August - September 2022

World Health Organization
European Region

JOINT MISSION REPORT

Gender-Based Violence and Prevention and Response to Sexual Exploitation and Abuse

Dates:

The joint mission on Gender Based Violence (GBV) / Prevention and Response to Sexual Exploitation and Abuse and Harassment (PRSEAH) in the support of the Poland country office took place in Krakow, Rzeszow, Radymno and Przemysl from Wednesday 24th August to September 1st, 2022 (see annexes for more details).

Participants:

- Melanie Hyde-GBV Specialist (Poland WCO)
- Erin MacDonald-PRSEAH Programme Manager (RHE)
- Anna Kavouras-Incident Management Team Assistant (Poland WCO)

Objectives:

- Identify needs and risks relevant to GBV in the respective areas and propose relevant recommendations.
- Identify PRSEAH needs and risks in the respective areas and propose relevant recommendations.

Methodology:

- Key informant interviews with partners and other stakeholders (unstructured).
- Site visits / field observation.

Limitations:

This was an introductory mission, therefore participatory research with the affected population during was limited. We recommend that any further GBV assessments build on the findings of this report by utilizing the Empowered Aid approach, integrating the voices of the refugee population. We also recommend that further assessments be conducted in other locations and coordinated through interagency coordination platforms and with national stakeholders.

1. Executive Summary:

1.1 Overall context

The overall impression following the visit to the accommodation centers (Rzeszow, Krakow and Przemysl) is that humanitarian GBV needs, for refugees that are Ukrainian, and non-Ukrainian remain a large unmet need, with current capacity unable to meet the needs of the arriving population, who are still arriving on a daily basis in large numbers.1 As the crisis drags on, and coping mechanisms are exhausted, the most vulnerable group are beginning to leave Ukraine and have limited to null means of personal protection.

For example, according to a discussion with one partner, there were at first, groups of refugees who had money, who came to stay with friends or relatives and had some means of supporting themselves. However now, there seem to be now more vulnerable groups who have taken a major risk and hardship to be moved, for example elderly people who were living in institutions, chronically ill, people with disabilities and persons with extremely severe mental health issues who are in need of urgent medical assistance.

There are reception centers/temporary shelters currently operating in train stations (one visited in Krakow, another in Przemsyl) that are currently able to provide temporary shelter for limited periods but are subject to entry requirements which have reportedly tightened in the past several months (12-48 hours total stay, onward ticket for journey, no stamp with previous entry into Poland). Shelters also appear to operate under uncertainty, with staff in both shelters visited reporting being told by local authorities that they may close at the end of September/October 2022. Among those interviewed, none had any knowledge about alternative options for populations in need of shelter. Moreover, personnel at both facilities mentioned that there are ongoing, serious needs that are not being met by the government and that services need to continue, especially with winter approaching, and the reality in many areas of Ukraine that basic services and amenities (water, heat, electricity, etc.) are no longer available.

Vulnerable, unaccompanied persons and children, need specialized care. Mothers, pregnant women, and infants need specialized support, care which seems to be limited or non-existent for transit populations in particular.2 For GBV survivors transiting through Poland, particularly those with intersecting vulnerabilities including survivors with disabilities, the elderly, and Roma populations, access to the Polish health system is limited by multiple barriers including lack of PESEL number facilitating access, lack of specialized services and support for GBV survivors in provincial areas, language barriers, lack of adequate long-term shelter options to receive continued care, and limited knowledge of and availability of clinical management of rape (CMR) and sexual and reproductive health services (SRH). Lack of civil documentation in some cases also poses barriers to accessing the public health system in Poland.

1 Registration officials at the Przemsyl train station reported approximately 2,000 arrivals per day, with between 100-300 persons per day accessing a 70-person waiting area (12-hour limit) attached to the train station and approximately 50-80 per day are reportedly accessing the reopened TESCO Shopping Center shelter (unconfirmed).

2 For the purposes of this report “transit populations” refers to displaced populations who have not applied for temporary protection in Poland. Many of these are in temporary or transit shelters, collective centers and reception centers. According to UNHCHR/REACH data from June 2022, 15% of those surveyed fell into this category.

1.2 Risks Identified

Overall risks identified were related to the increased and compounded vulnerabilities of the latest waves of refugees arriving (they are reported to have less resources than previous waves of refugees) as well as the reduction in humanitarian services available to them. Acute psychological trauma among the refugees was also identified as a vulnerability as according to a partner, many of them are coming from places of violence and are often exhausted, hungry and dehydrated after having some such a long way. The upcoming winter, alongside the shrinking services available were also identified as a risk, that is likely to become exacerbated.

1.3 GBV

The mission identified the following GBV risks, most relevant to the health sector members' operations:

a) **Lack of clarity around GBV referral pathways for health partners at local level**

Meetings with humanitarian health partners consistently identified limited use of the UN interagency GBV referral pathways. This was reportedly due to a lack of detailed information required to facilitate local-level referrals, information that was no longer accurate (due to changes in service providers) and the use of more advanced tools by local partners which have been adapted to the operating context. In one case, a partner dealing with a time sensitive GBV case "met a dead end" using the UN pathways in a critical situation. Another partner, who was closing services in Poland at the time of writing, has developed an innovative online referral pathway tool which could form the basis of an integrated tool expanded to different areas of the country. One partner reported a preference for paper referrals; indicating a need for adaptive online tools depending on organisational capacity and preferences.

b) Increased restrictions for entry of displaced populations into temporary shelters

Site visits and meetings with partners raised serious concerns about the accessibility of shelters to at-risk populations, including GBV survivors. As a key entry point for referrals to long-term accommodation and other essential services, restricting the conditions of entry into shelters is likely to have a detrimental impact on the most vulnerable. This is illustrated by one report received by a partner indicating that 20 children were reportedly refused entry into a shelter because they had previous entry stamps into Poland. Given the fluid nature of the movement of refugees between Poland and the Ukraine, and likely increased numbers over winter (including those who have already entered Poland), those refused access to temporary shelters will be at heightened risk of GBV, human trafficking, sexual exploitation, and abuse.

c) Varying levels of staff capacity and technical skills in GBV across partner organisations

In terms of GBV capacity, most partners reported receiving previous training and capacity building on psychological first aid and prevention of sexual exploitation and abuse (PSEA). At the same time, site visits and meetings confirmed a need for capacity building to better support frontline workers to handle cases of GBV disclosure and create spaces safe for survivors. For the Podkarpackie region, there was a clear request to do this as a matter of priority, given the expectation of increased arrivals over winter. Most partners have valuable field-level expertise they are willing to share (MHPSS, survivor centered approach, PFA), which could be combined with international expertise to address gaps. Partners were receptive to a coordinated capacity development response from interagency networks, specifically linking PSEA, GBV frontline response and counter-trafficking frameworks.

d) Lack of trained female health staff and interpreters and information about patient rights

A lack of female medical staff in the humanitarian partners, including translators was identified as a barrier for GBV survivors to access quality care in locations where health services were provided. Issues regarding the accessibility of the public health system for transit populations (without PESEL number) and lack of specialised services and preventative healthcare for women and girls in transit (SRH, maternal, newborn, child health) was similarly identified as a major barrier to accessing lifesaving GBV services for survivors. Patients were also not informed of their rights, or the ability to request the sex of the medical provider and/or their right to a support person to be present with them during examination, further limiting access to critical support and referrals.

e) Reduction of NGO actors providing health services in transit/border locations

The provision of health services is a key entry point for GBV survivors to receive information, advice, and referrals for specialized services. Since the onset of the emergency, many humanitarian organisation have scaled down or ceased to provide health services in Poland. One organization confirmed that at least three weeks would be required to scale-up in case of need. At the time of writing, two partners had ceased providing health services, a third was finishing by the end August, and another was actively scaling down. There are currently no medical services (beyond referrals to the hospital for acute emergencies) available at border crossing points, Przemsyl train station, Krakow train station, and the Tesco shopping center. Two cases regarding difficulty accessing local ambulances for Ukrainian refugees were reported and one partner noted issues around levied costs for hospital stays (in cases where the ambulance is free). Priority health needs include the provision of sexual and reproductive health services, and primary healthcare for maternal, newborn and child health.

f) Increased vulnerability and comprehensive needs of refugee arrivals

Meetings with shelter operators in transit locations and site visits confirmed and multiple intersecting vulnerabilities and higher needs amongst the profile of refugees arriving from Ukraine in the past several months. Multiple partners mentioned a higher proportion of individuals with mental health needs unable to be absorbed into the Polish public system (including access to temporary shelters), persons with disabilities, elderly and chronically ill. The socio-economic profile has also changed, with many arriving with only documents and no financial means. One shelter staff member who collected data on the point of origin of arrivals mentioned seeing "women who had travelled for days from war-torn and occupied regions, in late stages of pregnancy with babies, and were exhausted". Site visits also observed a high proportion of mothers with infants and children under 5-years with increased health needs. Shelter operators confirmed a need for the provision of primary health care, stating that they were hesitant to provide anything beyond basic medicines. Health care was limited to calling the ambulance in cases of emergency, however often volunteers would take patients directly to the hospital. Permission to provide health services in some locations was cited as an issue, with some having municipal approval, but not the necessary Voivodeship approvals.

g) Additional risks raised by partners

Additional risks identified below also increase the risk of GBV, particularly for transit populations and new arrivals. Mitigation measures are beyond the remit of WHO alone and will require close coordination and leadership by intersectoral forums and the host government. WHO is actively working with inter-sector coordination forums to support joint advocacy approaches to address these risks.

- Removal of government subsidy to Polish families supporting Ukrainian refugees.
- Free transport no longer offered by Polish government (one free train to Hannover, Germany).
- Rumours of closure / uncertain status of shelters beyond September / October 2022 (Krakow Train Station, Przemsyl train station).
- Predicted increased flow of refugees estimated within next 6 weeks due to combined factors of cold weather, fuel shortages and potential food shortages.

1.4 PRSEAH

PRSEAH was expressed as a risk among many of the humanitarian partners consulted, as well as a lack of accountability among volunteers;

"...When I came here, they did not even ask to check my credentials from (X nation), and I insisted on showing my (X nationality) license number and credential from (X nation). I believe there are issues here, another volunteer here went to the home of a volunteer on the response who was hosting a refugee, they were sleeping in the same bed..."

-Foreign volunteer health care provider

Another partner mentioned also that there is an issue with some organizations in a lack of vetting. There are reports of allegations of SEAH in multiple locations. These have been reported to the PSEA Network Coordinator for Poland and are being followed in accordance with international standards and relevant procedures. While positive that the reports are being made, the length of time that has elapsed between the alleged incidents and the reporting is concerning in terms of the effectiveness of the reporting mechanisms and protection for witnesses and survivors.

An issue was also raised regarding gender-balance of health providers or volunteers and that this could be something that could intimidate refugees or discourage reporting. An overall high turnover of foreign volunteers, in reception centers, and those who came in cars to the border was also an issue that was raised by partners consulted.

"...in the beginning there were so many people coming, there was no way of checking who any of them were, and people were just getting into cars, going to other parts of Europe and nobody could keep track of them..."

-From a partner

Fortunately, it was mentioned that the PSEA situation seems to have improved significantly, but it was also mentioned that facilities in general need some support in vetting humanitarian partners and volunteers, and could benefit from trainings. It was also mentioned by many partners that training on PRSEAH would be useful among all the humanitarian community and that they would be receptive to supporting it.

Risks of PRSEAH were identified that overlap with the risk of GBV and human trafficking. One partner mentioned that two buses full of women and children disappeared at the beginning of the crisis, and others mentioned that many women and children leaving shelters are taken reportedly to other parts of Europe but that there is very little accountability about where they are going. This is an area where partners, and volunteers in the humanitarian community need to be vetted effectively to assure that they are aware of these risks, potential scams and where humanitarian personnel may take advantage of the situation in order to carry out acts of SEA.

Another risk that was mentioned is that many partners and refugees are not aware of the risk of SEA and where/how they can report it. Having awareness raising materials, for refugees and humanitarian personnel was suggested, especially if it can be made available via telegram for the refugees. Trainings for humanitarian personnel, to understand and identify risks, as well as where to report them were also suggested.

2.0 Recommendations

For GBV actors:

1. Support the development of integrated online GBV referral pathways in coordination with the GBV Subsector and health partners: support bottom-up efforts utilizing local level pathways and tools developed by health partners to refer GBV cases and transition to an online integrated referral pathways modality for joint use, coordination, and verification. This will address risks involved with open publication of sensitive information, while ensuring that the rapidly changing needs and organisations providing services are regularly updated and verified.

2. Offer needs-based training on GBV topics to all health partners, including developing practical tools to support adherence to key GBV principles: Support an interagency needs-based training series combining the expertise of UN agencies and GBV subsector partners based on survey data collected by WHO on the training needs of health partners. Health sector partners consulted are reportedly open to participating in such training. Partners also reported that local authorities would be interested to participate. Podkarpackie region should be prioritised due to the specific requests for training and need for preparedness.

3. Increase the availability of trained, female staff to provide health care services to transit populations: support the expansion of GBV health services to meet critical gaps identified, including where populations are unable to access the public health system (transit populations) and increase the availability of trained female medical personnel to provide sexual and reproductive health services, and primary healthcare for maternal, newborn and child health via mobile health services with the capacity to scale-up to meet refugee influxes.

4. Increase the availability of accurate information on health services available for GBV survivors (including CMR and SRH) and make this available in border locations: ensure accurate information on available health services for sexual and reproductive health and GBV response across all refugee hosting countries, especially at border locations. WHO is recommended to support a regional approach to address this issue, particularly cross-border programming with WHO Ukraine to ensure accurate information on GBV response services is provided before crossing into Poland and that GBV messaging on information and awareness is consistent, culturally appropriate, and sufficient to make informed decisions.

5. Support the development of an interagency advocacy strategy: addressing joint objectives, interlocutors, approaches and challenges for the provision of health services respecting humanitarian principles and the fulfilment of WHOs health mandate.

For PRSEAH actors:

6. Awareness raising: this was recommended by partners, (especially if it can be communicated via telegram) as an important means to raise awareness among refugees about what SEA is and where it can be reported.

7. Training: Training of all volunteer, personnel and staff in the humanitarian response, especially in the border areas, reception centers and shelters was recommended, and should be prioritized.

8. Supporting partners in vetting personnel: It was recommended to support partners in vetting, sensitizing them on background checks, and also seeing if they can become a part of global humanitarian vetting mechanisms (ie. ClearCheck, etc).

9. Strengthening reporting and response mechanisms: This should be streamlined with GBV in terms of response, and in terms of detection, WHO can work with its partners to raise awareness on streamline reporting, referral and response mechanism using a victim centered approach to ensure adequate and efficient case management, including prompt investigations and enforcement of accountability measures as necessary.

For GBV and PRSEAH actors:

10. Ensure synergy and coordination on GBV response and risk mitigation with PRSEAH: Site visits and meetings with partners confirmed the need to minimise duplication and the burden on partners and where possible ensure joint understanding of the differences and overlap between GBV and PSEA. The tools developed for the Polish context (integrated questionnaire and safety audit / barrier identification) by PSEA and GBV specialist staff could support integration in relevant contexts and could be shared with partners (particularly INGOs working with local organisations).

11. Develop a joint action plan for GBV and PRSEAH based on the identified needs revealed during the visit: Given the considerable overlap in the risks identified, it is suggested that a joint action plan is developed for the recommendations (such as trainings and referral mapping) that concern both PRSEAH and GBV to assure accountability and to measure implementation.

3.0 Annexes

3.1 Agenda / schedule

Gender-Based Violence and Prevention and Response to Sexual Exploitation and Abuse Scoping Mission

Krakow, Rzeszow and Przemysl

24 August – 1 September 2022

1. Attendees:

Melanie Hyde, GBV Specialist

Erin MacDonald, PRSEAH Programme Manager, RHE, Krakow Poland

2. Mission objectives:

Gender-Based Violence (GBV)

a) To understand the information available to Ukrainian refugees entering Poland regarding health services for GBV survivors.
b) To assess the capacity needs of medical frontline workers (EMTs] to provide survivor centered GBV frontline support and safe referrals.
c) To understand what GBV response services are available and barriers / access issues.
d) To offer EMT partners / stakeholders training, tools and technical frontline support to improve access to GBV support services.
e) To identify GBV risks and potential mitigation measures.

Prevention and Response to Sexual Exploitation and Abuse (PRSEA)

a) Understand what information may be available on PSEA, and where to report for Ukrainian refugees, humanitarians and service providers who are working in the vicinity
b) Assess the awareness of frontline workers on PSEA and what to do if they suspect a case of receive a disclosure
c) Understand the level of awareness of EMTs on PSEA and what support they need to build their awareness
d) Offer training to partners and stakeholders
e) Create links for better coordination to launch PSEA efforts in awareness raising and capacity-building to come
f) Identify potential risks on PSEA to be mitigated

3. Expected outputs:

a) Mapping of essential health services for GBV survivors in target locations.
b) Entry points for improving essential health care for GBV survivors are identified.
c) EMT partners / stakeholders benefiting from GBV first line training are identified and discussion initiated during bilateral meetings.
d) Information on preferred training and tools is collected and verified with partners.
e) Key risks for GBV survivors are identified.
f) Quick report, with evidence-based recommendations

4. List of key partners / stakeholders:

5. Modalities:

- Meetings with organisation representatives (GBV checklist).
- Observation.
- GBV situational analysis (adapted version) / GBV safety audit (adapted version)
- Informal discussion.

6. Agenda

3.2 GBV/PRSEAH Questionnaire tool

WHO Poland Country Office

GBV/PRSEAH checklist for meetings with organisations providing health services to refugees[1]

A. ORGANISATIONAL DETAILS

Organisation (sector partner details):

Representative Position (Job Title) of Health Centre Representative interviewed:

Gender identity:

Issue	Question	Follow-up	Response action
1. Staff knowledge / awareness of GBV as a lifesaving health issue	Types of GBV (including against men and boys) Health impact of GBV: • Physical violence • Sexual violence • Psychological violence • Economic violence (denial resources/coercive control)	Capacity to flag potential issues (ie. Unexplained headaches/symptom). Capacity to handle signs of GBV and disclosures. Presence of screening tools/identification.	Explanation of the limitations of data on GBV due to low reporting, stigmatisation etc. Offer training. Confirm international standards/survivor centered approach.
2.Health services for GBV survivors (EC, STI, PEP)	Are there health services available to assist women who have experienced violence? If yes, ask the following: What services are available?	Do staff know about the time limits for provision of PEP (72hrs) and ECs (120hrs)? Is information about this provided to patients? Upon request? Information leaflets? What information is available in medical sites / mobile clinics?	Offer information materials – identify appropriate language, channels and target audience.
2.a) Other health services	primary health care; reproductive, maternal, neonatal and child health (RMNCH) including neonatal ICU, sexual and reproductive health	Possibility to offer or scale up existing services? Identify challenges with Polish health care system and provision of these services.	Identify avenues for provision of SRH health services through EMT teams / other health partners and/or through local Polish providers.
3.Referral pathways	• case management • psychosocial support (PFA) • cash assistance • legal • Other health services • Trafficking • SEA	Are UNHCR referral pathways known and used? [have copy with] Can they refer locally or outside of the areas? Information on services in other European countries?	Offer training to address any issues with referral pathways? Training also on the safe identification and referral of cases – WHO LIVES approach.
4.Policies (SOPs / guidelines for disclosure etc.)	Are there protocols in place and in use for various forms of GBV, including sexual violence?	Is there a need / demand for this or simplified tools?	Potentially link with GBV Subsector for use/training on the GBV Subsector SOPs.
5.Staffing (female / male ratio)	Are there female health workers available to treat women and girls who have experienced violence?	Are there other support staff available to support women and girls? Language / other barriers? Are there staff that support on SRH/pre-natal care? Midwife/OBGYN?	Offer secondary options if no possibility of female staff. Discuss funding options to fill gaps.
6.Clinical staff are trained on frontline support to GBV / other (CMR, CRSV)	Are health workers trained to treat women and girls who have experienced sexual and domestic violence?	Frontline survivor centered support? Psychological first aid? CRSV?	Offer training and assess scope of needs.

[1] Adapted to context from WHO Clinical Management of Rape and Intimate Partner Violence Survivors handbook and GBV AOR IASC tools.

3.2 GBV/PRSEAH Questionnaire tool

	If yes, ask the following: What services are they trained to provide?		
7.Consultation with affected population on accessing GBV services	Any consultations / assessments conducted on access to and quality of services?	Confirm if needs assessment would support better service provision or other barriers more important.	Brainstorm / discuss options for coordination of information on needs.
8.Risk factors of GBV	What are the main risk factors based on your knowledge of the population you serve?	Discuss mitigation measures. Eg. Are there links with anti-human trafficking initiatives; IPV/DV accommodation	Brainstorm / discuss risk mitigation options. Offer to discuss in training with other actors.
PSEA			
Information/Awareness	Is there any information available in this location on PSEA for the beneficiary population? Is there information available here for the staff/personnel? What would be the most appropriate media to disseminate this information to personnel and beneficiaries?	Capacity to assure that beneficiaries and staff/personnel are aware of PSEA	Explanation of why this is needed, potential to develop materials and share them Explanation of what PSEA is in the event they are not aware/have not been informed
Risks	What do you think that the risks here could be for PSEA? If there are identified risks, what do you think are potential prevention and mitigation measures that could be implemented?	Capacity to understand potential for risks, and to identify risks as needed	Offer training, guidance notes or sensitization on risk mitigation
Reporting	Do you know of anywhere that PSEA could be reported? If they have a contract with a UN agency or work under the cluster coordination system-Are you aware of the obligation to report suspected cases of SEA? What would be the most appropriate reporting channels to put in place or utilize in this context?	Capacity to report, and understand global standards on reporting	Offer global hotlines, ethics email addresses etc.
Training/vetting	Do personnel here undergo any vetting like criminal background checks, or background checks/reference checks before undertaking this role? Have you, or personnel here received any kind of training or sensitization on PSEA? Is there a code of conduct, or PSEA CoC that staff are asked to sign here?	Discuss potential of offering sensitization Discuss the possibility of offering CoCs to be developed or safeguarding policies	Offer trainings if feasible Offer prototype codes of conduct

B. COMMENTS AND OBSERVATIONS

3.3 GBV/PRSEAH Safety (observational) and barriers to accessing health tool

WHO Poland Country Office

GBV safety audit (observation) & barriers to accessing health services[1]

A. SITE DETAILS

Responsible operator/s: Location:

Barriers	Factors to consider	Observation / comments
1. Access to services	• Are facilities located within a reasonable distance? • Is the route to and from the facility safe to travel? • Are there other forms of physical barriers? Are there measures in place for PWD/elderly? • Are there any other safety concerns which may affect access? • Availability of safe latrines, menstrual hygiene products etc. • Are there mechanisms in place to assure that services are accessible in terms of language?	
2. Financial accessibility	• Are health services provided free of charge? • What other indirect costs are associated with the service (such as transport)?	
2. Administrative accessibility	• Are there procedural steps that must be completed before accessing certain services? • For example, is a particular kind of registration required? Registration / PESEL? Passport? • What level of literacy and/or numeracy is needed? • Are the facilities open at times that are convenient given the daily/weekly responsibilities and preferences of women and girls?	
3. Social accessibility	• Do service providers respect non-discrimination in the provision of services? • Are certain groups excluded from services because of language barriers? • Are there female frontline workers (including translators/interpreters, if necessary)? • Are there any risks of stigma related to a person being seeing in/around a certain facility? • Do childcaring responsibilities limit access to services? Is there space for children to play / nursing mothers to feed?	
4. Information accessibility	• How is information about services communicated to the community? • Is dissemination and content of the information accessible in Ukrainian? • Are there alternatives for PWD, elderly, limited literacy, child friendly? Is personal information treated confidentially? • Is information about other services available and visible in the location.	
5. Acceptability	• Are the services respectful of the culture of individuals, minorities, peoples and communities (ie. Roma/LGBTIQ+)? • Do service providers respect confidentiality and informed consent? • Are services gender- and age-sensitive? Are there certain characteristics of the service providers (i.e. gender, nationality etc.) that make the community more or less comfortable accessing services?	

[1] Adapted to Poland context from GBV AOR tools including GBV Safety Audit toolkit, Identifying & Mitigating Gender-based Violence Risks within the COVID-19 Response, Protection Cluster Checklists, and AAAQ Framework, see gbvguidelines.org

3.3 GBV/PRSEAH Safety (observational) and barriers to accessing health tool

6. Quality of health services	• Do service providers possess the necessary skills and training? • Are there adequate supplies? • Is the environment appropriate, non-discriminatory, private and confidential as needed? • Are the facilities safe and sanitary?	
Risks	**Factors to consider**	**Observation / comments**
7. Staffing	• Are there female health workers available to treat women and girls who have experienced violence? • Are staff aware of GBV risks and health consequences? • Are they able to provide first-line support in cases of disclosure? • Do staff have updated referral pathways posted in clear location in the site? Do staff feel comfortable making referrals with informed consent? • Are all staff trained in frontline support to GBV survivors including disclosure and referrals. • Is there a counsellor of social worker available to support immediate needs? • Are staff trained on PFA? • Are staff aware of /briefed on what PSEA is? • Are staff aware of where they may report cases of SEA where they may have a genuine suspicion? • Have staff been made aware of the potential risk of human trafficking?	
8. Protocols / procedures	• Are there protocols in place and in use for various forms of GBV, including sexual violence? • Existence of policy on SEA / code of conduct. • Are there registration / vetting procedures for staff / volunteers? • Are there any criminal background checks carried out? • Is there a monitoring system for entry/exit? • Do staff wear a uniform / other identification? • What are the procedures around the collection, storage and use of patient information?	
9. Participation / consultation with the affected population	• Does the service seek feedback / inputs from the target population about the services provided (women, men, boys and girls)? • Is there a way for patients to make confidential / anonymous complaints about services and receive feedback? • Can staff explain the complaints procedure and child friendly reporting? • Is there an SEA / GBV or CP focal point? • Are there visible signs with information about patient rights?	
10. Information about risks	• Is information visible and available about staying in private accommodation and trafficking risks / support? • Is there information about how to access other services visible / available (UNHCR cash assistance, family tracing, blue dots, shelters, education)? • Is there accurate information available about limitations of SRH/CMR in Poland? • Is there accurate information available about time limits for provision of ECs and PEP for CMR? • Is information about PSEA for awareness-raising, and reporting channels available in this location?	

B. ADDITIONAL COMMENTS AND/OR OBSERVATIONS