Harmonised Reporting Scheme: How To Conduct a Lessons Learned Review after an SEAH case

Featuring a case study from CBM

Introduction

Findings from the Harmonised Reporting Scheme (HRS) show that even when incidents of sexual exploitation, abuse, and harassment (SEAH) are reported, follow-up measures – either responsive or remedial – are not systematic, especially in complex operating contexts or where internal capacity is limited.

A lessons learned review following an incident is a critical step in improving policies and case handling procedures and preventing future incidents. It provides an opportunity to assess what worked well, identify areas of improvement and measures to better protect individuals.

It also provides an opportunity to seek input from those who raised concerns to understand their experience and explore how the practices could be made more supportive, secure, and effective. Importantly, a lesson learned review process should always be done with care, ensuring confidentiality and a victim/survivor-centred approach.

In this guide we will explore when and how to conduct a lessons learned review, who should participate, and key elements to focus on. We will also provide guidance on **how to turn these insights into actionable changes** for both the investigation process and broader organisational practices.

Following this is an example of a lessons learned review process from CBM.

When to conduct the review

A lesson learned review should take place shortly after the case has been closed, ideally within a few weeks of the case closure (unless any breaches, risks, retaliation or confidentiality concerns arise prior to case closure, in which case they should be immediately documented and dealt with).

It is important to allow adequate time for the findings to be carefully considered but not so much time that momentum is lost. If an investigation revealed systemic issues and or generated recommendations, it might be necessary to conduct an ongoing review, checking back periodically to see if changes have been made and are having the intended effect.

Who should participate

This is not a process for just one person to handle and should ideally and if possible be carried out by an independent expert. It requires a group of people who can speak to

different aspects of the case itself and how it was handled. All persons involved should sign a confidentiality statement.

Here is a list of suggest participants (should be present in the review session – pink) and key stakeholders (input is key, but participation modality can be flexible – yellow):

Investigator: To share what went well, challenges encountered during the investigation, and what could be improved in future cases.

Management: To reflect on incident handling at leader-ship level, and help translate lessons learned into change in policies, procedures & programming.

Safeguarding staff / case manager: To provide insights on how the response affected the victims/survivors & IF safeguarding systems need to be strengthened.

Victims/survivors or trusted intermediary: While confidentiality and do-no-harm principles are paramount, it's also important to include the voices of those affected—either directly or through trusted intermediaries. With informed consent and appropriate safeguards, victims/survivors or those who supported them may choose to participate in the session directly or share feedback in advance to be presented anonymously.Their involvement should always be voluntary and handled with sensitivity to ensure emotional safety and privacy.

Confidentiality and victim/survivor-centred approach

A lessons learned review must respect confidentiality and anonymity. Victims/ survivors' privacy must be protected at all costs, and any information shared should be done with their informed and explicit consent. Maintaining confidentiality does not mean avoiding discussion altogether – it means being intentionally respectful and safe about how talk about incidents, so we can learn from them without exposing individuals to further harm or risk.

More information about confidentiality in the context of complaints can be found in the Managing Complaints: A Best Practice Guide for Aid Organisations (CHS Alliance, 2023).

Here are some practical tips on how to share and discuss SEAH incidents in an anonymous, victim/survivor-centred way:

- **Require signed statements:** Ensure all parties involved in the incident review sign a confidentiality agreement and a declaration of no conflict of interest.
- **Use general descriptors:** Avoid sharing names, specific job titles, or locations. Instead, refer to roles more broadly (e.g. "a staff member" or "a community volunteer" or use unique identifiers).
- **Focus on systems, not individuals:** Frame the discussion around what processes worked or failed, rather than who did what. For example, say "there was a delay in acting on the complaint due to a lack of clarity on reporting lines" rather than naming staff involved.
- **Aggregate data or patterns:** If you're discussing trends, use aggregated data to avoid identifying individuals. For example: "Three complaints in the past year were linked to distribution sites, all involving third-party actors."

- **Remove identifying details:** Even seemingly harmless information — such as the type of aid provided or the timing of the event — can make an incident identifiable in small communities. Remove or redact all non-essential details from any summaries or reports.
- **Create composite examples:** When illustrating lessons learned, consider merging elements from multiple cases to build an example that conveys key learning without being traceable to a real case.
- **Involve safeguarding staff:** When preparing to discuss a case, involve safeguarding or protection experts to review whether the content respects survivor confidentiality and risk considerations.
- **Secure documentation and discussions:** Keep minutes and materials from lessons learned meetings in secure, access-controlled formats. Remind all participants that confidentiality applies even in learning exercises. Collect and destroy handouts.

Above all, **victims/survivors or complainants should never be pressured to share their story**.

If their perspective/feedback is included, this must be done with clear, informed consent, and with sensitivity to how it is represented. By taking these steps, organisations can foster a learning culture while upholding a victim/survivor centred approach.

More information on a survivor centred approach can be found here: https://www.chsalliance.org/victim-survivor-centred-approach/

How to conduct the review

The review process should be a structured, collaborative discussion that focuses on identifying lessons learned and turning them into concrete actions. It is helpful to consider two different processes as part of the review scope:

- **Review of the investigation process**: Focus on whether the investigation was carried out effectively, with recommendations for improvements in investigation practices.
- **Review of broader programs and processes**: Consider whether the incident was preventable and can be mitigated through changes in programs, such as how distributions/ activities are designed and implemented, or how staff are recruited/trained.
- The review might suggest changes at an organisational level, for example, changes to be made to organisational policies and procedures or program modalities, as well as improvement metrics, trainings, screening methods, documentation, sanctions etc.

Suggested approach:

1) **Start with a clear purpose**: Explain to participants that the goal is to improve practices and prevent future incidents, not to blame anyone. Everyone should be encouraged to speak openly, while maintaining confidentiality.

2) **Reflect on the investigation**:
   - **What worked well?** Did the investigation process follow the planned steps and timeline? Were the right people involved?
   - **What didn't work?** Were there delays? Did anyone refuse to engage with the process? Did anyone report and experience barriers to coming forward? Were the investigation procedures fair and transparent?
   - **What could have been done differently?** How could the process be improved next time?

3) **Review systems**: After reviewing the investigation itself, shift the focus to broader systems and programming. Did any organisational weaknesses contribute to the risk or impact of the incident? Think beyond the incident itself — this is a chance to examine the enabling environment. Did the incident happen because of weaknesses in broader systems, such as program modality, recruitment, or community outreach?

Guiding Questions:

Program design & delivery: • Were there risks in how activity or programme was designed? • Was the modality (e.g. in-kind vs cash, direct vs third-party delivery) appropriate and safe • Were there missed opportunities to apply VCA or gender-sensitive approaches?	Community engagement: • Did communities have safe, trusted ways to report concerns? • Were community members involved in identifying potential risks before activity began? • Were people aware of their rights and of how to report misconduct?	Staffing and supervision: • Was the manager-to-staff or staff-to-participant ration adequate for proper oversight? • Were roles and responsibilities clear to staff & volunteers? • Were there gaps in supervision or oversight that allowed for risks to go unnoticed?
Recruitment and HR: • Were staff and volunteers vetted properly? • Did everyone involved in the activity receive training on SEAH and sign a codes of conduct? • Were there any concerns about staff behaviour before the incident?	Org culture & accountability: • Were staff and community members confident that reporting would lead to action? • Was retaliation against complainants or whistleblowers adequately prevented? • Did staff feel safe raising concerns internally?	Previous learning: • Have similar incidents happened before? If so, were passed lessons learned implemented? • Did the organisation previously identify this area as high-risk and what was done about it?

4) **Develop an action plan**: Once insights have been **gathered**, an action plan should be developed. This plan will include specific actions to address the gaps identified, along with timelines and assigned responsibilities. Look at:
   - **Issues identified**: What problem or weakness was found?

- **Action to address the issues**: What specific steps will be taken to address this?
- **Timeline**: When will this action be completed?
- **Responsible person(s)**: Who will be responsible for carrying out this action?
- **Resources needed**: Are there resources or training required to implement the change?
- **Success indicator**: How will we measure whether this action is successful?

Spotlight: An example of best practice

After-Action Reviews in Christian Blind Mission (CBM)

In CBM, we conduct After Action Reviews (AARs) to reflect on and capture learning after a complex incident occurs. This practice brings together a group of key individuals involved in the incident for honest conversations about the recently concluded case in a safe environment.

Persons involved

The persons involved depend on the type of safeguarding case. The safeguarding team is always involved and leads the conversation. Additionally, a select group of people is invited to participate, comprising those who played a key role during the process and are responsible for implementing the action plan. Usually, they are the Country Director of the country office where the incident occurred, the responsible director, such as the Director of Global Programme Development and Implementation, or the Global Head of HR, if the incident is related to sexual misconduct in the workplace, and members of staff involved in the case. In some cases, we would also invite the Staff Council representative; however, the decision depends on the analysis we made at the beginning of the process. This practice helps us to ensure the survivor-centered approach is observed in each stage.

Session format

The session begins with a brief introduction to the AAR process and its purpose, followed by a review of the significant aspects of the incident. We ensure that no confidential information is disclosed, adhering to our duty of care and the principles of a survivor-centred approach. This is why only the key people involved with the case are invited to the meeting.

Report and action plan

A written summary report is prepared based on the discussion, which serves as the foundation for developing an action plan, which only contains anonymised information to encourage actions for risk mitigation, prevention, and better responses in the future. This practice has strengthened team building, trust, and understanding regarding the handling of sensitive information. It also fosters a continuous improvement process around Safeguarding and PSEAH. Furthermore, the AAR process enables a transition from individual learning to group learning, ultimately contributing to organisational learning.

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Conclusion

Conducting a lesson learned review is not just about reflecting on what went wrong. It is about making real changes that will protect vulnerable individuals and improve the way we prevent and respond to SEAH. By following a clear, structured process and engaging key stakeholders, organisations can create a culture of learning and continuous improvement.

More information

- PSEAH Index, CHS Alliance, 2024
- Managing Complaints: A Best-Practice Guide for Aid Organisations, CHS Alliance, 2023
- Whistleblower Protection Guidance: How to Create an Environment that Protects and Enables Reporters of Misconduct or Wrongdoing, CHS Alliance, 2022
- Sexual Exploitation, Abuse and Harassment Investigation Guide, CHS Alliance, 2022
- Delivering a Victim/Survivor Centred Approach to PSEAH in the Aid Sector, What Will it Take? Implementation Companion, CHS Alliance, 2024