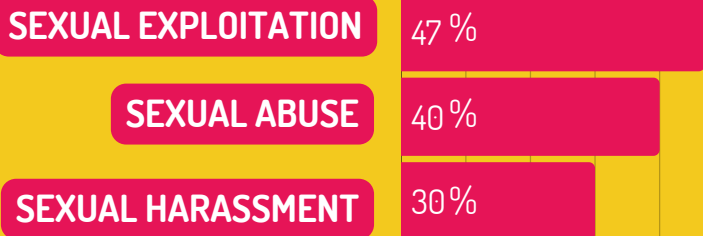# SEAH HARMONISED REPORTING SCHEME (HRS)

April-Sept 2025 Snapshots
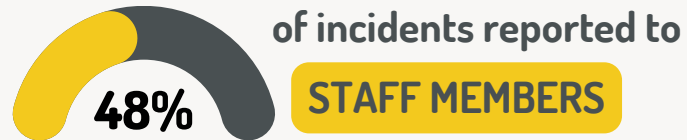
Sexual exploitation, abuse & harassment (SEAH) incidents **against aid recipients & their community**

CHSAlliance

TYPOLOGY OF INCIDENTS

SEXUAL EXPLOITATION — 47 %

SEXUAL ABUSE — 40 %

SEXUAL HARASSMENT — 30 %

Some incidents involve multiple categories, so percentages don't total 100.

REPORTING CHANNEL USED

48% of incidents reported to **STAFF MEMBERS**

CBCMs were used in 50% of reports
(Complaint box: 15% – hotline: 17% – complaint app: 18%)

1 in 4 incidents were reported by victims/survivors

VICTIM/SURVIVORS

44% ARE CHILDREN (UNDER 18)

90% are females. 8% are male. 2% are unknown.

58% of victim/survivors of <u>sexual abuse</u> are girls. Boys account for **8%.**

Women are most at risk of exploitation & harassment

➡ no substantial changes since last report

ALLEGED PERPETRATORS

20% ARE

OUTSOURCED PERSONNEL
Volunteers: 9%; Incentive workers: 4% Contractors: 7%

PARTNER STAFF account for 14%

FRONTLINE STAFF account for 25%

MANAGERS account for 8%

➡ no substantial changes since last report

RESPONSIVE ACTION TAKEN

31% OF INCIDENTS WERE SUBSTANTIATED

ALLEGED PERPETRATORS WERE

DISMISSED IN 25% OF INCIDENTS
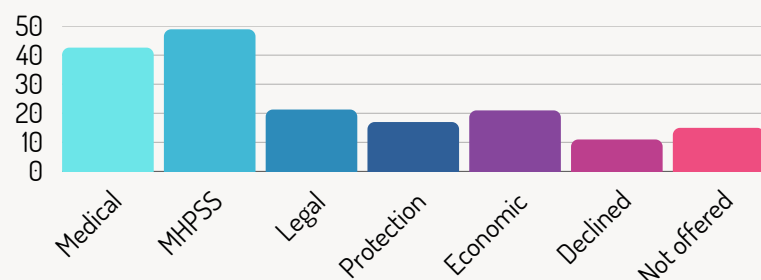and received warnings in 4% of incidents.

NO RESPONSIVE ACTION POSSIBLE
IN 25% OF INCIDENTS

Of those, 21% could not proceed because the information received at intake/ reporting was insufficient and 16% because of lack of capacity or resources.

ASSISTANCE PROVIDED

ASSISTANCE WAS NOT OFFERED TO 15% OF VICTIMS/SURVIVORS

This rises to 21% when victims/survivors are minors.

Medical | MHPSS | Legal | Protection | Economic | Declined | Not offered

SEAH HARMONISED REPORTING SCHEME (HRS)

April–Sept 2025 Snapshots

Sexual exploitation, abuse & harassment (SEAH) incidents **against staff members & affiliated personnel**

CHSAlliance

TYPOLOGY OF INCIDENTS

- SEXUAL EXPLOITATION — 21%
- SEXUAL ABUSE — 7%
- SEXUAL HARASSMENT — 80%

Some incidents involve multiple categories, so percentages don't total 100.

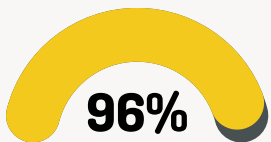## REPORTING CHANNEL USED

52% of incidents reported to another **STAFF**

Complaints apps/emails & internal whistleblowing mechanisms were used in 41% of reports

VICTIM/SURVIVORS

96% are **FEMALES**

MALES account for 4%

→ no substantial changes since last report

ALLEGED PERPETRATORS

46% ARE **MANAGERS** (22% middle managers, 24% senior managers)

21% ARE **FIELD STAFF**

RESPONSIVE ACTION TAKEN

ALLEGED PERPETRATORS WERE

DISMISSED IN 31% OF INCIDENTS

WARNED IN 11% OF INCIDENTS

NO RESPONSIVE ACTION POSSIBLE IN 14% OF INCIDENTS
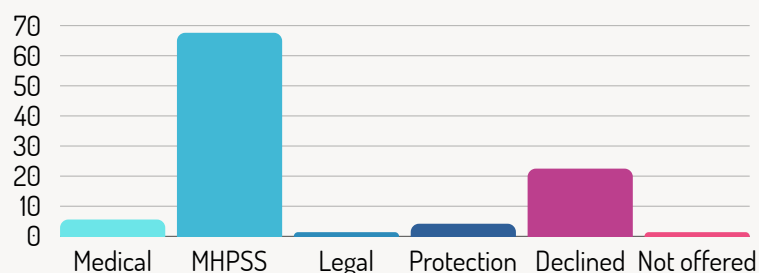
1 IN 4 INCIDENTS REMAIN **OPEN**

ASSISTANCE PROVIDED

67% RECEIVED **MENTAL HEALTH & PSYSCOSOCIAL SUPPORT**

22% OF VICTIMS/SURVIVORS **DECLINED THE ASSISTANCE OFFERED**

Bar chart (y-axis 0–70):
- Medical: ~5
- MHPSS: ~67
- Legal: ~1
- Protection: ~4
- Declined: ~22
- Not offered: ~1

The infographic is based on 147 incidents reported by HRS participating organisations over 6 months (April 25–Sept 25) – 38% of which were incidents against staff members or affiliated personnel.

These figures are not representative of the total SEAH incidents or SEAH prevalence in the aid sector. However, such figures provide a valuable foundation for understanding key issues and identifying effective starting points for intervention.

5 THINGS TO TAKE AWAY FROM THE DATA
AND WHAT TO DO ABOUT IT
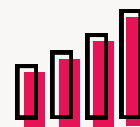
VICTIMS/SURVIVORS

Children remain a large proportion of victim/survivors – especially in sexual abuse cases

In SEAH incidents against communities, 44% of victims/survivors are children, mostly girls. They make up the vast majority (66%) of sexual abuse cases. **Only 15% of cases involving minors were reported to authorities.** This pattern is consistent across all HRS reporting cycles and mirrors UN iReport trends, highlighting it's a real systemic issue.

SO WHAT? This consistency shows that child safeguarding cannot sit on the margins of programming and PSEAH - it must be treated as a core risk across all activities. Organisations must assume children are systematically present wherever aid is delivered, assess the risks this creates, and ensure staff can respond safely to disclosures. Because outsourced personnel/providers are among the groups most frequently reported as perpetrators against children, partnerships must be underpinned by clear child-safeguarding requirements and active supervision. And when a child is harmed, the system must act fast: reporting options need to be child-safe and accessible, and referrals must be made without delay to both the relevant legal actors and specialised child-protection support services. Sexual abuse of children is a crime, and organisations have a legal obligation to report it.

REPORTING SYSTEMS

More reports are coming through community-based complaints mechanisms (CBCM) - but staff remain the main entry point.

Reporting through CBCMs has increased in incidents against communities (complaint box: 15%; hotline: 17%; complaint app: 18%), yet 48% of all reports still go directly to staff. For incidents involving minors, this rises to 69%.

SO WHAT? People use the channel that feels safest, and data shows staff remain the primary, and often preferred, entry point. The rise in CBCM use is positive, but not enough to know whether systems have genuinely strengthened. Organisations therefore need a few clear and trusted reporting routes, all linked to the same safe response pathway, rather than more standalone mechanisms. Existing options - in person, hotline, complaint box/app, or focal point - must be survivor-centred, reliable, and coordinated with inter-agency systems to avoid duplication. Frontline staff and trusted local intermediaries, who still receive most disclosures, must be trained/equipped to respond and refer safely and consistently. And because trust varies by context, reporting patterns must be analysed locally so that investments reinforce the channels communities actually trust and use.

ALLEGED PERPETRATORS

Outsourced personnel and providers continue to be a major risk

Two in five alleged perpetrators are outsourced personnel or providers (including volunteers, contractors, vendors, incentive workers & partners - see detailed breakdown on p3), a pattern consistent across reporting periods. In cases involving minors, this rises to 50%, with partner staff alone accounting for 29%.

SO WHAT? Because outsourced personnel often enter community-facing roles with limited screening, minimal induction, and little routine oversight, organisations need to set **realistic** but **non-negotiable safeguarding** standards tailored to these roles: basic vetting, signed codes of conduct, and mandatory SEAH induction before engagement. Partnerships should only proceed when partner organisations can demonstrate a workable safeguarding system - one that includes practical supervision arrangements for high-risk functions such as distribution teams, volunteers, and other frontline roles with direct and often unsupervised contact with communities (for example, close in-person oversight and periodic unannounced checks). And because partner

staff are frequently reported as perpetrators, organisations must track/analyse these incidents systematically and use the findings to strengthen partnership agreements, clarify expectations, and redesign operational arrangements where risk remains high.

ORGANISATIONAL CULTURE

Managers continue to be heavily implicated in workplace SEAH – especially senior managers

In staff-related incidents, 46% of alleged perpetrators are managers. Senior managers now account for 24% of perpetrators, compared with 10% in the previous report. Women remain the vast majority of victims (97%). This confirms a worrying rise in incidents driven by those with the most formal authority and influence over workplace culture.

SO WHAT? When those in leadership positions are among the most frequently reported perpetrators, reporting becomes riskier for staff and organisational culture deteriorates quickly. Organisations need to make leadership accountability explicit and measurable: PSEAH behaviour and team culture must carry real weight in performance reviews and promotion decisions. Staff also need safe, confidential ways to report managers so that concerns can surface without fear of retaliation. Managers require targeted support on culture-setting, power dynamics, and early risk detection, as technical training alone does not shift behaviour. And because seniority has too often shielded perpetrators from consequences, organisations must ensure that disciplinary actions are consistent and applied regardless of rank, signalling that misconduct at any level will be addressed.

OUTCOMES & ACTION

Persistent investigation gaps

Substantiation rates remain low at 31% (unchanged from last report), which is concerning given that uninvestigated or inconclusive cases - and even some unsubstantiated ones - often contain real SEAH incidents that never progressed far enough to be confirmed, especially since false reporting is rare. Only 25% of all reported incidents lead to dismissal, while more than 20% result in no action and 30% remain open. Together, these figures show that investigations are not happening, are delayed, or fail to reach closure, pointing to persistent gaps in investigation capacity and follow-through.

SO WHAT? These figures show that organisations are struggling not only to investigate cases, but also to take decisive action when misconduct is confirmed. Low dismissal rates, together with high numbers of uninvestigated, inconclusive, or still-open cases, mean alleged perpetrators often remain in post and risks go unaddressed. This reflects a systemic shortage of timely, accessible investigation capacity and inconsistent decision-making once findings are available. To close these gaps, organisations need to expand locally accessible investigator pools - for example by drawing on IQTS-trained investigators or regional rosters - budget for investigations upfront, set and enforce clear case-handling timeframes, and ensure outcomes lead to consistent consequences. Regular victim/survivor updates are also essential so cases do not quietly stall or drift into "open" status.

Interpreting this data: The number of organisations reporting to the Harmonised Reporting Scheme continues to grow, yet the number of incidents submitted this cycle is lower (148 vs 204 last cycle). **This does not indicate reduced SEAH risk or prevalence**. Instead, it may reflect reduced reporting capacity - potentially linked to funding cuts, the loss of PSEAH positions due to budget constraints, competing priorities, and, in some cases, limited ownership of PSEAH. For organisations with fewer resources, or where organisational culture does not prioritise PSEAH, it does not receive sustained attention, making it difficult to maintain the systems needed to address, prevent, and consistently report incidents into the HRS.

Expanded participation and shifts in who reports make case numbers harder to interpret, and some improvements may reflect the profile of organisations reporting into the HRS, rather than sector-wide change. The insights below focus on trends that appear consistently across reporting cycles, as these give us the strongest evidence of the deeper, system-wide issues in how SEAH is prevented, reported, and addressed.