kryzysowej /Crisis Interventon Centres**
  Countrywide Psychological support, legal assistance, and shelter
  http://www.interwencjakryzysowa.pl/osrodki-interwencji-kryzysowej

- **Fundacja Dajemy Dzieciom Siłę/Empowering Children's Foundation.**
  The hotline for children and teenagers who experience violence and sexual abuse: 116 111, Monday–Friday 14:00-18:00 (UKR and RUS), 24h/ 7 days a week (POL)

- **Centrum Pomocy Dzieciom w Warszawie (Children's Aid Centers)**
  ul. Przybyszewskiego 20/24
  01-849 Warszawa
  tel.: 22 826 88 62
  cpd@fdds.pl

- **Centrum Pomocy Dzieciom w Starogardzie Gdańskim**
  ul. Hallera 19a
  83-200 Starogard Gdański
  tel.: 515 235 716; 58 531 00 45
  cpdstarogard@fdds.pl

- **Centrum Pomocy Dzieciom w Gdańsku**
  ul. Jana Uphagena18
  80-237 Gdańsk
  tel.:515 235 714; 58 718 73 68
  cpdgdansk@fdds.pl

- **Centrum Pomocy Dzieciom**
  Stowarzyszenia dla Dzieci i Młodzieży SZANSA
  ul. Perseusza 13
  67-200 Głogów
  tel. 888 586 246
  kontakt@szansa.glogow.pl

- **Centrum Pomocy Dzieciom**
  Stowarzyszenia KLANZA w Białymstoku
  ul. Gen. F. Kleeberga 8
  15-691 Białystok
  tel. 85 652 54 94, 690 955 000
  cpdbialystok@centrum-klanza.pl

3.3.3 *Case Management* (see also Section 4 for Key Considerations for Documenting Case Management Services)

GBV case management involves a trained psychosocial support or social services actor: (1) ensuring that survivors are informed of all the options available to them and referring them to relevant services based on consent; (2) identifying and following up on issues that a survivor (and her family, if relevant) is facing in a coordinated way; and (3) providing the survivor with emotional support throughout the process.

GBV case management has become the primary entry point for GBV survivors to receive crisis and longer-term psychosocial support because of the lack of more established health and social support service providers in humanitarian settings. Please refer to the Interagency GBV Case Management Guidelines for full guidance on GBV case management.[35]

Currently in Poland case management is provided by

- **Centrum Praw Kobiet /Center for Women's Rights**
  Warsaw & Countrywide CPK's Centres: Warsaw, Krakow, Łódz, Poznań, Gdańsk, Wrocław Information, general and specialized support for all women who have experienced gender-based violence (GBV), including those who fled Ukraine. National hotline: +48 800 107 777, Monday–Friday 10:00-18:00 (UKR) +48 600 070 717, 24 h / 7 days a week (POL)

- **Feminoteka**
  Warsaw & Countrywide Hotline for women and adolescents who experience violence including sexual violence. Referrals for psychological, social support, and legal assistance.

[35] Interagency GBV Case Management Guidelines; see also GBV Minimum Standards.

+48 888 88 79 88, Monday–Friday 14:00-17:00 (UKR, RUS) +48 888 883 388, Monday–Friday 11:00-19:00 (POL)

- **FEDERA**
  Warsaw & Countrywide
  Hotline for all individuals who experience sexual violence.
  +48 22 635 93 92 Monday- Friday 16:00 – 20:00 (POL)

- **Fundacja Dajemy Dzieciom Siłę/Empowering Children's Foundation.**
  The hotline for children and teenagers who experience violence and sexual abuse:
  116 111, Monday–Friday 14:00-18:00 (UKR and RUS), 24h/ 7 days a week (POL)

  - **Centrum Pomocy Dzieciom w Warszawie (Children's Aid Centers)**
    ul. Przybyszewskiego 20/24
    01-849 Warszawa
    tel.: 22 826 88 62
    cpd@fdds.pl

  - **Centrum Pomocy Dzieciom w Starogardzie Gdańskim**
    ul. Hallera 19a
    83-200 Starogard Gdański
    tel.: 515 235 716; 58 531 00 45
    cpdstarogard@fdds.pl

  - **Centrum Pomocy Dzieciom w Gdańsku**
    ul. Jana Uphagena18
    80-237 Gdańsk
    tel.:515 235 714; 58 718 73 68
    cpdgdansk@fdds.pl

  - **Centrum Pomocy Dzieciom**
    Stowarzyszenia dla Dzieci i Młodzieży SZANSA
    ul. Perseusza 13
    67-200 Głogów
    tel. 888 586 246
    kontakt@szansa.glogow.pl

  - **Centrum Pomocy Dzieciom**
    Stowarzyszenia KLANZA w Białymstoku
    ul. Gen. F. Kleeberga 8
    15-691 Białystok
    tel. 85 652 54 94, 690 955 000
    cpdbialystok@centrum-klanza.pl

3.3.3.1 Remote GBV Case Management[36]

Remote case management is the provision of case management services across some distance, usually by phone or internet. Remote case management is an adaptation of in-person case management services so that survivors can access and receive safe and confidential services. Remote case management services also support the health and wellbeing of GBV case workers.

A hotline or helpline is a phone service that provides crisis support and information to any survivor who calls. It is open to the general public and sometimes, but not always, for extended hours. It is recommended to establish hotlines that operate with toll-free numbers if possible, so that callers can avoid incurring a fee.

It is critical that all hotline staff are trained on survivor centered support, PFA and all core functions related to their role. Equally, protocols should be in place for the functioning of the hotline and how to handle calls considering the following[37]:

- How to start a call (e.g. introductory statements, key messages that should be shared from the beginning of the call);
- Communicate the standards of confidentiality at the beginning of the call;
- Information that should and should not be collected by the hotline operator from a caller and how;
- How to ensure survivor safety during the call, to the extent possible;
- How to obtain verbal informed consent;
- How to conduct a safety plan;
- How to deal with calls that are cut short, including policies for call-back;
- What do when clients call back repeatedly;
- How to respond to survivors in immediate danger;
- How to respond to callers with high-risk mental health needs including suicide risk;
- When staff should immediately engage a supervisor for support and/or when they should engage security or the police;
- How to end the calls (e.g. what information and key messages should be shared when a call is ending).

- **Centrum Praw Kobiet /Center for Women's Rights**
  Warsaw & Countrywide CPK's Centres: Warsaw, Krakow, Łódz, Poznań, Gdańsk, Wrocław Information, general and specialized support for all women who have experienced gender-based violence (GBV), including those who fled Ukraine. National hotline: +48 800 107 777, Monday–Friday 10:00-18:00 (UKR) +48 600 070 717, 24 h / 7 days a week (POL)

- **Feminoteka**
  Warsaw & Countrywide Hotline for women and adolescents who experience violence including sexual violence. Referrals for psychological, social support, and legal assistance. +48 888 88 79 88, Monday–Friday 14:00-17:00 (UKR, RUS) +48 888 883 388, Monday–Friday 11:00-19:00 (POL)

- **FEDERA**

[36] For additional technical information on remote case management, please see, e.g. GBVIMS. COVID-19 Guidance on Remote GBV Services Focusing on Phone-based Case Management and Hotlines.
[37] GBV AoR. COVID-19 Guidance on Remote GBV Services Focusing on Phone-based Case Management and Hotlines (2021). IRC. 2018. Guidelines for Mobile and Remote Gender-Based Violence (GBV) Service Delivery.

Warsaw & Countrywide
Hotline for all individuals who experience sexual violence.
+48 22 635 93 92 Monday- Friday 16:00 – 20:00 (POL)

- **Fundacja Dajemy Dzieciom Siłę/Empowering Children's Foundation.**
  The hotline for children and teenagers who experience violence and sexual abuse: 116 111, Monday–Friday 14:00-18:00 (UKR and RUS), 24h/ 7 days a week (POL)

  - **Centrum Pomocy Dzieciom w Warszawie (Children's Aid Centers)**
    ul. Przybyszewskiego 20/24
    01-849 Warszawa
    tel.: 22 826 88 62
    cpd@fdds.pl

  - **Centrum Pomocy Dzieciom w Starogardzie Gdańskim**
    ul. Hallera 19a
    83-200 Starogard Gdański
    tel.: 515 235 716; 58 531 00 45
    cpdstarogard@fdds.pl

  - **Centrum Pomocy Dzieciom w Gdańsku**
    ul. Jana Uphagena18
    80-237 Gdańsk
    tel.:515 235 714; 58 718 73 68
    cpdgdansk@fdds.pl

  - **Centrum Pomocy Dzieciom**
    Stowarzyszenia dla Dzieci i Młodzieży SZANSA
    ul. Perseusza 13
    67-200 Głogów
    tel. 888 586 246
    kontakt@szansa.glogow.pl

  - **Centrum Pomocy Dzieciom**
    Stowarzyszenia KLANZA w Białymstoku
    ul. Gen. F. Kleeberga 8
    15-691 Białystok
    tel. 85 652 54 94, 690 955 000
    cpdbialystok@centrum-klanza.pl

3.3.3.2 Coordination with Child Protection Actor(s)

Essential Issues to Consider

Child protection and GBV caseworkers should work together closely to ensure that young and adolescent girls and boys who are sexually assaulted receive appropriate gender- and age-sensitive case management support. Both actors should both implement the *Caring for Child Survivors of Sexual Abuse: Guidelines for health and psychosocial service providers in humanitarian settings*, and invest in joint trainings and ongoing mentoring and supervision to increase the quality of case management support to child survivors.

In contexts with both child protection and GBV programme actors providing case management services, it is recommended that service-level coordination agreements are established between organisations. When both child protection and GBV response services are equipped to meet the needs of child survivors of sexual abuse, then young and adolescent girls and boys benefit from increased access to age- and gender-sensitive case management support services.

Engaging in joint coordination and mapping of response services, joint referral pathways, and clear criteria for offering specialized support to young and adolescent girls and boys are key actions for child protection and GBV response actors. See the Gender-Based Violence and Child Protection Field Cooperation Framework (2021) to support work to address service provision gaps and promote complementarity.

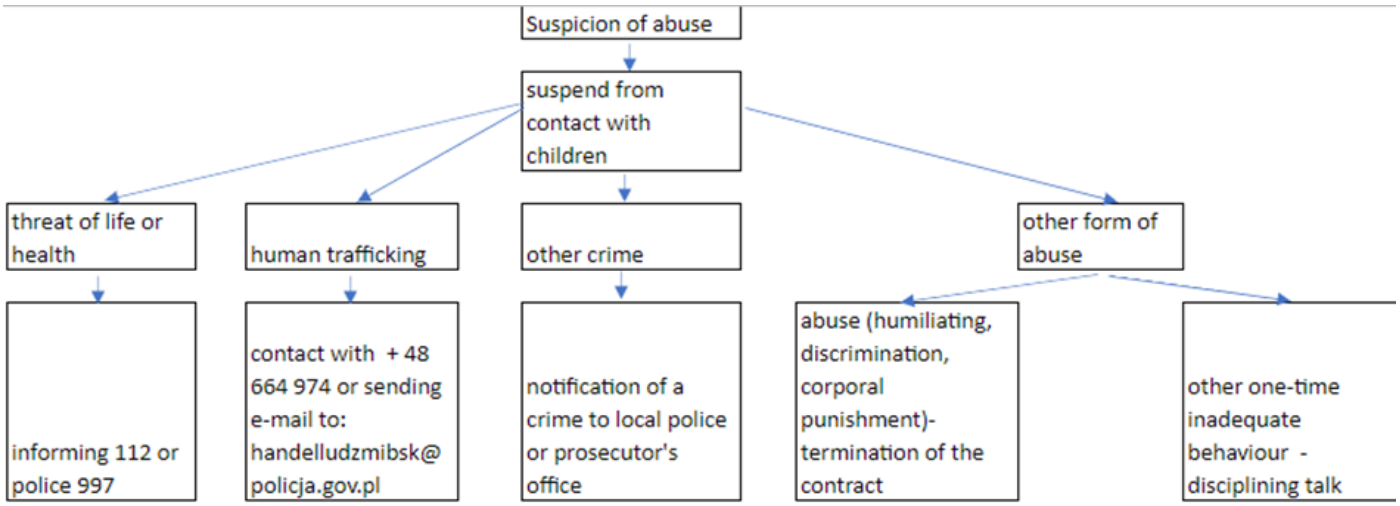
See Annex 1 for resources on GBV and Child Protection collaboration.

In Poland, GBV violence against children in certain cases constitutes a crime that undergoes mandatory reporting. Pursuant to article art. 240 mandatory reporting related to GBV includes: rape with particular cruelty, group rape, sexual abuse of any kind of a minor under 15, rape towards a dependent family member, deprivation of liberty, causing serious damage to health, sexual exploitation of the helplessness or insanity of another person. In such cases, nearest police station or prosecution office adequate for the site of crime should be informed in writing. Organizations should have a template in place that will be easy to fill in and send.

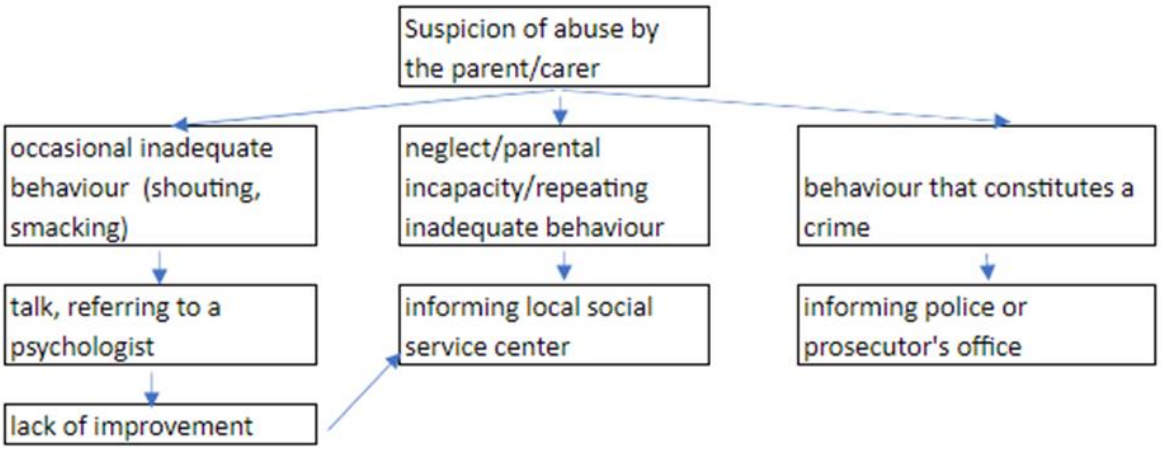
As indicated in this document earlier, another legal provision important in counteracting GBV against children, is the Act of 29 July 2005 on counteracting domestic violence. It introduced the mechanism of so-called Blue Cards which is a help mechanism in case of domestic violence and may be opened without the consent of the survivor. In case of violence against children, it is important to open the Blue Card, without delegating the decision to the child as it may be seen as too overburdening to a child to take a decision on their own protection. The blue card procedure may be opened by any of the following 5 services: police, social services, health providers, education or Municipal Commission for Solving Alcohol Problems. If other actors are informed about domestic violence, the best way is to report it to the nearest Social Service Center (Ośrodek Pomocy Społecznej) or police. Opening a Blue Card procedure is not tantamount to filing a criminal complaint. The Blue Card procedure is an assistance-providing procedure not a penal one. Once opened, an interdisciplinary group will assess the needs of the child and the family, set out a protection and help plan and monitor the situation. If the situation escalates, the interdisciplinary group will take further action of reporting the situation to the prosecution office (if crime is suspected) or the Family Court (if well-being of the child is endangered).

Below you may see intervention schemes for different situations.

Scheme 1: Suspicion of abuse by individual other than parent/caregiver



Scheme 2: Suspicion of abuse by a family member



A child should always be informed in an age-appropriate manner of what is going to happen, where the information will be reported, and what to expect. Information and reporting should be made on a need-to-know basis. Never promise to a child that what he or she is saying will stay completely confidential.

List of organizations:

Helplines:

- 116111 – helpline for children and youth – 24/7 in Polish, from Monday to Friday 14:00-18:00 in Ukrainian and Russian, free of charge, operated by the Empowering Children Foundation
- https://116111.pl/ - Sending a message through the helpsite - Polish
- https://116111.pl/ua/ - Sending a message through the helpsite - Ukrainian
- 800121212 – helpline for children in parents, 24/7 in Polish, operated by Ombudsman for Children Rights with the possibility to take immediate legal action
- https://800121212.pl/ - Sending a message through the helpsite - Polish & Ukrainian
- 800100100 – helpline for parents and professionals on the safety of children, in Polish, Monday to Friday – 12:00-15:00.

For specialized complex services (psychological, legal, social, medical, educational) following the Barnahus/Child Advocacy model with services available also in Ukrainian:
Centrum Pomocy Dzieciom in Warsaw, ul. Przybyszewskiego 20/24, tel: 22 826 88 62:
Centrum Pomocy Dzieciom in Starogard Gdański, ul. Hallera 19a tel.: 515 235 716;
Centrum Pomocy Dzieciom in Gdańsk,ul. Jana Uphagena 18 tel.: 515 235 714;
Centrum Pomocy Dzieciom in Głogów, ul. Perseusza 13, tel. 888 586 246;
Centrum Pomocy Dzieciom in Białystok, ul. Gen. F. Kleeberga 8, tel. 85 652 54 94.

More general help for victims of crime can be sought in the Centers for Assistance to Victims of Crime financed by the Ministry of Justice. The full list is available here: https://www.funduszsprawiedliwosci.gov.pl/pl/znajdz-osrodek-pomocy/

The nearest Social Service center (Ośrodek Pomocy Społecznej) can be found here: Baza instytucji • Portal OPS.PL

Prevention of PSEA

It is important to make sure that children who are benefitting from the assistance of humanitarian organizations, stay safe and do not fall victim to further victimization at the hands of the humanitarian sector employees and volunteers. Children may be particularly vulnerable to SEA.

As outlined in the UN Secretary-General's Bulletin (SGB) for Protection from Sexual Exploitation and Abuse[38], sexual exploitation and abuse violates universally recognized international legal norms and standards and have always been unacceptable behaviour and prohibited conduct for United Nations staff. It harms those whom humanitarian actors are mandated to protect.

The SGB helped established six Core Principles and from thereon, well defined **standards of conduct expected of humanitarian personnel**, including: a) SEA constitutes acts of serious misconduct and may lead to disciplinary measures and dismissal; b) the express prohibition to engage in any sort of sexual activity with minors, regardless of the age of majority or age consent locally; c) the prohibition to exchange money, employment, goods or services for sexual favours, including any exchange of humanitarian assistance due to beneficiaries; d) the discouragement (and then prohibition) of sexual relationships between humanitarians and beneficiaries of aid, as these are based on inherently unequal power dynamics; e) the obligation to report concerns or suspicions of SEA by a humanitarian staffer, through the established reporting mechanisms; and, f) the obligation to actively prevent SEA and procure an environment that supports and develops systems for this purpose.

As best practice, humanitarian organizations should:

1. Have a PSEA policy in place, which shall be communicated to all staff, volunteers, and third-party contractors. It should include clear internal procedures for reporting and investigation.
2. Have a Code of Conduct on PSEA. All staff and volunteers should sign it as a personal acknowledgement of their PSEA responsibilities and a copy of the signed document should be stored as part of their personal file by the human resources department.
3. As part of the recruitment process of staff and volunteers, a vetting process should be put in place and the results of the enquiry should be properly registered. Mandatory references of staff and volunteers involved in care, treatment or education activities must

[38] United Nations Secretary-General, 2003. Secretary-General's Bulletin: Special Measures for Protection from Sexual Exploitation and Sexual Abuse, ST/ SGB/2003/13.

be received. The organization should also confirm these references personally and/or through the official Register of Sex Offenders. All staff and volunteers should be asked to sign a declaration confirming they have no criminal record or not having been involved in investigations of the sort.

More on minimum child safeguarding standards with templates of useful documents can be found here (also in English): PODSTAWOWE ZASADY OCHRONY DZIECI PRZED KRZYWDZENIEM W SYTUACJI KRYZYSU HUMANITARNEGO (fdds.pl)

3.3.4 Women's and Girls' Safe Spaces

The creation of safe spaces for women and girls is a vital component of gender-based violence programming. Women and Girls Safe Spaces serve as an entry point for women and girls to report protection concerns, express their needs, receive services, engage in empowerment activities, and connect with the community.[39]

A WGSS is "a structured place where women and girls' physical and emotional safety is respected and where women and girls are supported through processes of empowerment to seek, share, and obtain information, access services, express themselves, enhance psychosocial wellbeing, and more fully realize their rights." Safe spaces may also be a venue for sexual and reproductive health information and materials (e.g., as part of menstrual health and hygiene management), laundering of menstrual materials, and access to justice services.[40]

"Safe spaces" are also exclusively for women and girls; Female-only safe spaces help reduce risks of further harm during acute emergency situations. These spaces provide women and adolescent girls with a safe entry point for services and a place to access information. Additionally, safe gathering points provide them with opportunities to engage with each other, exchange information, and rebuild community networks and support. As a result, safe spaces can serve as a catalyst for women and girls to build their social capital.[41]

3.3.4.1 *How to Establish and Operate WGSS*

The table below outlines key actions and considerations for establishing women and girl safe spaces:

Key Actions Women and Girls Safe Spaces	Preparedness	Response	Recovery
Conduct an assessment with women and adolescent girls prior to establishing the WGSS to gather basic information on the feasibility of establishing and supporting it, and about their	×	×	×

[39] IRC and International Medical Corps (2019). Advancing Women's and Girls' Empowerment in Humanitarian Settings: A Global Toolkit for Women's and Girls' Safe Spaces
[40] Ibid
[41] Ibid

needs, preferences and constraints related to access to, and participation in, safe space programming. • Map informal meeting places and networks with women and girls to identify an existing or new location to establish a safe space and validate with a wider participatory assessment. • Engage with women's groups and civil society to identify existing WGSS. • Partner with local women's organizations to establish WGSS in new areas hosting displaced women and girls.			
Consult regularly with women, girls and other community members to understand key security risks in the community, and types of community support systems that existed for women and girls before the crisis	×	×	×
Engage regularly with women, girls, men and boys from the affected community to explain WGSS activities, facilitate community acceptance and address barriers to women's and girls' attendance.	×	×	×
Coordinate with child protection partners to determine the most appropriate model for facilitating adolescent girls' access to safe spaces.		×	
Ensure the WGSS is safe, accessible, and has adequate water and sanitation facilities, including by considering the surrounding area, lighting and potential threats. Provide childcare to facilitate participation by mothers	×	×	×
Establish and train staff on available GBV response services and the referral system to support access to multisectoral services.			
Develop mobile teams and/or outreach activities for those who cannot reach the WGSS.	×	×	×
Train all staff on WGSS principles and concepts.	×	×	×
Hire at least three female staff and female community volunteers to operate the safe space. Train WGSS female staff and volunteers on GBV Guiding Principles and other relevant principles, policies and procedures, including a code of conduct.	×	×	×
Establish advisory groups to support women's and girls' leadership and accountability, and WGSS sustainability		×	×

Train the WGSS advisory groups to facilitate activities and progressively assume responsibilities for the WGSS.		×	×
Properly secure case files (if case management is provided through the WGSS), documentation of services and client data kept at the WGSS	×	×	×
Provide regular staff supervision, self-care activities and safety monitoring, and adapt programming as needed.	×	×	×
Organize and distribute dignity kits through the WGSS		×	
Assess potential partnerships and collaborations to complement safe space programming with other services such as livelihoods or education programmes	×	×	×
Develop an exit strategy in consultation with women, adolescent girls, and female and male community leaders to minimize harm if the safe space needs to close.		×	×

Adapted from: Inter-Agency Minumum Standards for Gender Based Violence Emergencies Programming

3.3.4.1 Women and Girls Safe Space Approach

The WGSS may be implemented directly or through partners and can be established as permanent, temporary, or mobile spaces.

In a static service delivery model, women and girls travel to the WGSS to access programming, whereas in a mobile service delivery model, the WGSS team travels to where women and girls are to provide temporary safe spaces and programming. In either case, both approaches have benefits and risks that vary according to the context. Ultimately, both approaches must be safe, appropriate, and beneficial for women and girls. The decision on the most suitable approach will be guided by the following considerations:

a. **Distance from services** – consider the urban versus rural areas in Poland; public transport connections, schedules and costs; time that travel would require. For example, if there are many refugee women and girls renting apartments in the outskirts of urban areas, it may be beneficial to consider organizing mobile teams in some remote areas.
b. **Access barriers and restrictions of movement** – consider if the refugee women in Poland are facing any administrative barriers preventing them from free movement. In the Polish context, administrative barriers may not pose a significant challenge, except in cases of COVID-19 containment measures (e.g. lockdown, curfews). However, as refugee women in Poland are attempting to identify durable solutions for integration – such as employment, Polish courses – they may be bound by strict working schedules.

c. **Scale of need and geographic coverage area** – this is closely linked with the above two considerations. In the Polish contest also consider the number of actors responding in a specific location.
d. **Safety** – the selected approach must take into account whether it may expose women and girls to further risks, such as having to travel to the safe space location during late hours, through areas that are poorly lit or where public transport has limited coverage.
e. **Availability of other services** – check the locations where other services for women are available to decide on approach and location. For example – consider the districts where there are health clinics nearby for easy referral.

3.3.4.2 WGSS Activities

All activities and services should be determined in consultation with women and girls so that the activities are responsive to their needs and experiences, are context and age appropriate, and consider the types of activities that women and girls participated in before their displacement. Childcare services should be made available to increase access to WGSS for women and adolescent girls with young children. These services can be provided by either volunteer or incentive-based staff working in the safe space. At a minimum, toys should be made available for children. [42]

The following list - extracted from the WGSS Toolkit - illustrates the links between the WGSS objectives, the activities that WGSS members participate in, and the types of empowerment these activities promote. While the activities are representative of what is delivered in WGSS in many contexts, they are not intended as a set of standard activities. As much as possible, activities provided in the safe spaces should be determined after consultation with women and girls, allowing them to take the lead in decision making.

Objective 1: WGSS facilitate access for all women and girls to knowledge, skills and a range of relevant services. Illustrative WGSS activities that support the achievement of this objective include

- Orientation for new members
- Information dissemination on available services
- Referrals to other humanitarian services (for all women and girls, not specific to survivors)
- Periodic service mapping
- Hosted information sessions from other service providers (e.g. legal, nutrition or sexual reproductive health service providers)
- Life skills sessions for groups of adolescent girls
- Skills-building groups or hosted skills training (e.g. vocational or livelihood service providers)

Objective 2: WGSS supports women's and girls' psychosocial well-being and creation of social networks

- Arts-based activities (e.g., music, dancing, theatre, drawing)
- Exercise and sport (e.g., yoga, volleyball, football)
- Leisure and relaxation activities (e.g., coffee or tea ceremonies, meditation, storytelling, movies

[42] Inter-agency Minimum Standards, UNFPA 2019

- Craft-making (e.g., soap making, tailoring, beading, basket making)
- Community development initiatives (e.g., gardening, rehabilitation of community spaces)
- Positive support groups (young mother support groups, community development groups)
- Communal income-generating activities to support the WGSS

Objective 3: WGSS serve as a place where women and girls can organize and access information to reduce risk of violence

- Facilitated discussions to understand concerns and safety risks
- Awareness sessions on risks to GBV, including SEA, and available response services
- Awareness sessions on feedback and reporting mechanisms
- Community mapping and safety planning exercises including safety audits
- Hosted information sessions from safety/security actors (e.g., peacekeepers, police, community watch groups)
- Direct or hosted distribution of dignity kits, cash, or voucher assistance

Objective 4: WGSS serves as a key entry point for specialized services for GBV survivors

- Information dissemination on available GBV response services
- Safe referral to GBV response services or any other relevant service
- Basic response to survivors who report incidents of GBV
- Provision of GBV case management services and individualized psychosocial support services for survivors of GBV
- Confidential integration of survivors into WGSS group activities

Objective 5: WGSS provide a place where women and girls are safe and encouraged to use their voice and collectively raise attention to their rights and needs

- Facilitated discussions (FGDs or meetings) to understand women's and girls' perspectives and needs
- Women's forum meetings and advocacy planning
- Mentorship, peer facilitation, and side-by-side support from active members
- Meetings of women and girl-led initiatives (e.g., associations, savings and loans groups)
- Leadership and advocacy training

3.3.4.3 Staffing

The WGSS staffing structure depends on multiple factors, including needs, population size and the scope of program interventions. Staff should consist of volunteers, staff provided with incentives and paid staff, reflecting the diversity of the population. WGSS staff should be trained so that they are able to perform their duties safely, effectively, and ethically. They should be selected carefully and trained on GBV core concepts and Guiding Principles, the referral pathway, communication skills and how to organize group activities; caseworkers require thorough training and supervision [43]All staff should sign a code of conduct that includes provisions on protection from sexual exploitation and abuse[44] See The Safe Space Tool Kit Pg 208 for detailed guidance on WGSS staffing structure.

[43] IRC and International Medical Corps (2019). Advancing Women's and Girls' Empowerment in Humanitarian Settings: A Global Toolkit for Women's and Girls' Safe Spaces

[44]Inter-agency Minimum Standards, UNFPA 2019

During recruitment, the following considerations should be considered:

1. **Labor law:** Workers should be recruited, employed and treated in accordance with the Polish Labor law. That includes employee rights, salaries, benefits and working hours. Job descriptions and vacancy announcements should always comply with local regulations.
2. **Clear roles and responsibilities:** Organogram and job descriptions should clearly indicate the supervisory lines, and roles and responsibilities of different team members. Job descriptions and vacancy announcements should also highlight specific responsibilities and the technical capacities or certification required for these.
3. **Candidate attitude and beliefs:** It is recommended to inquire about personal attitudes and beliefs towards gender roles, GBV, women's empowerment, humanitarian and protection principles. The Global Toolkit for Women and Girl Safe Spaces encourages using the tool *WGSS Candidate Attitude and Beliefs Survey for Recruitment* to assess the candidate attitudes during recruitment.
4. **Inclusion of diverse women:** it is highly recommended to have a diversified team of staff at the WGSS to represent various ethnic, religious and minority groups, women with disability, elderly women, and other under-represented groups to encourage enrollment of women and girls from various backgrounds, including the most vulnerable and marginalized.

It is highly recommended to have written policies and practices around **staff care** and **self-care** to prevent burnout and support quality services. The Global Toolkit for Women and Girl Safe Spaces (page 226) recommends a number of tools to be applied by the staff and supervisors at WGSS, including on stress management, identifying signs of stress and team wellness.

3.3.4.4 WGSS Guiding Principles

- Empowerment: Women and girls have the ability for self-determination as well as to create and contribute to broader social change. Therefore, it is crucial to ensure that women and girls are involved in WGSS planning, implementation, and monitoring and evaluation.

- Solidarity: Safe spaces enable women and girls to gain an understanding of how their personal experiences relate to the larger power and social injustices in which they live. By encouraging sharing, mentoring, and cooperation, WGSS provides opportunities for individuals and groups to connect. Supportive relationships increase self-esteem, positive coping mechanisms, and social assets critical for the emotional safety and healing of women, girls, and survivors.

- Accountability: Women and girls can openly share their challenges and experiences and receive support and confidentiality as needed. All aspects of the WGSS, including location, design, and programming, prioritize the safety and confidentiality of women and girls. These components contribute to ensuring that WGSS is a safe and nurturing space for women and girls.

- Inclusion: A safe space is inclusive of all women and girls. Staff and volunteers are extensively trained on the principles of inclusion and non-discrimination. Women and girls are: Involved in the design and implementation of WGSS and provided opportunities to participate as staff or volunteers; Supported to engage in the range of services and activities offered by WGSS; and engaged actively through tailor-made outreach strategies in order to mitigate access barriers that hinder their equal participation.

- The WGSS should serve to connect women and girls to services through strong referral networks. Local civil society organizations, particularly women's civil society organizations or networks, are a key component of the WGSS approach, and are also vital in ensuring sustainability. Partnering with local entities should be considered during the assessment phase and should be implemented during the establishment of the WGSS.

Safe and Meaningful Access:

The safe space should be located in an area that is conveniently accessible to women and girls and assures safety and privacy. The decision on where to locate the safe space should be led by women and girls. In terms of accessibility, it is important to consider the best times and days for women and girls. If possible, consideration should be given to supporting the transportation costs to and from the facility. In addition, the WGSS should ensure that a Code of Conduct is adopted and that all staff members are trained on it.

Structural requirements: All WGSS should be accessible to all women and girls (including those with physical disabilities) and should withstand all weather conditions (e.g., not located in flood zones). Furthermore, outlined below are the minimum requirements that all WGSS globally should follow[45]:

1 activity room	This would be the space for group activities. Ideally a WGSS would have more than one group activity rooms to allow diversification of activities and accommodate a greater number of women and girls, where there is such a need. Where there is only one room available, consider setting schedules for each type of activity. Make sure that activities for adolescent girls have a dedicated room / schedule.
1 private conversation room	This requirement is very important to support confidentiality of conversation. This requirement is mandatory regardless of whether the WGSS provides case management or not.

[45] IRC and International Medical Corps (2019). Advancing Women's and Girls' Empowerment in Humanitarian Settings: A Global Toolkit for Women's and Girls' Safe Spaces

1 toilet and access to water	Women and girls attending the WGSS must have access to toilet, hand washing area and clean drinking water for hygienic purposes.
1 childcare space	Refugee women oftentimes do not have solutions for their young children. To encourage regular attendance and participation, a childcare space would allow women to attend to their own needs while their children are safe and taken care of.
1 room for storage of assets and materials	This is strongly recommended by the Global Toolkit for Women and Girls Safe Spaces for quality programming.

List WGSS in the setting and any specific services or activities provided there. Describe considerations for safety and security of WGSS, and any coordination with child-friendly spaces, or other similar initiatives, within other sectoral programming.

3.3.5 Security and Safety[46]

This section focuses on actors in the setting who contribute to women's, girls' and GBV survivors' safety and security in the setting. All service providers should prioritise the safety and security of survivors and their families as well as of staff providing care to survivors. A safety and security assessment is part of GBV case management and service delivery. GBV caseworkers, service providers and survivors should assess security risks and conduct safety planning.[47]

3.3.5.1 Security Actors

In the vast majority of cases, referrals will be made to national justice systems by the police only if the victim/survivor has given her informed consent. Police or any other security actor should be contacted as a referral to a service provider following the process in section 3.2 and following the guiding principles, thus survivor informed consent should be sought for the referral.

The police are the key security actor in Poland responsible for the safety and protection of survivors of GBV. They can be contacted in an emergency situation on the hotline emergency number **997**. Also, there is the general emergency line **112** that can be contacted in an emergency situation.

There is no need to have documents/be registered in the country to call the police. If you have any migration issues, it may be safer to contact an anti-violence support center rather than the police. If domestic violence is discovered, the "Blue Card" procedure applies. It may be initiated by the Police, the Committee for Solving Alcohol Problems, educational, healthcare and social

[46] See, e.g. Handbook on Gender-Responsive Police Services for Women and Girls Subject to Violence and From evidence to action: Tackling gender-based violence against migrant women and girls.
[47] See GBV Case Management Guidelines, Section 1.2.3 for 'Planning for Safety', pgs. 101-102.

welfare institutions. The abovementioned services are charged with the task of providing immediate assistance to the victim and taking further steps – establishing a “Blue Card”.

The new legal provisions, initiated by the Minister of Justice and adopted almost unanimously by the Polish Parliament, entered into force on November 30th, 2020. It is the perpetrator of physical violence threatening health or lives of household members that has to leave home immediately. This person can also be banned from getting close to home. Sanctions are enforced immediately by the Police and court has to deal with the case without delay.

According to the new law, the police are getting new powers. A policeman intervening evaluates whether the perpetrator of domestic violence threatens health or lives of household members. If there is such a risk, the policeman will give the perpetrator a binding order to move out immediately. This person will be allowed to take necessities with him. The order is enforced, also by necessary coercive measures, even if the perpetrator declares that he has nowhere to go. The policeman will advise this person of places offering overnight accommodation, such as homeless shelters. Also, the policeman is authorized to give the perpetrator a restraining order requiring him to stay away from the home and its direct surroundings.

Such an order to leave the apartment and the restraining order given by the police are effective for two weeks but may be prolonged by a court at the victim’s request. The new law provides for judicial control over the application of new measures. In justified cases, courts are able to consider complaints from perpetrators and cancel such orders, though victims will retain their right to re-apply for the orders. The police has a duty to make routine checks on whether the perpetrator complies with the sanction. If not, the police will have the right to use coercive measures to enforce the order. In addition, the perpetrator will risk being put under arrest, restriction of freedom or a fine. The same rules will apply to the eviction order.

The medical help can be contacted in an emergency situation on the hotline emergency number **999.** Ukrainians (persons with Ukrainian passports) do not need special documents. They are covered by a special protection scheme. Other people have a right only to emergency medical assistance, if they do not have insurance or unemployed. Persons who, in connection with the performance of their official or professional duties, have a suspicion that a crime involving family violence prosecuted ex officio has been committed, shall immediately notify the Police or a public prosecutor. Persons who are witnesses should notify the Police, public prosecutor, or other entity acting in support of preventing family violence.

Legislation punishing domestic and intimate partner sexual violence is mostly Article 207 of the Polish Criminal Code:

§ 1. Anyone who physically or mentally abuses a person close to him or another person in a permanent or temporary relationship depending on the perpetrator, shall be subject to the penalty of deprivation of liberty for a term of between 3 months and 5 years.

§ 1a. Who harasses physically or mentally a helpless person because of their age, mental state or physical, punishable by imprisonment from 6 months to 8 years.

§2 If the act specified in §1 or 1a is connected with the use of a particular cruelty, the perpetrator is punishable by imprisonment from one year to 10 years.

§ 3. If the consequence of the act specified in § 1-2 is the victim's own life, the perpetrator is punishable by imprisonment from 2 to 12 years.

3.3.5.2 Safe Houses/Shelter

Safe houses/shelters are places that provide immediate security, temporary refuge, and support to survivors who are escaping violent or abusive situations. This service is made available to survivors of GBV who are in imminent danger. Ideally, a safe shelter or house is accredited and staffed by professionals. Admission is contingent on specific criteria and strict standard operating procedures. Locations of the safe houses should be safe and confidential.[48]

Core standards for the delivery of safe shelters for GBV survivors are as follows[49]:

- Safe shelter services should be free of charge
- Safe shelters should have clear safety protocols in place with clear procedures in place in case of a security threat/incident
- Safe shelters should be accessible 24/7, this should consider safe transport options (survivors should be accompanied by women staff in transportation to shelters)
- Safe shelters should try to maintain a room/rooms available for emergency needs
- Survivors should have the right to access independently safe shelters without needs of police or other institution/organization referral, lengthy processes to receive survivors should be avoided
- The duration of stay should be discussed with the survivor and decided by the survivor based on her individual needs
- Safe shelters should provide quality and holistic services to survivors by trained gender sensitive staff, at minimum this should include case management and PSS services provided internally. Survivors and their children in shelters should also have safe access to other services according to their needs (e.g. healthcare, legal support, livelihoods, education, etc.)
- Safe shelters should provide comprehensive support for the children of survivors. This entails all children below the age of 18 regardless of gender, and children with specific needs should receive tailored support.
- All survivors of violence need to receive support regardless of their nationality or status in Poland.
- Survivors with specific needs should have access to safe shelters and tailored support

Entities providing safe shelter for GBV survivors in Poland (full details are in referral pathways include):

- **Ośrodki Interwencji Kryzysowej/Crisis Intervention Centres**

Shelter for women & children who experience domestic violence

Warsaw +48 514 202 619
Lublin +48 733 588 600
Rzeszów +48 17 863-53-89
Kraków +48 12 421 92 82
Poznań +48 61 814 22 71
Wrocław +48 71 352 94 03
Gdańsk +48 58 511 01 21
Szczecin +48 91 48 57 601
Toruń +48 56 477 00 91
Olsztyn +48 89 523 64 02
Łódz +48 42 630 11 02;
Katowice +48 32 251 15 99
Opole +48 77455 63 90

[48] GBV Minimum Standards, p. 64.
[49] See Quality Guidelines for Shelters for Victims of Violence against Women and Domestic Violence, Council of Europe, 2021, https://wave-network.org/wp-content/uploads/Shelter_Guideline_ENG-1.pdf

Kielce +48 41 366 4847
Zielona Góra +48 68 3244900

- **Centrum Praw Kobiet/ Women's Rights Centre**

Warsaw, Kraków, Wrocław Shelter for women who have experienced gender-based violence (GBV) +48 600 070 717, 24 h / 7 days a week (POL)

- **LAMBDA**

Warsaw Shelter for refugees from Ukraine who experience violence or discrimination based on their sexual orientation or gender identity +48 226285252, Monday Friday, 12:00-14:00 (POL) 16:00-18:00 (UKR, RUS) CARITAS Warsaw +48 660 424 014 +48 22 619 44 76 Food and non - food items including clothing, hygiene items, baby supplies Białystok +48 85 740 39 11

3.3.6 Justice and Legal Aid[50]

Legal actors will clearly and honestly inform the survivor of the procedures, limitations, benefits and risks of all existing legal options. This includes:

- Information about available security measures that can prevent further harm by the alleged perpetrator;
- Information about procedures, timelines, and any inadequacies or problems in national or informal justice solutions (i.e. justice mechanisms that do not meet international legal standards).
- Information about available support if formal legal proceedings or remedies through alternative justice systems are initiated.
- Information about other civil/non-criminal services or procedures that help survivors access their rights (e.g. ration card division, asylum hearings, etc.).

It is crucial that legal actors provide survivor-centered accompaniment and follow up for cases throughout the process. Equally, actors should make provisions for covering any related costs (e.g. transportation costs, clothes for court hearings, translation of legal documents, interpretation if needed, etc.), if the legal actor does not have the means to provide this support there should be an urgent referral for cash assistance to cover these costs.

Organisations that provide legal and administrative advice and counseling for survivors:

- **Centrum Praw Kobiet /Center for Women's Rights**

Warsaw & Countrywide CPK's Centres: Warsaw, Krakow, Łódz, Poznań, Gdańsk, Wrocław National hotline: +48 800 107 777, Monday–Friday 10:00-18:00 (UKR) +48 600 070 717, 24 h / 7 days a week (POL)

- **Feminoteka**

Warsaw & Countrywide
+48 888 88 79 88, Monday–Friday 14:00-17:00 (UKR, RUS) +48 888 883 388, Monday–Friday 11-19:00 (POL)

- **FEDERA**

[50] UN Women. 2018. A Practitioner's Toolkit on Women's Access to Justice Programming.

Warsaw & Countrywide
+48 22 635 93 93 Monday- Friday 16:00 – 20:00 (POL)

- **Centrum Pomocy Prawnej im. Haliny Nieć/ Halina Nieć Legal Aid Center (HNLAC)** Warsaw & Countrywide Legal advice services +48 725449374 and +48 693390502, Monday-Friday 9:00- 15:00 (POL, UKR, RUS, ENG)

- **Stowarzyszenie Interwencji Prawnej/Association of Legal Intervention**
Warsaw & Countrywide Legal advice services +48 880145372, Monday- Friday 14:00-16:00 (POL, UKR, RUS, ENG)

- **Centrum Koordynacji Pomocy Prawnej/ Centre of Coordination of Legal Help** Warsaw & Countrywide Legal advice services +48 800 088 544, Monday- Friday 9:00-19:00 (POL, UKR, RUS, ENG)

- **Fundacja Instytut na rzecz Państwa Prawa/ The Rule of Law Institute Foundation** Lublin & Countrywide Legal advice services +48 606 703 933, Monday-Friday 12:00-14:00 (UKR, POL)

- **Homo Faber** Lublin Psychological support, legal assistance, and referral to a shelter. +48 533391569, 24h/ 7 days a week (UKR, RUS, PL, ENG)

- **Krajowe Centrum Interwencyjno-Konsultacyjne dla Ofiar Handlu Ludzmi (KCIK)/ National Intervention and Consultation Center for Victims of Human Trafficking** Countrywide Hotline for victims of human trafficking, forced labor, and slavery. Psychological, legal, and social assistance. Operated by La Strada organization. +48 22 628 01 20, 24 hours / 7 days a week (POL, UKR, RUS) KCIK +48 22 628 99 99, 24 hours/ 7 days a week (POL, UKR, RUS, ENG) La Strada +48 605 687 750, 24 hours/ 7 days a week (POL, UKR, RUS, ENG) La Strada

- **Fundacja Ocalenie Help Centre for Foreigners** Warsaw, Łódź, Łomża Legal advice, psychological counseling, and material support +48 22 828 50 02, Monday-Friday 08:00-17:00 (UKR, POL)

- **Kampania Przeciwko Homofobii/Campaign Against** Homophobia Warsaw & Countrywide Legal advice services for all individuals who experience discrimination based on sexual orientation or gender identity/expression +48 22 423 64 38, Monday-Friday 10:00-17:00 (POL)

3.3.7 Dignity Kits

Essential Issues to Consider

Dignity kit content must be based on the input and preferences of women and girls in the community and include context-specific items (e.g. headscarves in settings where women cannot appear in public without them). Consult with women and girls to inform dignity kit content, including women and girls' practices related to menstruation and their preference for menstrual products.

To identify relevant, appropriate content for dignity kits, organizations should consider the following basic parameters: Relevance of the items, cultural sensitivity, context, environment, quantity, frequency of distribution and price.

Dignity kits may be procured and distributed by WASH or Shelter, Settlement and Recovery actors. GBV programme actors should coordinate with other sectors to ensure dignity kits are responsive to the needs of women and girls, maximize the distribution potential of all items, and avoid gaps or unnecessary duplication of efforts. (IASC GBV Guidelines, 2015, p. 292.) Whenever possible, questions should be integrated into other assessments (e.g. sexual and reproductive health, WASH) to minimize duplication and avoid overburdening women and girls.

Women and girls need basic items to interact comfortably in public and maintain personal hygiene, particularly menstrual hygiene. Without access to culturally appropriate clothing and hygiene products, women and adolescent girls are at greater risk of GBV, their health is compromised, their mobility is restricted, and they may become increasingly isolated.

Humanitarian actors often distribute dignity kits that typically contain menstrual hygiene materials, soap, underwear and information on available GBV services, including where and how to access those services. Dignity kits may also include items that may help mitigate GBV risks such as radios, whistles and lights.[51]

To reduce risk of GBV and other violence, dignity kit distribution outside of GBV specialized services should include multiple of categories of women (e.g. women heads of households, women with disabilities); it should not only target survivors of GBV.

It is important to conduct post-distribution monitoring to assess the distribution results, whether the right beneficiaries received the kits or any risks resulting from the distribution.[52]

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51 https://www.humanitarianresponse.info/sites/www.humanitarianresponse.info/files/documents/files/dignity_kits_guidance_note_en.pdf

52 Post-distribution monitoring can be done through focus group discussions (FGDs) with women and girls 1-3 months after distribution to assess whether the kits achieved the intended focus. It is important to ensure women and girls who received the kits are involved in the post-distribution FGDs. See e.g. for guidance on conducting post-distribution monitoring.

3.3.8 Cash & Voucher Assistance[53] (see also Section 6.2)

Essential Issues to Consider

Cash and voucher assistance (CVA) refers to all programmes where cash transfers or vouchers for goods or services are provided directly to recipients. In the context of humanitarian assistance, the term is used to refer to the provision of cash transfers or vouchers to individuals and household or community recipients only (not to governments or other State actors). The terms "cash" or "cash assistance" refer specifically to cash transfers (and do not include vouchers).

Cash can be both a (1) risk mitigation modality and (2) component of survivor-centred GBV case management services. In situations where core GBV response services (e.g. health or legal services) have associated costs and/or are not available free of charge, cash transfers can facilitate access and support recovery.

GBV case management should assess any financial needs that a survivor might have (e.g. that may hinder service access) and refer the client for cash assistance. Cash works best when it complements rather than replaces other types of assistance and services within GBV case management. It should be viewed as one option among GBV response services and wider prevention and empowerment efforts.

GBV programme actors in humanitarian settings must establish clear internal or inter-agency protocols to outline the roles and responsibilities of cash and GBV programme actors to ensure the availability of quality services and timely and accessible care for survivors.

Coordination between cash and GBV programme actors is essential to prioritizing clients and developing systems and procedures that effectively meet the specific needs of diverse populations, including women and girls at increased risk of GBV, while preserving confidentiality and safety.

To reduce risk of GBV and other violence, dignity kit distribution outside of GBV specialized services should include multiple of categories of women (e.g. women heads of households, women with disabilities); it should not only target survivors of GBV. [54]

It is important to conduct post-distribution monitoring to assess the distribution results, whether the right beneficiaries received the kits or any risks resulted from the distribution.

3.3.9 Economic Empowerment and Livelihoods

GBV specialised actors are not usually responsible for direct provision of economic empowerment and livelihood support. Instead, they should consider how to work best with livelihood programmes and/or other partners to establish linkages and ensure that GBV survivors can access livelihood support as part of a comprehensive multisectoral approach to addressing GBV. As a response measure, livelihood and economic empowerment programmes can be entry points for GBV survivors to receive information and access services, and may also provide an outlet for emotional support and healing activities.

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[53] UNHCR, Cash Assistance and Gender; UNHCR, Guide for Protection in Cash-based Interventions; Cash and Voucher Assistance for GBV Cases: Standard Operating Procedures, Turkey Cross-border/Northwest Syria; IASC GBV Guidelines: Cash & Voucher Assistance and GBV Compendium: Practical Guidance for Humanitarian Practitioners; Women's Refugee Commission, Resources for Mainstreaming Gender-Based Violence (GBV) Considerations in Cash and Voucher Assistance (CVA) and Utilizing CVA in GBV Prevention and Response.

[54] Market based programming for WASH Guidance on CVA for menstrual products, pgs. 146-147.

GBV survivors should not be the sole participants in a specific livelihood programme, as this can increase stigma and compromise confidentiality, safety and security. One approach is to work with communities to identify the women and adolescent girls who are most at risk of violence. Programmes can target these groups and/or individuals as well as survivors, in a way that does not compromise confidentiality or expose the survivors.

3.4 Referral Pathway

Essential Issues to Consider on Developing a Safe Referral System

It is important to establish a clear reporting and referral system in each city and/or voivodeship so that survivors of and/or witnesses to a GBV incident know to whom they should report and what sort of assistance survivors can expect to receive from the health, psychosocial, case management and other sectors.

Survivors are more likely to come forward to seek help and report a GBV incident in a place that they perceive is safe, private, confidential, and accessible.

To establish a GBV safe referral pathway, consult with women, girls and other community members about where and with what the "entry point(s)" organisation(s) for GBV response services should be located and what might make these entry points safer and more accessible.

The referral pathway should consist specific information about each service listed, including but not limited to:

How to access the service;
The hours of operation and service availability;
If the service costs money and how much; and
Who the services are for (i.e. if limited to specific populations).

Illustrate the entry points and include basic and information about reporting and referrals in the local language(s) and/or as a pictorial presentation.

Conduct targeted outreach campaigns to disseminate referral pathway and GBV response service entry points information to diverse community members so that as many people as possible are aware of where to go for help and what to expect.

Implement specific access adaptations to the referral pathway for groups of persons who face additional barriers to access, such as survivors with disabilities and older women.

Involve representatives and members of groups who face barriers to access in the development of the GBV SOPS and referral pathway to ensure appropriate adaptations and increase marginalized groups' safe access to services.

GBV survivors must be able to access life-saving services quickly and safely at all times and in all settings. At a minimum, this requires: (1) a network of qualified multisectoral service providers; and (2) an established referral pathway or system that supports survivors' timely, safe and confidential access to services.

A referral pathway should include easy-to-understand terms explaining what to do and where to go for immediate service delivery. The people who are most likely to refer survivors to services need to understand the referral pathway; this means that they must be involved in developing it. Referral pathways must be updated when service providers change. Service providers should agree on how to share the referral pathway so that it reaches key community members.

The aim of distributing and sharing the referral pathway in the community is to balance protection risks to survivors and service providers with accessibility. For example, in certain contexts, a referral pathway that contains contact information for GBV service providers could pose risks to those service providers if the information is publicly shared. Proceed with extreme caution in settings where public discussion about the establishment or existence of GBV services poses security risks. In these cases, it may be most effective for GBV coordinators and partners to develop an initial referral pathway with accompanying basic protocols for survivors and distribute this only to those who fully understand the GBV Guiding Principles. When and if the situation improves, the referral pathway may be revised and disseminated more publicly. In settings where it is safe to include more detailed information about entry points however, the referral pathway should include both (1) the name of the organization and (2) its GBV focal point, with the contact phone number and/or address.

To establish referral pathways, please use the Inter-Agency GBV Referral Pathway template in Annex 2 to agree on and list entry points for receiving reports of GBV incidents and pathway for referrals and follow up in a specific location. The template provides summary information only; details and procedures are described in Section 3.3.

Feedback about the referral pathway use should be gathered regularly by:

- Opening and promoting channels (hotline, text message, email, etc.) for survivors to submit feedback and complain about contacting and using the service(s) in the referral pathway
- Regular workshop (every 3 or 6 months) with service providers including those who provide safe referrals to survivors to assess the implementation of referral pathways
- Analysing the result of client feedback survey administered by service providers.

The feedback then will be analysed. The result will be used as a basis to improve and ensure the referral pathways are understandable, accessible and available – including language-wise – for the population(s) of concern.

Before referring a survivor to another service, please remember that a survivor has the freedom and the right to disclose an incident to anyone. Always follow the basic principles of safety, confidentiality, dignity and self-determination as well as non-discrimination. At all times, prioritise survivor and staff safety and security. No action should be taken without the express permission of the survivor – within the bounds of the law. All service providers should always prioritise the confidentiality and security of survivors.

To make referral, please use the Referral Form in Annex 3. This form should be filled with minimum basic important information only, such as nickname of the survivor or if necessary their initial. The form then will be sent to the service(s) who will follow up the client's specific needs via email. The form should be protected by password – which will be shared only to the focal point of the service(s) referred via other method of communication other than email (this is also why communication between services beyond survivor referral must be established). If more comprehensive information about the survivor, such as name per identity document (when booking an accommodation), if needed, this should be informed to the service provider(s) focal point not by writing it on the referral form. Moreover, it is suggested when sharing information about a survivor to other service provider(s) focal point to do it in incremental way dividing information into several parts and time, rather than in one body of message – so it will be harder to track the survivor.

3.4.1 Outreach[55] to Increase Safe Access to Services

[55] For additional information on community engagement and awareness-raising about enhancing safe and timely access to services, see Interagency GBV Minimum Standards, p. 57.

In the context of GBV response programming, the objectives of community outreach and awareness-raising are to increase timely and safe access to services and mitigate risks of GBV. On its own, outreach is insufficient to achieve prevention outcomes; therefore, outreach is focused on improving awareness of and access to response services.

The referral pathway is a critical part of creating awareness of and access to services. Awareness-raising efforts should focus on:

- Access to services, especially life-saving and time-sensitive health services, because survivors need to know where to find help; and

- Activities that can help reduce women's and girls' risk of GBV, especially sexual violence.

Community engagement and outreach methods may vary based on the context and should always leverage preferred and trusted communication channels. To understand which channels can be best used to share information with different groups in a particular context an information and communications assessment is advisable (if not already completed). Some ideas include loudspeakers; sharing of information, education, communication materials (IEC) (e.g. posters, pamphlets); meetings or small-group discussions; sharing information at distributions
of materials or food; social media and websites.

Safety is an essential element to consider in designing community outreach and awareness-raising information and methods. It is important to assess how certain information may be viewed by different members of the community or armed groups, and what this may mean for staff and women and girls. The means of sharing information with communities must also be weighed; e.g. in some contexts, men will not allow women to meet together or mobilize. All GBV outreach should be led by or coordinated with GBV specialized actors.

When deciding when and how to share information, consider the barriers that women and girls may face in accessing information. It is important to use multiple channels to share information and consider how women and girls prefer to access information.

All awareness-raising on GBV must include information on how survivors can access support. It is not recommended to conduct community awareness-raising activities on GBV in locations where response services have not yet been established.

SECTION 4: Key Considerations for Documenting Case Management Services

Quality GBV case management services require a survivor-centered approach that includes the GBV Guiding Principles and supports survivors to meet their needs through a series of steps (see also Section 3.3.3). Effective GBV coordination is necessary for quality GBV case management by ensuring that relevant actors know their roles and work according to minimum standards for compassionate and competent care as well as existing service mapping.

Appropriate and safe documentation of service provision information throughout the case management process is necessary to ensure quality of GBV case management services.

4.1. Case Documentation[56]

GBV case management documentation refers to the documentation of information (either on paper or digitally) relating to an individual survivor's case management service provision by a case management organisation. Generally, case documentation information includes dates of services and summaries of discussions; a brief description of the incident and the survivor's situation; relevant action plans and follow-up appointment information. Case documentation also includes the date and reason for closing the survivor's case.

Although documentation supports the quality of service provision to survivors and promotes accountability, it is not required to provide quality case management services. Setting up a system to document individual case information is appropriate only if a service is offered and documentation can be securely stored. Any type of survivor information should only be collected in the framework of service provision and only when reported directly by the survivor or their caregiver in the presence of the survivor. It is not appropriate, for example, to seek out or record identifiable information about survivors solely for the purpose of protection or human rights monitoring.

It is important to be cautious in all contexts when deciding if and when to begin documenting and maintaining survivor case files because of the security risks to survivors, their families and staff. The decision of whether to collect survivor data depends on an organisation's capacity to ensure safe, confidential storage of all information. All documentation containing information about survivors should be collected and stored in adherence to international standards that prioritise survivors' confidentiality, safety and security. In the absence of specific information storage systems, it should be assumed that data is not secure and may be subject to unauthorized access and dissemination.

The basis for case management is the coded Standard GBV Intake and Assessment Form (see Annex 6); it is completed by a caseworker upon receiving a GBV case.

4.1.1. Case Management Forms and Case Files[57]

If it is safe to establish a system for case management documentation, you should develop and use a Consent Form and Standard GBV Intake and Assessment Form. Other forms that can be part of case documentation include a case action plan[58], a written safety plan, follow-up

[56] Please see the Interagency GBV Case Management Guidelines for additional guidance, including the range of case management forms. For forms, see also Annex 6.
[57] See the Interagency GBV Case Management Guidelines and gbvims.com for all case management forms. The standardised forms that are available are hyperlinked in the main text. See Annex 6 for all forms.
[58] Interagency GBV Case Management Guidelines, p. 180.

form, a referral form, a case follow-up form[59] and a case closure form[60] (see the Case Management Guidelines).[61] These can be added as your case management system becomes more developed. If case management services existed prior to the emergency, you should consult these service providers about the tools they use and determine whether they are standardized tools that should be used across agencies.

Each survivor should have a separate case file that includes all relevant completed case management forms. A code should be assigned to and marked on the front of each case file. To protect confidentiality, a list linking the case file codes to the survivors' names should be stored in a different location, stored electronically through a password protected file, or in a secure digital case management platform. Consent forms, which contain identifiable information about the survivor, should be stored separately to the case file.

Information collected about survivors belongs to them, and they must have access to information collected about them as part of GBV service provision at any time as part of their meaningful participation.

SECTION 5: PROTECTION FROM SEXUAL EXPLOITATION AND ABUSE

4.1. Definitions

Protection from sexual exploitation and abuse (PSEA), is a term used by the United Nations and the wider humanitarian community, to refer to measures taken to protect vulnerable people from sexual exploitation and abuse by staff and associated personnel proving humanitarian assistance to people in need.

4.2. Core Principles and standards of conduct

As outlined in the UN Secretary-General's Bulletin (SGB) for Protection from Sexual Exploitation and Abuse[62], sexual exploitation and abuse violates universally recognized international legal norms and standards and have always been unacceptable behaviour and prohibited conduct for United Nations staff. It harms those whom humanitarian actors are mandated to protect.

The SGB helped established six Core Principles and from thereon, well defined **standards of conduct expected of humanitarian personnel**, including: a) SEA constitutes acts of serious misconduct and may lead to disciplinary measures and dismissal; b) the express prohibition to engage in any sort of sexual activity with minors, regardless of the age of majority or age consent locally; c) the prohibition to exchange money, employment, goods or services for sexual favours, including any exchange of humanitarian assistance due to beneficiaries; d) the discouragement (and then prohibition) of sexual relationships between humanitarians and beneficiaries of aid, as these are based on inherently unequal power dynamics; e) the obligation to report concerns or suspicions of SEA by a humanitarian staffer, through the established reporting mechanisms; and, f) the obligation to actively prevent SEA and procure an environment that supports and develops systems for this purpose.

The Statement of Commitment on Eliminating Sexual Exploitation and Abuse by UN and Non-UN Personnel (2006), was endorsed by 42 UN agencies and 36 Non-UN entities (as of 2008), binding all signatories to the Core Principles and prevention measures as outlined in the SGB.

[59] Ibid. p. 181.
[60] Ibid. p. 183.
[61] Ibid. p. 34.
[62] United Nations Secretary-General, 2003. Secretary-General's Bulletin: Special Measures for Protection from Sexual Exploitation and Sexual Abuse, ST/ SGB/2003/13.

4.3 Management of PSEA

Protection from sexual exploitation and abuse is the responsibility of entire organizations, including management, operations, human resources, and programme sections. All sectors have a critical role to play in designing and implementing interventions in a way that minimizes risks of sexual exploitation and abuse and helps connect survivors of this and other forms of GBV, to appropriate care and services.

All humanitarian aid organizations are required to adopt or develop, fund and implement effective and comprehensive PSEA mechanisms.

Managers and human resources staff are responsible for ensuring that all personnel are trained on PSEA, mechanisms are in place for reporting, and that staff understand their individual responsibilities to report any suspected incidents. Organizations should also have in place a code of conduct, incorporating the Core Principles and signed copies of such documents should be filed in each personal file as an acknowledgement of their PSEA responsibilities.

Although GBV programme staff can play a role in advocating for PSEA measures, implementation of internal measures and the coordination of inter-agency processes to address sexual exploitation and abuse is outside the scopepurview of the GBV sub-sectorsubcluster or working group. They are the responsibility of the UN country team assigned PSEA focal points. This is important to ensure the independence, integrity and confidentiality of mandatory reporting mechanisms and investigation processes.

4.3. Reports of SEA

As indicated, reporting SEA is mandatory (see Section 3.2.3) for UN staff, its implementing partners and all personnel involved in humanitarian efforts. **All reporting must be confidential** through each organization's PSEA focal point, which is designated by their Senior Management, at the national and subnational levels. Managers and human resources staff are responsible for ensuring that all personnel are aware of the mechanisms in place for mandatory reporting. Staff that make reports in good faith of any SEA concerns or suspicions are to be protected from retaliation are should be offered psicosocial or other sort of support if needed.

Limits to Confidentiality

There are mandatory reporting policies for cases of sexual exploitation and abuse that involve humanitarian workers. In these situations, organizations need to be clear on the inter-agency protocol and inform the survivor as to whom the case would be reported; what information would be shared; and what the expectations would be regarding the survivor's involvement (e.g. will the survivor have to file a report and, if so, to whom?)

Complaints of SEA may also be received directly from survivors or members of the community, through Community-Based Feedback Mechanisms (CBFM). GBV response service providers should be aware of community-based reporting mechanisms and investigation processes to ensure informed consent when supporting survivors of sexual abuse and exploitation (see Section 3.2.2 on Consent and Section 3.3.3 on Case Management). In this case, the members of the CBFM shall inform the PSEA focal points of the organizations involved, including the PSEA Coordinator. This shall be done on a need-to-know basis using the Inter-Agency Referral Form (annex 5)

4.4. Response to SEA allegations

> **Response Services for SEA**
> Survivors of sexual exploitation and abuse are survivors of GBV and should be referred to existing GBV services; no parallel referral pathway should be established.
>
> The GBV response system is the appropriate referral system for women and girls to access support if they experience sexual exploitation and abuse perpetrated by humanitarian actors or other duty bearers.
>
> *Interagency GBV Minimum Standards, p. 23.*

Besides mandatory reporting, cases of SEA shall be handled as per the provisions of these SOPs as a GBV incident. Survivors of sexual exploitation and abuse are survivors of GBV and should be referred to existing GBV services as per the existing referral pathways. **As such, no parallel referral pathway should be established.** The GBV response system is the appropriate referral system for women and girls to access support if they experience sexual exploitation and abuse perpetrated by humanitarian actors or other duty bearers.[63]

The GBV sub-sector and the PSEA Network in Poland are in permanent communication and its co-chairs actively participate in each other's respective groups. Identified best practices indicate that some of the members are conducting joint training on GBV and PSEA, with the aim of providing a holistic framework for prevention and response. Currently[64], the PSEA Network in Poland does not have an established inter-agency referral mechanism but its aim work on this as part of their action plan for 2022. Nonetheless, it has developed an Inter-Agency Referral Form as an initial tool to facilitate referrals. Preliminarily, a list of PSEA focal points in each organization, to whom SEA complaints can be reported, has been developed. This list is a living document and it is updated periodically.

In whatever case, placing the safety, needs and desires of the survivor in the center of the response must be the priority for all those involved.

SECTION 6: RISK MITIGATION

Risk mitigation focuses on reducing the risks of GBV, including sexual exploitation and abuse, that women and girls face in the emergency and post-emergency contexts, and protecting those who have already experienced violence from further harm. Risk mitigation focuses primarily on addressing "contributing factors" to GBV that might expose women and girls to increased risk of violence. For example, codes of conduct, training and accountability mechanisms for staff about sexual exploitation and abuse will help decrease risk of GBV.

All humanitarian sectors and actors are responsible for promoting women's and girls' safety, and reducing their risk of GBV.[65] Reducing risk by implementing GBV mitigation strategies across all areas of humanitarian response, from the pre-emergency to the recovery stages, is necessary for maximising protection and saving lives. Protecting women and girls from GBV risks from all national and international actors' essential duty to protect those affected by crisis.

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[63] See also UNFPA. 2022. Tip Sheet: Defining Linkages to Better Assist Survivors of Sexual Exploitation and Abuse.
[64] September 2022.
[65] IASC GBV Guidelines.

Essential Issues to Consider
In emergencies, women and girls face a wide range of GBV risks that increase during displacement and conflict, including sexual exploitation and abuse perpetrated by male humanitarian actors. Humanitarian agencies may unintentionally increase these risks without properly identifying and addressing the needs of women and girls, and the potential obstacles they may face in accessing services safely.
Humanitarian actors can both mitigate risks in advance (e.g. through code of conduct training) and quickly address many of these once they arise. Failure to take action against GBV represents a failure by humanitarian actors to meet their most basic responsibilities for promoting and protecting the rights of affected populations. Inaction and/or poorly designed programmes can cause further harm.
Risk mitigation strategies must be led by the relevant sector, with technical support from GBV specialists if needed, and community involvement.

GBV specialized actors must be aware of risks to women and girls to inform advocacy with the sectors responsible for mitigating these risks. GBV specialised actors' role is to facilitate support to non-GBV sectors and actors to safely and ethically analyse the GBV risks in their environment, using available information and data from an age, gender and diversity perspective; and to provide technical inputs to other sectors' coordination and programming actions on GBV risk mitigation. This encompasses how to consult safely with affected communities, especially women and girls, on barriers to accessing services as well as safety concerns they may have, including sexual exploitation and abuse perpetrated by humanitarian actors.[66]

Essential Issues to Consider

In emergencies, women and girls face a wide range of GBV risks that increase during displacement and conflict, including sexual exploitation and abuse perpetrated by male humanitarian actors. Humanitarian agencies may unintentionally increase these risks without properly identifying and addressing the needs of women and girls and the potential obstacles they may face in accessing services safely.

All humanitarian sectors and actors are responsible for promoting women's and girls' safety, and reducing their risk of GBV. The IASC GBV Guidelines state clearly and prominently: "All humanitarian actors must be aware of the risks of GBV and – acting collectively to ensure a comprehensive response – prevent and mitigate these risks as quickly as possible within their areas of operation." (p. 24). Protecting women and girls from GBV stems from all national and international actors' essential duty to protect those affected by crisis.

Integration of GBV risk mitigation actions in humanitarian response is the process of ensuring that humanitarian interventions across all clusters/sectors: (1) do not cause or increase the likelihood of GBV; (2) proactively seek to identify and take action to mitigate GBV risks in the environment and in programme design and implementation; and (3) proactively facilitate and monitor vulnerable groups' safe access to services. GBV integration is distinct from, but complementary to, GBV specialized programming, which includes response services for GBV survivors and longer-term prevention interventions.

Failure to take action against GBV represents a failure by humanitarian actors to meet their most basic responsibilities for promoting and protecting the rights of affected populations. Inaction and/or poorly designed programmes can cause further harm.

Risk mitigation strategies must be led by the relevant sector, with technical support from GBV specialists if needed, and community involvement.

[66] GBV Minimum Standards, pgs. 71-72.

GBV specialists' commitments to advise[67] other humanitarian sectors on efforts to reduce risk of GBV in the setting include but are not limited to:	**Non-GBV actors'** commitments to mitigate risk of GBV, including but not limited to the following:
- Providing accurate and accessible information on available GBV services and referral processes; - Supporting non-GBV actors to analyse the GBV risks safely and ethically in their environment; - Providing technical inputs to other sectors' coordination and programming actions on GBV risk mitigation, including how to consult safely with affected communities, especially women and girls, on barriers to accessing services as well as safety concerns they may have, including sexual exploitation and abuse perpetrated by humanitarian actors; - Supporting or providing training about gender-based violence, the Interagency GBV Minimum Standards, IASC GBV Guidelines, these GBV SOPs, and other relevant materials, to ensure that all staff: (1) Have at least a basic understanding of gender-based violence, the GBV Minimum Standards and the IASC GBV Guidelines. (2) Know how and where to refer a survivor for support and assistance (using a Psychological First Aid approach, in line with the GBV Pocket Guide).	- Require code of conduct commitments by all staff and create accountability mechanisms for staff about sexual exploitation and abuse; - Identify an active GBV focal point per sector; - Include GBV risk mitigation interventions in all Humanitarian Response Plans and Refugee Response Plans; - Conduct and track safety audits[68]; - Set up functional community-based feedback and complaint mechanisms that can respond to sexual exploitation and abuse, including complaint referral forms.

6.1 Outreach (see also Section 3.5.2)

Community outreach and awareness-raising in emergencies may increase timely and safe access to services and mitigate risks of GBV. Outreach or awareness-raising in communities

[67] GBV staff are not expected to have specialized knowledge of each humanitarian sector. Efforts to integrate GBV risk reduction strategies into different sectoral responses should be led by sector actors to ensure that any recommendations from GBV specialised actors are relevant and feasible within the sectoral response.
[68] UNHCR (2021). Safety Audit Toolkit.

to ensure that communities – and particularly survivors – are aware of relevant services and how to access them, is also an important element of risk reduction.

Community engagement messages and activities should focus on:

(3) Access to services, especially life-saving and time-sensitive health services, because survivors need to know where to find help.

(4) Activities that can help reduce women's and girls' risk of GBV, especially sexual violence.

GBV specialised actors must advise and inform other sectors' messaging and also align outreach and educational messaging with other sectors, including but not limited to Health and Water, Sanitation and Hygiene (WASH).

6.2 Cash and Voucher Assistance[69](see also section 3.3.8)

Cash and voucher assistance (CVA), when utilized as part of a broader protection intervention, may help address a range of commodity-based needs. It refers to all initiatives through which cash transfers or vouchers for goods or services are provided directly to individual, household or community recipients. CVA is also a modality other sectors use to meet women's and girls' needs.

Cash can be lifesaving; for example, it can help a survivor meet the costs (e.g. rent, temporary shelter, transportation, food, clothing, etc.) associated with fleeing an abusive relationship.

Cash can be both a risk mitigation modality and a component of survivor-centred GBV case management services in humanitarian settings. In situations where core GBV response services (e.g. health or legal services) have associated costs and/or are not available free of charge, cash transfers can facilitate access and support recovery. See Section 3.4.8 for further information cash and voucher assistance as part of case management.

Key categories of risk include for women and girls include but are not limited to living space and physical camp/site layout (e.g. lack of lighting in public spaces; latrines are made of plastic, do not have locks, and are not separated for men and women); unmet needs (e.g. lack of non-food items that can lead to exploitation in exchange for necessities); service delivery (e.g. distribution and health staff are all male and have not been properly trained); and information and participation (e.g. lack of consultation leads to latrines being located far from settlement, insufficient water points, and lack of bathing facilities and menstrual hygiene materials).[70]

[69] IASC GBV Guidelines, Cash & Voucher Assistance and GBV Compendium: Practical Guidance for Humanitarian Practitioners (2019).
[70] See GBV Minimum Standards, pgs. 72-73.

SECTION 7: PRIMARY PREVENTION

GBV prevention and empowerment programming aims mainly to address the root causes of GBV; the primary outcome of GBV prevention programming is the improved safety and equality of women and girls. The preventative value of response services (e.g. health, psychosocial support, case management) is essential for designing an effective GBV prevention approach with realistic objectives and sufficient resources.

GBV prevention programming requires working along a spectrum ranging from immediate risk mitigation in the acute emergency (see Section 6) to longer term social norms and systemic change. GBV prevention approaches can be described in four categories[71]:

1. **Risk mitigation**: Risk mitigation aims to reduce the risk of exposure to GBV through all aspects of service provision. Risk mitigation focuses primarily on addressing "contributing factors" to GBV that might expose women and girls to increased risk of violence.

2. **Primary prevention or "tackling the root cause"**: Primary prevention includes strategies that focus on preventing GBV before it occurs by tackling its root cause – gender inequality. These approaches focus on behaviour modification and attitudinal change, and require long-term resources.

3. **Secondary prevention**: Secondary prevention includes strategies that focus on response for survivors and consequences for perpetrators. This includes addressing the consequences of various forms of violence, mitigating the harm this violence can cause, and taking steps to prevent the violence from happening again.

4. **Tertiary prevention**: Tertiary prevention includes actions that focus on the long-term impact of violence when untreated, such as community reintegration and acceptance, addressing trauma, and the long-term medical and psychosocial needs a survivor may have.

[71] See Interagency GBV Minimum Standards, pgs. 101-102.

SECTION 8: COORDINATION

8.1 Coordination Among GBV Specialised Actors & Other Service Providers

Coordination systems help plan interventions and strategies, manage information, mobilize resources, uphold accountability, fill gaps and avoid duplication. Coordination is also important in ensuring capacity gaps are addressed, including by supporting governments on preparedness and contingency planning.

The primary goals of GBV coordination are to:

1. Ensure accessible, safe, quality services are prioritised and available to survivors through strategic planning;

2. Promote appropriate attention to prevention of GBV across sectors and actors in line with the IASC GBV Guidelines; and

3. Secure sufficient funding to support GBV-specialized programming.

In cluster settings, these goals are achieved through a set of deliverables organised around the **six core functions** of coordination, namely:

1. **To support service delivery by:**
   - Providing a platform that ensures service delivery is driven by the Humanitarian/Refugee Response Plan and strategic priorities.
   - Developing mechanisms to eliminate duplication of service delivery.

2. **To inform the Humanitarian Coordinator/Humanitarian Country Team/Refugee Coordinator's strategic decision-making by:**
   - Preparing needs assessments and analysis of gaps to inform priority-setting.
   - Identifying and finding solutions for (emerging) gaps, obstacles, duplication and cross-cutting issues.
   - Formulating priorities on the basis of analysis.

3. **To plan and implement the subcluster/sector strategy by:**
   - Developing a GBV sectoral plan, objectives and indicators that directly support realization of the overall response's strategic objectives.
   - Applying and adhering to common standards and guidelines.
   - Clarifying funding requirements, helping to set priorities, and agreeing on subcluster/ sector contributions to the Humanitarian Coordinator/Humanitarian Country Team/ Refugee Coordinator's overall humanitarian funding proposals.

4. **To monitor and evaluate performance by:**
   - Monitoring and reporting on activities and needs.
   - Measuring progress against the subcluster/sector strategy and agreed results.
   - Recommending corrective action where necessary.

5. **To build national capacity in preparedness and contingency planning.**

6. **To support robust advocacy by:**
   - Identifying concerns, and contributing key information and messages to the Humanitarian Coordinator and Humanitarian Country Team messaging and

action.

- Undertaking advocacy on behalf of the cluster/sector, cluster/sector members and affected people.

In refugee contexts, UNHCR provides coordination and leadership structured around sectors and working groups based on its Refugee Coordination Model. Depending on the context and capacity, other agencies may co-lead the GBV sub-working group in coordination with UNHCR. Regardless of the form the coordination model takes, UNHCR maintains coordination and oversight structures that allow it to fulfil its ultimate accountability for ensuring the international protection and delivery of services to refugees.

In Poland GBV prevention and response in the refugee context is coordinated through the GBV Sub-Sector Working Group (GBV SWG). The GBV SWG seeks to strengthen GBV prevention, risk mitigation and response in emergency settings and facilitates multi-sectoral interagency action. It aims to ensure coherent, coordinated and effective GBV prevention, risk mitigation and response approaches through the mobilization of relevant government agencies, international organizations, UN Agencies, national and international non-governmental organizations (NGOs), civil society networks, national refugee-led organizations, refugee women-led organizations. The GBV SWG will deliver on the 6 core functions of GBV Coordination: support service delivery, inform high-level humanitarian decision-making, plan and implement sub-sector strategies, monitor and evaluate performance, build national capacity in preparedness and contingency planning and support robust advocacy.

The GBV SWG in Poland meets on a bi-weekly basis on Tuesday from 10:00 – 11:00 a.m. The meetings are held online. Simultaneous interpretation into English and Polish is available. Any actor (government, UN agency, local NGO, civil society, international NGO, etc.) conducting GBV prevention and response activities in the Poland refugee context can participate. The GBV SWG is currently co-led by UNHCR and Centrum Praw Kobiet (CPK). Task Forces can be called on an ad-hoc basis under the GBV SWG to conduct specific functions such as the ‘GBV SOPs Reference Group’ and then close once their original purpose is met. The GBV SWG reports to the Protection Sector within the Refugee Coordination Forum.

Annex 1: Resources

This Annex lists essential GBV resources and materials for the GBV SOPs development process and content; capacity strengthening; and GBV programming in general. Please also see below for thematic resources.

General

1. Handbook for Coordinating Gender-based Violence Interventions in Emergencies (2019);

2. *The Interagency Minimum Standards for Gender-based Violence Programing in Emergencies (GBV Minimum Standards) (2019);*

3. IASC. Guidelines for Integrating Gender-Based Violence Interventions in Humanitarian Action: Reducing risk, promoting resilience and aiding recovery *(IASC GBV Guidelines) (2015);*

4. UNHCR Policy on the Prevention of, Risk Mitigation and Response to Gender-based Violence (2020);

5. World Health Organization (WHO), United Nations Population Fund (UNFPA), United Nations High Commissioner for Refugees (UNHCR). Clinical management of rape and intimate partner violence survivors: developing protocols for use in humanitarian settings. Geneva: WHO; 2019.

6. WHO. *WHO ethical and safety recommendations for researching, documenting and monitoring sexual violence in emergencies*. Geneva, World Health Organization, 2007.

7. UN Women, UNFPA, WHO, UNDP and UNODC 2021. Essential Services Package for Women and Girls Subject to Violence.

8. UNHCR. 2018. UNHCR Policy on Age, Gender and Diversity.

Risk Assessment

1. Interaction. Module 1: GBV Risk Analysis. (Note that this Module is part of a broader package on evaluating GBV prevention work; however, this introductory module is useful in performing a GBV risk analysis.)

Case Management (including Remote Case Management)

1. GBVIMS Steering Committee. 2017. Interagency GBV Case Management Guidelines: Providing Care and Case Management Services to Gender-Based Violence Survivors in Humanitarian Settings.

2. IRC & UNICEF. *Caring for Child Survivors of Sexual Abuse: Guidelines for health and psychosocial service providers in humanitarian settings*

3. International Rescue Committee. 2018. Guidelines for Mobile and Remote Gender-Based Violence (GBV) Service Delivery.

4. GBV AoR (2021). COVID-19 Guidance on Remote GBV Services Focusing on Phone-based Case Management and Hotlines.

Child Protection

1. Gender-Based Violence and Child Protection Field Cooperation Framework (2021).

2. The Alliance for Child Protection in Humanitarian Action (2019). Minimum Standards for Child Protection in Humanitarian Action.

3. Global Child Protection Working Group. (2014). Interagency Guidelines for Case Management & Child Protection.

4. UN High Commissioner for Refugees (UNHCR), *2021 UNHCR Best Interests Procedure Guidelines: Assessing and Determining the Best Interests of the Child*, May 2021, available at: https://www.refworld.org/docid/5c18d7254.html [accessed 14 March 2022]

Psychosocial

1. IASC 2007. IASC Guidelines on Mental Health and Psychosocial Support in Emergency Settings.

2. UNFPA. Guidelines for the provision of remote psychosocial support services for GBV survivors.

3. IASC 2015. IASC GBV Pocket Guide.

Women's and Girls' Safe Spaces

1. IRC and International Medical Corps (2019). Advancing Women's and Girls' Empowerment in Humanitarian Settings: A Global Toolkit for Women's and Girls' Safe Spaces.

Safety and Security

1. UN Women. Handbook on Gender-Responsive Police Services for Women and Girls Subject to Violence

Cash and Voucher Assistance

1. UNHCR, Cash Assistance and Gender

2. UNHCR, Guide for Protection in Cash-based Interventions

3. Cash and Voucher Assistance for GBV Cases: Standard Operating Procedures, Turkey Cross-border/Northwest Syria

4. IASC GBV Guidelines, Cash & Voucher Assistance and GBV Compendium: Practical Guidance for Humanitarian Practitioners (2019)

5. Women's Refugee Commission, Resources for Mainstreaming Gender-Based Violence (GBV) Considerations in Cash and Voucher Assistance (CVA) and Utilizing CVA in GBV Prevention and Response.

Menstrual Health and Hygiene

1. Columbia Public Health. MHM in Emergencies Toolkit.

2. Columbia University & International Rescue Committee. 2020. A Compendium: Menstrual Disposal, Waste Management & Laundering in Emergencies

3. MHM Operational 2-pager for GBV

4. FGD Guide for Menstruation related preferences, English, French, Arabic, Spanish

5. Checklist for MHM Friendly latrines, English, French, Arabic, Spanish

6. Market Based Programming for WASH Guidance on the provision of menstrual materials through CVA.

Annex 2: Referral Pathway

1. Sample Referral Protocol ,
2. Pocket Guide for non-specialized actors: https://gbvguidelines.org/en/pocketguide/

HELP-SEEKING AND REFERRAL PATHWAY FOR [NAME OF SITE]

Use the following template to fill in details of the referral pathway for your setting. These referral pathways must be specific to one site (camp, town, or other location). If these GBV SOPs cover more than one site, there must be a separate and specific referral pathway page for each site.

TELLING SOMEONE AND SEEKING HELP (REPORTING)	
Survivor tells family, friend, community member; that person accompanies survivor to the health or psychosocial entry point	Survivor self-reports to any service provider

IMMEDIATE RESPONSE The service provider must provide a safe, caring environment and respect the confidentiality and wishes of the survivor; learn the immediate needs; give honest and clear information about services available. If agreed and requested by survivor, obtain informed consent and make referrals; accompany the survivor to assist her in accessing services		
Health care entry point [Enter name of the health centre(s) in this role and name and contact information of the focal point if it is safe to do so]	**Psychosocial support entry point** [Enter name of the psychosocial provider(s) in this role and name and contact information of the focal point if it is safe to do so]	**Case management entry point** [Enter name of the case management provider(s) in this role and name and contact information of the focal point if it is safe to do so]

IF THE SURVIVOR WANTS TO PURSUE POLICE/LEGAL ACTION - OR - IF THERE ARE IMMEDIATE SAFETY AND SECURITY RISKS TO OTHERS Refer and accompany survivor to police/security - or - to legal assistance/protection officers for information and assistance with referral to police	
Police/Security [Enter specific information about the security actor(s) to contact, including name and contact information of the focal point if it is safe to do so]	**Legal Assistance Counsellors or Protection Officers** [Enter names of organisations and name and contact information of the focal point if it is safe to do so]

AFTER IMMEDIATE RESPONSE, FOLLOW-UP AND OTHER SERVICES Over time and based on survivor's choices can include any of the following (details in Section 3):

Health Care	Psychosocial Support	Case Management	Protection, security, and justice actors	Basic needs, such as shelter, ration card, children's services, or other

Annex 3: Referral Form

REFERRAL FORM

Referral Form		
When to complete	During the case management or safe referral process: For clients to provide permission to share their information with other service providers for each referral conducted or case transfer.	
Who should complete it	Caseworker assigned to the case.	
Purpose of the form	Record the client's permission to share information with other service providers. Only record minimum information required for the receiving agency to respond.	
Priority	**Date of identification**	**Referral date**
Indicate the priority of the case so that the receiving agency knows the timeframe for response. Consider if there are indications of immediate risk to personal safety.		
High risk (48 hours) Medium risk (1-7 days) Low risk		

Referred by	**Referred to**
Insert the contact information of referring agency	Insert the contact information of receiving agency
Sector Agency Location **Focal Point name E-mail** **Phone**	**Sector Agency Location** **Focal Point name E-mail** **Phone**

Client information (only include if consent has been obtained)	
Insert the person's individual bio data and contact. Check your service mapping to see whether additional information requirements are needed to access the service. **Only include the identifying information required for the receiving agency to provide the service.**	
Nickname or initial (no full name): **Address:** **Phone:** **Phone belongs to whom: Preferred method of contact: Preferred date/time for contact:**	**UNHCR Registration no. (if applicable):** **Age:** **Sex:** **Disability status** (based on the outcome of your Washington group questions in the identification & intake form): Y/N

Caregiver information (for minors under 18 years)
Nickname or initial (no full name): **Relationship to the child:** **Address:** **Phone:** **Caregiver informed of referral:** Y/N **Explain if No:**
Indicate the service(s) you are referring for. Please refer to the service mapping to ensure the service is available and the case meets the eligibility requirements for the service. Update explanations of services available in your context. See examples for CP, GBV and MHPSS.
Child protection: This may include children at risk of exploitation, violence and abuse, children engaged in the worst forms of child labour, unaccompanied and separated children **Gender-based violence:** Women at risk of gender-based violence who can benefit from prevention and response services, including case management, safe spaces, early marriage cases **Health:** **Mental health and psychosocial support (MHPSS) services:** This may include service providers in health, protection, and beyond; depending on the referral needs of the client and available MHPSS services providers in the area. **Legal:** **Basic needs (food, nutrition)** **Shelter** **Water, sanitation and hygiene** **Education** **Livelihood** **Other**
Case narrative
Describe the minimum information required for the receiving agency to respond. For example, problem description, whether the client receives other assistance, number in the household. Also include what accessibility/reasonable accommodation measures should be in place/put in place by the receiving organisation to support access to the service. For example, temporary ramp, interpreter. Remember, for referrals to SGBV, CP and Legal case management services do not provide details of the incident or case.

Consent to release information
Read the disclosure with the individual. Inform the individual of how the service provider will use their data and answer any questions they might have before they sign the disclosure. For children under the age of 18 where the caregiver may be implicated in the abuse, informed assent should be sought instead. Explain to the individual that they have the right to request that their information not be documented and can request retrieval of the information at any time. They have the right to refuse to answer any questions they prefer not to and the right to ask questions or for explanations about the referral process at any time.

I_____(clients name), acknowledge that the service provider, ____ (service provider name) has clearly explained the procedure for the referral to me and has listed the exact information that is to be disclosed. I understand that my information will be treated with confidentiality and respect, and will only be shared as needed to provide assistance and may be used for the purposes of humanitarian analysis. By signing this form, I authorize this exchange of information to the specified service provider/s for the specific purpose of providing assistance.

Signature of client: **Date:**

Note for caseworker

Please save this form protected by password that you generate on your own, which consists of:

- *At least 8 characters*
- *At least 1 lower case*
- *At least 1 upper case*
- *At least 1 symbol.*

The form should be sent via email to the focal point of the service provider(s).

The password should not be written in that email. Instead, provide the password to the focal point of the other service provider(s) via other means of communication than email (e.g. text message or phone call).

Annex 4: Consent for Release of Information

Incident ID

Client Code

CONFIDENTIAL

Consent for Release of Information

This form should be read to the client or guardian in her first language. It should be clearly explained to the client that she / he can choose any or none of the options listed.

I,_____, give my permission for (***Name of Organization***) to share information about the incident I have reported to them as explained below:

1. I understand that in giving my authorization below, I am giving (***Name of Organization***) permission to share the specific case information from my incident report with the service provider(s) I have indicated, so that I can receive help with safety, health, psychosocial, and/or legal needs.

   I understand that shared information will be treated with confidentiality and respect, and shared only as needed to provide the assistance I request.

   I understand that releasing this information means that a person from the agency or service ticked below may come to talk to me. At any point, I have the right to change my mind about sharing information with the designated agency / focal point listed below.

   I would like information released to the following:

   (Tick all that apply, and specify name, facility and agency/organization as applicable)

Yes No

☐ ☐ Security Services (specify):

_____

☐ ☐ Psychosocial Services (specify):

_____

☐ ☐ Health/Medical Services (specify):

_____

☐ ☐ Safe House / Shelter (specify):_____

☐ ☐ Legal Assistance Services (specify): _____

☐ ☐ Livelihoods Services (specify):

_____

☐ ☐ Other (specify type of service, name, and agency):

_____

1. Authorization to be marked by client:	☐ **Yes**	☐ **No**

2. I have been informed and understand that some non-identifiable information may also be shared for reporting. Any information shared will not be specific to me or the incident. There will be no way for someone to identify me based on the information that is shared. I understand that shared information will be treated with confidentiality and respect.

2. Authorization to be marked by client: ***(or parent/guardian if client is under***	☐ **Yes**	☐ **No**

Signature/Thumbprint of client:

_____

(or parent/guardian if client is under 18)

Caseworker Code:_____ **Date:**

_____

Consent for Release of Information Form

Version 2 (Finalized October 2010)

INFORMATION FOR CASE MANAGEMENT
(OPTIONAL-DELETE IF NOT NECESSARY)

Client's Name: _____

*Name of Caregiver (if client is a minor):*_____

Contact Number: _____

Address: _____

- - - -

Annex 5: Consent for Release of Information

INTER-AGENCY REFERRAL FORM
FOR COMPLAINTS ABOUT SEXUAL EXPLOITATION AND ABUSE
(in the context of the refugee response in Poland)
Please refer to the one-pager with instructions on how to fill this form and what to do with it once completed.

REMEMBER: *All cases must be handled confidentially and with a survivor-centred approach.*
If the survivor(s) is (are) in need of medical, psychological and/or legal support, please contact the GBV focal point in your organisation and/or activate the GBV referral pathways for Poland available on: https://data.unhcr.org/en/documents/details/94681

INFORMATION ABOUT THE COMPLAINANT

Name of Complainant: Name of Organisation: Address: Phone number: Email address: Other contact details:	Nationality/Ethnic origin: Document of Identity number: Gender (male, female, non-binary, prefer not to say): Age:

How does the complainant prefer to be contacted (channel)?

Preferred time of day for contact (day/afternoon/night):

What is the complainant's preferred language for communication (circle the best option)?

Ukrainian / Russian / Romani / Belarusian /Romanian / English/ Polish/Ukrainian Sign Language / Other:_____

INFORMATION ABOUT THE SURVIVOR
(Consent must be obtained before collecting any identifying information for the survivor)

Name (and nickname) of survivor (if not the complainant): Address: Phone number: Email address: Other contact details:	Ethnic origin/Nationality: Document of Identity number: Gender (male, female, non-binary, prefer not to say): Age:

How does the survivor prefer to be contacted (channel)?

Preferred time of day for contact (day/afternoon/night):

What is the survivor's preferred language for communication (circle the best option)?

Ukrainian / Russian / Romani / Belarusian /Romanian / English/ Polish/Ukrainian Sign Language / Other:_____

Has the survivor given consent for the completion of this form and referral (circle the best option)? Yes / No / Don´t know Any urgent needs identified for the survivor/complainant, including safety concerns? Please explain:
Has the survivor been referred to an organisation for assistance (please give details about the organisation's name and services provided):
If victim/survivor is a minor (under 18 years-old): Name(s) and contact details of parent/guardian: The minor is (circle the best option): with family / unaccompanied / separated.
INFORMATION ABOUT THE INCIDENT *(Please complete only the parts on which you have information. Do not contact the survivor to answer all questions.*

Date of incident(s): Time of incident(s):	Location of incident(s):
Brief description of incident(s) in the words of the survivor / complainant:	

Name (and nickname) of alleged perpetrator: Name of the humanitarian organisation the alleged perpetrator belongs to: Position / Job title of alleged perpetrator: Type of entity (circle the best option): UN Agency / International NGO / Local NGO / Civil Governmental Actor / Non-Civil Governmental Actor / Volunteer / Other (please specify). Address or location of the organisation where the alleged perpetrator works: Any other information/ details considered useful:
INFORMATION ABOUT THE AGENCY OR ORGANISATION FORWARDING THE COMPLAINT

Report completed by (Name of PSEA focal point): Position/Job title: Name of the organisation for which the PSEA focal point work: Date completed:
INFORMATION ABOUT THE AGENCY OR ORGANISATION RECEIVING THE COMPLAINT (ACKNOWLEDGMENT OF RECEIPT)
Report completed by (Name of PSEA focal point): Position/Job title: Name of the organisation for which the PSEA focal point work: Date received: