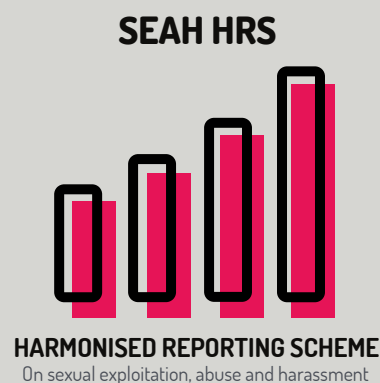




# TRENDS IN SEXUAL EXPLOITATION, ABUSE & HARASSMENT (SEAH) IN THE AID SECTOR: A SIX-MONTH OVERVIEW

Harmonised Reporting Scheme (HRS) on SEAH  
October 2024 - March 2025



# TABLE OF CONTENTS

1

## INTRODUCTION

5 things you need to know from this report.....	3
Background .....	4

2

## SEAH TRENDS AGAINST AID RECIPIENTS AND THEIR COMMUNITIES

What type of incidents were reported?.....	6
Where were incidents reported from?.....	7
Who reported incidents and how?.....	9
Who were the victims/survivors?.....	11
Who were the alleged perpetrators? .....	13
What was the outcome of incidents?.....	16
What responsive measures were taken?.....	18
What remedial actions were taken?.....	21

3

## TRENDS ON SEAH AGAINST STAFF MEMBERS

What type of incidents were reported?.....	23
Where were incidents reported from?.....	23
Who reported incidents and how?.....	24
Who was involved in the incidents?.....	24
What was the outcome and response to incidents?.....	25
What responsive measures were taken?.....	26
What remedial actions were taken?.....	26

## REFERENCES

To reference this report, please use the following citation:

CHS Alliance, Trends in Sexual Exploitation, Abuse and Harassment (SEAH) in the Aid Sector:  
A Six-Month Overview, June 2025

If quoting specific sections, please ensure accurate attribution and specify page number where relevant.

For further inquiries, please contact [seah.hrs@chsalliance.org](mailto:seah.hrs@chsalliance.org).

Funded by



Foreign, Commonwealth  
& Development Office

# 5 THINGS YOU NEED TO KNOW from this report – and what to do about them



## Most disclosures are made face to face – often to staff.

56% of SEAH reports were made to staff. In sensitive cases like sexual abuse or incidents involving minors, that figure rises even higher.

**SO WHAT?** Victims/survivors turn to people they trust, making staff and community members critical first responders. They must be trained to respond safely and refer appropriately – one misstep can break trust in the whole system. But choice matters: 30% used hotlines or email. Multiple reporting options are essential so people can report in the way that feels safest.

## Children under 18 – in vast majority girls – make up 2 in 5 victims.

They accounted for 40% of all cases against aid recipients. Over a third received no support. Only 38% of child survivors of sexual abuse accessed medical care. Even fewer received legal aid.

**SO WHAT?** Child safeguarding must be built into all community-facing activities – not just education or child protection programmes. Every programme should assume children may be present – and ask: could this create risk? Safeguards must be built into design and delivery. Reporting systems and assistance must be tailored, accessible, and age-appropriate for children.



## 2 in 5 alleged perpetrators are outsourced personnel or providers.

These include volunteers, contractors, vendors, incentive workers & partners – often operating with less training, oversight, or accountability – but holding real power over communities.

**SO WHAT?** We must hold them to the same safeguarding standards. Vet them before engagement. Brief them on expected conduct and consequences. Assign a focal point on site to supervise. If an activity can't be safely overseen, it shouldn't go ahead. Communities see them as us – and they're right. We are responsible. If we can't manage the risk, we shouldn't take it.

## Only 30% of cases are substantiated – and only half lead to dismissal.

False reporting is rare, yet most cases don't reach a confirmed outcome. Even when they do, consequences vary – with those in positions of power less likely to face dismissal.

**SO WHAT?** Investigations must be stronger, fairer, and victim/survivor-centred – not built around doubt or disbelief. Organisations need trained, well-supported investigators and clear processes that don't put the burden on victims/survivors. When harm is confirmed, action must be taken – consistently and regardless of who the perpetrator is.



## Nearly half of workplace SEAH cases involve managers – who rarely face consequences.

33% are middle managers. 10% are senior managers. The latter are less likely to be dismissed.

**SO WHAT?** Power still protects perpetrators. When managers cause harm, reporting becomes even harder, and the impact goes beyond the organisation. We need visible accountability at every level. Leaders must be selected and trained to shape culture, not just manage risk – to build trust, address abuse of power, and model the standards we set.

## BACKGROUND

Sexual exploitation, abuse, and harassment (SEAH) continue to harm the people we serve and the people we work with. **Behind each report is a person whose trust was broken, often by those meant to help.** These violations shake confidence in the aid system and make it harder for assistance to reach those who need it most. When people do not feel safe to report – or when reports are not handled with care and urgency – the harm is compounded. SEAH represents one of the most egregious failures of accountability, and addressing it is central to Commitment 5 of the [Core Humanitarian Standard](#), which calls on organisations to ensure that communities can safely raise concerns and receive a timely, respectful response.

**The Common Approach to Protection from SEAH** ([CAPSEAH](#)) defines SEAH as:

- **Sexual exploitation** is any actual or attempted abuse of a position of vulnerability, differential power or trust for sexual purposes, including, but not limited to, profiting monetarily, socially or politically from the sexual exploitation of another. For example, coercing individuals into engaging in sexual activities in exchange for aid, services, employment opportunities, or other benefits.
- **Sexual abuse** is the actual or threatened physical intrusion of a sexual nature, whether by force or under unequal or coercive conditions. This includes sexual assault, rape, molestation, and other forms of non-consensual sexual activity.
- **Sexual harassment** is a range of unacceptable and unwelcome behaviours and practices of a sexual nature that may include, but are not limited to, sexual suggestions or demands, requests for ‘sexual favours’, sexual, verbal or physical conduct, or gestures that are or might reasonably be perceived as offensive or humiliating. This includes jokes, comments or messages of a sexual nature; suggestive looks, staring or leering; display of or circulation of pornographic material. It is sometimes used to describe behaviour in a work environment but can also occur in communities and public spaces.

CAPSEAH uses the collective term SEAH because each of sexual exploitation, sexual abuse and sexual harassment are driven by power imbalances and inequality, particularly gender inequality, and all require action. Linking them encourages action to tackle all harmful and unwanted sexual behaviour by people delivering HDP work, regardless of where the incident happens or who the victim/survivor is.

Aid organisations have been working hard to prevent and respond to SEAH. Policies have been strengthened, reporting systems are in place in many countries, and dedicated staff at organisations are doing their best in often complex and under-resourced environments. Since the [HRS](#) began collecting data in 2023, more than 700 incidents have been reported – and that’s just the tip of the iceberg. These cases show that **SEAH is not the exception, but a systemic risk that requires sustained, collective action.**

During this reporting period, **widespread funding reductions led to significant staffing cuts and disruptions to core safeguarding activities.** A [survey](#) conducted by the Inter-Agency Standing Committee (IASC) with in-country PSEA Networks between March and April 2025 found that 29% of organisations had reduced or suspended their PSEA operations, programs or activities, and 30% reported that dedicated PSEA personnel were directly affected. In some cases, community feedback mechanisms were deactivated due to the suspension of grants including those supported by USAID’s Bureau for Humanitarian Assistance. These factors likely

contributed to even higher numbers of under-reporting during the period – with some incidents potentially going unnoticed or being reported at a later stage.

**Funding cuts, staff reductions, and program closures across the aid sector directly increase the risk of SEAH.** When aid is reduced or withdrawn, the most vulnerable – often women and children – become more exposed to abuse. At the same time, communities and staff alike may fear that reporting SEAH could lead to further aid cuts or retaliation. With fewer staff and less oversight, the ability to prevent, detect, and respond to SEAH weakens. Case management slows, investigations stall, and assistance becomes harder to access. All this erodes trust in the aid system and makes incidents less likely to be reported. We cannot afford to lose the fragile progress made. **Now more than ever, organisations must use their PSEAH resources strategically – focusing on evidence-backed priorities and targeting efforts where they will have the greatest impact.**

The HRS was designed to help with that. It offers a shared way for aid organisations to report anonymised SEAH data, helping the sector build a clearer picture of what is happening – and where action is most needed. As of June 2025, 92 organisations contribute to the scheme. Participation continues to grow, including from institutional donors – showing a shared commitment to being transparent, learning from what the data tells us, and doing more to stop SEAH. It's a move away from words alone, toward real action.

This report examines **204 SEAH incidents** that occurred between **October 1st 2024 & March 31st 2025**, as well as cases with unknown dates that were reported during this period. It includes incidents involving victims/survivors who were aid recipients, accounting for 65% of the total (133 cases), and workplace-related cases where the victim/survivor was an aid worker, which make up the remaining 35% (71 cases).

It's important to note that under-reporting remains widespread, and HRS participants still represent only part of the aid sector. **Numbers in this report do not reflect the true scale of SEAH globally** and some fluctuations in the data may reflect changes in who is reporting rather than shifts in actual SEAH patterns. As the Scheme membership grows, trends can be influenced by new organisations' profiles, capacity, or geographical focus. While some comparisons over time are included in the report, we caution against interpreting increases or decreases too strongly at this stage. A more robust comparative trends analysis between periods will be possible once participation levels stabilise.

**Nonetheless, when certain trends hold steady across multiple reporting rounds or contexts** – such as how incidents are reported, the proportion of victims/survivors who are children, substantiation rates, or recurrent profiles of alleged perpetrators – these can be interpreted with more confidence and point to deeper, systemic issues that cut across organisations and settings.

**The data is thus a call to act and a roadmap of where to begin.** It helps us orient our SEAH prevention and identify where efforts are most needed. But this is only the beginning: the more data we receive, the stronger and more precise our analysis will become – allowing us to track evolution over time, compare trends across countries, and tailor prevention strategies to specific contexts.

If your organisation is not yet part of the HRS, we encourage you to [get in touch and join](#) this free global initiative. **Your SEAH data can help drive change – both within your own organisation and for the sector as a whole.**

# I. SEAH TRENDS AGAINST AID RECIPIENTS

## WHAT TYPE OF INCIDENTS WERE REPORTED?

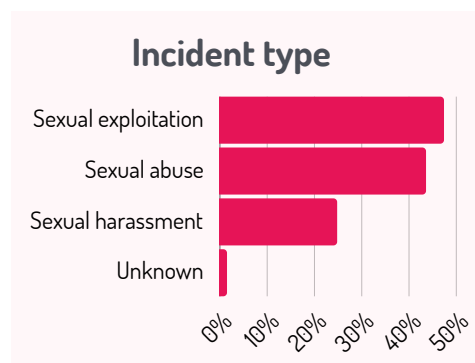
Globally, **sexual exploitation accounts for nearly half (48%) of reports**. Sexual abuse makes up 44%, and sexual harassment 25%. This marks a shift from the previous period, with a more even distribution across typologies. Harassment reporting decreased from 34% to 25%.

Whether this reflects a real shift or differences in classification practices is difficult to determine, particularly with the recent growth in HRS participation. What's evident is that **harassment remains underreported**.

In many communities where gender-based violence (GBV) is normalised and certain behaviours are not even recognised as abuse, harassment is rarely reported – not because it isn't happening, but because people may not know they have the right to speak out. Additionally, organisations do not consistently define or track it as part of SEAH, and even fewer raise awareness on it within communities. This is a gap that matters: **it can be a precursor to more serious violations and is often the first warning sign**.

There are also notable differences in typology of incidents between countries with the most reports. In the Democratic Republic of the Congo, sexual exploitation is the most reported type; in Syria, it's sexual harassment; and in Bangladesh, sexual abuse. These differences may reflect variations in how organisations operate, how incidents are classified, and who is reporting – rather than actual differences in prevalence.

Additionally, these topline trends offer only part of the picture. Later sections of this report explore differences in typology by gender and age group of victim/survivors, profile of the alleged perpetrators, and in actions taken in response – offering clearer insight into how different forms of SEAH manifest and are handled.



Totals exceed 100% as some incidents involve multiple types of misconduct.

### RECOMMENDATION

**Sexual harassment is not a lesser offence – it's often a warning sign of further abuse.** Yet many organisations still fail to define, track, or address it properly. All actors must adopt and apply a shared definition of SEAH that includes sexual harassment, as outlined in the CAPSEAH. This must be understood by both staff and communities: harassment is serious, unacceptable, and reportable, and people have the right to be protected from it. Classifying incidents clearly and consistently – distinguishing between exploitation, abuse, and harassment – helps us identify patterns, understand how these violations may occur on a continuum, and see where prevention or response is falling short. While grouped under SEAH, each typology has distinct dynamics and permissive settings, making it essential to analyse and address them individually. This means going beyond policies: organisations must actively work to prevent and respond to harassment through training, safe reporting channels, visible leadership, awareness raising in communities, and victim/survivor-centred response.

## WHERE WERE INCIDENTS REPORTED FROM?

SEAH incidents were reported across 35 countries distributed across several regions<sup>1</sup>:

- **Eastern Africa accounts for the highest proportion of reports** – 29% of all incidents – followed by Central Africa with 25%. **Western Africa** accounts for 9% of incidents. Together, these three African subregions make up for almost two thirds of incidents in this period, in line with trends observed in previous reports.
- **Western Asia (Middle East)** and **Southern Asia** also feature prominently, with 10% and 9% of incidents respectively.
- Reporting remained relatively low in regions such as South America and Eastern Europe.

**Higher reporting numbers only partly reflect elevated risks. They can also indicate stronger reporting and response mechanisms.** The presence or absence of reports from a country or region should not systematically

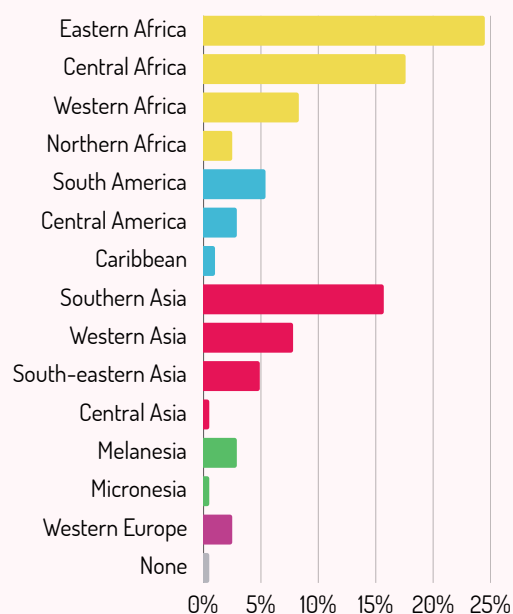
be interpreted as evidence of higher or lower SEAH incidence. **Rather, we must seek to identify why incidents are being reported in some settings but remain invisible in others where the risk is equally high**, using country-specific assessment or tools with country-level data like the [IASC SEA Risk Overview Index](#)<sup>2</sup> (SEAR0).

At the country level:

- **Democratic Republic of the Congo (DRC)**, is the largest source of reports, with **21% of all cases**. This is consistent with past reporting periods. It's worth noting that several organisations were unable to collect or report data during this period due to the escalation of conflict, suggesting that the actual number of cases may be significantly higher.
- **Syria** (10%), **Bangladesh** (6%), **Kenya** (6%), and **Ethiopia** (6%) follow, rounding out the top five reporting countries.
- All other countries represented less than 5% of total reported incidents due to the vast geographical span of incidents

**NB:** Higher reporting in the DRC, Bangladesh, and Ethiopia is partly influenced by strong HRS presence – through extensive outreach with PSEA Networks in the DRC and ongoing country pilots in Bangladesh and Ethiopia. These factors contribute to broader engagement and reporting, beyond contextual risk alone.

Regions of reported incidents

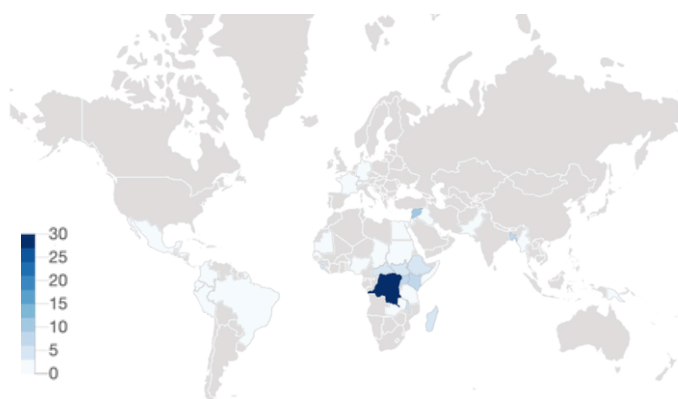


<sup>1</sup> Regional classifications in this report follow the United Nations geoscheme for statistical purposes. For more information and a full list of countries by region, see: <https://unstats.un.org/unsd/methodology/m49/>

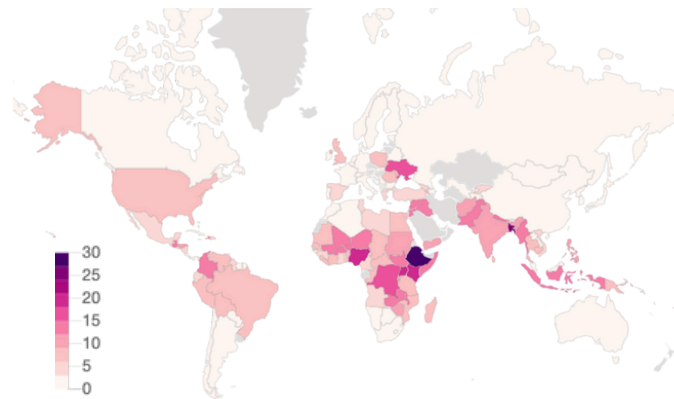
<sup>2</sup> The IASC SEA Risk Overview (SEAR0) Index offers a broad composite measure of SEA risk based on enabling environment, situational and operational contexts, and protective mechanisms. While the overall score gives a snapshot of risk, users can disaggregate the index and explore specific indicators more directly related to SEA reporting and programmatic exposure. For example, the "Reporting & Accountability" and "Survivor Assistance" components within the Protective Environment dimension, as well as "Operational Design" and "Organizational Culture" under the Operational Context, provide insights into factors that may support or inhibit reporting. These can help identify settings where enabling conditions for reporting are stronger, even if SEA risk is high.



Map of reported incidents



Map of HRS operational presence



A closer look at where HRS organisations operate also reveals interesting findings on under-reporting. Some countries with concentrations of HRS members – such as **Sudan**, **Haiti**, and **Mali** – once again reported no incidents, despite being considered high risk on the SEA RO (respectively 6th, 12th and 10th on the SEARO index). Others, including **Somalia**, **Chad**, **South Sudan**, and **Afghanistan**, recorded only a few incidents.

Other regions including **West Africa**, **Latin America**, and **Eastern Europe** also continue to show consistently low reporting at country level, even where HRS participation is strong. These trends point to persistent barriers in SEAH reporting and blind spots in our understanding of SEAH risk and raise the question: what is keeping victims/survivors, witnesses, and staff from speaking out in these countries or regions?

What encourages or discourages reporting varies by context, but **people are more likely to report when mechanisms are safe, confidential, easy to access, and lead to meaningful action**. Barriers such as fear of retaliation, stigma, limited feedback, and lack of awareness or inclusive access continue to deter many, just like structural issues (language, physical inaccessibility, or digital dividers). These barriers are often more pronounced in remote, high-risk, or conflict-affected areas – frequently the same places where SEAH risks are greatest.

## RECOMMENDATIONS

- **Build a connected SEAH reporting architecture from local to global:** To truly understand and respond to SEAH, we need one system that connects reporting from the country level all the way up to global oversight. This means harmonising how we collect, analyse, and share data – across international NGOs, national NGOs, UN agencies, and PSEA Networks. The HRS is a first step toward this goal, but making it work for everyone will require close collaboration and alignment. A common system wouldn't solve underreporting on its own, but it would allow more data to be brought together and transformed into shared country-level dashboards – giving us a valuable tool to understand what works, what doesn't, and what's getting in the way of reporting in each context.
- **Dig deeper into low-reporting contexts:** In countries with high operational presence but few reports, PSEA Networks and organisations should jointly assess what is preventing disclosures. This includes looking at accessibility of mechanisms, cultural norms, trust, and perceived safety.



## WHO REPORTED INCIDENTS AND HOW?

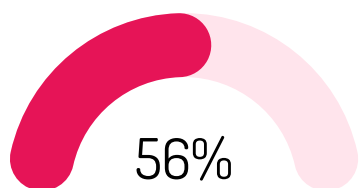
Only 19% of SEAH incidents were reported directly by the victim/survivor.

Staff were the most frequent reporters overall, responsible for 43% of reports (32% by staff from the reporting organisation and 11% by staff from another).

This reflects a positive shift in staff recognising their responsibility to report, but also shows how barriers still prevent victims/survivors from coming forward themselves (stigma, lack of trust, fear of retaliation or just not knowing how).

More often, victims/survivors relied on those around them: family members (13%), community members (11%), or community volunteers (5%). Anonymous reporting remains rare: just 7% of cases. When the victim/survivor reports, the type of incident matters: they are significantly less likely to report sexual abuse themselves (8%) than they are to report sexual exploitation (21%) or sexual harassment (31%).

### Profile of the person who reported



**MORE THAN HALF THE INCIDENTS WERE REPORTED FACE-TO-FACE TO AN AID WORKER**

This reporting period reaffirms that staff members remain the main entry point for SEAH disclosures across all incident types and reporter profiles. In total, 56% of incidents were reported to staff member. Of these, 42% to staff from the same organisation as the alleged perpetrator, 10% to designated PSEAH focal points from the reporting organisation, and 4% to staff from another organisation.

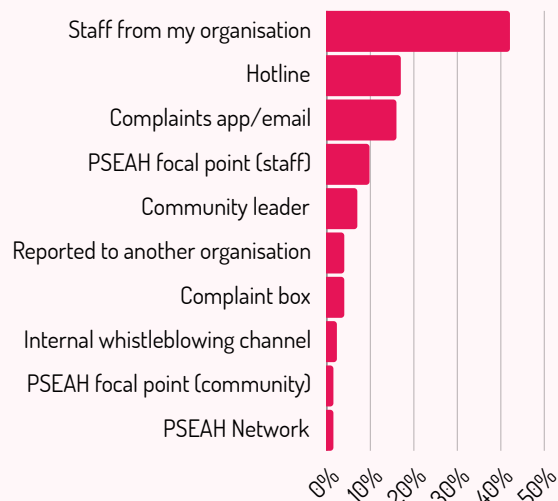
This may mean that other mechanisms were unavailable, or may reflect a tendency to turn to trusted individuals rather than formal systems, especially in sensitive cases.

Disclosing to a person can offer a sense of control and safety, particularly when the victim/survivor can choose who to approach and how. But it also places a heavy burden on frontline staff, who may not be trained, equipped, or supported to handle disclosures appropriately. Strengthening their capacity and well-being is key to building a system that victims/survivors can trust.

Reporting to staff rather than systems is even more pronounced in sensitive cases:

- For incidents involving minors, the proportion of incidents reported to staff rises to 70%.
- In cases of sexual abuse, 77% were reported to a staff member.

### Reporting channel used



**Hotlines and complaint apps/emails** were the second most commonly used channel overall, making up respectively **17% and 16% of reports**. The role of hotlines is particularly important when victims/survivors are the first reporters: in those cases, hotlines were used in 47% of incidents. This suggests that in some situations or for some people, hotlines may feel safer or less stigmatising, especially where anonymity is valued or fear of retaliation is high. However, hotlines require access to a phone – something many women and children may not have – and coverage – which is often unavailable in remote areas.

Some nuances also emerge across tools used per type of incident. Whereas sexual abuse is most frequently reported to staff, **hotlines are most used in harassment and exploitation cases**.

**Country-level variations in the choice of reporting channels are also important.** In Bangladesh, hotlines were heavily used, while in the DRC most reports went to staff members, and Syria showed a wider mix of channels, including hotlines, staff, and community leaders. These differences may reflect not only how organisations define and communicate reporting options, but also what’s practically available and what communities trust. They’re also shaped by context – what works in one region of a country may not work in another. **That’s why country-level analysis matters.** Without it, we miss the nuance of what’s working and where we’re falling short.

### Reporting channel used per country

Mechanism used	DRC	Syria	Bangladesh
Hotline	10%	25%	67%
Complaint app/email	-	25%	-
PSEAH focal point (community)	-	-	-
PSEAH focal point (staff)	10%	-	16%
Reported to a staff from my org	75%	25%	17%
Reported to a staff of another org	-	25%	-

These findings tell several stories. On one hand, **most people prefer reporting to someone than to a system**: a familiar face, a trusted staff member. But reporting systems also matter. Hotlines, apps, and other formal mechanisms provide an essential alternative for those who might otherwise stay silent. Ultimately, **the reporting channel that feels safe or accessible depends on many factors: who is reporting, the nature of the misconduct, the surrounding context, and the power dynamics at play.** There is no one-size-fits-all solution – so it’s critical that organisations offer multiple, flexible entry points for reporting.

But neither matters if action doesn’t follow. People report to stop the abuse, protect others, and see perpetrators held accountable. If systems fail to respond, trust breaks – and so does the willingness to report. The credibility of any mechanism depends not just on how it’s built, but on what happens after the report is made.

## RECOMMENDATIONS

- **Equip and care for staff receiving disclosures:** Frontline staff are the first point of contact for most SEAH reports. They must be trained to receive disclosures with care, refer survivors safely, and respond using a survivor-centred approach. Just as crucially, they need support themselves, including supervision & attention to their wellbeing. Handling SEAH disclosures is emotionally demanding. Investing in this is worth it: just one poor response can break trust in the entire system.

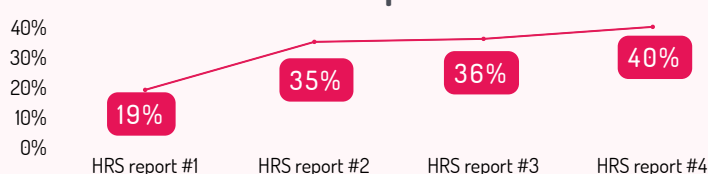
- **Implement & raise awareness of inter-agency SEAH referral procedures:** the significant number of SEAH cases involve staff from different organisations underscores the need for clear, coordinated referral pathways. All actors should implement the [IASC Inter-Agency SEA Referral Procedures](#) and inform staff on how to use them, so that victims/survivors receive timely and appropriate support, regardless of who the alleged perpetrator works for.
- **Strengthen existing reporting systems but don't multiply them:** While face-to-face remains the preferred option in many contexts, hotlines, complaint systems or boxes still play an important role. But creating too many new, standalone systems risks fragmentation and missed cases. Instead, invest in strengthening internal, community-based mechanisms and linking with existing national or inter-agency helplines. Prioritise visibility, local language access, and a fast, confidential response.
- **Encourage and support safe whistleblowing:** The fact that most reports come from staff is encouraging, however it means they need clear guidelines on doing it safely, and that we need to protect whistleblowers from retaliation. See the CHS Alliance resources on [managing complaints](#) and [whistleblower protection](#) to strengthen your internal processes.
- **Reduce barriers for victims/survivor & community reporting:** Few incidents are reported directly by victims/survivors. Engage communities and civil society intermediaries using participatory approaches to understand why. Use that feedback to redesign reporting pathways that are safe, convenient and accessible for the community they are intended for. This can significantly increase reporting. Invest in SEAH capacity strengthening for national NGOs and community-based organisations, who often hold deeper community trust and access. Training on SEAH prevention, reporting protocols, and victim/survivor-centred approaches can significantly improve local-level reporting and response. Check out the CHS Alliance Victim/Survivor Centered Approach [Implementation Companion](#) and [Monitoring, Evaluation and Learning Toolkit](#) to learn more about SEAH responses that work for survivors.

## WHO WERE THE VICTIMS/SURVIVORS?

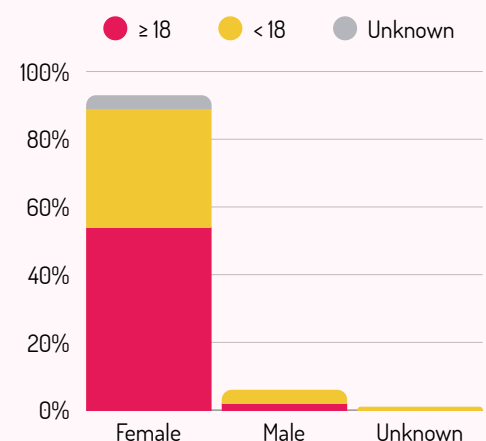
**Most victims/survivors of SEAH are women and girls.** Overall, 93% were female, and 40% were under the age of 18 (slightly higher than in the previous reporting cycle, 36%).

**This means nearly 2 in every 5 incidents involved a child below 18,** a trend that has remained alarmingly consistent across all HRS reporting periods, and even higher than in [UN iReport](#) figures (25% for 2023, 23% for 2024).

### Evolution of % of victims/survivor below 18 in HRS reports



### Victim/survivor by sex & age group



**Male victims/survivors continue to be under-represented**, with only 6% of all victims/survivors being male (two thirds of whom were below 18). This is higher than the previous report (2%) but may still likely reflects under reporting for this group.

Profiles of victims/survivors vary by type of misconduct:

- **Sexual exploitation:** 65% were adult women, while 25% were girls. Boys represented 4%.
- **Sexual abuse:** Girls made up 55% of cases (unchanged from last report). Adult women accounted for 35%, and boys for 4%.
- **Sexual harassment:** Adult women were the majority (63%), followed by girls (21%). Harassment was also the category with the highest proportion of male victims - 11% adult men and 5% boys.

Across all incident types, only 8% of cases had no identified victims/survivor, a positive decrease from 22% in previous reports.

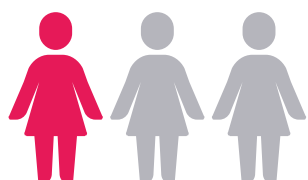
**Assistance and support for victims/survivors remains inconsistent.** While some services are being delivered, too many victims/survivors remain without support.

**Mental health and psychosocial support was the most commonly provided service** (46%), followed by medical assistance (29%). Fewer than 1 in 5 victims/survivors received legal or economic support. **32% of victims/survivors still did not receive any form of assistance:**

- **In 17% of cases, it was declined** – a choice victims/survivors have the right to make, but that must be an informed, empowered one, not driven by fear of retaliation or stigma.
- **In 13% of cases, no support was offered.**
- **In 2%, assistance simply wasn't available**, a significant drop from the last report.

This aligns with UN iReport 2024 data, where 33% did not receive assistance.

**Sexual exploitation is where support gaps are most acute.** Nearly 40% of victims/survivors of sexual exploitation received no assistance – 18% declined and 19% were not offered any. This raises concerns not just about systemic failures to offer victim/survivor centred support, but also about the unique barriers victims/survivors of exploitation may face in seeking or accepting support (fear being blamed, judged, or disbelieved).

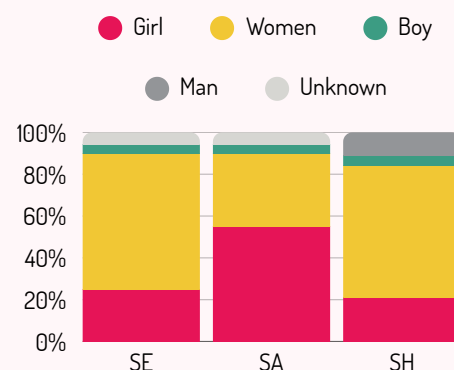


**1 IN 3 VICTIMS/  
SURVIVORS DID NOT  
RECEIVE ASSISTANCE**



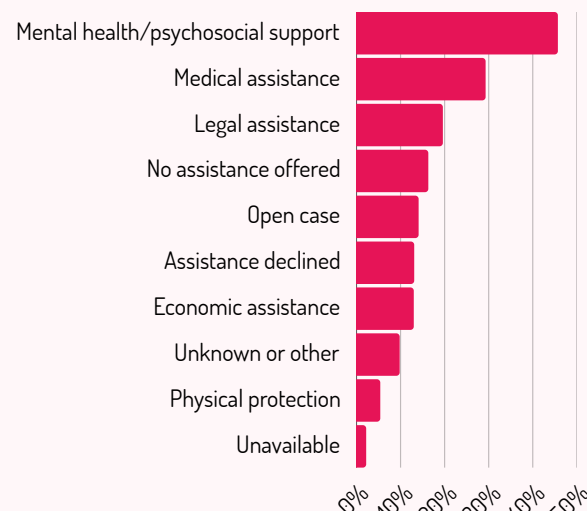
**2 IN 5 VICTIMS/SURVIVORS WERE  
CHILDREN. MOST WERE GIRLS.**

### Profile per type of incident



**HALF THE VICTIMS/  
SURVIVORS OF SEXUAL  
ABUSE ARE GIRLS**

### Assistance rendered to victim/survivor



Over a third (36%) of child survivors received no support at all whether because they declined, were not offered, or services were unavailable. 55% accessed mental health or psychosocial assistance, 40% medical support, but just 15% accessed legal aid.

One figure stands out starkly: among child survivors of sexual abuse, just 38% received medical care. This figure highlights a critical shortfall in meeting our duty of care. Child survivors face heightened and long-term risks when left unsupported. Getting them timely, age-appropriate, and trauma-informed care is urgent.



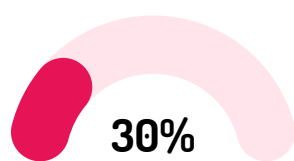
For victims/survivors, assistance is often the visible outcome of reporting. Internal accountability processes often remain opaque, but access to support is something they directly experience. If that link breaks, so does trust in the entire system. We must do more and must do better.

## RECOMMENDATIONS

- **Make assistance systematic:** Ensure every SEAH case triggers an offer of support, regardless of whether the victim/survivor chooses to accept it. This must include access to medical care, mental health and psychosocial support, legal advice, safety measures, economic assistance, and redress. Never assume what a victim/survivor might need based on what they've disclosed. Many may only share part of the experience due to fear or stigma. It's our responsibility to clearly explain what's available and let them decide what's right for them. Support shouldn't end when the case file closes – it should remain available for as long as the victim/survivor needs it.
- **Map services:** Your organisation won't be able to provide all services, but must know who can, and shouldn't wait for a case to figure this out. Maintain an up-to-date service mapping for your areas of operation and know where to refer victims/survivors in a timely, safe way. Speak to the PSEA Network and to the Gender-Based Violence (GBV) and Child Protection (CP) Areas of Responsibility (AoRs) in your country, who often coordinate service mapping at the national and regional level. See the Safeguarding Resource & Support Hub tip sheet on developing a referral pathway [here](#).
- **Remove cost as a barrier:** Victims/survivors should never have to choose between getting help and affording it. The cost of medical care, legal assistance, transportation, or other essential support should be covered. Organisations can set up dedicated funds for these expenses, or – where feasible – contribute to pooled/inter-agency funds at country level to ensure coordinated and equitable access. Related costs should be included in SOPs and funding proposals, with a clear explanation of their purpose.
- **Equip your team to support child survivors:** Child survivors face greater risks and require specialised care. Ensure your staff know how to respond in an age-appropriate, trauma-informed way and connect with child protection actors for specialised support.

## WHO WERE THE ALLEGED PERPETRATORS?

**Men remain the primary perpetrators in SEAH cases.** In 88% of reported incidents, the alleged perpetrator was male. Just 3% were female, while in 9% of cases, the individual was either not identified or their sex was not disclosed.

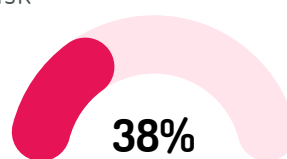
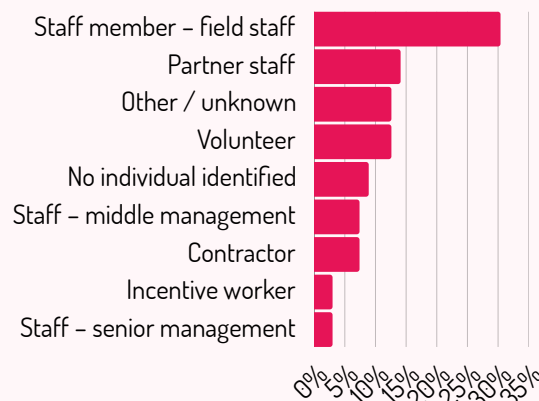


### 30% OF ALLEGED PERPETRATORS ARE FRONTLINE STAFF

On the role of perpetrators within organisations, **field staff remain the most frequently reported group across all incident types (30%)**. These are individuals with frequent and direct contact with affected populations. The proximity, the access and opportunity and power imbalance, combined with lack of consistent oversight, untrained staff and poor and long investigative practices, increase risk for SEAH. They represent:

- 36% of alleged perpetrators in abuse cases
- 35% in exploitation
- 27% in harassment.

### Profile of the alleged perpetrator



### 2 IN 5 ARE OUTSOURCED PERSONNEL OR SERVICE PROVIDERS

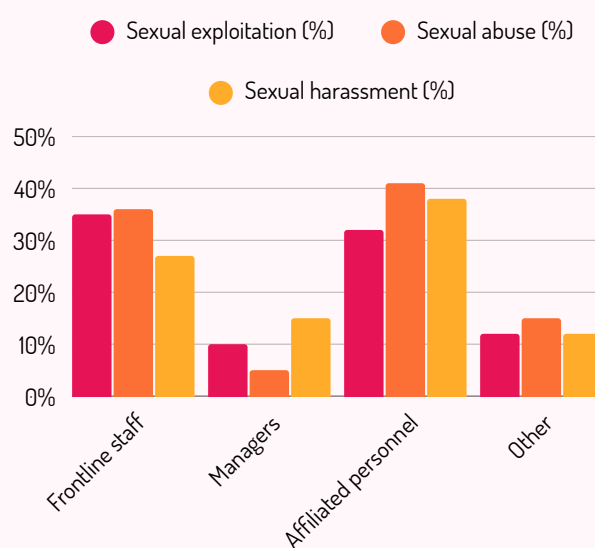
**Outsourced personnel or service providers (volunteers, contractors, incentive workers, and implementing partner staff) make up about 2 in 5 of all perpetrators (38%)**. Specifically:

- Implementing partner staff<sup>3</sup> were implicated in 16% of abuse cases, 12% of exploitation cases, and 9% of harassment cases.
- Volunteers<sup>4</sup> were involved in 16% of abuse cases, 9% of exploitation, and 15% of harassment.
- Contractors<sup>5</sup> accounted for 7% of abuse cases, 6% of exploitation, and 12% of harassment.
- Incentive workers<sup>6</sup> were identified in 2% of abuse, 5% of exploitation, and 6% of harassment incidents.

These individuals work on behalf of aid actors, often on shorter assignments, with inadequate screening. In some cases, like for volunteers and incentive workers, they may not have formal contracts. **As they often serve as the link between the community and the organisation, they hold significant power – but being embedded within the community also means the community may be less likely to report them**, fearing retaliation or social repercussions. This dual position makes them a high risk group for SEAH and underscores the need for stronger oversight and clear safeguarding expectations.

**Managers were implicated in 11% of cases** (of which 8% are middle managers and 3% senior managers), consistent with trends in previous reports. This likely reflect underreporting rather

### Type of incident per profile of alleged perpetrator



<sup>3</sup> An employee of a partner organisation that collaborates with the reporting organisation on projects or initiatives.

<sup>4</sup> Person offering their time / skills to support the organisation's activities without receiving financial compensation.

<sup>5</sup> Person contracted to provide specific services or complete particular tasks for the organisation on a temporary basis.

<sup>6</sup> Person receiving small allowance or non-monetary benefits in exchange for their services, often recruited from the local community to support project activities.



than absence of – power dynamics and fear of retaliation can act as strong disincentives to report misconduct by senior staff in positions of power.

**A number of alleged perpetrators labelled as “other” were specified to be teachers**, which may relate to the high number of incidents involving minors. Their position of authority and unsupervised access to children underscores the need for rigorous safeguarding in education programming – and for close collaboration with schools to embed PSEAH principles and ensure clear protocols for reporting and response. In 9% of all cases, no perpetrator was identified. This figure is lower than in past reports and may signal improved reporting or investigation practices.

**It’s interesting to note that unidentified perpetrators were more common in sexual exploitation cases** – where power dynamics can feel less overt, and the exchange of aid for favours may feel transactional rather than coercive. Victims/survivors may fear losing access to assistance or being blamed, making it harder to name those involved, especially when the perpetrator holds influence or control over access to assistance.

**Most perpetrators are national staff (69%)**, accounting for:

- 74% of alleged perpetrators in sexual abuse cases
- 72% in sexual exploitation
- 68% in sexual harassment

**International staff accounted for 8% of alleged perpetrators**, a notable proportion given the size of the international workforce relative to national staff in most operations, and an increase from 4% and 6% in the last two reports. They are more frequently implicated in sexual harassment and abuse (9% in each) than in exploitation (5%), aligned with patterns seen in earlier reports, where harassment is often linked to those in senior or international roles.

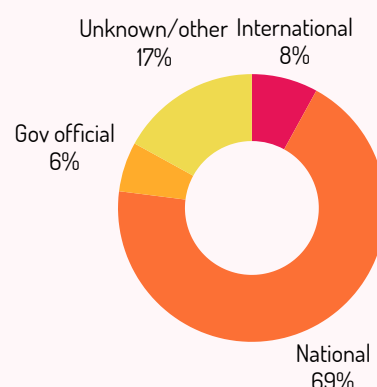
**Government officials, accounting for 6% of alleged perpetrators**, appear more frequently in abuse (9%) and exploitation (5%) and haven’t been reported as perpetrators in harassment cases – most probably reflecting differences reporting standards.

**The profile of alleged perpetrators in cases involving minors follows patterns similar to the overall dataset, but with some slight variations worth noting.** National staff are still the most frequently reported group, making up 74% of alleged perpetrators. International staff were rarely implicated (3%), lower than the overall rate of 8%. Government officials appeared in 9% of cases involving minors, a small increase that may reflect specific community-facing roles, such as teachers or local authorities. In terms of profiles, field staff remain the most reported group (36%, up from 30%), followed by implementing partner staff (18%, versus 14% overall). These are individuals with regular contact with communities – including children – which can increase both risk and visibility.

**69%**

**69% OF ALLEGED  
PERPETRATORS ARE  
NATIONAL STAFF**

#### Status of the alleged perpetrator



## RECOMMENDATIONS

- **Strengthen safeguards for all who engage with communities** – frontline staff & affiliated personnel alike. they pose the highest risk if left unsupervised or untrained. Ensure they are



aware of and guided by, the [Core Humanitarian Standard](#) on Quality & Accountability, which sets out how to work respectfully and safely with people and communities in situations of crisis and vulnerability.

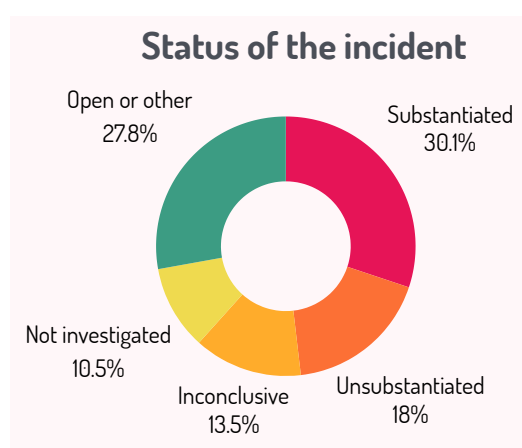
- **Vet thoroughly before deployment:** Use behaviour-based interviews, reference checks, and where feasible, apply the [Misconduct Disclosure Scheme](#).
- **Set clear expectations:** Use signed codes of conduct and verbal commitments in the local language. Don't let contract status be a barrier.
- **Limit opportunity for harm:** Avoid deploying staff alone, rotate duties, ensure gender balance, and conduct unannounced field supervision.
- **Brief and train:** Brief all field-facing personnel – even short-term workers – with real-life SEAH scenarios and clear dos and don'ts before they engage with communities.
- **Supervise and track:** Assign focal points for oversight, track issues with affiliated personnel in simple HR systems, and ensure re-offenders aren't rehired.
- **Inform communities:** Make reporting options known and safe. Use low-tech and community-based methods to raise awareness.
- **Embed PSEAH standards at management level:** Managers play a key supervision and quality control role. They have a responsibility to mitigate risks and prevent SEAH
  - **Provide targeted PSEAH training for all managers** to equip them with a clear understanding of their duties – including how to create a safe team culture, spot risks early in programming, and respond to concerns appropriately.
  - Include PSEAH metrics in performance reviews.
  - Ensure confidential reporting options exist for staff to report managers without fear.

## WHAT WAS THE OUTCOME OF INCIDENTS?

**Only 30% of SEAH reports were substantiated during this period** – the highest proportion across all outcomes. While it signals progress in investigation processes, it also means that 7 out of 10 reports did not lead to a confirmed outcome.

**In a context where we know false reporting to be the exception, these figures point to serious gaps in investigations**, including whether victims/survivors are protected throughout the process and whether all credible allegations are thoroughly and fairly assessed. To ensure timely and effective responses, investigation teams must be adequately staffed, trained, and resourced. This includes having the capacity to gather evidence swiftly, conduct on-the-ground interviews, and manage the emotional toll of vicarious trauma.

**Unsubstantiated cases stand at 18%, while 14% were classified as inconclusive.** At the time of reporting, over 1 in 4 incidents remained open (26%) – a pattern also seen in the UN iReport – raising accountability concerns about the speed, capacity and quality of investigations.

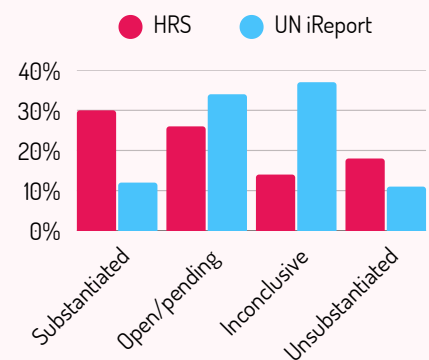


**30%**  
**ONLY 30% OF INCIDENTS WERE SUBSTANTIATED**

**11% of all incidents were not investigated, an increase from 7% last reporting period.** The rise in un-investigated cases may be linked to the growing number of national NGOs joining the HRS, many of whom have flagged limited capacity and financial resources to carry out investigations and requested support. This underscores the importance of locally-available investigation support (including trained pools at country level) and the need to expand initiatives like the [CHS Alliance's Investigation Qualification Training Scheme](#) to better equip local actors.

Compared to HRS data, the UN iReport 2024 shows lower rates of substantiated cases (12% vs 30%) and a higher proportion of open or pending cases (34% vs 26%). Inconclusive outcomes are also significantly higher in the UN system, with 37% of cases closed due to insufficient information, lack of corroboration, or lack of jurisdiction – compared to 14% in the HRS. Unsubstantiated cases are lower in the UN data (11%) than in the HRS (18%).

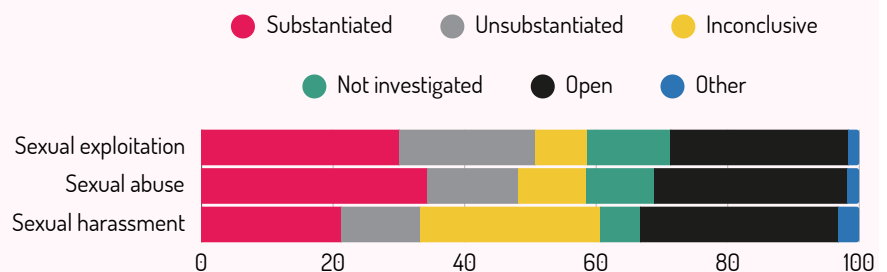
**Comparison of outcomes between UN & HRS data**



When looking across types of misconduct in HRS data:

- **Sexual abuse was more often substantiated (34%),** less often unsubstantiated (14%) and was not investigated or inconclusive in 10%.
- **Sexual exploitation was more often substantiated (30%),** but frequently unsubstantiated (20%). These reports were not investigated in 13% of cases, and inconclusive in 10%.
- **Sexual harassment had the lowest rate of substantiation (19%),** the highest of open cases (31%), and many inconclusive outcomes (28%). It was not investigated in minor proportions: 6%.

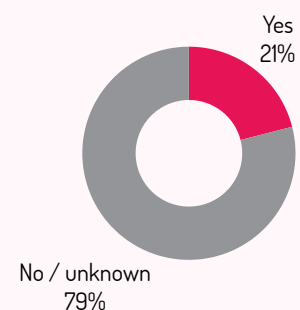
**Status of incident by type of incident**



**One in five incidents (21%) were reported to local authorities, an increase from previous periods.** Most were sexual abuse cases (57%). Cases of exploitation (27%) and harassment (16%) were less frequently referred. **Only 34% of cases involving minors were referred to local authorities.**

While criminal accountability is key to ensure that perpetrators face justice beyond administrative sanctions and are stopped from harming others, it's important to recognise that in some contexts it can increase risks for the victim/survivor or create further harm. Still, **organisations have a duty to inform victims/survivors of their right to pursue legal recourse, and to support them if they choose to do so.** That decision must never be withheld to avoid reputational damage or the complications of a criminal process. Victims/survivors must be empowered to make the choice that feels safest and most meaningful to them.

**Reported to authorities?**



**ONLY 1 IN 3 CASES AGAINST MINORS WERE REPORTED TO AUTHORITIES**

## RECOMMENDATIONS

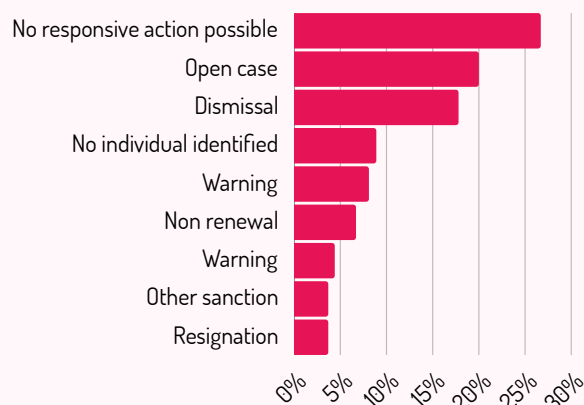
- **Make investigations timely, fair and victim/survivor-centred: unresolved or slow cases erode trust and cause harm.**
  - **Set realistic timeframes** for each step of the case handling process (e.g. 5 days to assign investigator, 30 days to complete the investigation), while taking into account available capacity and the pace that is safe/appropriate for victim/survivors. Ensure timelines are clearly communicated across the organisation.
  - **Track and flag delays:** use simple case monitoring tools to stay on top of progress – and ensure cases that stall are flagged early, so bottlenecks can be understood & addressed.
  - **Communicate consistently:** Ensure victims/survivors know what's happening, who to contact, and receive regular updates – even when there's no new information. Providing a clear point of contact (or multiple, as relevant) helps ensure they feel supported and informed throughout the process. Silence causes doubt.
  - See the CHS Alliance [SEAH Investigator's Toolkit](#) for tools, templates and guidance.
- **Build local investigative capacity and make it accessible.**
  - Scale the Investigation [Qualification Training Scheme \(IOTS\)](#), ensuring it is accessible to organisations with limited resources.
  - Complement training with mentorship opportunities, pairing new investigators or smaller organisations with experienced professionals from larger entities to provide technical support and peer learning.
  - Expand national or regional pools of trained investigators, with a focus on women and local language speakers. Where possible, use shared services or regional support networks to reduce cost and duplication.
  - Ensure all partners and donors budget for investigation costs – staffing, travel, and victim/survivor support must be funded, not optional.
- **Support access to justice without forcing it:** inform victims/survivors of their right to pursue legal action and support them if they choose to do so, but never pressure them or withhold the option to protect the organisation's image.

## WHAT RESPONSIVE MEASURES WERE TAKEN?

**Disciplinary action remains the most frequent outcome in SEAH cases** – but accountability still falls short in many instances. In all reported incidents, nearly one in three incidents end without sanction, echoing the previous reporting period.

**In substantiated cases (29%), dismissal was applied in half of the cases.** Contract non-renewal followed in 10%, and in 5%, the subject resigned before the investigation was concluded. In another 10%, the perpetrator received a formal warning or another sanction short of separation. In 15%, no responsive action was possible.

### Responsive action taken



The fact that only 50% of perpetrators were dismissed in substantiated cases raises concerns. While dismissal isn't always warranted, organisations must ensure that consequences are proportionate to the severity of the misconduct. Low dismissal rates suggest hesitation to apply strict sanctions, which can reflect a broader culture in which perpetrators are seen as "repentant" or "not a repeat risk," particularly in harassment cases. This mindset overlooks that SEAH behaviours exist on a continuum - and that tolerance of "low-level" misconduct normalises harm, signals impunity, and enables escalation. **This requires a cultural shift within organisations that ensures all forms of misconduct are taken seriously and that consequences are applied consistently, fairly, and in proportion to the severity of the incident.**

For inconclusive and non-investigated cases (amounting to 24% of all cases), no responsive action was possible in a majority of cases (27%)

The alleged perpetrator was dismissed in 17% of cases, received a warning or sanction in 8% of cases, was not renewed in 7%, and resigned prior to any disciplinary action in 4%.

These outcomes suggest that some level of misconduct was identified in a significant portion of cases, even those without formal substantiation. This reinforces the likelihood that the actual rate of substantiated SEAH incidents is higher than 30% - and serves as **an important reminder that a 30% substantiation rate does not mean only 30% of cases are effectively SEAH.**

In this reporting period, 27% of incidents resulted in no responsive action across all incidents. In half, the reason given was that the case was not substantiated. But a closer look shows other common barriers: **in 20%, the reporting organisation didn't have the authority or jurisdiction to act**, for example, when the perpetrator worked for a partner, on a short-term contract, or for third party (contractor). In another 11%, internal resource limitations meant the organisation could not investigate to take action. Some

stalled due to non-cooperation from complainants (6%), insufficient information (6%), or because the location of the incident was inaccessible (3%). In a small number, the alleged perpetrator no longer worked for the organisation when the incident was reported.

**About 20% of all incidents remain open** - a static figure compared to the previous period. This reinforces the need to review trends over a longer timeframe, ideally annually, when more cases are likely to be closed and final outcomes available.

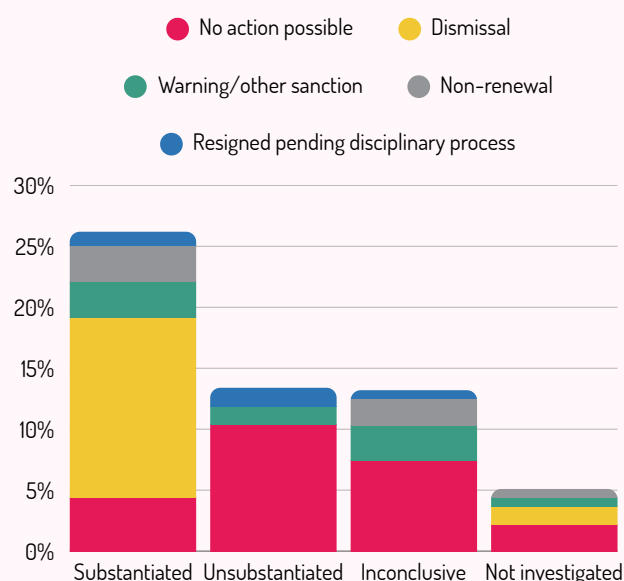
**The status of the incident also depends on the typology of incident:**

- **Sexual abuse** had the lowest unsubstantiation rate (35%) but the highest share where organisations couldn't act due to lack of authority (24%) or organisational capacity (18%).



**HALF OF PERPETRATORS WERE DISMISSED IN SUBSTANTIATED CASES.**

### Responsive action per incident status



**27%**  
**27% OF INCIDENTS ENDED WITHOUT ANY RESPONSIVE ACTION**

- **Sexual exploitation** cases had similar unsubstantiation rates (35%) but faced external barriers: lack of authority to investigate (21%) or insufficient information (11%).
- **Sexual harassment** was unsubstantiated in 67% of cases, the highest across categories. When substantiated, 17% still stalled either because the victim/survivor did not give consent to proceed, or because the location was inaccessible.

Similarly, the sanctions for substantiated incidents also depend on the type of incident:

- **In sexual exploitation and sexual abuse, dismissal remains the primary outcome** – reported in 52% and 50% of cases respectively. In both categories, formal warnings or other sanctions were applied in 7-10% of cases. A small number saw contract non-renewals (6%) or resignations before sanction (3-6%).
- **Sexual harassment shows a more even spread of outcomes:** 50% were dismissed, 16% resigned during the investigation, 16% were not renewed, and 16% remained open.

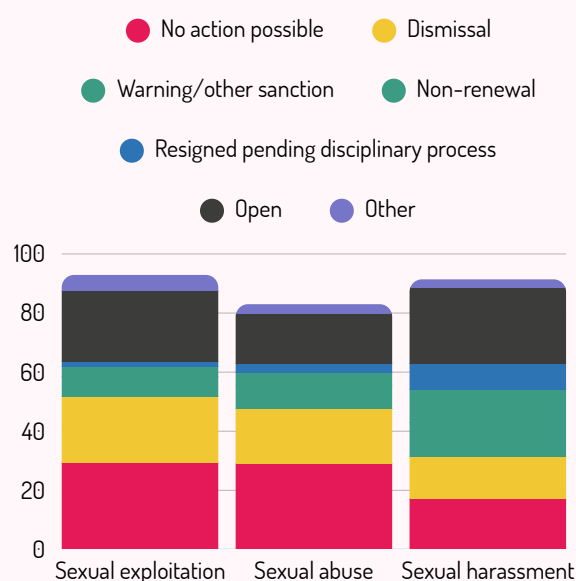
This suggests that harassment cases are more likely to result in resignation or remain open - and less likely to trigger formal sanctions - compared to abuse or exploitation.

**Incidents involving minors were more likely to lead to a dismissal** - consistent with the broader trend of sexual abuse cases (which most often involve minor) resulting more frequently in dismissal. These cases also had a much higher rate of ongoing investigations: 33% remained open, compared to 15% for incidents involving adults. The proportion of cases where no responsive action was possible was also slightly higher for incidents against minors (28%) than for those against adults (23%).

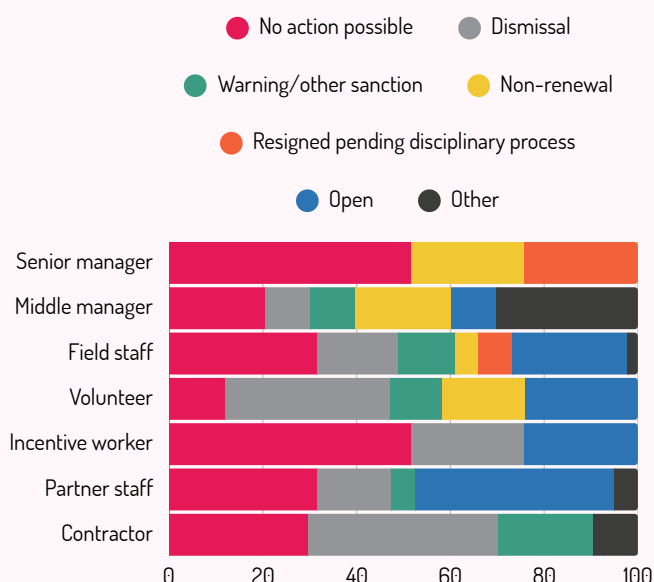
The profile of the perpetrator also influenced the outcome, as highlighted in the graph:

- **Senior managers were never dismissed:** they either resigned or were not renewed.
- **Mid managers faced a mix of outcomes:** dismissals and warnings were frequent, but a large proportion received other sanctions or saw no responsive action.
- **Field staff were more likely to face dismissal than other groups,** but they also made up a large share of cases where no responsive action was taken.
- **Volunteers** saw varied responses. While dismissals were common, **a considerable number of cases ended in resignation or non-renewal.**

## Responsive action by type of incident



## Responsive action by perpetrator profile



- **Incentive workers had the highest rates of inaction.** Few were dismissed or sanctioned, with a significant share of cases still open
- **Partner staff followed a similar trend: few dismissals, frequent inaction, and many unresolved cases, likely due to jurisdictional limitations**
- Contractors were most often dismissed, but many cases resulted in no action or “other” outcomes – indicating varied responses depending on contract terms or oversight mechanism.

These patterns reflect more than just disciplinary decisions – **they point to deep-rooted power dynamics within the aid system.** Senior and middle managers are more likely to receive alternative sanctions or see no action at all – raising serious questions about accountability, organisational culture, and the protection that power and proximity to leadership can afford. In contrast, field staff – who typically hold less influence, have shorter contracts, and less familiarity with internal systems – face dismissal more often. **To prevent SEAH, we need to look at how power is held, used, and protected within our own structures.**

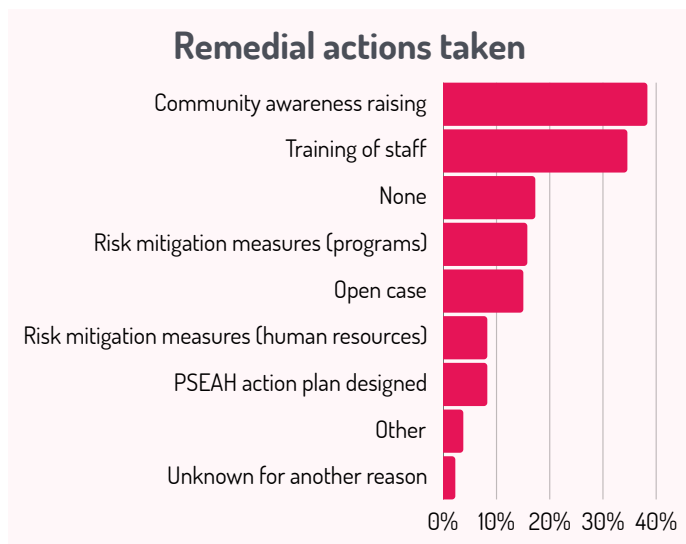
## RECOMMENDATIONS

- **Ensure consistent and transparent disciplinary outcomes:** Disciplinary decisions must reflect the severity of misconduct – not the perpetrator’s status. When similar cases result in different outcomes, it undermines organisational culture, deters reporting, and allows perpetrators to reoffend.
  - **Apply a sanctions matrix** to guide proportionate and consistent consequences, regardless of contract type, role, or seniority.
  - **Track and review outcomes** by country, office, or partner to spot inconsistencies and strengthen fairness.
  - **Document all disciplinary measures** – including for affiliated personnel – in a secure tracking system to prevent repeat hiring across teams or partners.
  - **Ensure organisational learning:** Regularly review past disciplinary decisions to identify gaps and adjust guidance or training accordingly. Read our [HRS how-to-guide on Conducting a Lessons Learned Review After an SEAH Case](#).

## WHAT REMEDIAL ACTIONS WERE TAKEN?

Organisations are still far more likely to **train staff or raise community awareness after a SEAH incident than to take structural action** – like changing ways in which aid is delivered, rethinking decision-making processes, addressing power imbalances, or challenging workplace norms that enable abuse.

Training and awareness raising – though very important – don’t always tackle the deeper, underlying risks that led to the harm in the first place and that allows it to perpetuate.



Across all types of incidents, the most frequent responses were awareness raising (38%) and staff training (35%), **showing our reliance on education and messaging as the main form of remedial action.**

**But deeper systemic fixes remain rare.** Programmatic risk mitigation – like changes in the way aid is delivered – was taken in only 18% of cases overall. Human resources-focused measures, (such as strengthening PSEAH in the recruitment process or modifying supervision structures), were reported in just 14%. Formal PSEAH action plans were designed in only 10% of incidents.

There are some noteworthy variations by type of misconduct:

- **Sexual abuse had the highest rate of community awareness actions** (47%) – perhaps reflecting stronger recognition that victims/survivors need support and information to come forward. But it also had the lowest rate of staff training (28%). This imbalance suggests that organisations may be investing more in victim/survivor outreach than in preparing staff to prevent or respond to abuse.
- **Sexual exploitation cases showed the most balanced response across different types of remedial action.** Programmatic and HR-focused changes were more common here than in other categories – yet still under 25%. This might reflect greater willingness or ability to intervene when the incident involves exchange-based dynamics (like aid for sex), rather than direct abuse.
- **Sexual harassment, often the most under-addressed form of misconduct, shows slightly better numbers this period.** Staff training and awareness both reached 38%, but other remedial actions remained low. In 9% of harassment cases, no remedial measure was taken at all. That's the highest “no action” rate across the three types of misconduct.

## RECOMMENDATIONS

- **Conduct a lessons learned review after every case:** don't just close the file – use it. Review what went wrong and what could have been done differently and focus on systems, not individuals. Did supervision break down? Did the programme design introduce unnecessary risk? Were communities sidelined from risk identification? Read our HRS how-to guide on [Conducting a Lessons Learned Review After an SEAH Case](#) to learn more.
- **Actively consult communities to identify risks:** Community members almost always know where the risks are – but are rarely asked. When designing programmes, ask people directly what would make them feel safer. Integrate this feedback into programme design.
- **Prioritise risk mitigation, don't only focus on prevention and response:** Training and awareness-raising are important, but they can't reduce risk unless the way aid is delivered is safe. SEAH risk mitigation means making practical adjustments to programme design and implementation to reduce opportunities for abuse – for example, hiring more female staff, ensuring safe travel routes to aid points, or involving women in decision-making about how aid is delivered. Check out [Empowered Aid resources](#) for concrete, field-tested SEAH risk mitigation actions you can implement now, tailored to different contexts and sectors



## II. SEAH TRENDS AGAINST STAFF MEMBERS

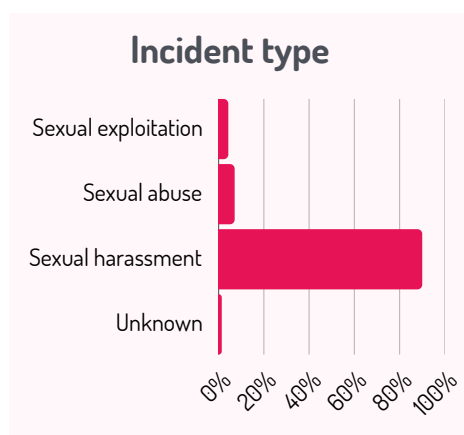
This section focuses on SEAH incidents involving staff or affiliated personnel only. Definitions of SEAH vary across organisations, leading to inconsistent classification: some group all staff-related cases under harassment, while others distinguish between abuse, exploitation, and harassment. As a result, some incidents may be excluded from SEAH reporting if handled separately by HR.

To improve accuracy, the HRS requires organisations to indicate whether incidents involve staff or aid recipients and to analyse them separately. However, classifying all staff-related SEAH as harassment can inflate harassment figures and obscure trends. These inconsistencies, combined with the relatively low number of reported workplace incidents, limit the level of analysis possible – both due to small sample sizes and confidentiality risks. This is why this section is shorter and less detailed than the first.

### WHAT TYPE OF INCIDENTS WERE REPORTED?

Among SEAH incidents involving staff, **sexual harassment** accounts for 90% of cases, while **sexual abuse** accounts for 7% and **exploitation** for 4%. The typology of the incident is unknown in 1% of cases.

The high proportion of harassment cases may reflect systems where all staff-related SEAH incidents, even criminal acts like rape, are broadly categorised as harassment, which limits a clear understanding of workplace SEAH dynamics. It highlights the need for organisations to adopt clearer, more specific definitions: improving these classifications would enhance trend analysis and support more effective prevention and response strategies.



### WHERE WERE INCIDENTS REPORTED FROM?

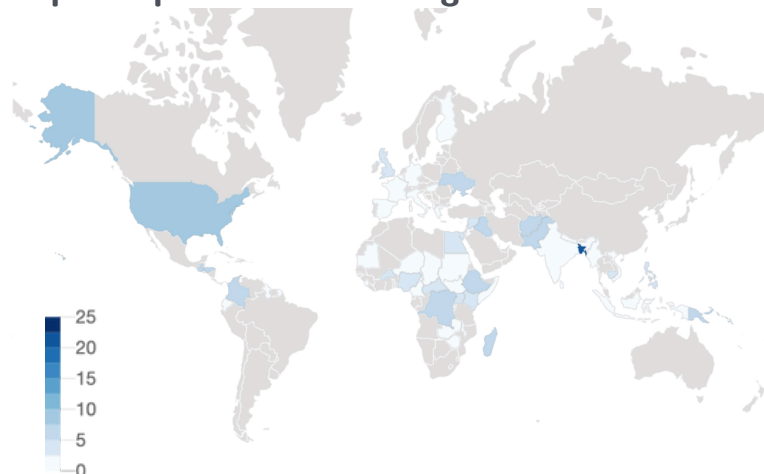
**Incidents involving staff members were reported across 40 countries** in this report, with many countries accounting for only a small share of cases, often just two or three.

To limit any risk of identification of the organisation, alleged perpetrators and victims/survivors, country-level or more in-depth analyses are not conducted in this section.

**The regions<sup>7</sup> with most reports are:**

- Southern Asia: 30%
- Eastern Africa: 15% of cases
- South-eastern Asia: 8%

**Map of reported incidents against staff members**



<sup>7</sup> Regional classifications in this report follow the United Nations geoscheme for statistical purposes. For more information and a full list of countries by region, see: <https://unstats.un.org/unsd/methodology/m49/>

## WHO REPORTED INCIDENTS AND HOW?

Most SEAH incidents are reported face to face. **In 44% of cases, the first disclosure was made directly to another staff member.** This was nearly twice as common as using a hotline (18%) or a complaints app or email (21%). Dedicated PSEAH focal points were the first point of contact in only 10% of cases.

**Whistleblowers continue to play an important role in surfacing incidents.** In fact, nearly two-thirds of all incidents (62%) were reported by a staff member other than the victim/survivor, and another 13% came from staff working in a different organisation.

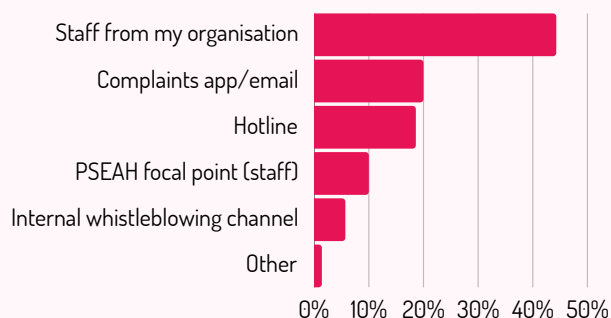
**Only a fourth of cases were reported by the victim/survivor.** This low figure isn't surprising, but it reinforces the importance of making reporting safe, supportive, and victim/survivor-centred.

Reporting trends vary by type of incident:

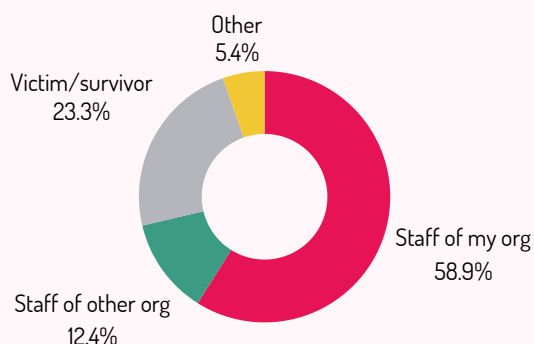
- **Sexual abuse was most often reported directly to staff** (40%), followed by complaints apps/emails and PSEAH focal points (20% each).
- **Sexual exploitation** was most often reported via hotlines and in-person (33% each).
- For **sexual harassment, 44% were reported in person**, 19-20% through complaints apps or hotlines, only 9% to PSEAH focal points, and 6% through internal whistleblowing channels.

These patterns reinforce a key message: **people report through channels they trust, and trust looks different for everyone.** Some may turn to a colleague, others to a phone line or email. That means investing in people and systems – and making sure both are equipped to listen, respond, and act.

### Reporting channel used



### Profile of the person who reported



## WHO WAS INVOLVED IN THE INCIDENTS?

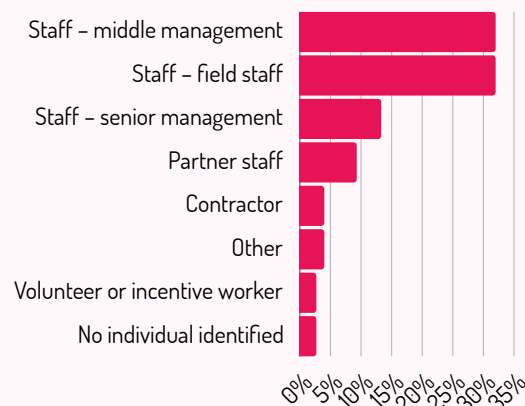
**Women account for 97% of victims/survivors in reported SEAH cases.** Men account for the remaining 3%. All victims were adults.

Perpetrators span all levels of the organisational hierarchy but are concentrated at top levels:

- **Field staff:** 32% of incidents
- **Middle managers:** 32% of incidents
- **Senior management:** 13% of incidents

While the share of field staff remained stable compared to the last reporting period, **incidents involving managers increased – from 39% to 45%.**

### Profile of alleged perpetrator



This reinforces concerns about abuse of power at leadership levels. Senior and middle managers were most frequently reported as perpetrators in sexual exploitation and sexual abuse cases – in nearly two-thirds of incidents involving either type of misconduct.

**45% OF WORKPLACE SEAH CASES INVOLVE MID OR SENIOR MANAGERS.**



In terms of employment status, **national staff were implicated in 88% of cases.** International staff were named in 8% – a decrease from 17% last semester, though still notable given their smaller numbers in most organisations.

This trend of SEAH on the workplace being perpetrated by those in positions of power is unlikely to reverse – particularly as the aid sector faces shrinking budgets and widespread staffing cuts. In such environments, fear of losing employment may further discourage victims and witnesses from reporting, especially when the alleged perpetrator holds a position of influence.

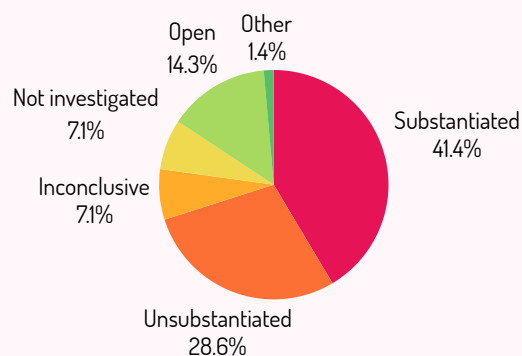
## WHAT WAS THE OUTCOME & RESPONSE TO INCIDENTS?

**42% of incidents reported against staff were substantiated** – the strongest substantiation rate recorded so far and a signal that more investigations are leading to clear findings. With increased investment and capacity building on SEAH investigations this figure should continue to increase. It also underlines the importance of staff members knowing their rights and organisational obligations towards them.

In total 28% percent of cases were unsubstantiated, 14% remain open, 7% were never investigated, and a further 7% were inconclusive, often due to lack of access, insufficient information, or no collaboration from the complainant.

**Disciplinary measures were taken in the majority of cases.** When looking across all cases, dismissal was the most common outcome (seen in 61% of all responsive actions), followed by warnings (14%), non-renewals (8%), and resignations before disciplinary action (4–5%). A small portion of incidents (4%) had no responsive action possible and the reasons provided were lacked jurisdiction or authority (5%), insufficient information (5%), or lack of consent from the victim/survivor to proceed (11%).

**Overall status of incidents**

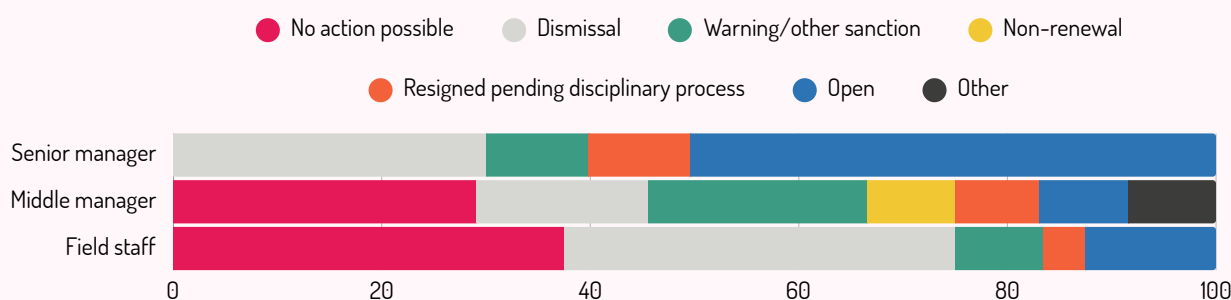


**When we isolate substantiated cases, dismissal is applied in 66% of cases.** In these confirmed incidents, formal warnings were issued in 16%, and non-renewals accounted for 8%. In just 3% of substantiated cases, no responsive action could be taken. This suggests that once an incident is confirmed, disciplinary consequences are usually enforced, and, most often lead to a separation from the organisation.

Responsive actions taken per profile of the alleged perpetrator also vary.

- **Field staff had the highest dismissal rate (37%)** – but were equally likely (37%) to see no responsive action taken, highlighting uneven enforcement at the operational level.
- **Middle managers were the least likely to be dismissed (17%)** and more often received a warning (21%) or no action at all (29%), reflecting a continued gap in accountability
- **Senior managers had the highest share of unresolved cases** – with 50% still open – and a dismissal rate (30%) slightly below that of field staff, suggesting greater delays or barriers in taking action against those in senior leadership.

### Responsive action for main categories of perpetrators

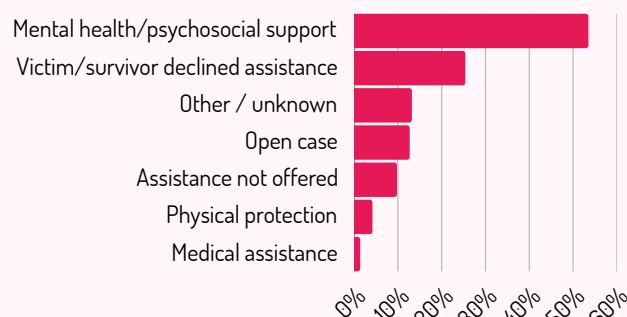


**Just over half of all victims/ survivors (51%) received mental health or psychosocial support**, the most commonly reported form of assistance.

**However, 25% of victims/survivors declined assistance**, a significant proportion that points to possible **concerns about confidentiality, stigma, or lack of trust in services offered**.

10% were not offered assistance altogether.

### Assistance rendered to the victim/survivor



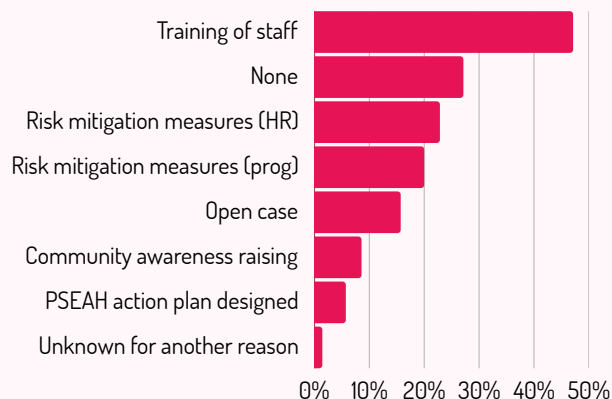
## WHAT REMEDIAL ACTIONS WERE TAKEN?

**Staff training was the most common remedial measure**, implemented in 47% of all incidents – confirming that education and awareness among staff remains a key priority for organisations.

**Risk mitigation actions related to human resource processes followed** at 23%, and programmatic risk adaptations arrived close behind at 20%. PSEAH action plans were developed in only 5% of cases, pointing to limited use of systemic, long-term approaches.

**In over a quarter of incidents (27%), no remedial action was taken at all.** 16% of cases remain open at the time of reporting.

### Remedial actions taken



Compared to previous periods, the overall patterns remain consistent, pointing to some embedded practices – both good and bad. **While training is now standard, more strategic and systemic risk mitigation measures are still not the norm.** Although awareness is a first step, we must shift now from awareness to action. Each incident should prompt a review of how activities are run and how the workplace functions – from staffing arrangements and reporting lines to organisational culture and leadership accountability.

## RECOMMENDATIONS

**Workplace sexual harassment isn't just a matter of HR policy, it's about organisational culture and power.** When harassment or abuse is tolerated – or minimised – at the top, it sends a clear message: this behaviour is normal, accepted, or untouchable. That message doesn't stay inside the office walls but bleeds outward, shaping how programmes are run, how risks are managed, and ultimately, how community members are treated. We can't prevent SEAH in communities if we don't first confront what's happening internally. The standards we set inside our organisations are the standards we export to communities we serve.

To shift this culture, managers must be held to the highest bar. They need to model the conduct and accountability we expect from others. And they need to lead in creating workplaces that are respectful, safe, and open to feedback.

### Five actions to strengthen leadership accountability and organisational culture:

- **Build accountability into leadership objectives:** Make conduct and safeguarding performance part of annual appraisals and promotion decisions. Leaders must be rewarded not only for results, but for how they achieve them.
- **Recruit and train managers as culture-setters, not just risk managers:** Move beyond basic PSEAH compliance. Equip managers with tools to foster respectful teams, de-escalate toxic dynamics, and lead with emotional intelligence.
- **Ensure safe upward feedback:** Create safe and regular ways for staff to flag concerns about team culture or management behaviour (surveys, hotlines, exit interviews or peer feedback).
- **Address SEAH swiftly and visibly:** When senior staff breach standards, action must be decisive. While discretion may be needed for safety reasons, quiet exits should not become the norm. Failing to act visibly when safe to do so signals that status protects perpetrators.
- **Normalise speaking up:** Build spaces for open dialogue about power, behaviour, and boundaries. Culture doesn't shift through policy alone; it shifts when staff see that speaking up is safe, respected, and acted upon.

**Ending SEAH is about how aid is delivered, but also about how organisations are run. If we want to protect communities, we need to start with our organisation and our staff.**

### Further resources:

- [2024 CHS Alliance PSEAH Index](#) – to help organisations determine if they have the policies and practices in place to protect their staff and people in vulnerable situations
- [CHS Alliance Whistleblowing Guidance](#) – practical steps for safe, confidential reporting
- [Victim/Survivor-Centered Approach to PSEAH Implementation Companion](#) – includes recommendations on redress, retaliation, and compensation