SEA Risk Identification and Mitigation Checklist
Health

Sexual exploitation and abuse (SEA) involves humanitarian and development workers committing unwanted acts of a sexual nature against beneficiaries and members of affected communities. It is a serious abuse of power and trust. Everyone involved in health has a duty to protect affected communities from SEA. This includes ensuring assistance is delivered safely, respectfully, and without harm.

This checklist is designed for humanitarian aid workers to identify and address SEA risks in health programming. It is not exhaustive, and can be adapted to each context. For additional resources, consult the IASC PSEA guidelines, IASC SEA Risk Point Mapping methodology, and Empowered Aid materials linked below, all of which support further contextualisation.

KEY SEA RISK POINTS: HEALTH RESPONSE

Below are key risks points in Health responses. In many contexts, surge health partners and community members are unaware of their rights or what constitutes SEA and/or have limited knowledge of how or where to report abuse confidentially. This heightens risks of SEA.

OVERALL RISKS

Power imbalances & weak oversight

- **Most outreach workers & casual health staff are men,** due to qualification requirements, and lack PSEA training and regular supervision/oversight.
- **Women are excluded from leadership roles** and may face coercion for jobs or promotions.
- **Insecure, short-term contracts** increase vulnerability to abuse.
- **Government counterparts** play key roles but are **not held to the same conduct standards or accountability systems** as UN/NGOs.
- **Data protection**: Info that is not safely managed and stored can be used as leverage for committing SEA.

HEALTH EMERGENCY SCALE-UP *Greater risk with weaker controls*

- **Vulnerable groups** (e.g. women, girls, persons with disabilities) **may be coerced** due to urgent health needs and limited options.
- **Fast-paced recruitment processes skip vetting steps,** enabling known or potential abusers to join the response.
- **Surge partners & contractors** (such as drivers for mobile teams and vaccine transporters) **often lack PSEA training** and do not inform communities about their rights or how to report SEA.
- **Informal transporters (e.g. ambulatory care) and translators are used** without vetting or supervision.

Limited reporting options and community information

- **Affected communities/beneficiaries unaware** of what constitutes SEA and of their rights.
- **Complaint channels may be absent or fragmented, & rarely based on consultation with communities/women & girls.** They may lack confidentiality & be inaccessible when not adapted to literacy, language, or disability needs.
- **Health facilities often lack visible information on rights, SEA reporting, or how to safely raise concerns.**
- **Outreach and volunteers** often receive delayed/no PSEA briefing.
- **Perception of impunity for government officials & community leaders** deters reporting, especially when no clear disciplinary or reporting structures exist.

- **Patients may be alone with male providers during treatment,** without knowing what to expect or what behaviour is appropriate.
- SEA risks unique to health assessments, including abuse of power due to **intimate contact during exams/treatment.**
- **GBV services may be unavailable or unknown to staff or third party service providers, or not assessed;** many health workers are not trained to respond appropriately to SEA disclosures.
- **Government personnel often control reporting mechanisms without adequate resources, guidance, or accountability**, creating fear and mistrust among survivors.

COMMUNITY-LEVEL OUTREACH & MOBILE HEALTH SERVICES

Limited safeguards in decentralised services

- **Reliance on government actors & community representatives for community mobilisation, with no clear framework for SEA** oversight or accountability.
- **Male community leaders typically select male outreach workers and volunteers,** with little transparency or monitoring in the recruitment process.
- **Code of conduct is applied inconsistently** or not at all among community-level staff.
- **Vaccination campaigns and mobile clinics often ignore barriers faced by women and girls** – such as safety concerns, mobility restrictions, or care responsibilities – leading to exclusion.
- **Outreach staff and mobile teams frequently work in remote or isolated areas without oversight** or regular feedback mechanisms.
- **Home visits and community-based care involve one-on-one interactions, often with male health workers,** without safeguards to prevent misconduct.
- **Women and girls, especially of sexual and reproductive age, may lack coping mechanisms & face coercion,** with limited options to speak out.
- **Sale and exchange of sex and other forms of SEA may be normalised due to lack of awareness, stigma, and fear of retaliation.** Reporting remains low.

> **I went to the hospital with back pain and the medic told me to wait outside. Later when he summoned me into his office, he asked whether I have a husband or if I live with him. When I told him, 'I do not stay with my husband,' he said I am not sick [I] am just sex-starved, and he can help me overcome that back pain if I accept to have sex with him.**
>
> – Workshop with women in Kakuma Refugee Camp, Kenya, Empowered Aid research

UNDERSTANDING AND CONTEXTUALISING SEA RISKS

WITH COMMUNITIES: RECOGNISING THEIR EXPERTISE

Women, girls, and other marginalised groups are experts in identifying the SEA risks they face when accessing aid. They know which people, places, and processes feel unsafe – and what helps reduce those risks. **Their meaningful participation to assess and monitor risks is essential for designing safer programmes**.

WITH PARTNERS: IDENTIFYING RISK POINTS IN ACTIVITIES

SEA risks also need to be identified within internal processes. The IASC SEA Risk Point Mapping exercise is designed for staff and partners, not community members. It provides a practical entry point for reflecting on SEA risks in day-to-day programming.

Consult them by using participatory methods (see Empowered Aid's Contextualisation Toolkit or M&E Tip Sheets). Ensure discussions are:

- Led by trained, same-sex facilitators in safe, confidential spaces
- Focused on community-level risks, not personal experiences

Examples of safe and unsafe questions:

- ✅ "Are there parts of the [activity or aid process] where women, girls, or other marginalised groups feel unsafe?"
- ✅ "What are women/girls/marginalised groups' suggestions to make these activities safer, or be delivered in a safer environment?
- ❌ "Have you experienced SEA?" or "Who was the perpetrator?"

Facilitators (e.g. Cluster Coordinators) guide participants through:

- A short introduction on SEA risks and threats
- A group discussion to map potential risk points in at least two core activities they implement
- A focus on recognising risks – not yet mitigating them – to strengthen awareness and support mainstreaming of PSEA

This exercise can be done in person using flipcharts or online via Miro or PowerPoint. For full guidance, refer to the IASC SEA Risk Point Mapping Tool (Link to workshop package)

As risks evolve, continuous participatory monitoring ensures programmes remain responsive and community-centred.

Before consulting women and girls directly, consult the PSEA network and GBV sub cluster to obtain existing relevant information and coordinate around any consultations you plan to conduct (e.g. safety planning, sharing findings).

RISK MITIGATION MEASURES

CROSS-CUTTING RISK MITIGATION MEASURES

Hiring & training response personnel

- **Hire more women as outreach workers and daily/casual workers** (aim for at least 60%[1]). Share job info in local languages, using accessible formats, and focus on skills like community engagement.
- **Induct or brief all personnel – health workers, infrastructure teams, drivers, volunteers, and government partners** – on PSEA reporting channels & referral pathways **before service delivery begins.**
- **Support line ministries to brief their own personnel on PSEA policies** including codes of conduct.

[1] Interim Guidance (2024): Checklist for integrating PSEA in Country Preparedness and Response to MPOX.

Coordination, reporting & information

- **Coordinate with GBV/protection clusters and women-led organisations** to establish safe, confidential referral pathways.
- **Link SEA reporting channels to the broader cluster referral system** and prioritise trusted female intermediaries.
- **Support government counterparts t**o appoint PSEA focal points; ensure all personnel are oriented & sign codes of conduct; engage in PSEA community complaint mechanisms; and participate in joint UN-government referral processes.
- Provide clear, **multilingual information** on the right to access services without coercion and how to report SEA safely.

Quality assurance

- **Consult women and girls** on preferred service provider gender, timing, and location of services.
- **Ensure health centres and emergency teams have both female and male staff,** all trained on PSEA.
- **Display PSEA information** in health facilities, assessment areas, and community spaces.
- **Involve women's groups in selecting and vetting informal workers** such as **transporters and translators.**
- **Organise informal workers** into identifiable groups, **train them on PSEA, and monitor their conduct** via community feedback.

Strengthen agreements & collaboration

- **Run regular refresher sessions,** especially during **surge deployments.**
- **Designate PSEA focal points** and include PSEA in all coordination meetings (Ministry, district, community level).
- **Include PSEA clauses in partner agreements,** monitor compliance (e.g. training records, complaint logs), and roll out the UN IP PSEA Capacity Assessment.
- **Strengthen local NGOs and health facilities to adopt and enforce PSEA standards.**

- **Use trusted and accessible communication channels**– radio, posters, megaphones, visuals, and women leaders – adapted to low literacy and local language.
- **Coordinate with other sectors** (e.g. food, shelter, education, WASH) **to deliver standardised PSEA messages.**
- Test communication materials with target users before dissemination.
- **For tools, templates and resources,** see: PSEA at the Frontline – Together We Say No | IASC / PSEA.

- **Integrate PSEA into field monitoring tools and third-party evaluations.**
- Use **spot checks, exit interviews, and local feedback** to detect and address risks.
- **Individuals should be informed that they have the option to be accompanied by a trusted person,** specifically in the case of clinical care.

HEALTH EMERGENCY SCALE-UP

Based on the Ebola/Mpox experience

Preparedness, recruitment & conduct standards

- **Integrate SEA risk mapping and mitigation into emergency preparedness and response plans.**
- **Proactively recruit and promote women at all levels** – frontline, supervisory, and government roles.
- **Place women in visible positions** (e.g. triage, hotlines) to increase accessibility for survivors.
- **Conduct background and reference checks for all personnel,** including government staff. Pay attention to past SEA allegations.
- **Oversee volunteer recruitment and supervision,** involving women's groups in vetting and reference checks.
- **Standardise induction on codes of conduct and PSEA** across all responders, contractors, and volunteers. Require signed agreements.
- **Brief third-party contractors** (e.g. transporters, logisticians on expected conduct, and include PSEA clauses in contracts.
- **Display and explain organisational codes of conduct at health facilities** and community gathering points.
- **Clearly communicate the role of everyone in safeguarding in emergency responses using tailored strategies & accessible formats** – visuals, local languages, and radio.

Monitoring, reporting & coordination

- **Provide multiple SEA reporting channels,** including anonymous and gender-sensitive options (e.g. female focal points).
- **Coordinate with protection/GBV actors and PSEA networks** to ensure survivor-centred referral pathways are in place and functioning.
- **Train and support trusted community members** – especially women – to act as paid PSEA community group/committee points.
- **Share regular updates with communities about rights, reporting options, and follow-up actions** – using tested, inclusive communication channels.
- **Monitor staff and volunteer conduct through spot checks, complaints analysis, and feedback channels** during the emergency phase.

COMMUNITY-LEVEL OUTREACH & MOBILE HEALTH SERVICES

Supervision, awareness & safeguards

- **Deploy mobile monitors** or supervisors to high-risk/remote areas.
- **Run culturally appropriate awareness sessions** on the right to safe, abuse-free healthcare – especially in **SRH/nutrition** activities.
- **Work with trusted community actors** (e.g. women's groups, drama troupes, local CBOs) to **explain the intervention** and **reinforce accountability.**
- **Display and explain codes of conduct** in health posts and community spaces.
- **Reduce mobility-related risks by offering mobile services with female or mixed-gender teams.**

Community-based monitoring & reporting

- **Involve women's groups in selecting and supervising community volunteers and consult women on the timing and location of outreach to ensure safety and access.**
- **Ensure diverse and accessible SEA reporting channels,** including anonymous options and female focal points.
- **Train and compensate trusted community members to act as PSEA community groups/committees**.
- **Regularly gather feedback on risks, misconduct, and safety concerns** to adjust programming.
- **Coordinate with PSEA networks** to ensure community-facing mechanisms link to formal referral pathways.

ROLES & RESPONSIBILITIES

Cluster Coordination Team

- Share SEA risk information across the sector and advocate for risk mitigation at every stage of programming.
- Support partners to apply SEA risk mitigation measures in line with this checklist.
- Liaise with the PSEA Network to ensure coordinated capacity building including on reporting and referral pathways.

All Health Partners

- Brief all staff, volunteers, & third-party providers on SEA and expected conduct.
- Inform communities about their rights and safe ways to report concerns.
- Act immediately and confidentially on SEA reports—use referral pathways and prioritise the survivor's needs.
- Monitor staff behaviour & regularly gather community feedback to identify & reduce risks.

PSEA Network, Focal Points, Advisory Groups, GBV AoR & Women's groups

- Train focal points and staff on how to receive disclosures and refer safely.
- Keep referral pathways updated and share them with cluster members.
- Provide guidance on safe, survivor-centred SEA reporting systems.
- Support awareness-raising and safe feedback mechanisms in communities.

WHAT TO DO IF YOU SEE, HEAR, OR SUSPECT SEA

If someone shares a concern with you, or you witness or suspect SEA, it's your responsibility to act – safely and appropriately. Here's how:

- Stay calm and listen. Don't pressure the person to share more. Never ask for details.
- Believe them. Don't question their story or make promises you can't keep.
- Keep it confidential. Only share the information with those who need to know to take action.
- Follow your organisation's reporting procedure. If you're not sure how, speak to your PSEA focal point, local PSEA network, or supervisor immediately.

Always put the survivor's safety, dignity, and wishes at the centre of your response.
Do not try to investigate or intervene yourself.