# Independent, Comprehensive Stocktaking Exercise to assess WHO's Institutionalization of the Prevention of and Response to Sexual Misconduct

## World Health Organization (WHO)

## Stocktaking Report
## Volume 1

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**FINAL**
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TDV Global inc.

# Acronyms

| | |
|---|---|
| CO | WHO Country Office |
| CRE | Compliance, Risk Management and Ethics |
| DG | Director-General WHO |
| DGO | Director-General's Office |
| DRC | Democratic Republic of the Congo |
| E2E IMS | end-to-end incident management system |
| EB | Executive Board |
| ERF | Emergency Response Framework |
| HQ | WHO Headquarters |
| IASC | Inter-Agency Standing Committee |
| IEOAC | Independent Expert Oversight and Administration Committee |
| IOAC | Independent Oversight Advisory Committee for Health Emergencies |
| IOS | Internal Oversight Services |
| IPs | Implementing Partners |
| OSCSEA | Office of the UN Special Coordinator for Preventing Sexual Exploitation and Abuse |
| OVRA | UN Office of the Victims' Rights Advocate |
| PAAC | Policy on Addressing Abusive Conduct |
| PASM | Policy on the Prevention and Response to Sexual Misconduct |
| PBAC | Programme, Budget and Administration Committee of the Executive Board |
| PRS | Prevention of and Response to Sexual Misconduct, Department of |
| PRSEAH | Prevention and Response to Sexual Exploitation, Abuse and Harassment |
| RO | WHO Regional Office |
| SEAH | Sexual exploitation, sexual abuse, and sexual harassment |
| SM | Sexual Misconduct |
| SOP | Standard Operating Procedure |
| SoW | Statement of Work |
| UN PSEA | United Nations Preventing and Responding to Sexual Exploitation and Abuse |
| VSCA | victim-and survivor-centred approach |
| WHA | World Health Assembly |
| WHE | WHO Health Emergencies Department |
| WHO | World Health Organization |

# Acknowledgment

We would like to thank the PRS Office for providing the TDV Global team with support, and advice throughout the exercise. A special thank you to the Independent External Oversight Advisory Committee (IEOAC) of the WHO Executive Board played a key role in providing oversight from start to finish. We would also like to thank the Directors of the Accountability Departments for their input and thoughtful insights. Thank you to the PRS Focal Points, Member State representatives and other WHO staff and external stakeholders who took part in the interviews, focus groups, and survey.

# Contents

# Executive Summary

## Stocktaking Overview

Following from recommendations of the Programme, Budget and Administration Committee and the Executive Board, WHO commissioned this independent, comprehensive stocktaking exercise that assessed the World Health Organization's (WHO) progress in institutionalizing the prevention of and response to sexual misconduct (PRS), encompassing sexual exploitation, abuse, and harassment. Covering the period from October 2021 to October 2024, the review evaluates the implementation of the current WHO Preventing and Responding to Sexual Misconduct (PRS) Strategy (2023–2025) which builds upon the 2021–2022 Management Response Plan developed following the Independent Commission's investigation into sexual misconduct during the 10th Ebola outbreak in the Democratic Republic of the Congo.

The stocktaking included 58 key informant interviews, case studies, document review and an online survey of PRS Focal Points. A Prosci® PCT™ tool and ADKAR® tool were also used to assess the change management approach. The stocktaking was commissioned by the World Health Organization pursuant to a recommendation/request of the Independent Expert Oversight and Advisory Committee (IEOAC). It provides findings across five core pillars: Governance and Strategy, Policy, Implementation Management, Resources and Sustainability, and Change Management. The report highlights areas of progress, identifies remaining gaps and offers recommendations to support the institutionalization and sustainability of WHO's efforts in PRS.

## Findings

**Pillar 1: Governance and Strategy**

- **Leadership** is rated exceptional, with strong advocacy at headquarters driven by the Director-General and PRS Director. However, advocacy at regional and country levels remains inconsistent.
- **Coordination** mechanisms, such as bi-weekly HQ accountability department director meetings (chaired by the Director-General), are in place but implementation is uneven and hindered by siloed operations and unclear roles.
- **Emergency contexts** are addressed via WHO's Emergency Response Framework (2024), yet practical integration and decision-making collaboration, particularly with the WHO Health Emergencies (WHE) Department, remain inconsistent.
- The **PRS Strategy** is well-articulated and widely supported across the organization; however, challenges exist in field-level contextualization.
- **Audit and compliance** mechanisms are present but not systematically institutionalized.

**Pillar 2: Policy**

- The **Policy on the Prevention and Response to Sexual Misconduct (PASM)** is viewed as comprehensive, current, and aligned with UN standards, integrating SEA and SH under a unified approach.
- A robust suite of **supportive policies,** on retaliation, abusive conduct, and ethics, has been updated and aligned with the PASM, though implementation is still variable.
- **Accountabilities** are clearly laid out in the policies and the accountability framework, but operational clarity remains inconsistent, especially in high-risk or emergency contexts.
- While mechanisms to **monitor compliance** exist, there is no unified compliance strategy, and enforcement mechanisms are not uniformly applied.

**Pillar 3: Implementation Management**

- The **PRS implementation plan** is detailed and well-monitored at headquarters, but field-level planning and budgeting remain fragmented.
- Implementation of **supportive policies** significantly lags behind PASM, representing the lowest-rated aspect of the stocktaking.
- Despite a well-designed **incident management system**, operational gaps such as investigation delays and inconsistent accessibility remain a key challenge.
- Integration of PRS into **humanitarian and emergency operations** is guided by policy but inconsistently implemented across settings.
- The **victim/survivor-centred approach** is not yet institutionalized across all levels, although foundational work has begun.
- WHO's efforts to **build capacity**, especially through tailored training and e-learning platforms, have expanded significantly, though coverage and sustainability remain areas for development.

**Pillar 4: Resources and Sustainability**

- PRS activities are partially institutionalized, with concerns about long-term **sustainability** if the dedicated PRS Department is dissolved.
- **Human resources** are unevenly distributed, particularly in emergency contexts, and field staff often face competing responsibilities.
- **Technology systems** to support PRS work, such as case management tools and feedback mechanisms, are insufficient and fragmented.

**Pillar 5: Change Management**

- The ADKAR and PCT assessments reveal that **awareness and desire for change** are high, particularly among PRS focal points.
- However, **reinforcement and ability to maintain change** are lower, indicating the need for deeper organizational integration and incentive structures.
- Cultural change efforts are underway but remain fragile and highly dependent on individual leadership and ongoing engagement.

## Conclusions

The WHO has made substantial progress in institutionalizing its approach to preventing and responding to sexual misconduct. Leadership commitment, updated policy frameworks, and dedicated resourcing have catalysed meaningful organizational change. However, gaps remain in interdepartmental coordination, field-level implementation, emergency integration, and sustainability planning.

To embed PRS efforts into WHO's institutional fabric, stronger ownership across departments, consistent application of accountability mechanisms, more inclusive policy implementation, and sustained change management strategies are required. These findings will inform WHO's 2026–2027 Consolidation Strategy and ongoing efforts to uphold a zero-tolerance approach to sexual misconduct.

## Recommendations

Based on the findings outlined above and throughout this report, the stocktaking exercise proposes the following recommendations:

1. **Assign a single unit with clear senior leadership for the full implementation of supporting policies (PAAC and PAR) using the same successful approach that was used for implementation of the Prevention and Response to Sexual Misconduct (PASM) policy**
   This recommendation should integrate the following components:
   a) consider best practices drawn from the implementation of the PASM policy and PRSEAH Strategy;
   b) consider effective and efficient use of resources in a constrained financial landscape;
   c) use a project management and change management approach as was used for the implementation of the PASM policy; and
   d) accelerate the organizational culture change strategy implementation to fully support the sustainability of this work.

2. **Prioritize Operational Coordination with WHE**
   Strengthen the operational coordination between the WHO Health Emergencies (WHE) Programme and the Prevention and Response to Sexual Misconduct department (PRS), at the three-levels of the Organization, particularly in implementing the PRSEAH components of the Emergency Response Framework (ERF). This would help avoid duplication, clarify roles and responsibilities, and ensure that high-risk contexts remain a top priority.

3. **Build on the effective risk management approach for minimizing risks in WHO's operations including by:**
   a) collaborating within the UN system to more clearly define the scope and limits of accountability for WHO and other UN agencies in relation to Implementing Partners and Member States;
   b) strengthening implementing partners' capacity for safeguarding from SEAH; and
   c) intensify support to host governments/Member States for safeguarding during joint WHO-government operations as per the Member States Accountability Framework for PRSEAH.

4. **Maintain Organizational Standing for PRS work**
   Retain the current structural positioning of the PRS Department for the short term (2–3 years) and maintain the current level of core resourcing for sexual misconduct prevention and response work. Doing so will continue to signal strong leadership and senior management commitment to PRS as an organizational priority.

5. **Plan for accelerated institutionalization of the PASM policy and PRS work**
   Ensure that the next phase of the PASM strategy includes a clear roadmap for transitioning PRS efforts into an integrated model of implementation monitoring and ensuring full institutionalization and accountability across the Organization.

6. **Strengthen IOS Resourcing for Investigations**
   Provide the Office of Internal Oversight Services (IOS) with adequate resources, capacity development and an effective case management system to reduce and monitor investigation timelines and integrate victim/survivor-centred approaches. Without improvements in this area, the sustainability of not only PASM, but broader organizational change efforts, will remain at serious risk.

# 1.0 Introduction

Following from a recommendation from the 38th Programme, Budget and Administration Committee (PBAC)[1] and the 154th Executive Board (EB)[2], the WHO Preventing and Responding to Sexual Misconduct Department (PRS) commission an independent, comprehensive stocktaking exercise to assess the World Health Organization's (WHO) institutionalization of the prevention and response to sexual misconduct and to assess the progress made by WHO against agreed milestones to date. The stocktaking exercise was conducted from January to May 2025, and was overseen by the Independent External Oversight Advisory Committee (IEOAC) of the WHO Executive Board.

This report presents the findings of the stocktaking exercise along with conclusions and recommendations.

## 1.1 Context

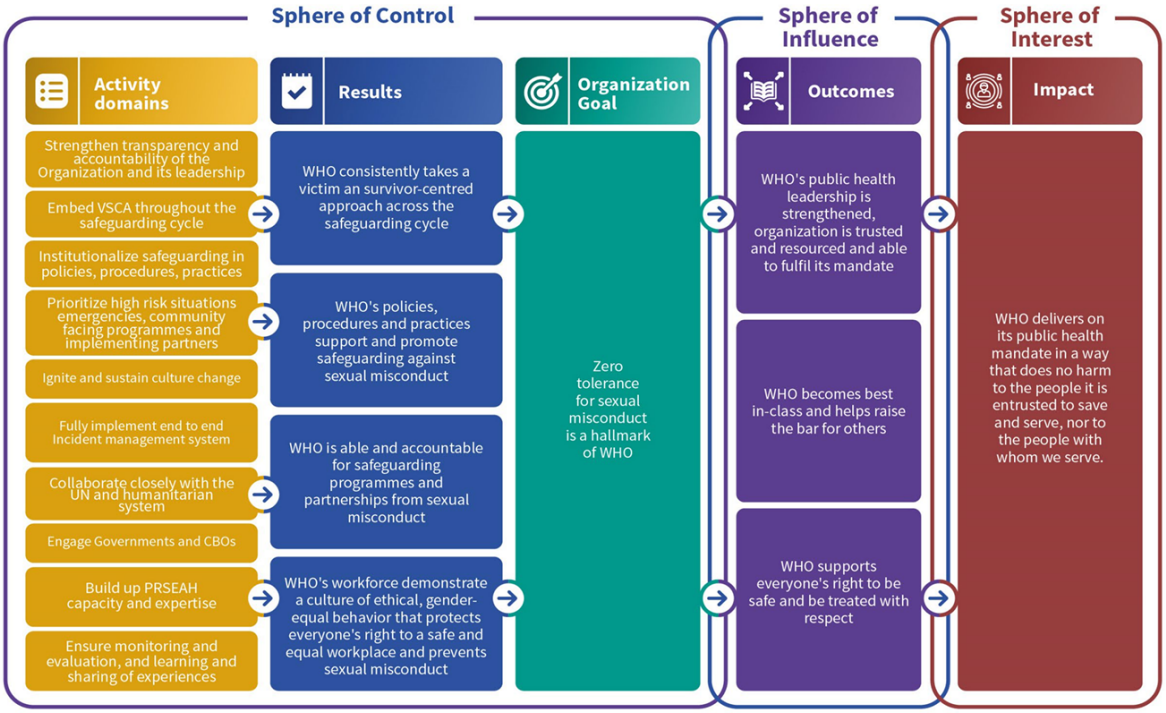
In 2021, serious allegations of sexual exploitation and abuse implicating WHO personnel during the 10th Ebola outbreak in the Democratic Republic of the Congo (DRC) prompted major organizational changes to prevent future exploitation and abuse. In 2021, in a landmark move for the UN system, the WHO Director-General appointed an Independent Commission to investigate the allegations and launched comprehensive, Organization-wide efforts to strengthen systems for preventing and responding to sexual misconduct, a term encompassing sexual exploitation, abuse, and harassment.

Following the Commission's report, the WHO Secretariat developed and implemented a broad Management Response Plan (MRP) for 2021–2022, accompanied by an implementation plan that concluded in December 2022. By the end of the monitoring period, 92% of the plan's 150 actions had been completed. The remaining open actions were integrated into WHO's current Three-year Strategy for preventing and responding to sexual misconduct (2023–2025).

The latter strategy marshals WHO's efforts and seeks to translate into institutional policy, processes and practice the highest standards of integrity and accountability within WHO and its operations. The strategy outlines key actions and initiatives to ensure that all forms of sexual misconduct are effectively prevented and addressed. The theory of change of the strategy framework is presented at **Figure 1** and is aligned with an accountability framework that sets accountabilities for the entire WHO workforce. This is operationalized and monitored through annual implementation plans.

[1] Document A76/39 (May 2023)
[2] Document EB154/4, January 2024

***Figure 1: PRS Strategy Framework***




Since 2021, Member States and the WHO Secretariat, including its independent accountability functions, have conducted extensive oversight and monitoring of WHO's efforts to prevent and respond to sexual misconduct. In parallel, various external entities have conducted numerous assessments of WHO's, and other UN organizations', work on preventing and responding to sexual exploitation and abuse (SEA) and sexual harassment (SH). Although the scope and terms of reference of these reviews vary, they offer a valuable opportunity to consolidate and analyse emerging findings, lessons learned and identified gaps to inform the current stocktaking exercise. Key reviews include those by the Multilateral Organization Performance Assessment Network (MOPAN), the UN Joint Inspection Unit (JIU), and bilateral development agencies such as USAID's Bureau for Humanitarian Affairs (which assessed WHO's PRSEA efforts in emergency operations).

The previous reviews and assessments of WHO's work on the prevention of and response to sexual misconduct have focused on elements or systems components, while this stocktaking exercise focuses on the degree to which prevention of and response to sexual misconduct have been institutionalized across the Organization and what remains to be done to meet expectations for progress against the agreed upon plan. Findings of the exercise will inform the 2026-27 Consolidation Strategy.

## 1.2 The PRS Department and global area of work

As of June 2025, the Prevention of and Response to Sexual Misconduct (PRS) Department reports to the Director-General and is responsible for creating the institutional capacity and operational capability for sexual misconduct prevention and response across the Organization. It works in close coordination and collaboration with all leadership, accountability, enabling and programme functions across the three levels of WHO.

WHO maintains a stated policy of zero tolerance for sexual misconduct committed by its workforce or implementing partners and is equally committed to protecting its personnel from becoming targets of such misconduct. The Organization's approach to the prevention of and response to sexual misconduct aligns with the broader, system-wide framework adopted across the United Nations.

The programme's strategic objective is to raise awareness of sexual misconduct risks across all WHO activities, promote policies and systems that equip the Organization to manage the complexities of prevention, response, and safeguarding, and support the effective implementation of safeguarding measures at all levels of the Organization.

# 2.0 Objectives and Scope

The WHO PRS stocktaking exercise was undertaken between January and June 2025, and has the following objectives:

a) Assess the degree of institutional change, at this time and based on implementation plans' actions and outputs, of the current Three-year strategy on preventing and addressing sexual misconduct within WHO;
b) Review and conduct a synthesis of findings, lessons, issues, and recommendations from internal and external reviews, and governing body documents with relation to sexual misconduct prevention and response since 2021;
c) Identify any early achievements, major enablers, challenges, and gaps in the implementation process;
d) Provide recommendations for:
    i. improving the implementation of the current strategy in the remaining period;
    ii. further enhancing and ensuring institutionalization of prevention of and response to sexual misconduct goals and results across the Organization, with a view to ensuring sustainability; and
    iii. improving the effectiveness of WHO's sexual misconduct prevention and response efforts and to address identified gaps through the consolidation strategy 2026-2027.

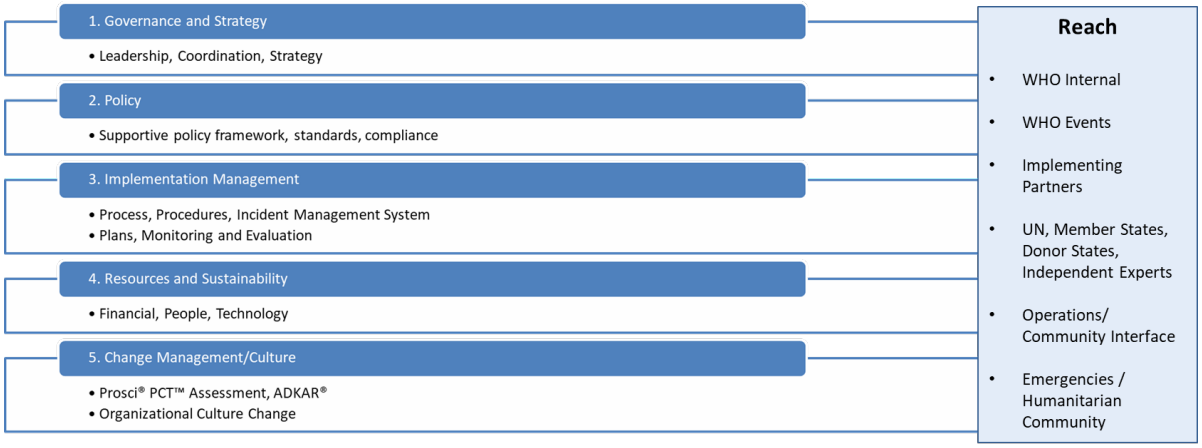
The scope of the stocktaking exercise covers the period October 2021 to October 2024. The Terms of Reference is found in **Annex A**.

# 3.0 Methodology

The methodology, as outlined in the approved Inception Report, is summarized below. It was specifically designed to meet the objectives of this assignment and to provide an independent, external stocktaking of progress. Additionally, the methodology was developed to serve as a replicable tool that can be used periodically to assess ongoing progress through similar exercises.

**Figure 2** presents the overall stocktaking framework based on five pillars: Governance and Strategy, Policy, Implementation Management, Change Management and Culture Change, and Resources (Financial, People, Technology).

***Figure 2: Stocktaking Framework***




To collect and organize data along this framework, a stocktaking assessment tool was designed to provide an assessment of the "as is" position of WHO's Policy on Prevention and Response to Sexual Misconduct (PASM) and the work of the PRS Department, structured around five pillars. For the change management and culture aspect of the stocktaking framework, the Prosci® PCT™ Tool and ADKAR® Assessment were used. Data was collected through interviews, an online survey, case studies and document review. The following table indicates how the various tools were used with the various data collection methods and targeted stakeholders. Please see **Annex B** for the stocktaking tool.

***Table 1: Mapping Tools to Data Collection Methods***

| Method | Interviews | | | Survey | Case Studies | Document review |
|---|---|---|---|---|---|---|
| | Accountability Departments[3] | PRS | Others | PRS Focal Points | | |
| **Stocktaking Assessment Tool** | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |
| **PCT™ Tool** | ✓ | ✓ | | | | ✓ |
| **ADKAR® Assessment** | | | | ✓ | | |

[3] Includes the Office of Internal Oversight Services (audit, investigation), Evaluation Office, as well as functions in the Compliance, Ethics and Risk department, internal justice in the Human Resourced and Talent Management department, the Ombuds Office, and the Global Board of Appeals.

The following sections elaborate on each aspect of the methodology.

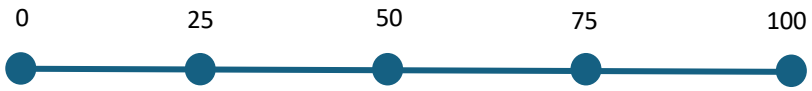
## 3.1 Stocktaking Assessment Tool

The tool includes a detailed list of questions, along with accompanying ratings, for four pillars of the stocktaking framework (i.e., governance and strategy, policy, implementation management, and resources and sustainability), with change management addressed separately using the Prosci® methods as described in the following section.

The exercise was conducted by document review, interviews, case studies and an online survey. The data collection methods are further explained in the following sections.

A five-point anchored rating scale, increasing in 25-point increments, is illustrated in **Figure 3** below. This rating design is well-suited to the survey format, as it provides respondents with a clear and structured means of indicating varying levels of proficiency across each element of the pillar. The scale supports nuanced responses while maintaining consistency in data interpretation.

***Figure 3: 5-Point Rating System***




The following is an example of a question included in the stocktaking assessment tool which illustrates the rating scale's intended use:

> **Question**: LEADERSHIP: Is there an "advocate" in WHO that is leading, engaging and promoting the benefits of PRS across the organization (and at three levels), with implementing partners and Member States?
>
> - Don't know.
> - 0 = None.
> - 25 = Informal role.
> - 50 = Defined role and person/unit exists with vision.
> - 75 = Actively driving change across organization with tangible outcomes.
> - 100 = Actively driving change across organization, implementing partners and influencing Member States with tangible outcomes.

Assessment questions allowed for rating during interviews and surveys, with interviews also offering the opportunity to capture comments and reflections. Some questions were open-ended and will not be rated, as they were critical for meeting the requirements of the Statement of Work (SoW).

**Figure 4** presents a screen capture of the data collection instrument used in the stocktaking assessment, illustrating the sample question referenced above.

The Stocktaking Assessment Tool can be found in **Appendix B**.

***Figure 3: Stocktaking Assessment Tool***

| Ref | Question/ Indicator | Scoring Guide | Guidance | Scoring Response | Interview Response |
|---|---|---|---|---|---|
| 1.1 | **Leadership**: Is there an "advocate" in WHO that is leading, engaging and promoting the benefits of PRS across the organization (and at three levels), with implementing partners and Member States? | Don't know<br>0 = None.<br>25 = Informal role.<br>50 = Defined role and person/unit exists with vision.<br>75 = Actively driving change across organization with tangible outcomes.<br>100 = Actively driving change across organization, implementing partners and influencing Member States with tangible outcomes. | **This indicator assesses the strength of the advocate promoting PRS.**<br>There should be a clearly identifiable individual(s) or unit (s), senior and influential, that is actively leading, engaging and promoting PRS vision and associated benefits across all stakeholder groups, resulting in tangible outcomes . This is essential for awareness, desire and reinforces change. | | |

The following is the list of key questions under each pillar of the stocktaking framework.

**Pillar 1: Governance and Strategy**
This pillar establishes the foundation for leadership, governance, and a clearly defined value proposition to ensure organization-wide commitment to positioning WHO as a global leader in PRS.

The objective is to secure leadership endorsement, reinforce institutional mandates, and enhance cooperation and coordination across departments and all three organizational levels. This will be achieved through a shared vision and a collective understanding of the importance of PRS, as well as clearly articulated roles and responsibilities necessary to realize that vision.

- **1.1 Leadership**: Is there an "advocate" in WHO that is leading, engaging and promoting the benefits of PRS across the organization (and at three levels), with implementing partners and Member States?
- **1.2 Coordinated Response**: The achievement of the PRS Vision (procedures but also change management) requires multiple WHO departments working towards the same results (e.g. IOS, HR, Finance, DGO among others). How well have interdepartmental coordination/cooperation mechanisms been put in place to facilitate decision-making for PRS implementation?
- **1.3 Humanitarian/Emergency**: Is there a separately defined approach/strategy for humanitarian/emergency contexts and situations at WHO that addresses the unique challenges of such situations?
- **1.4 Division of Labour**: The structural and division-of-labour efficiencies between departments and offices that impact the prevention of and response to sexual misconduct are clearly defined and implemented? Is that the same for emergency/humanitarian contexts and situations?
- **1.5 Established Working Groups**: Have specialist Working Groups (subject matter experts) been established to provide advice and guidance to the Advocate?
- **1.6 Strategy**: Is there a PRS Strategy that identifies vision, mission, goals and objectives?
- **1.7 Strategic Alignment**: Has the process to formulate the PRS strategy been fully inclusive? Did it involve capturing the requirements of all key stakeholders and partners?
- **1.8 Audit and Compliance**: Has an audit function been assigned to any organizational unit to ensure compliance with the new policy(ies), procedures for across the organization (all levels)?

**Pillar 2: Policy**
This pillar establishes a robust policy framework that is essential for instituting change and compliance throughout the organization.

The objective is to address current policy issues by improving the policies associated with, and having an impact on, sexual exploitation, sexual abuse, and sexual harassment (SEAH). This is achieved by

proactively monitoring the implementation of relevant corporate policies, including mandating responsibility for data/reporting, and keeping abreast of issues and challenges arising.

- **2.1 Policy**: Is there a Policy on the Prevention of and Response to Sexual Misconduct that is complete, up to date and integrates the most current knowledge about preventing sexual misconduct?
- **2.2 Supportive Policies**: Are there other policies that support the PRS policy (such as HR policies, Code of Conduct, Retaliation, Abusive Conduct) that are complete and up to date?
- **2.3 Humanitarian/Emergency**: Have WHO emergency response/humanitarian operations, through policies, procedures and practices, integrated PRS?
- **2.4 Accountabilities**: Are accountabilities for all positions in the organization clear on the implementation of any policy. Does the Policy on the Prevention of and Response to Sexual Misconduct have clear accountabilities?
- **2.5 Compliance**: Is there a Compliance Strategy or something similar that defines how individuals are encouraged to comply with policies and how compliance will be monitored? a) with the PRS Policy and b) with other supportive policies?

**Pillar 3: Implementation Management**

This pillar focuses on overseeing the implementation of the PRS Strategy, ensuring robust project management practices and effective performance monitoring, including the assessment of results.

The objective is to manage time, costs and scope of the strategy to deliver activities and produce necessary outputs that will lead to expected results.

- **3.1 Implementation Plan PRS**: Is there an existing Implementation Plan that details how the PRS will meet its strategic goals and objectives, when, by whom and with what budget?
- **3.2 Implementation Plan – Supportive Policies**: Is there an existing Implementation Plan that details how supportive policies (Abusive Conduct, Retaliation) will meet their objectives, when, by whom and with what budget?
- **3.3 Humanitarian/Emergency:** How do WHO emergency/humanitarian operations integrate and apply PRS policies, procedures, and practices?
- **3.4 Delivery**: What is the implementation status of key actions as outlined in the strategy and annual implementation plans including on procedural and practice changes as well as on agreed milestones.[4]
- **3.5 Achievement of Results**: Is PRS Strategy implementation on track to achieve the intended results? What does WHO have to do in the next three years to fully achieve results?
    - WHO consistently takes a victim and survivor-centred approach across the safeguarding cycle
    - WHO's policies, procedures and practices support and promote safeguarding against sexual misconduct
    - WHO is able and accountable for safeguarding programmes and partnerships from sexual misconduct
    - WHO's workforce demonstrate a culture of ethical, gender-equal behaviour that protects everyone's right to a safe and equal workplace and prevents sexual misconduct
- **3.6 Best practices**: Has the PRS integrated best practices, identified challenges and mitigations and any gaps in policies and plans?

[4] This was further broken down into 10 activity clusters as per the workplan elements.

**3.7 Communications:** How well does WHO communicate 1) expectations (zero tolerance), 2) the written policies, 3) the recourse mechanisms, and 4) the safety/non-retaliatory nature of such mechanisms?

**3.8 Monitoring and evaluation**: Is there a monitoring and evaluation framework for the Strategy and is data collected as identified (frequency), and reported for decision-making?

**Pillar 4: Resources and Sustainability**

In this context, sustainability refers specifically to the durability of results over time. It is assumed that, eventually, the mandate of the PRS Department will be fulfilled, with all related activities fully integrated into the relevant Director-General's Office (DGO) units. The key question is whether the results achieved will be sustained once this transition occurs.

**4.1 Sustainability**: Are the activities developed, led and delivered by PRS sustainable? If the PRS department were to disband, would the policies continue to be implemented, processes and procedures followed and would the expected results of the PRS Strategy be realized and sustained? What must occur to ensure institutionalization and sustainability?

**4.2 Financial**: Is there a consistent level of resourcing to maintain existing infrastructure and activities for PRS strategy implementation?

**4.3 People**: The PRS includes the PRS Department, PRS Focal Points, and Field Coordinators. Is there sufficient staffing of PRS and with the requisite knowledge, skills, and abilities?

**4.4 Technology**: Technology refers to any non-existing corporate software, hardware or web presence that is required to achieve the results of the Strategy. Are there adequate technology resources for achieving the results of the Strategy?

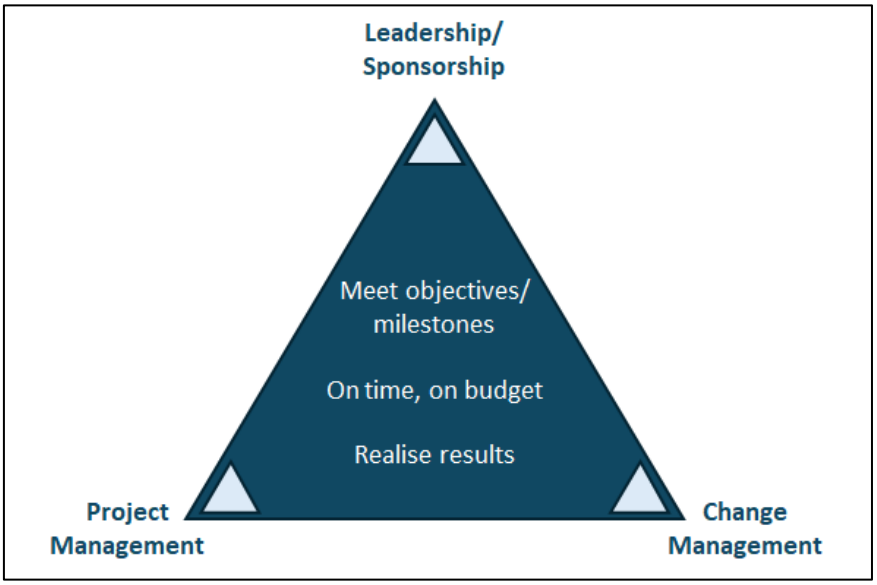
## 3.2 Pillar 5 – Change Management Assessment

The Prosci® tools were used to assess the state of change management at WHO in relation to: (i) the implementation of the PRS strategy, and (ii) the advancement of a supportive organizational culture. Two specific tools were applied, the PCT™ Method and the ADKAR® Assessment, each of which generated a standalone report. The findings from these assessments were incorporated as a line of evidence within the broader stocktaking framework. They are aligned with one of the strategy's intended results: *"WHO's workforce demonstrates a culture of ethical, gender-equal behaviour that protects everyone's right to a safe and equal workplace and prevents sexual misconduct."*

**PCT™ Tool**

The Prosci® PCT™ Method (**Figure 5**) is a framework that describes the elements (i.e., Leadership / Sponsorship, Project Management, Change Management) needed for change initiative to be successful. The assessment targeted the Directors and staff of the accountability departments. A total of nine individuals participated in the PCT. Two assessments were undertaken: one regarding PRS strategy implementation and the other on supportive organizational culture change.

*Figure 4: Prosci® PCT™ Triangle*




Each element is divided into ten distinct factors, which participants were asked to rate. With a slight modification[5], the rating scale used aligns with that of the broader assessment tool, enabling the integration of results from this pillar with those of the other pillars in the stocktaking framework. The assessment results were submitted in a separate report, and the findings were subsequently incorporated into the overall evidence matrix.

### ADKAR® Assessment

The ADKAR® Assessment is a tool designed to evaluate an individual's progression through five key elements of change: Awareness, Desire, Knowledge, Ability, and Reinforcement. As part of this initiative, the ADKAR® Assessment was embedded in a targeted survey distributed to PRS Focal Points. A brief overview of the tool is provided in **Table 2**.

*Table 2: ADKAR® Assessment Tool*

| | |
|---|---|
| **Awareness** | What is your assessment of the people in your area of operation regarding their awareness of the need to change. In your view, what do they think is driving the change? |
| | Degree to which they are aware of and understand the reasons for this change: Rank 0 (no awareness), 25 (a little), 50 (some), 75 (a lot of), 100 (complete awareness). |
| **Desire** | List the motivating factors or consequences (good and bad) related to this change that impact their desire to change, including compelling reasons to support the change and specific objections to the change. |
| | Assess their desire to change: Rank 0 (no desire), 25 (a little), 50 (some), 75 (a lot of), 100 (complete desire). |
| **Knowledge** | List the skills and knowledge they need to support this change, both during and after the transition. |
| | Have they received training or education in these areas? Rank 0 (none), 25 (a little), 50 (some), 75 (a lot of), 100 (all necessary training). |
| **Ability** | Considering the skills and knowledge from above, assess your overall ability to implement this change. What challenges do you foresee? |

[5] Prosci suggest the following ranking on PCT: 1 = inadequate, 2 = adequate, 3 = exceptional. This has been modified to 0, 25, 50, 75, 100, aligned to the stocktaking assessment tool.

| | |
|---|---|
| | To what extent do they have the ability to implement the new skills, knowledge and behaviours associated with this change? Rank 0 (none), 25 (a little), 50 (some), 75 (a lot of), 100 (all necessary ability). |
| **Reinforcement** | List the reinforcements in your organization that will help to retain the change. Are incentives in place to help make the change stick? Are there incentives not to change? |
| | To what degree are they receiving reinforcement for demonstrating the change? Rank 0 (no reinforcement), 25 (a little), 50 (some), 75 (a lot of), 100 (complete reinforcement). |

It is important to note that broader perceptions and attitudes among the WHO general workforce are already captured through the annual UN survey on sexual exploitation and abuse (SEA). The ADKAR® Assessment, by contrast, focuses specifically on measuring change related to sexual exploitation, abuse, and harassment (SEAH) within the context of the PRS Strategy.

## 3.3 Data Collection Methods

Data collection commenced following the approval of the Inception Report. **Figure 6** provides an overview of the volume and scope of the data collected. The subsequent sections offer a detailed explanation of each line of evidence.

***Figure 5: Data Collection Methods***

| | |
|---|---|
| Interviews | •Plan was to conduct 50-60 interviews<br>•57 completed (67% female) |
| Document review | •140 documents including Governing Bodies, PRS outputs and external studies |
| Online Survey of PRS Focal Points | •130 respondents with complete answers (74% female, 70% were part-time focal points) |
| Case studies | •Yemen, DRC, Laos PDR, Türkiye, Egypt |
| Prosci Change Management | •PCT - 9 interviews<br>•ADKAR - 110 responses |

### 3.3.1 Interviews

The project team conducted 47 virtual semi-structured interviews (with an additional 10 interviews done for case studies) with key informants, primarily WHO management, staff or contracted experts across global, regional and country levels. Interviews were conducted in English, French and Spanish as needed, based on the master interview guide (see **Annex C**). All interviews were confidential, with no attribution of comments to specific individuals to encourage frank responses. Interview notes were organized according to assessment (sub)questions, as per the Stocktaking Assessment Tool (please see **Annex B**).

***Table 3: Stakeholder Coverage***

| Stakeholders | Interviews | Case Studies | Survey |
|---|---|---|---|
| WHO PRS headquarters | 4 | | |
| WHO HQ Assistant Director-Generals, Directors of accountability departments | 11 | | |
| WHO Regional Offices | 7 | | |
| Head of WHO Country Offices (HWCO) | 4 | 2 | |

| Stakeholders | Interviews | Case Studies | Survey |
|---|---|---|---|
| WHO PRS Focal Points | 9 | 8 | 130 |
| IEOAC | 1 | | |
| External (Experts, MOPAN, UN, JIU) | 9 | | |
| Member States | 2 | | |
| ***Total*** | ***47*** | ***10*** | ***130*** |

### 3.3.2 Case Studies

A case study protocol was developed during the Inception Phase and selected countries based on their PRS risk ranking (2 countries from high, medium and low risk), and coverage of at least 3 WHO regions. The completed case study countries are found in **Table 4**. The objective was to conduct 2-3 interviews per country. A total of ten individuals from 5 countries were interviewed.

***Table 4: Case study countries***

| Country | Risk Ranking | Region | |
|---|---|---|---|
| Yemen | Very high | EMRO | 2 |
| DRC | Very high | AFRO | 1 |
| Laos | Medium | WPRO | 2 |
| Türkiye | Medium | EURO | 2 |
| Egypt | Low | EMRO | 3 |

### 3.3.3 Document Review

A total of 140 documents were reviewed, with evidence extracted and coded in relation to the relevant stocktaking questions. The documents were categorized into six groups: PRS management and outputs, WHO Governing Body reports, Assessments and Audits, International Guidance and Norms, WHO Corporate Policies, and Others. A complete list of the documents reviewed is provided in **Annex D.**

### 3.3.4 Online Survey of PRS Focal Points

A self-administered online survey was developed and disseminated in English, Spanish, and French. The target audience comprised PRS Focal Points at both regional and country levels. The survey included selected stocktaking questions as well as the ADKAR Assessment, as described in the previous section (see **Annex E** for the full survey instrument). To accommodate participants with limited internet access, a mail-in survey option was also made available.

The survey was distributed by the PRS Department and remained open for a period of four weeks, during which weekly reminders were issued to encourage participation. A total of 130 responses were received for the stocktaking questions, and 110 responses were submitted for the ADKAR component.

## 3.4 Analysis

Responses to all interview questions were analysed using qualitative methods including a content and/or thematic analysis. Responses to questions that had a ranking assessment component also underwent quantitative analysis using the ranking scale. Demographic information was captured for

interviews and surveys, including level of WHO (i.e., country, regional, headquarters), region/country, gender.

For each stocktaking question there was evidence from i) ranked questions, ii) qualitative data from interviews, document review, case studies and surveys (open-ended questions), and iii) qualitative data from document review (e.g. trends in cases/investigations) and ADKAR Assessment and PCT Method. This was compiled in an evidence matrix from which summary findings were made for each stocktaking question.

With respect to the rating approach, respondents were asked to evaluate the stocktaking questions using the following scale:

| 0 | 25 | 50 | 75 | 100 | Don't know |
|---|---|---|---|---|---|
| None | Inadequate | Good but areas for improvement | Adequate | Exceptional | |

For each question, ratings were disaggregated by respondent group (i.e., headquarters (HQ), regional offices (RO) and country offices (CO), and external stakeholders) to identify consistencies or differences in perspectives. An overall score was then calculated by summing the individual ratings and dividing by the total number of respondents.

Based on this analysis, conclusions and recommendations were formulated. The resulting evidence matrix was shared with the PRS Department to identify any information gaps or correct factual inaccuracies. A preliminary findings presentation was subsequently developed and delivered to WHO senior management. Feedback received during this validation process has been incorporated into the final report.

## 3.5 Ethical Considerations

Participants were informed of the purpose of the stocktaking exercise and were asked to provide verbal consent before participating. It was clearly explained that the exercise aimed to capture their experiences and perspectives—there were no right or wrong answers. Participants were assured that they could share only what they felt comfortable disclosing and could withdraw from the exercise at any time without consequence. The report includes only a summary table indicating the number of interviewees, their positions or affiliated entities, locations, and gender disaggregation.

Interview notes were collected solely for internal use by **TDV Global Inc (TDV)**, with all personal identifiers removed to protect confidentiality. Survey data was aggregated, and all information gathered during the exercise was accessible only to **TDV** team members. This information was used exclusively for the purposes of the stocktaking exercise. Any personal data is securely stored by **TDV** and will be retained only until the final completion of the contract.

## 3.6 Limitations of the Exercise

Any review of this scope and complexity will have potential limitations, which can include:

**Ranking Calibration:** Stakeholders may have interpreted the ranking scale differently based on personal or cultural perspectives. This was partially mitigated through anchored scoring descriptors (e.g., "none," "inadequate," "adequate," "exceptional") and segmented analysis by WHO level (HQ, RO/CO) and stakeholder group.

**Survey Respondents:** The survey targeted only PRS Focal Points. This was intentional, given their strategic role and access to other workforce-wide data from the annual UN Preventing and Responding to Sexual Exploitation and Abuse (UN PSEA) survey. The survey also included ADKAR-based questions best suited to individuals engaged directly in PRS implementation.

**Scope vs. Time Constraints:** The PRS agenda spans the entire organization (9000+ staff across 155 locations), making full coverage unfeasible within the timeline. While interviews were conducted across HQ, RO, CO levels and with external actors, the findings reflect a time-bound snapshot and may not capture evolving dynamics.

**Response Bias:** Some stakeholders may have tailored their responses based on perceived organizational expectations or reputational concerns, despite the exercise being external and confidential. This was mitigated by covering a range of WHO regions, positions and WHO levels (HQ, ROs, and COs) as well as by triangulation of evidence in an evidence matrix.

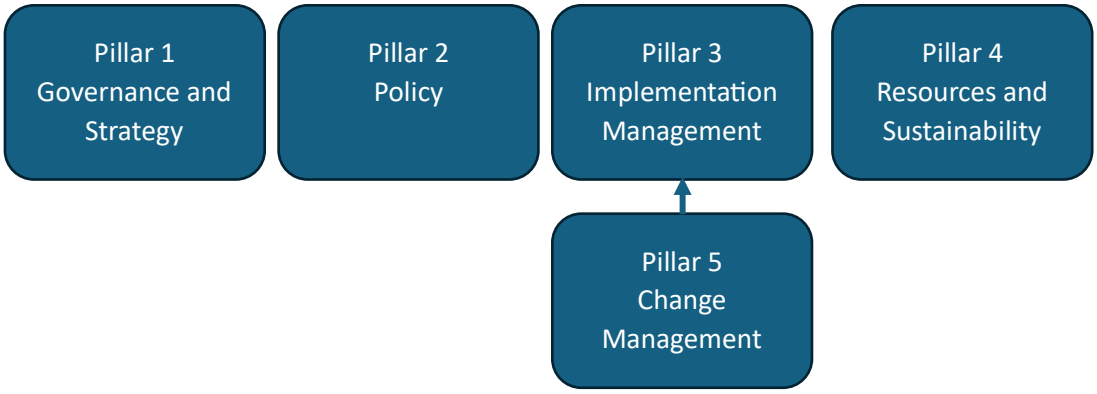
**No direct observation**: Given the resource constraints, no field missions were conducted and therefore no direct observation was possible. This was partially mitigated by integrating case studies, which allowed the team to interview several people from the same country office.

Note that the impact of these limitations were mitigated by a variety of factors, which included the triangulation of responses, consistency in responses across similar stakeholders, and considering the qualitative responses which assisted in providing a deeper understanding of why specific responses were provided.

# 4.0 Findings

This section presents the findings organized by the stocktaking pillars and their corresponding questions. Given that PRSEAH in emergency and humanitarian contexts was identified as a key theme in the Terms of Reference, it has been addressed through standalone questions within Pillars 1, 2, and 3. As previously noted, Pillar 5: Change Management and Culture has been integrated into the findings under Pillar 3.

***Figure 6: Stocktaking Pillars***




## 4.1 Findings related to Pillar 1: Governance and Strategy

### 4.1.1 Leadership: Is there an "advocate" in WHO that is leading, engaging and promoting the benefits of PRS across the organization (and at three levels), with implementing partners and Member States?

| Rating | HQ | RO/CO | Others | Total | | Considered exceptional |
|---|---|---|---|---|---|---|
| | 90.9 | 88.5 | 93.8 | 90.2 | | |
| **Finding**: WHO has exceptional leadership, particularly at HQ, with strong advocacy led by the Director-General particularly during the initial phases, and then by the PRS Director. There is strategic engagement by the IEOAC and Executive Board. The organization's high-level commitment is reflected in policies, funding, and visibility. | | | | | | |

From a headquarters perspective, WHO demonstrates strong and consistent advocacy for PRS. The Director-General (DG) played a critical enabling role, especially during the early development phase, although his visible advocacy has slightly decreased over time. The Director of PRS is widely recognized as the central champion. She is described as highly engaged, proactive, and instrumental in building and implementing the PRS agenda across all levels.

At the regional and country levels, advocacy exists but is less consistent. Some regions (e.g., EURO, EMRO, SEARO) show strong engagement and leadership. Other regions and country offices display variability, often depending on local leadership, risk assessments, and the operational context.

Respondents identified several challenges, including a potential overreliance on a small number of key individuals to sustain advocacy efforts, and the need for stronger collaboration with governments and implementing partners. These concerns are reinforced by the survey findings. Among the 130 PRS Focal Point survey respondents, 67% indicated that there is an advocate who is either actively

driving change across the organization and influencing Member States and implementing partners (rated 100) or actively driving change within the organization with tangible outcomes (rated 75). A further 20% of respondents rated leadership (as defined role and person exists with vision) as 50.

Despite these challenges, WHO is seen as a leader in PRS advocacy, being the first UN organization to appoint a dedicated PRS Director and to maintain high levels of governance oversight through the IEOAC, Executive Board (EB) and World Health Assembly (WHA) processes.

### 4.1.2 Coordinated Response: The achievement of the PRS Vision requires multiple WHO departments working towards the same results. To what extent have interdepartmental coordination/cooperation mechanisms been put in place to facilitate decision-making for PRS implementation?

| Rating | HQ | RO/CO | Others | Total | | Good, with areas for improvement |
|---|---|---|---|---|---|---|
| | 61.4 | 69.2 | 87.5 | 67.3 | | |
| **Finding**: While structures such as bi-weekly accountability meetings exist, implementation remains inconsistent. Departmental silos, unclear roles (especially HR, IOS, Ombudsman), and competing priorities hinder consistent decision-making. | | | | | | |

At headquarters there is coordination, via the accountability department meetings which are currently held bi-weekly and when possible chaired by the DG. The feedback is that coordination is working, but the implementation may be lacking. Following the DRC crisis, meetings within the accountability departments were primarily focused on implementing the management response to the Independent Commission's findings. As the programme has matured, this singular focus has broadened to encompass a wider range of organizational priorities.

Coordination varies across the three levels, with interviewees rating country coordination higher than at regional or headquarter level. That is supported by focal point survey findings, with 87% of respondents indicating at least some level of coordination, and 70% indicating high levels of coordination, but that can vary greatly.

From a regional and country office perspective, coordination exists but is uneven. The depth and consistency of coordination vary widely by office, region, and department. Countries such as Jordan, Ukraine, and Nepal were cited as having strong coordination at the field level. In contrast, some regions (e.g., Pan American Health Organization) struggle with information-sharing and transparency in outcomes, limiting the effectiveness of collaboration.

### 4.1.3 Humanitarian / Emergency: To what extent is there a separately defined approach/strategy for humanitarian/emergency contexts and situations at WHO that addresses the unique challenges of such situations?

| Rating | HQ | RO/CO | Others | Total | | Adequate |
|---|---|---|---|---|---|---|
| | 83.3 | 76.9 | 62.5 | 78.1 | | |
| **Finding**: WHO has developed a defined PRS approach for emergency and humanitarian settings, embedded in the 2024 Emergency Response Framework (ERF) and aligned with Inter-Agency Standing Committee (IASC) standards. | | | | | | |

From a strategic perspective, defined approaches are in place to guide WHE-related actions, including the Emergency Response Framework (ERF 2024), the WHO Strategic Plan of Action on PSEAH, and activities outlined in the workplan of the WHE PSEAH Technical Unit.

In the ERF 2024, PSEAH is emphasized as both a core commitment and guiding principle, aligned with the IASC PSEA core principles. Notably, the framework includes an updated PSEAH Implementation Framework in Graded Emergencies (Appendix 4), reflecting enhancements from previous versions.

Interviewees reported that although the policy framework is in place, practical implementation varies by region and context. Integration of PRS into emergency operations is often fragmented or parallel, especially where PRS focal points are excluded from key decision-making spaces. This implementation theme is carried forward under Pillar 3.

> *"PRS Regional Coordinators have not been included in decision-making by heads of emergency programmes… parallel structures that were not well coordinated."* ***Interviewee***

WHO's Health Emergencies Programme (WHE) has incorporated PRS into training, risk assessments, and standard operating procedures (SOPs). However, risk tools from WHE and PRS were developed separately, and alignment between the two remains a challenge.

### 4.1.4 Division of Labour: The structural and division-of-labour efficiencies between departments and offices that impact the prevention of and response to sexual misconduct are clearly defined and implemented?

| Rating | HQ | RO/CO | Others | Total | | Good but areas for improvement |
|---|---|---|---|---|---|---|
| | 65.6 | 66.7 | 50 | 65.5 | | |
| **Finding**: Responsibilities are well-defined in policy (e.g., PASM, accountability framework), but clarity and enforcement vary by level and region. Confusion remains in some areas, especially in field operations and emergency contexts. | | | | | | |

From a strategy perspective, the PRS 3-year strategy implementation plans clearly identify the "responsible entities" for each activity. The division of labour is also defined through the PRS policy and accountability framework.

At regional and country level, there is clarity but some cases of confusion of roles, with some confusion between the PRS, Ombudsman, IOS, and HRT being specifically mentioned. Multiple responses noted that PRS roles are clearer at the country level, where focal points coordinate efforts and policies are more visible in day-to-day work. However, country-level implementation can still be uneven, depending on local emergencies, staffing, or the presence of dedicated focal points. From the survey of PRS Focal Points, 57% of respondents indicated that there is clarity on the division of labour (rating either 75 or 100), with an additional 26% indicating that it is currently being formulated but not yet in place.

### 4.1.5 Established Working Groups: To what extent have specialist Working Groups (subject matter experts) been established to provide advice and guidance to the Advocate?

| Rating | HQ | RO/CO | Others | Total | Adequate |
|---|---|---|---|---|---|
| | 75 | 75 | 75 | 75 | |

**Finding**: Technical and policy-focused working groups, as well as communities of practice, support implementation and guidance, though these are formed on an ad hoc basis rather than being institutionalized.

Working groups have been established for various purposes and as needed. At the beginning of the DRC crisis, a task force was created to assist in the early response, along with policy-focused working groups. There is ongoing engagement with PRS focal points in their community of practice, and ongoing engagement in UN/IASC working groups by the PRS team.

Regional and country offices indicated working groups have been widely established across WHO at all levels, with varying effectiveness and structure. While some regions and offices report strong, operational working groups (e.g., Nepal, Jordan), others cite gaps in clarity, resources, or consistent engagement.

The importance of the PRS Focal Points was emphasized. According to respondents, Focal Points are often the bridge between HQ and country level and function as de facto advisors to management. Their presence is consistent, and some report regular regional and global coordination meetings.

### 4.1.6 Strategy: To what extent is there a PRS Strategy that identifies vision, mission, goals and objectives?

| Rating | HQ | RO/CO | Others | Total | Exceptional |
|---|---|---|---|---|---|
| | 93.8 | 91.7 | 97.5 | 91.7 | |

**Finding**: The PRS strategy clearly defines the vision, mission, and objectives and is widely seen as comprehensive and actionable.

The PRS 3-year strategy is in place and is regarded highly as a solid, comprehensive approach and document that has helped to guide implementation.

From a HQ perspective, the strategy was rated highly by all respondents (75-100) as being comprehensive, clear and the cornerstone for the PRS initiative. There can always be scope for improvement, for example, with aligning to ISAC in emergency situations.

Regional and country level respondents consistently rated the PRS Strategy highly, with most scores ranging from 75 to 100, indicating a strong and clearly articulated vision, mission, goals, and objectives. The Strategy is widely viewed as well-structured, aligned with WHO's broader mission, and effective in guiding action.

However, some noted challenges in contextualization, field-level application, and implementation monitoring, especially in lower-risk or under-resourced settings which will require continued monitoring and adaptation in future strategies.

External stakeholders also view the strategy as a clear document, comprehensive and well-thought out. The goals are ambitious which may have implications if they cannot be reached. The issue of sexual misconduct spans beyond any one organization and progress is influenced by social norms and cultures.

#### 4.1.7 Strategic Alignment: To what extent has the process to formulate the PRS strategy been fully inclusive? Did it involve capturing the requirements of all key stakeholders and partners?

| Rating | HQ | RO/CO | Others | Total | Adequate |
|---|---|---|---|---|---|
| | 75 | 78.6 | NA | 76.9 | |
| **Finding**: The strategy development was inclusive of key stakeholders, including some survivors and Member States, though some gaps remain in field-level and culturally specific consultations. | | | | | |

The formulation of the PASM Strategy was seen by most respondents as largely inclusive and consultative, at all levels. Inputs were sought from Member States, civil society, donors, and in some cases, survivors. However, a few respondents noted gaps in field-level engagement, cultural contextualization, and inclusion of operational teams, suggesting that implementation could benefit from deeper stakeholder integration and more culturally sensitive adaptation.

#### 4.1.8 Audit and Compliance: Has an audit function been assigned to any organizational unit to ensure compliance with the new policy(ies), procedures for across the organization (all levels)?

| Rating | HQ | RO/CO | Others | Total | Good, but areas for improvement |
|---|---|---|---|---|---|
| | 65 | 67.9 | NA | 66.7 | |
| **Finding**: Compliance monitoring is done by a range of mechanisms that are not all institutionalized with overall monitoring being done by PRS Department. | | | | | |

This should be read in conjunction with Question 2.5 under the Policy Pillar. The PRS Department serves as the designated “owner” of the policy. Compliance is monitored through various mechanisms, including representation letters, internal oversight processes, risk registers, and regional audits. The PRS Department is also responsible for overseeing the implementation of workplans. While internal audits may occasionally address issues related to investigations and PRS, they do not do so in a focused or systematic manner.

## 4.2 Findings related to Pillar 2: Policy

#### 4.2.1 Policy: To what extent is there a Policy on the Prevention of and Response to Sexual Misconduct that is complete, up to date and integrates the most current knowledge about preventing sexual misconduct?

| Rating | HQ | RO/CO | Others | Total | Adequate+ |
|---|---|---|---|---|---|
| | 75 | 90.4 | 87.5 | 84.3 | |
| **Finding**: The PASM is rated exceptional for scope, alignment with UN standards, and strategic clarity. | | | | | |

The WHO Policy for Preventing and Addressing Sexual Misconduct (PASM, 2023) is widely regarded as comprehensive, current, and well-aligned with international standards**.** It integrates Sexual

Exploitation and Abuse (SEA) and Sexual Harassment (SH) under a unified approach of Sexual Misconduct (SM), which many view as innovative**.**

The policy is widely regarded as comprehensive and aligned with current UN standards. Respondents emphasized the importance of regular updates to ensure continued relevance, address operational complexities, and reinforce both victim-centred approaches and due process as mutually reinforcing principles within implementation. Many respondents rated the policy highly (scores of 100 and 75). This finding was supported by the online survey, where 86% of the respondents indicated that it was "complete" (ranked 100, 61%) or "mostly complete" (ranked 75, 25%).

The policy's "innovative" and "revolutionary" approach, particularly its combination of SEA (Sexual Exploitation and Abuse) and SH (Sexual Harassment) into a single framework (SM - Sexual Misconduct), was both praised and seen as controversial. While the policy has been recognized as a significant advancement, respondents identified several areas for improvement:

- Clarity and tracking of informal resolution processes to ensure transparency and consistency;
- Workplace reintegration procedures for both victims and alleged offenders, to support recovery and maintain a safe working environment;
- Investigation timelines, which need to be more reasonable and achievable within operational constraints;
- Guidance for emergency situations and IASC coordination, to ensure timely and coherent responses across agencies;
- Cultural and regional contextualization, with respondents noting the need for greater adaptation to effect progress in view of local social, cultural, and religious sensitivities; and
- Enhanced case management and survivor support, including the development of a standardized case management SOP to ensure timely, safe, and coordinated investigations and follow-up.

### 4.2.2 Supportive Policies: To what extent are there other policies that support the PRS policy (such as HR policies, Code of Conduct, Retaliation, Abusive Conduct) that are complete and up to date?

| Rating | HQ | RO/CO | Others | Total | Adequate+ |
|---|---|---|---|---|---|
| | 80 | 88.5 | 58.3 | 81.7 | |
| **Finding**: Supportive policies are up to date and address critical areas such as retaliation and abusive conduct. | | | | | |

WHO has a set of recently updated and well-aligned supporting policies (as of 2023), such as the Code of Ethics, Policy on Retaliation, Policy on Abusive Conduct, and Legal Framework for Standards

**Renewed policy suite**

- **Code of Ethics (2023):** replaced the 2017 version on 1 July 2023 to align with the revised PASM and reflects updated standards on conduct, including sexual misconduct.
- **Policy on Preventing and Addressing Retaliation (July 2023):** replaces the 2015 Whistleblowing and Protection against Retaliation Policy, now includes explicit protections for whistle-blowers and victims of sexual misconduct, such as sexual harassment.
- **Policy on Addressing Abusive Conduct (PAAC) (June 2023):** updated to complement PASM and reflect enhanced standards for preventing abusive behaviour.
- **Legal Framework for Addressing Non-Compliance with Standards of Conduct:** Also updated to align with the new PRS standards.

of Conduct, that complement and support the PRS policy**.** These documents reflect WHO's commitment to preventing sexual misconduct and abusive behaviour.

Most interviewees agree that WHO's related policies have been recently updated and are aligned with the PRS policy. This is supported by the survey, where 80% of survey respondents indicated either that "all supportive policies are in place and up to date" (ranked 100, 44%), or that most supporting policies are up to date with some gaps (ranked 75, 36%).

Many respondents acknowledged that these elements form a complementary and comprehensive framework; however, persistent challenges remain, including implementation gaps, unclear leadership, and disputes over ownership.

### 4.2.3 Humanitarian / Emergency: Have WHO emergency response/humanitarian operations, through policies, procedures and practices, integrated PRS?

| **Rating** | **HQ** | **RO/CO** | **Others** | **Total** | Adequate |
|---|---|---|---|---|---|
| | 78.6 | 77.1 | NA | 77.6 | |
| **Finding**: PRS integration into emergency and humanitarian response is formalized via WHO's Emergency Response Framework (ERF) and related operational tools, and with dedicated deployments. | | | | | |

Most interviewees noted that the ERF serves as the primary mechanism for integrating PRS into WHO's emergency operations. However, implementation remains challenging due to resource constraints. One interviewee highlighted that the WHO Controller has issued guidance to promote more sustainable funding for PRS activities in emergencies, requiring the inclusion of a dedicated safeguarding budget in response plans.

The WHE Programme has taken steps to strengthen the application of organizational policies, guidelines, and operational frameworks related to PSEAH. While the stocktaking did not assess implementation directly, several efforts were cited as examples of progress:

- Use of the IASC UN Partner Portal PSEA Module, with reports indicating that 80% of implementing partners (IPs) in high-risk countries have been assessed;
- Integration of safeguarding measures into recruitment processes, including the use of ClearCheck;
- Inclusion of PSEAH considerations in the planning of responses to graded emergencies; and
- Integration of PSEAH into resource mobilization efforts for WHO emergency operations.

An external interviewee suggested there may be opportunities to improve coordination with the broader UN humanitarian system, advocating for more collaborative approaches rather than parallel efforts. The example cited was the independent development of a risk management toolkit.

### 4.2.4 Accountabilities: Are accountabilities for all positions in the organization clear on the implementation of any policy? Does the Policy on the Prevention of and Response to Sexual Misconduct have clear accountabilities?

| **Rating** | **HQ** | **RO/CO** | **Others** | **Total** | Adequate+ |
|---|---|---|---|---|---|
| | 80 | 82.7 | 83.3 | 81.7 | |
| **Finding**: PASM has clear accountabilities as laid out in the policy and the accountability framework. | | | | | |

Most interviewee respondents agree that PASM includes a clear accountability framework, particularly at the organizational and managerial levels. However, some raised concerns about ambiguity at operational levels, especially in complex or emergency settings, and noted gaps in linking internal accountability to external stakeholders and affected populations.

> *"While some policies are in place, there is a lack of enforcement and monitoring mechanisms to ensure that all staff are obligated to implement these policies, particularly in coordination with partners and governments in contexts where PRS is considered a sensitive issue."* ***Survey respondent***

While WHO has developed its internal framework, some respondents emphasized that Member States have agreed to create their own, but this is still under development. This perspective is supported by the survey, where 78% of respondents indicated that accountabilities are "completely" (ranked 100, 48%) or "mostly completely" (ranked 75, 30%) clarified for the whole organization.

However, implementation and consistency at the country level, particularly when working with non-WHO staff and implementing partners, remains a key challenge. Some respondents noted gaps in policy coverage, a need for stronger enforcement mechanisms, and greater integration into everyday practices. Progress is being made, but operationalization is uneven across settings.

### 4.2.5 Compliance: Is there a Compliance Strategy or something similar that defines how individuals are encouraged to comply with policies and how compliance will be monitored?

| **Rating** | **HQ** | **RO/CO** | **Others** | **Total** | | Adequate |
|---|---|---|---|---|---|---|
| | 65 | 77.3 | 75 | 73.5 | | |
| **Finding**: There are mechanisms in place to support compliance. | | | | | | |

Most interviewees indicated that while WHO does not have a standalone "compliance strategy", it implements a variety of mechanisms, both formal and informal, that encourage compliance and monitor adherence to policies, particularly related to PRS. These include codes of conduct, risk management frameworks, mandatory trainings, internal control systems, and performance evaluations.

Several respondents emphasized that compliance is embedded across distinct functions (e.g., HR, IOS, CRE), with regional and country-level adaptations. However, gaps remain, especially in terms of awareness, consistency, robust monitoring, and coverage of non-staff and implementing partners.

Document review revealed that there is extensive reporting to WHO Government Bodies, and ongoing monitoring (quarterly briefings) with Member States. Since January 2023, progress is being tracked against the 2023-25 strategy and related workplans. There is also a PRSEAH Dashboard where activities on areas such as case reporting and training activities, are updated regularly. A range of reports are available on the website, including updates by the Secretariat and Secretary-General, internal and external audits, and independent reports.

Auditing falls under the mandate of the Office of Internal Oversight Services (Audit). A review of reports submitted to the World Health Assembly (WHA) from 2021 to the present indicates that Sexual Misconduct (SM) is addressed in various ways. It may appear as an area for improvement within country-level audits, in relation to investigations, or as a standalone item within the audit reports.

## 4.3 Findings related to Pillar 3: Implementation Management

### 4.3.1 Implementation Plan PRS: Is there an existing Implementation Plan that details how the PRS will meet its strategic goals and objectives, when, by whom and with what budget?

| Rating | HQ | RO/CO | Others | Total | Adequate |
|---|---|---|---|---|---|
| | 83.3 | 72.9 | 83.3 | 78.1 | |

**Finding**: The implementation plan at headquarters is robust, with detailed annual workplans, assigned responsibilities, and regular monitoring. Some regions and countries also demonstrate proactive planning and contextualized approaches.

From a headquarters perspective, there is general agreement that the implementation plan exists and is aligned with the PRS strategy. However, concerns were raised about clarity around responsibilities, tracking of outcomes, and adequacy of the budget. While several respondents affirmed the existence and utility of the plan, others pointed out that gaps remain, particularly in emergency contexts.

> *"PRS is not an area of work in the WHO. PRS is not a technical area. PRS is a governance and ethics issue, compliance and risk. We adopted a very programmatic approach, governance of ethics, and monitoring implementation plans."* **Interviewee.**

At regional and country level, most respondents agreed that implementation plans exist at global, regional, and country levels, aligned with the three-year strategy (2023–2025). The plan typically includes annual workplans, assigned responsibilities, and costed activities. However, concerns were raised around clarity in high-risk or complex environments, limited field-level integration, and budget gaps, especially for emergency contexts. A few respondents noted limited visibility into budgeting processes or local implementation details. At the country level, the degree of planning varies and is influenced by several factors, including the assessed risk level, the amount of time PRS Focal Points can allocate to these issues, and the availability of resources.

### 4.3.2 Implementation Plan – Supportive Policies: Is there an existing Implementation Plan that details how supportive policies (Abusive Conduct, Retaliation) will meet their objectives, when, by whom and with what budget?

| Rating | HQ | RO/CO | Others | Total | Inadequate |
|---|---|---|---|---|---|
| | 28.1 | 63.6 | NA | 48.7 | |

**Finding**: This was the lowest rated question of all the stocktaking questions. Implementation of supportive policies lags behind PASM and lacks dedicated resources and ownership. There needs to be more work in this area.

There is a mixed picture regarding the existence and robustness of implementation plans for supportive policies (e.g., Abusive Conduct, Retaliation). While some country offices (e.g., Jordan, Nepal) and regions have developed implementation plans or integrated measures, many respondents highlighted gaps, particularly in funding, formal planning, and clarity at the country level. There is also a heavy reliance on existing resources, and inconsistencies in how these policies are implemented and supported across the organization.

One interviewee indicated that PAAC did have an action plan starting in 2022, and that it was delivered with limited resources.

### 4.3.3 Humanitarian / Emergency: How do WHO emergency/humanitarian operations integrate and apply PRS policies, procedures, practices?

| Rating | HQ | RO/CO | Others | Total | Good but areas for improvement |
|---|---|---|---|---|---|
| | 67.9 | 68.2 | 100 | 69.7 | |
| **Finding**: While planning is present, it remains inconsistent and highly context-dependent, often constrained by politics, resources, or the limitations of Member State partnerships. There is a call for better operational coordination between PRS Department and WHE. | | | | | |

Across interviewees, most responses suggest that WHO has made considerable progress in integrating PRS into its emergency and humanitarian operations through frameworks like the ERF, risk-based planning, and training protocols. However, the degree of implementation varies, with many pointing to gaps between policy and practice, resource constraints, training limitations, and ambiguities in roles and accountability, especially in high-risk or complex field settings.

> *"People think PRSEAH is a minimal budget, but in emergencies it is a huge effort and investment - ensure reporting systems, psychological first aid, investigations, safety—all that requires funding."* ***Interviewee***

According to some external stakeholders, there may be a degree of resentment within the broader humanitarian community, based on the perception that WHO addressed the issue primarily by allocating significant financial resources. However, WHO did share some of these resources with partners, and it was suggested that others may not have responded with the same urgency given the scale and immediacy of the crisis faced by WHO.

### 4.3.4 Delivery: What is the implementation status of key actions[6] as outlined in the strategy and annual implementation plans including on procedural and practice changes as well as on agreed milestones.

This question was further broken down into 10 sub-questions related to the activity clusters in the 3-year strategy and annual workplans.

**a) strengthen the transparency and accountability of the Organization and its leadership**

| Rating | HQ | RO/CO | Others | Total | Adequate+ |
|---|---|---|---|---|---|
| | 85 | 91.7 | 75 | 87.5 | |
| **Finding**: There is improved transparency and accountability. The dashboard and accountability frameworks are evidence of such measures, as well as extensive reporting to Member States and Governing Bodies. | | | | | |

[6] A.7 MRAP (2021-2022): 92% of the 150 actions in the implementation plan on the Management Response Plan had been fully implemented
A.11, (2023): 82% of activities completed (60 activities), 15% in progress (12 activities), 3% not started (2 activities) = 74 activities in total
A.48 (2024): 83% completion rate (68 activities), 17% ongoing (14 activities) = 82 activities

Overall, 22 of 24 workplan activities were completed (92%). Workplan activities[7] included i) regular updates on dashboards, progress reports on strategy (100% completed both in 2023 and 2024), ii) quarterly updates to Member States (MS), reporting to Governing Bodies, UN PSEA Surveys (100% completed in 2022, 2023 and 2024), iii) participate in IEOAC reviews and external assessments / evaluations, MOPAN and UN progress reviews, and share findings (100% completed in 2023 and 2024), iv) team discussions (completed in 2023), Town halls (not 100% completed), Senior management letters (completed in 2025).

The Secretariat conducted quarterly Member State briefings on PRSEAH and updated public dashboards on allegations and disciplinary action for sexual and other forms of misconduct. WHO provides reporting of SEA cases to the UN Secretary-General's iReport system, reported to the United Nations System Chief Executives Board, and participated in the United Nations annual planning exercise and workforce perception survey.

From 2025 onwards, all heads of WHO country offices and Regional Directors provide an annual letter to the Director-General on their accountabilities concerning PRSEAH, fostering a culture of transparency and accountability and help to identify areas where leadership needs support.

Regarding external assessments, the MOPAN assessment (2023) rated as satisfactory all elements (15) on SEAH and the results were made public. There is also an ongoing JIU review of PRSEA that is not yet complete at the time of this report, and a recently completed evaluation of PSEAH in WHO emergency operations. Finally, there is comprehensive information on the WHO public site (https://www.who.int/initiatives/preventing-and-responding-to-sexual-exploitation-abuse-and-harassment), as well as the WHO intranet (Our Work) on PRSEAH resource materials, and reporting.

Based on the completed activities most interviewees indicate that PRS actions have contributed positively to transparency and accountability in WHO, particularly by increasing awareness, visibility, and structural commitments. 74% of focal point survey respondents indicated that this was in progress and on track (75) or was completed successfully (100), and 16% indicated that this was in progress but delayed (50).

**b) embed Victim/Survivor-Centred Approach (VSCA) throughout the safeguarding cycle**

| **Rating** | **HQ** | **RO/CO** | **Others** | **Total** | | Good but areas for improvement |
|---|---|---|---|---|---|---|
| | 47.2 | 79.5 | 62.5 | 64.8 | | |

**Finding**: Implementation remains at an early stage. The position of Victim/Survivor Support Officer (VSSO) was only established in September 2024, and this activity cluster currently has the lowest completion rate, at 69%. Notable differences emerged between responses from headquarters and those from regional and country offices. This variance is attributable to the greater involvement of regional and country-level staff in case management and their direct knowledge of the support mechanisms available at the country level.

Workplan activities include i) working on VSCA with the Office of the UN Special Coordinator for Preventing Sexual Exploitation and Abuse (OSCSEA), UN Office of the Victims' Rights Advocate (OVRA), IASC Champion i) advocacy efforts, guidance, consultations, ii) establish a VSS function at WHO including SAF, iii) strengthen VSA case management

> *"It's a generic term—it still needs clear definition and training at global, regional, field levels."* ***Interviewee***

[7] Where possible, MRAP activities in 2022 have been cross walked to the PRS annual workplan category of activities.

(training), iv) strengthen investigative processes, and v) create mechanisms for feedback from victim/survivors. Overall, 29 activities, 20 completed (69%).

The Victim/Survivor-Centred Approach (VSCA) has not yet been systematically integrated across all WHO operations, particularly at the field level and in engagements with implementing partners. Significant gaps persist in its operationalization, coordination, and in creating a trusted environment where victims feel safe to report incidents and access support.

For example, the WHO hotline is not accessible in areas without internet connectivity; staff may lack clarity regarding their roles, procedures, and key definitions; and a coordinated, multi-departmental response is often required but not consistently in place. Additionally, cultural factors, such as fear of retaliation, continue to inhibit reporting. The prolonged duration of investigative processes further undermines the effectiveness and credibility of a survivor-centred approach.

**c) institutionalize safeguarding in policies, procedures and practices**

| **Rating** | **HQ** | **RO/CO** | **Others** | **Total** | Adequate |
|---|---|---|---|---|---|
| | 63.9 | 87.5 | 100 | 79.3 | |
| **Finding**: There are clear indications of institutionalization as noted by updated policies, and in the case of PASM, implementation support, and procedures such as risk assessments, internal control frameworks. | | | | | |

Workplan activities include i) reviewing policies to make them consistent with PASM and annual reviews to identify gaps, ii) develop guidance and tools including end-to-end Incident Management System (IMS) and standard operating procedures (SOPs), iii) policy implementation review meetings, iv) communications, trainings, webinars and v) cooperation with the UN system on ClearCheck. Overall, 22 activities, 19 completed (86%).

Interview findings indicate clear signs of institutionalization, including the integration of PRS-related measures into onboarding processes for new staff, employee and contractor screening, organizational policies and procedures, performance assessments (e.g., ePMDS), the Internal Control Framework, and risk assessments.

Among PRS Focal Point survey respondents (n = 121), 67% indicated that institutionalization efforts were either on track or successfully completed, rating them at 75 ("in progress and on track") or 100 ("completed successfully"). An additional 18% reported that progress was being made but experiencing delays.

**d) Ignite and sustain culture change**

| **Rating** | **HQ** | **RO/CO** | **Others** | **Total** | Good but areas for improvement |
|---|---|---|---|---|---|
| | 50 | 77.1 | 37.5 | 63 | |
| **Finding**: There is broad consensus that culture change related to PRS within WHO has begun; however, it will need to be sustained and further deepened. In addition, efforts should be expanded to promote a more comprehensive organizational culture change centred on appropriate conduct. | | | | | |

Workplan activities include i) develop an organizational culture change strategy, ii) address structural barriers to change including gender and diversity, equity and inclusion (DEI), iii) creation of safe

spaces, iv) build capacity and v) conduct regular perception surveys. Overall, 20 activities, 14 completed (70%).

A review of key documents, including the IC Report, MOPAN Assessment, PwC Report[8], CALI report[9], confirms the recognized need to bridge gaps in organizational culture and approach. These gaps extend beyond behaviour related solely to SM, encompassing all forms of inappropriate conduct. Notable progress has been made, including leadership signalling through zero-tolerance messaging, the introduction of new policies and procedures, increased reporting, and greater engagement and learning. However, the unified culture change strategy remains under development and continues to face deeply entrenched institutional challenges.

> "*When one wants to have a cultural change, you have to reflect on the quantity of focus on SEAH specifically versus other overlapping and competing issues that can drive SEAH (e.g., general abuse, retaliation). The key question across the board is how SEAH can be integrated across all good practices, and avoidance of bad practices for everyone at all levels while prioritizing high risk situations*." **Interviewee**

Interviews provided additional evidence that culture change related to safeguarding, particularly in the area of sexual misconduct, has begun to take hold. Respondents highlighted improvements in awareness, reporting, leadership messaging, and accountability mechanisms. Several interviewees viewed the increase in reported SM cases as a sign of growing trust in the system and as a positive indicator of cultural shift. Nevertheless, sustaining this progress remains a significant challenge, particularly at the field level and in regions where taboos, stigma, or mistrust are more prevalent. While there has been a notable move away from silence and impunity, ensuring the long-term sustainability, consistency, and leadership-driven nature of culture change continues to require focused effort. Interviewees also emphasized the importance of broadening the scope of change to address all forms of misconduct, including not only SEAH but also abusive behaviour, harassment, and retaliation.

Survey results reinforced these insights. Among respondents, 64% indicated that culture change efforts were either on track (54% rated it at 75) or fully achieved (10% rated it at 100). Meanwhile, 28% reported that progress was underway but delayed (rating it at 50).

**e) prioritize high risk situations, emergencies, and community facing programmes and implementing partners**

| **Rating** | **HQ** | **RO/CO** | **Others** | **Total** | | Adequate |
|---|---|---|---|---|---|---|
| | 72.5 | 84.1 | 75 | 78.3 | | |
| **Finding**: Progress has been made in prioritizing high-risk situations (policies, risk assessments, resources). By their very nature, community facing programmes such as the Polio Programme and emergencies are complex situations that require significant operational resourcing for effective PRSEAH. | | | | | | |

Workplan activities included working with WHE and Polio Programme, etc., on i) emergency risk assessments and SM prevention trainings (completed in 2023), 10 core activities in high risk situations applied in 50% of WHO CO high risk (completed in 2023, partial in 2024), emergency risk

[8] Audit Report: Sexual Exploitation and Abuse, Sexual Harassment (SEAH) and Harassment Internal Audit Services under IEOAC Oversight, Price Waterhouse Coopers, August 2022

[9] Independent Review of WHO Leadership Culture for Prevention of and Response to Sexual Exploitation, Abuse and Sexual Harassment, CALI (Center for Asia Leadership Initiatives), February 2023

assessments in all Grade 3 emergencies (completed in 2024) ii) deploy full-time PRSEAH experts in high priority countries, completed in 2022, 15 experts deployed in 2023 (completed), 15 in 2024 (completed) iii) work under UN Resident or Humanitarian Coordinator or IASC, iv) Management Response Action Plan (MRAP) completed, Head of WHO Country Office (HWCO) engaged with IASC at least 50 countries in 2023 and 65 in 2024 (completed), v) implement PRSEAH commitments in ERF (met targets in 2023), ongoing in 2024), vi) operationalize UN protocol on IPs, done in 10 high-risk countries in 2023, and 15 in 2024. (20 activities, 18 completed or 96%).

The majority of interviewees indicated that WHO has made meaningful progress in prioritizing high-risk contexts, particularly emergencies and community-facing programmes, through the PRS approach. While increased resources and attention have been directed to these areas, gaps remain in terms of investment, consistent implementation, and oversight of implementing partners.

Survey results support these observations: 67% of PRS Focal Point respondents reported that efforts in this area were either in progress and on track (53% rated it at 75) or successfully completed (14% rated it at 100).

**f) strengthen systems to identify and manage sexual misconduct risk**

| **Rating** | **HQ** | **RO/CO** | **Others** | **Total** | Good but areas for improvement |
|---|---|---|---|---|---|
| | 65 | 72 | 68 | 68 | |
| **Finding**: There has been progress made and the SEAH risk assessment has been institutionalized but still requires further development and oversight. There is a need for closer collaboration with WHE and IASC to ensure there is no overlap or duplication of efforts in terms of risk assessments in emergency situations. | | | | | |

Workplan activities include i) have all HWCO, ROs, and HQ programmes complete SM risk assessment including Internal Control Framework (ICF) /Annual Letter, and tools, ii) develop tools and templates for country level, iii) measures to mitigate risk in the workplace, external collaborators, NSA, CC etc. including review of contractual documents, Collaborating Centre assessments, iv) conduct risk management trainings, and v) work with UN to exchange data including sharing of data and risk mitigation. Overall, 18 actions, 17 complete (94%).

According to interviews across WHO's three levels, the Organization has adopted a risk-based approach to safeguarding. The SEAH Risk Assessment Tool, first introduced in 2023, has continued to evolve, with a strong focus on risk mitigation throughout 2024 and continued rollout underway. Interviewees emphasized the need for ongoing coordination with the WHE and IASC to avoid duplication or overlap of efforts.

Interviewees highlighted several ongoing risks that warrant continued attention. One area of concern is engagement with governments serving as implementing partners. While WHO remains firmly committed to upholding its zero-tolerance policy, respondents noted that progress may vary across country contexts due to differing capacities, legal frameworks, and political environments. Language related to PRSEAH within the UN Sustainable Development Cooperation Frameworks remains optional or aspirational. Furthermore, although a draft Member State Accountability Framework was tabled at the Executive Board in February 2025, its adoption and practical implementation remain uncertain.

Second, concerns were raised regarding the effectiveness of oversight for implementing partners. Although the PSEA Capacity Assessment is being applied, some interviewees consider it to represent only a minimum standard. A UN working group, led by UNICEF and with WHO's participation, is actively exploring ways to strengthen accountability mechanisms for implementing partners.

**g) Build up PRSEAH capacity and expertise**

| Rating | HQ | RO/CO | Others | Total | | Adequate |
|---|---|---|---|---|---|---|
| | 57.1 | 85.4 | 75 | 75 | | |
| **Finding**: There has been a considerable increase in both course offerings as well as participation since 2021. Specific participation in courses was not assessed. There is some monitoring of the training outcomes (increased knowledge, skill, and use) through annual PSEA surveys, and separate training evaluations. Training is something that has to be continuous given staff turnover and its key role in change management. | | | | | | |

Workplan activities include i) compliance with UN mandatory training and WHO-specific PRSEAH training, targeted training, ii) develop learning pathways for job categories, iii) integrate PRS accountabilities into performance management system, iv) contribute to UN on PRSEAH professionalization, v) develop and support a pool of experts. Overall, 23 activities, with 16 completed (70%).

While the effectiveness of training was not assessed as part of this review, there has been a notable increase in both the availability of courses and participation in training related to PRSEAH. Key developments include:

- The launch of a comprehensive PRSEAH learning pathway in 2023, offering mandatory and tailored training for five distinct risk profiles, including managers, PSEA focal points, and field staff;
- High compliance with mandatory training requirements: by the end of 2022, 91% of supervisors and 92% of general staff had completed UN-mandated training, with compliance remaining above 90% in both 2023 and 2024;
- Reported 93% compliance with Zero Tolerance training;
- Expanded availability of training content on platforms such as the WHO Academy and OpenWHO, including multilingual offerings and modules for implementing partners;
- A diversified training program format, now including in-person sessions, webinars, and self-paced online learning, with future plans for gamified learning modules and new agency-specific mandatory courses to be launched in 2025; and
- More than 80,000 enrolments in online PRSEAH-related training to date.

However, results from the UN PSEA surveys reveal mixed trends. While there were significant improvements in induction and refresher training uptake between 2020/2021 and 2024 (including a 25.9% increase in respondents receiving induction training (2021–2024) and a 26.5% increase in refresher training (2020–2024)) there was a decline between the 2023 and 2024 survey periods. Specifically, the number of respondents reporting that they had received additional PRSEAH training dropped by more than 10%.

Interviews further suggest measurable progress in building PRSEAH capacity and expertise across the organization, particularly at the regional and country office levels. Although gaps and inconsistencies persist, especially in emergency settings, the majority of responses reflect a positive trend in institutional learning, training investments, and awareness-raising. Differences in how headquarters

and regional/country office interviewees rated this area may reflect the fact that many regional and country office staff had directly participated in these training initiatives.

The ADKAR assessment identified *Knowledge* (defined as the skills and understanding required to support the PASM change) as relatively strong among PRS Focal Points. A total of 72% of respondents reported having "a lot" or "complete" knowledge, while only 3% indicated "little" or "none."

As part of the assessment, PRS Focal Points were also asked to list the skills and knowledge they believe are necessary to support this change. Responses yielded a broad and insightful range of competencies, including communication and advocacy, emotional intelligence and empathy, conflict resolution and mediation, as well as technical knowledge of PASM policies, standards, practices, and the broader UN system.

Survey findings reinforce these results. Seventy-five percent of PRS Focal Point survey respondents indicated that efforts in this area were either in progress and on track (57% rated it at 75) or successfully completed (18% rated it at 100).

Despite these strengths, respondents also identified several areas for improvement. These included the need for more targeted and context-specific training, particularly in local languages, as well as the development of standardized training materials (e.g., templates and case studies). Additionally, there was a strong call to move beyond one-time training efforts toward ongoing, sustained capacity building.

**h) fully implement end-to-end incident management system (E2E IMS)**

| **Rating** | **HQ** | **RO/CO** | **Others** | **Total** | | Good but areas for improvement |
|---|---|---|---|---|---|---|
| | 47.2 | 72.9 | 50 | 60.9 | | |
| **Finding**: Overall, the IMS is both designed and operational; however, several challenges remain. These include delays in the investigation process and a fragmented electronic case management system. As a result, there is currently no end-to-end IMS accessible to all relevant duty bearers. | | | | | | |

Workplan activities included i) IMS design and division of labour, ii) reduce barriers to reporting, iii) implement case management system, iv) ensure training for related personnel, v) communicate on anonymized monitoring data. Overall, 14 activities, 13 complete (93%).

While some activities have been marked as completed, several areas previously identified as challenges remain unresolved, and proposed solutions are not clearly articulated in the documentation reviewed. For example, issues related to hotline accessibility and the rollout of a comprehensive end-to-end IMS continue to persist. These gaps are explicitly noted as risks in the PRS Risk Register.

Interview findings indicate broad recognition that an incident management system exists and is conceptually well-structured, particularly at the global level, supported by strong engagement from key departments, including IOS, CRE, and PRS. However, significant operational challenges remain. These include delays in the investigation process and a fragmented electronic case management system that limits effectiveness and accessibility.

There is notable divergence in perspectives between headquarters and regional or country office staff. This may be attributed to the fact that many interviewees at headquarters are direct users and duty bearers of the system, whereas those at the regional and country levels often experience implementation gaps firsthand.

Case study findings further highlight the need for improvement. Concerns were raised about data security and trust in the system, and prolonged investigation timelines were consistently cited as a key weakness. This concern was echoed in the open-ended comments of the survey, where the duration of investigations emerged as a prominent theme.

**i) System-wide action with UN and humanitarian stakeholders, governments & civil society**

***Note**: given the extensive nature of this activity area, it was divided into two parts. There was little or no information on engaging civil society (not including Implementing Partners).*

**Governments**

| **Rating** | **HQ** | **RO/CO** | **Others** | **Total** | Good but areas for improvement |
|---|---|---|---|---|---|
| | 56.3 | 64.6 | 62.5 | 61.4 | |
| **Finding**: With respect to Member States, it is acknowledged that WHO's direct influence may be limited. Nonetheless, progress has been made through a UN working group, led by UNICEF with active participation from WHO, which successfully integrated a PSEA clause into the UN Sustainable Development Cooperation Framework. Concurrently, WHO has engaged with Member States to negotiate a draft voluntary accountability framework for PRSEAH, intended for use during joint operations with the Organization. | | | | | |

**UN and humanitarian**

| **Rating** | **HQ** | **RO/CO** | **Others** | **Total** | Adequate + |
|---|---|---|---|---|---|
| | 83.3 | 85.4 | 75 | 83.7 | |
| **Finding**: WHO is collaborating at all levels with the UN and humanitarian system. WHO has taken leadership roles in certain contexts but there are areas for improvement in leading initiatives and resource and burden sharing. | | | | | |

Workplan activities included i) contributing to pool of inter-agency PSEA coordinators, 2 in 2023, and 2024 (completed), ii) work with UN/IASC on VSCA, 2002, engagement and consultations completed in 2023, 2024, iii) provide guidance to all HWCO met targets in 2023, 2024, iv) consultations with government counterparts, met targets in 2023 and 2024, v) engagement of civil society , tools, events, consultations met most targets. Overall, 17 activities, 16 completed (94%).

**Government Engagement**

Document review indicates that some Member States, such as Jordan, Malawi, and the Syrian Arab Republic, have made notable progress in addressing PSEAH. However, engagement efforts must navigate a wide range of cultural contexts, each with varying levels of tolerance and sensitivity around SEAH. WHO has developed a voluntary accountability framework for PSEAH (see *EB156/28*) for use by Member States, issued a briefing note for Ministries of Health on SEAH, and continues to advocate for strengthened action on this issue.

> *"PRSEAH issues are mostly contract law and administrative issues – so unless you hold the contract then it is hard to enforce"* ***Interviewee***

Interviews suggest that WHO's engagement with governments on PRS is visible but uneven. In some countries, particularly those with supportive Ministries of Health, moderate to strong engagement was reported. However, efforts are often constrained by systemic and cultural barriers, as well as political sensitivities. A formal framework for engaging Member States on PRS is currently under development. Interviewees also noted that, as expected, WHO's influence over Member States is more limited compared to its influence over implementing partners, where formal contractual and funding relationships provide clearer levers for accountability.

**Engagement with the UN and Humanitarian Systems**

Interviews highlighted that WHO's collaboration on PRS within the UN and broader humanitarian system is strong and continuing to improve, particularly in the area of interagency coordination. This collaboration is rated highly (typically between 75 and 100); however, concerns persist regarding field-level implementation, resource constraints, and uneven engagement across UN agencies.

External stakeholders acknowledged WHO's leadership in certain contexts but also identified opportunities for improvement—particularly in assuming greater responsibility for leading initiatives and ensuring more equitable resource and burden sharing.

Examples of WHO's Engagement in Interagency Efforts include:

- Joined the IASC Technical Advisory Group (TAG) on PSEAH and the UN SEA Working Group in 2021;
- Began working with the IASC Partner Portal in 2023;
- Developed and disseminated guidance, materials, and training for Heads of WHO Country Offices (HWCOs) on UN/IASC collaboration (e.g., *Briefing Note on Joint UN-Government Framework for PSEA*, *PSEA Toolkit for UN Leaders*, and WHO procedures for sharing SEA case information with UN officials in-country);
- Collaborated with UN Country Teams/Humanitarian Country Teams to support staffing of two PSEAH coordinator positions;
- Co-funded and co-facilitated the IASC PSEAH Coordinator Training, and hosted the 2024 interagency meeting on investigations;
- Supported the interagency workstream on training reform and participated in the 2024 interagency meeting on the trust fund for survivors.

**j) ensure monitoring, evaluation, learning and sharing of experiences**

| **Rating** | **HQ** | **RO/CO** | **Others** | **Total** | | Adequate |
|---|---|---|---|---|---|---|
| | 77.8 | 77.1 | 75 | 77.2 | | |
| **Finding**: There is ongoing monitoring and reporting on the implementation of the annual workplans, as well as monitoring of key performance indicators related to cases/investigations. | | | | | | |

Workplan activities include i) develop a monitoring and evaluation framework, ii) agreement on indicators, iii) quarterly reporting, iv) lessons learned exercises and sharing, v) one external evaluation in 2025. 13 activities (not including 2025 evaluation) 12 completed (92%).

The document review confirmed that WHO's three-year PRSEAH strategy is supported by annual implementation plans that clearly outline timelines, indicators, targets, and key responsibility centres. Progress against these plans is regularly monitored and reported through quarterly Member State briefings. Additionally, a MOPAN assessment, covering multiple UN agencies, was conducted in 2023, with the final report released in early 2024. An independent evaluation of PRSEAH in WHO emergency operations was completed in May 2025, and a JIU review of PRSEA was underway during the time of this stocktaking exercise.

Due to the internal nature of monitoring and evaluation functions, few interviewees provided detailed responses on this topic. However, those who did noted the existence of a monitoring system that includes annual workplans and a case management dashboard. Regular updates are provided through Member State briefings and annual reports submitted by the Director-General to both the Executive Board and the UN Secretary-General. Furthermore, annual stakeholder conferences were held in 2023 and 2024 to support transparency and continued engagement.

### 4.3.5 Achievement of Results: To what extent is PRS Strategy implementation on track to achieve the intended results[10]?

This question was further broken down to the four results as outlined in the 3-year strategy.

**a) WHO consistently takes a victim and survivor-centred approach across the safeguarding cycle**

| **Rating** | **HQ** | **RO/CO** | **Others** | **Total** | Good but areas for improvement |
|---|---|---|---|---|---|
| | 50 | 81.8 | 75 | 67.9 | |

**Finding**: While much work has been completed and there is progress towards achieving this outcome, there are factors that will put its achievement at risk. Most fundamentally, the need for continued broad, organizational culture change, and the need to address the investigative process timeline. The recent addition of the VSSO position has the potential to accelerate developments in this area over the next 2-3 years.

According to the three-year strategy, this result is mapped to action areas 1, 2, 3, 4, 5, 8 and 9. Given the level of completion of the workplan, work on VSCA (Activity Area #2) and Culture Change (Activity Area #4) should be prioritized in order to achieve a fully implemented result.

| Activity Area | 1 | 2 | 3 | 4 | 5 | 8 | 9 |
|---|---|---|---|---|---|---|---|
| % workplan completed | 92% | 69% | 86% | 77% | 96% | 93% | 94% |

According to interviews, there is clear institutional commitment and growing momentum toward embedding a VSCA throughout WHO's safeguarding cycle. While some meaningful steps have already been taken, including policy development and training, implementation remains uneven, in terms of operational consistency.

[10] The assessment of achievement of outcomes was not part of the ToR given this was a stocktaking exercise and an evaluation is planned for later in 2025. What follows here is an overview of activity outputs related to "results".

Many respondents noted that the practical application of the VSCA is still in its early stages or remains conceptual, particularly at the country office level, raising concerns about how VSCA is implemented in practice. While WHO has made efforts to prioritize survivor safety, dignity, and confidentiality, delays in the investigation process continue to undermine the effectiveness of this approach.

These concerns were echoed in case studies, which also highlighted the existence of a Community of Practice on VSCA that is helping to reinforce the adoption and institutionalization of the approach. Some respondents suggested that support mechanisms should be extended to both alleged victims and alleged offenders, including access to appropriate rehabilitation services. It was also emphasized that the existing investigation backlog poses a significant barrier to the effective implementation of a truly survivor-centred model.

**b) WHO policies, procedures and practices support and promote safeguarding against sexual misconduct**

| Rating | HQ | RO/CO | Others | Total | Good with areas for improvement |
|---|---|---|---|---|---|
| | 63.9 | 90.9 | 75 | 67.9 | |

**Finding**: On track to achieve this outcome in terms of policies and procedures which have been updated and continue to be reviewed as needed. The issue around practices will be more challenging and will take more time in an organization as diverse as WHO with a subject that is influenced by social norms and regional culture. That can impact results internally to WHO, and externally with IPs and government partners. There will need to be tailored approaches to specific contexts.

According to the three-year strategy, this result is mapped to action areas 1, 2, 3, 4, 5, 8 and 9. Given the level of completion of the workplan, work on VSCA (Activity Area #2) and Culture Change (Activity Area #4) should be prioritized in order to achieve a fully implemented result.

| Activity Area | 1 | 2 | 3 | 4 | 5 | 6 | 8 | 9 |
|---|---|---|---|---|---|---|---|---|
| % workplan completed | 92% | 69% | 86% | 77% | 96% | 94% | 93% | 94% |

Building on previous evidence, it is clear that WHO has taken significant steps to support and promote safeguarding against sexual misconduct. The Organization's policies and procedures are rated highly. However, in practice, the effectiveness of implementation varies depending on the specific area of inquiry.

Interviews and case studies consistently indicate that while most respondents agree that robust policies and procedures are in place, a key weakness lies in the prolonged delays in the investigation process. These delays are attributed to the current limited capacity of the IOS to meet established benchmarks (120 + 60 days). Additional challenges identified include persistent cultural barriers at the country level, which continue to hinder the consistent application of safeguarding measures.

**c) WHO is able and accountable for safeguarding programmes and partnerships from sexual misconduct**

| Rating | HQ | RO/CO | Others | Total | Good with areas for improvement |
|---|---|---|---|---|---|
| | 40.6 | 81.8 | 75 | 65 | |

**Finding**: There has been progress on safeguarding programmes with a number of initiatives undertaken. The amount of influence WHO has is greater with Implementing Partners, consultants and direct hires given there is a contractual relationship. The challenge and risk are working with Member States as implementing partners. Depending on the context, PRSEAH can be a sensitive topic. On the other hand, some Member States have already started taking this on. It is likely the results will be mixed over the short to medium-term, as messages about PRS are reinforced.

According to the three-year strategy, this result is mapped to action areas 1, 2, 3, 4, 5, 8 and 9. Given the level of completion of the workplan, work on Culture Change (Activity Area #4) and Capacity Building (Activity Area #7) should be prioritized in order to achieve a fully implemented result.

| Activity Area | 1 | 3 | 4 | 5 | 6 | 7 | 8 | 9 |
|---|---|---|---|---|---|---|---|---|
| % workplan completed | 92% | 86% | 77% | 96% | 94% | 70% | 93% | 94% |

According to interview findings, some respondents noted that the current results are influenced by numerous external factors and that engagement with Member States on PRSEAH is still in its early stages. While WHO is actively assessing and monitoring its Implementing Partners, where contractual relationships allow for clearer accountability, working with Member States is inherently more complex due to sovereignty and the absence of binding agreements. Nevertheless, WHO can and should maintain a degree of accountability by continuing to engage through UN system mechanisms, such as the inclusion of PRSEAH provisions in UN Sustainable Development Cooperation Frameworks.

Respondents also highlighted that deeply rooted cultural taboos and social stigma can make discussions on PRSEAH particularly challenging with governments and communities. Other significant barriers include entrenched gender inequality and prevailing social norms related to honour, shame, and fear of retaliation.

To address these challenges, respondents emphasized the importance of community engagement and the development of culturally sensitive strategies tailored to local contexts. These approaches were seen as essential to the successful implementation and acceptance of PRSEAH efforts.

> *"Without community buy-in, this will not work. We need to use language they understand and respect."* ***Interviewee***

**d) WHO's workforce demonstrate a culture of ethical, gender-equal behaviour that protects everyone's right to a safe and equal workplace and prevents sexual misconduct**

| Rating | HQ | RO/CO | Others | Total | | Good but areas for improvement |
|---|---|---|---|---|---|---|
| | 40.6 | 75 | 50 | 60 | | |

**Finding**: This was the lowest rated result PRS Strategy Implementation. Despite the interview ranking, this result is at risk of not being realized. The result speaks to WHO's organizational culture, and there is a growing recognition that organizational culture change is not restricted to SEAH but also needs to take a broader view against any inappropriate behaviour, including abusive conduct, retaliation, breaches in ethics, alongside SEAH.

It is also recognized that while some strides have been made regarding SEAH, it is still fragile and not fully institutionalized. Work on the broader organizational culture change agenda has not started in any meaningful way, with a draft strategy set to be reviewed by Member States in May 2025.

According to the three-year strategy, this result is mapped to action areas 1, 2, 3, 4, 5, 8 and 9. Given the level of completion of the workplan, work on Culture Change (Activity Area #4) should be prioritized in order to achieve a fully implemented result.

| Activity Area | 1 | 4 | 8 |
|---|---|---|---|
| % workplan completed | 92% | 77% | 93% |

According to interviews, there is a growing awareness and policy-level commitment within WHO to fostering an ethical, gender-equal workplace culture. However, the consistent demonstration of these values across the workforce remains uneven and is still in the process of evolving.

Many respondents acknowledged that the appropriate structures and initiatives are in place, such as the Code of Conduct, DEI initiatives, training programmes, and PRSEAH-related surveys. Nonetheless, these efforts are not always fully embedded or reflected in day-to-day workplace behaviours, particularly across different country contexts and hierarchical levels.

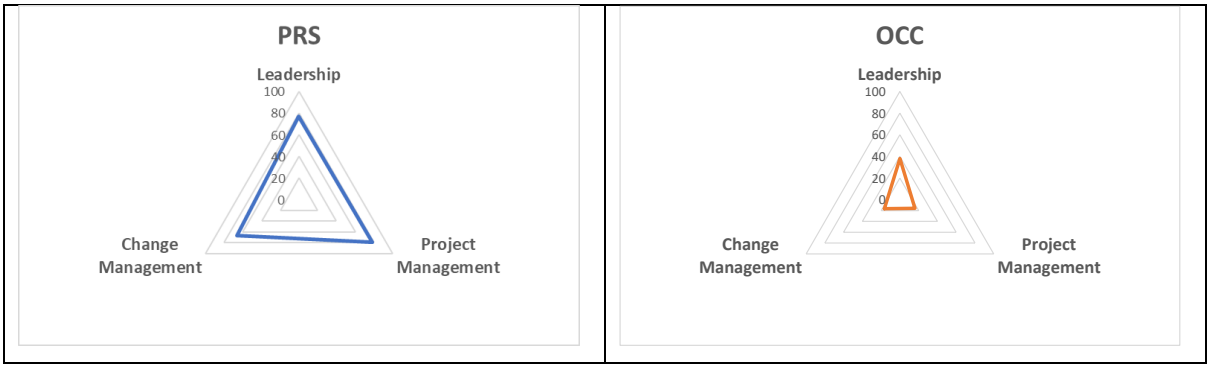
Case studies further highlighted that broader workplace issues, including harassment and bullying, continue to be prevalent and require stronger, more targeted interventions. Additionally, not all staff uniformly accept or understand the categorization of certain behaviours as inappropriate, underscoring the need for ongoing awareness-raising and behavioural change initiatives.

The Prosci® PCT™ assessment (see **Figure 8**) found that the PASM initiative is supported by strong leadership and effective project management, both of which are universally recognized across the organization. Although a change management approach is in place, the assessment identified several areas for improvement to enhance the initiative's overall effectiveness.

In contrast, the Organizational Culture Change initiative is still in the strategy development phase. While it received its highest scores (**Figure 8**) in the area of leadership, reflecting a degree of support from senior management, significant opportunities for improvement remain. In particular, the absence of a formal project plan resulted in low scores for both project management and change management, which were identified as high-risk components in the assessment.

***Figure 7: PCT Scores***

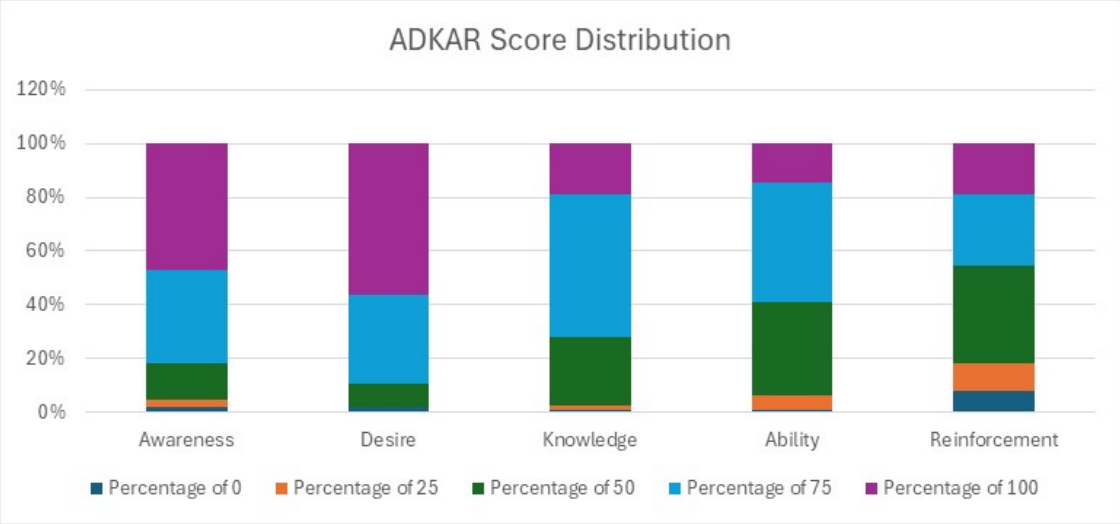
| **0–50: Indicates potential risks; the project may be at risk or in jeopardy.** | | |
|---|---|---|
| **51–75: Suggests the project is progressing but has notable areas for improvement.** | | |
| **76–100: Reflects a strong position for success, with key elements of the project well in place.** | | |
| | **PRS** | **Organizational Culture Change (OCC)** |
| **Leadership** | 77 | 32 |
| **Project Management** | 78 | 16 |
| **Change Management** | 66 | 17 |




The ADKAR Assessment focused specifically on the implementation of the PASM initiative and was administered via an online survey to PRS Focal Points (n = 110). As illustrated in **Figure 9**, the assessment reveals encouraging momentum for change among PRS Focal Points at WHO. High levels of *awareness* and *desire* indicate a strong ethical commitment and a clear understanding of the need for organizational transformation in the prevention of and response to sexual misconduct.

While *knowledge* levels are also relatively strong, the assessment highlights notable gaps in *ability* and, most significantly, in *reinforcement*. These areas will require targeted attention to sustain progress and translate individual commitment into systemic change.

***Figure 8: ADKAR Score Distribution***

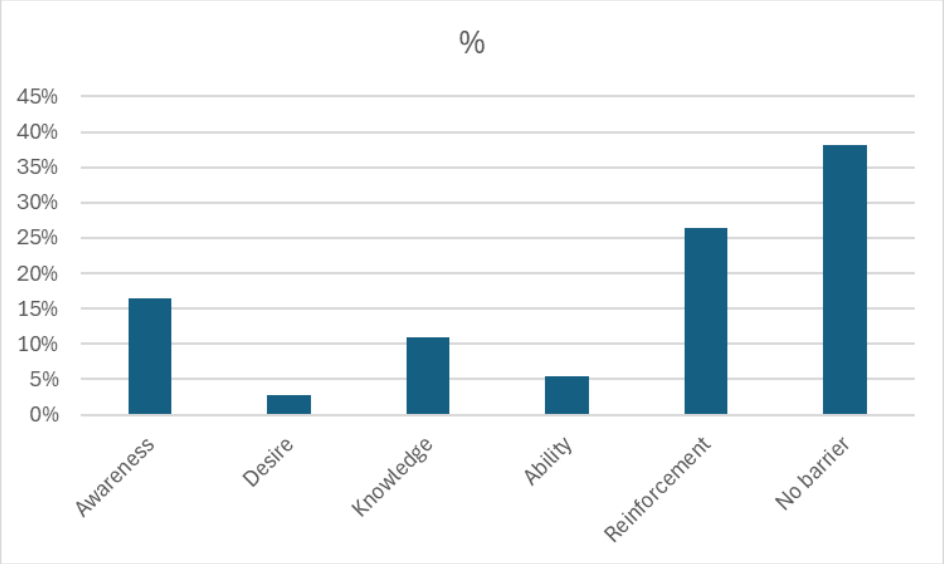



| | Awareness | Desire | Knowledge | Ability | Reinforcement |
|---|---|---|---|---|---|
| **Percentage of 0** | 2% | 2% | 1% | 1% | 8% |
| **Percentage of 25** | 3% | 0 | 2% | 5% | 10% |
| **Percentage of 50** | 14% | 9% | 25% | 35% | 36% |
| **Percentage of 75** | 35% | 33% | 53% | 45% | 26% |
| **Percentage of 100** | 47% | 56% | 19% | 15% | 19% |
| **Average Score** | 81 | 86 | 70 | 67 | 60 |

To sustain and institutionalize progress, greater emphasis is needed on practical support mechanisms, sustained leadership engagement, targeted resource allocation, and the formal recognition of PRS-related efforts. Addressing these gaps will be essential to transforming individual commitment into systemic, long-term cultural change across the organization.

The Barrier Point Analysis[11] (see **Figure 10**) further reinforces the finding that *reinforcement* is the area most in need of improvement to enhance the effectiveness of PRS Focal Points in driving change. Encouragingly, 40% of respondents reported encountering no significant barriers to implementing change, indicating a solid foundation of motivation and readiness upon which further progress can be built.

***Figure 9: ADKAR Barrier Point Analysis***




### 4.3.6 Best practices: Has the PRS integrated best practices, identified challenges and mitigations and any gaps in policies and plans?

| Rating | HQ | RO/CO | Others | Total | | Adequate |
|---|---|---|---|---|---|---|
| | 71.4 | 80.6 | 75 | 76.5 | | |
| **Finding**: WHO benefited from incorporating best practice of others into its early response. As the initiative progressed, WHO is now generating their own best practices that can be of benefit to the larger UN community (and others). | | | | | | |

According to interviews, WHO's efforts are strongly aligned with global best practices, particularly in policy design, victim- and survivor-centred approaches, and training. This is in part because WHO was "late to the party" and could draw on the work of other UN agencies in this area. The approach on policy was seen by some to be innovative, combining SEA and SH under Sexual Misconduct (SM).

WHO has also developed their own good practices. Examples of best practice include supporting regional meetings, communities of practice and annual stakeholder consultations, podcasts, and using case studies in trainings.

Regarding gaps in policies, interviews indicate that there is an awareness that the policy will need to be revised periodically. A few respondents indicated a desire to see WHO take a more leadership role

[11] Barrier Point Analysis is based on individual responses, and any response to any of the five elements that is rated 50 or below. If there are more than one ADKAR element this is rated 50 or less, it is the first element in the ADKAR continuum that is the barrier point.

in joint UN approach activities, stating that for recruitment ClearCheck is the bare minimum and more could be done, as well as with IPs.

### 4.3.7 Communications: How well does WHO communicate 1) expectations (zero tolerance), 2) the written policies, 3) the recourse mechanisms, and 4) the safety/non-retaliatory nature of such mechanisms?

| Rating | HQ | RO/CO | Others | Total | | Adequate |
|---|---|---|---|---|---|---|
| | 81.3 | 77.5 | NA | 79.2 | | |
| **Finding**: WHO communicates well on the subject of PRS. The responses were often inter-twined with other corporate policies such as retaliation which is less well understood. An area that needs strengthening is communications with communities. | | | | | | |

Interviews indicate that WHO has been effective in communicating expectations and core policies related to sexual misconduct, particularly through frequent messaging, training, and visible leadership engagement, especially around its "zero tolerance" stance. However, there is an inconsistent understanding across the organization of what "zero tolerance" concretely entails. Moreover, mechanisms for recourse, particularly non-retaliation assurances, are less well understood and, in some contexts, less trusted.

The quality and clarity of communication vary significantly by context, geographic location, and the visibility of local leadership. While communication is a shared institutional responsibility, the Director of PRS was frequently cited in interviews as a particularly strong and effective communicator on these issues.

Survey responses echoed many of the concerns identified in interviews. Qualitative feedback revealed widespread apprehension around the fear of retaliation, with several respondents expressing a lack of confidence in the effective implementation of anti-retaliation policy measures. Concerns were also raised regarding the reporting process, with a general perception that investigations remain slow and lack transparency.

There is considerable evidence of WHO's investment in communication across a range of platforms and formats. Examples include:

- 29 podcasts developed and published on the WHO website;
- 9 newsletters issued between 2021 and 2023;
- Annual webinars on various aspects of PRSEAH, with consistent delivery of four per year, with 7,112 participants in 2024 and 9,362 in 2023;
- Four "open door" sessions with accountability functions held in 2024, attracting 3,000 staff;
- A well-maintained WHO website and intranet with accessible resources, briefing materials, background information, and training tools;
- 17 face-to-face, virtual, regional, and country-level missions or hybrid events in 2024, involving over 1,000 participants; and
- Two annual stakeholder conferences focused on PRSEAH engagement and progress.

Data from the WHO component of the UN PSEA surveys reveal mixed results regarding communication with affected communities. Between 2020 and 2024, there was a 10.7% increase in respondents who *strongly agreed* or *agreed* that internal communication on how and where to report incidents of SEAH had improved. However, the same period saw a 14.9% decrease in positive

responses regarding the clarity of information provided to communities at duty stations on how to report SEAH allegations, indicating a need for more targeted community engagement and external communication strategies.

### 4.3.8 Monitoring and evaluation: Is there a monitoring and evaluation framework for the Strategy and is data collected as identified (frequency), and reported for decision-making?

| Rating | HQ | RO/CO | Others | Total | | Adequate |
|---|---|---|---|---|---|---|
| | 83.3 | 71.9 | 75 | 76.7 | | |
| **Finding**: There is a strong reporting function in the PRS Department, based primarily on the implementation of the 3-year strategy and close oversight by IEOAC, and reporting to Governing Bodies and Member States. See also findings under 4.3.4.j). | | | | | | |

The PRS Department has established a strong reporting function, anchored in the implementation of the three-year strategy and supported by close oversight from the IEOAC. PRSEAH is now a standing item on the agenda of WHO's Governing Bodies, and reporting lines are well-defined:

- The IEOAC reports to the Programme, Budget and Administration Committee (PBAC) of the Executive Board;
- The IEOAC also reports to both the Executive Board (EB) and the World Health Assembly (WHA);
- The Director-General reports to the EB, WHA, and the UN Secretary-General;
- The Office of Internal Audit reports to the WHA; and
- The PRS Department reports directly to the DG and provides quarterly updates to Member States.

A Theory of Change (ToC) underpins the PRS strategy and serves as the basis for monitoring and evaluation. However, the assessment found that the ToC would benefit from refinement. Specifically, many of the results categorized within the sphere of influence are better classified as *immediate outcomes* in a standard logic model but are currently framed in overly aspirational terms. While key performance indicators (KPIs) are being tracked, the strategy lacks a standalone performance measurement framework, which would be essential for a comprehensive evaluation.

In terms of external oversight and evaluation, several major assessments have been conducted or are underway:

- MOPAN completed its assessment in 2024;
- The JIU is expected to finalize its review in 2025;
- An independent evaluation of PRSEAH in Emergencies was published in May 2025; and
- The current stocktaking exercise provides further insight into implementation progress.

Although an evaluation of the broader PRS initiative is planned for 2025, given the extensive scrutiny the initiative has already undergone, consideration could be given to postponing this evaluation to a future stage when more mature results are available for review.

## 4.4 Findings related to Pillar 4: Resource and Sustainability

### 4.4.1 Sustainability: Are the activities developed, led and delivered by PRS sustainable?

**a) If the PRS department were to disband, would the policies continue to be implemented, processes and procedures followed?**

While PRS policies and structures are partially institutionalized, most respondents believe that implementation would falter and in some cases regress if the PRS department were disbanded at this stage. At this point there needs to be a proactive leader who retains focus on PRS, continued training and support.

Interviews, case studies and the survey delivered the same finding. There is a strong consensus that sustained leadership, visibility, dedicated personnel, and funding are still essential. Without these, momentum could be lost, and PRS risks being deprioritized or inadequately implemented across the organization. This can be exacerbated given the competing priorities during a time when WHO is facing deep and significant budget cuts.

Qualitative responses from the survey indicated that given the current resources climate, there is concern that PRS will not be sustained without dedicated financial resources for personnel (i.e., focal points) and buy-in from management and top leadership. While it is agreed that PRS is a collective responsibility and should not fall on the focal points alone to effect change, culture change requires sustained effort, particularly as it manifests around the world in diverse cultures and contexts. Continued and increased engagement with Member States is seen as a key, which will also take sustained effort. A final motivating factor notes that internal progress fosters external progress concerning Member State governments, implementing partners, and communities.

**b) What must occur to ensure institutionalization and sustainability?**

Interviews, case studies, and survey findings consistently identified several key elements required to ensure the institutionalization and long-term sustainability of the PASM initiative:

- Integrate PASM into core business functions, including incorporation into the eManual, staff performance management systems (e.g., evaluations), organizational workplans, and contracts with non-state actors (NSAs);
- Embed PASM into project and programme planning where relevant, to ensure it is systematically considered across operational areas;
- Foster broader organizational culture change, addressing all aspects of a healthy workplace and reinforcing this through senior leadership support, continuous learning, training, and implementation assistance;
- Maintain clear leadership and ownership of PASM, with continued positioning of the PRS Department as the central coordinating entity;
- Ensure predictable and sustained core funding, maintaining levels consistent with current allocations to support continuity and capacity; and
- Adapt approaches to reflect complex cultural contexts, ensuring sensitivity and relevance in diverse operating environments.

### 4.4.2 Financial: Is there a consistent level of resourcing to maintain existing infrastructure and activities for PRS strategy implementation?

| Rating | HQ | RO/CO | Others | Total | Adequate |
|---|---|---|---|---|---|
| | 75 | 75 | NA | 75 | |
| **Finding**: To date there has been consistent resourcing, although lower than originally committed. The current budget cuts, however, will require adjustments that are not clear at the time of this report. | | | | | |

There is broad support and commitment to PASM strategy implementation. While resourcing has been significant, there is now considerable uncertainty due to current financial constraints and changing donor dynamics. While core funding and dedicated budget lines exist, sustainability and integration into long-term organizational planning remain key concerns. At the same time this will remain a key focus for many donor countries.

### 4.4.3 People: The PRS includes the PRS Department, PRS Focal Points, and Field Coordinators. Is there sufficient staffing of PRS and with the requisite knowledge, skills, and abilities?

| Rating | HQ | RO/CO | Others | Total | Good but areas for improvement |
|---|---|---|---|---|---|
| | 63.9 | 72.9 | NA | 69 | |
| **Finding**: To date the people resources have been good although there can be gaps in finding the right expertise, and some country level part-time focal points may not be able to allocate as much time to PASM as is needed. | | | | | |

According to the document review, the PRS Department comprises four full-time staff members, supported by consultants. There are currently six PRS Coordinators at the P5 level based in Regional Offices and 15 PRS Focal Points at the P4 level positioned in priority high-risk countries, including the Central African Republic, Democratic Republic of the Congo, Ethiopia, Nigeria, South Sudan, Bangladesh, Afghanistan, Pakistan, Somalia, Sudan, Syria, Yemen, and Venezuela. In total, approximately 413 PRS Focal Points are active globally, with 155 of WHO's 175 offices having at least one part-time PRS focal point. PRS resources have also contributed to supporting investigators within the IOS and IASC PRSEAH Coordinators.

Interview feedback suggests that WHO maintains a moderate to high level of staffing and technical expertise for PASM, particularly at headquarters and in select high-risk country offices. However, notable gaps persist, especially at the field level, in areas such as implementation capacity, technical specialization, and staffing continuity. Many PRS Focal Points are "double- or triple-hatted," leading to what was described as "time poverty," which limits their ability to fully engage with PRS responsibilities. Despite opportunities to develop skills and share best practices, capacity and expertise also vary across regions.

While some respondents viewed WHO's level of PRSEAH staffing and resourcing as strong, especially in comparison to other UN agencies, it was also recognized that WHO is a large and decentralized organization. As such, the existing resource levels were considered appropriate, though continued investment will be required to sustain progress and close remaining gaps.

### 4.4.4 Technology: Technology refers to any non-existing corporate software, hardware or web presence that is required to achieve the results of the Strategy. Are there adequate technology resources for achieving the results of the Strategy?

| Rating | HQ | RO/CO | Others | Total | | Good but areas for improvement |
|---|---|---|---|---|---|---|
| | 50 | 75 | NA | 65 | | |

**Finding**: There can be some technological barriers with community-facing programmes and engagement (e.g. hotline accessibility, general connectivity). There is also a recommendation to assist case management by implementing an electronic tracking system of the E2E IMS.

According to interviews, technological resources to support PRS implementation are considered moderately adequate, particularly at WHO headquarters and regional levels. These levels benefit from robust tools for communication, learning, and reporting. However, significant gaps remain at the country and community levels, especially concerning context-specific accessibility, digital inclusion, and trust in reporting mechanisms.

Community-level reporting presents particular challenges. Respondents highlighted the absence of functional, accessible complaint mechanisms at the local level. Common issues include integrity hotlines that are not trusted or reachable, the use of international phone numbers or non-local languages, and barriers related to low literacy or poor internet connectivity in certain communities.

Despite these challenges, there is high satisfaction with WHO's PRS-related digital tools and platforms. Respondents positively referenced the PRS website, podcasts, dashboards, and learning platforms such as the Learning Passport. Digital training modules, risk assessment tools, and webinars were also viewed as effective and valuable.

Several interviewees noted the need for dedicated incident management software. This concern was reinforced by the document review, which identified the absence of a comprehensive incident management system as a major risk to effective PRS implementation.

# 5.0 Conclusions

## 5.1 Overview

Drawing on interview ratings collected during the stocktaking exercise, the overall status of PASM strategy implementation is summarized in **Figure 11**.

To date, WHO has demonstrated a strong commitment to achieving and upholding a zero-tolerance approach to sexual misconduct. While there are early indications of progress, these initial gains require sustained effort, continued investment, and ongoing monitoring and oversight to ensure long-term impact and institutionalization.

***Figure 10: Overview of stocktaking ratings***

| None | Inadequate | Good but Requiring More | Adequate | Exceptional |
|---|---|---|---|---|
| | | | | |
| # | 1 | 15 | 19 | 2 |
| % | 2.7% | 40.5% | 51.3% | 5.4% |

| Pillar 1 Governance/ Strategy | | Pillar 2 Policy | | Pillar 3 Implementation | | Pillar 4 Resources | |
|---|---|---|---|---|---|---|---|
| 1.1 Leadership | 90 | 2.1 Policy | 84 | 3.1 PRS Implementation Plan | 75 | 4.2 Financial* | 75 |
| 1.2 Coordinated Response | 67.3 | 2.2 Supportive policies | 81 | 3.2 Implementation Plan – supportive policies | 48 | 4.3 People | 69 |
| 1.3 Emergency/ Humanitarian | 75 | 2.3 Emergency/ Humanitarian | 77.6 | 3.3 Emergency/ Humanitarian | 70 | 4.4 Technology | 65 |
| 1.4 Division of Labour | 65 | 2.4 Accountabilities | 81.7 | 3.4.a transparency and accountability | 88 | | |
| 1.5 Working Groups | 75 | 2.5 Compliance | 73.5 | 3.4.b VSCA | 65 | | |
| 1.6 Strategy | 92 | | | 3.4.c institutionalize | 79 | | |
| 1.7 Strategic Alignment | 77 | | | 3.4.d culture change | 63 | | |
| 1.8 Compliance | 67 | | | 3.4.e prioritize high risk | 78 | | |
| | | | | 3.4.f strengthen systems risk | 68 | | |
| | | | | 3.4.g build capacity | 75 | | |
| | | | | 3.4.h E2E IMS | 61 | | |
| | | | | 3.4.i (a) engage governments | 61 | | |
| | | | | 3.4. (b) collaborate UN | 84 | | |
| | | | | 3.4.j Lessons learned | 77 | | |
| | | | | 3.5.a VSCA result | 68 | | |
| | | | | 3.5.b policy result | 68 | | |
| | | | | 3.5.c system result | 65 | | |
| | | | | 3.5.d culture change result | 60 | | |
| | | | | 3.6 Best Practices | 77 | | |
| | | | | 3.7 Communications | 79 | | |
| | | | | 3.8 Monitoring and evaluation | 77 | | |

## 5.2 Conclusion by Pillar

**Conclusions on Pillar 1: Governance and Strategy**
WHO has made substantial progress, over a brief period**,** in establishing a strong governance and strategic foundation for the Policy on the Prevention and Response to Sexual Misconduct (PASM)**.** The organization is now recognized as a leader in the UN system in this area, amongst others, notably through the appointment of a dedicated PRS Director and the adoption of a comprehensive 3-year strategy for implementation of PASM**.** Governance structures, such as oversight by the Director-General, the IEOAC, the Executive Board, and the World Health Assembly**,** provide high-level backing and legitimacy.

The strengths include leadership (rated 90), strategy (rated 92), integration into emergency operations (rated 75) and strategic alignment (rated 77). Areas for improvement include:

- **Interdepartmental Coordination (rated 67):** While structures such as bi-weekly accountability meetings exist, implementation remains inconsistent. Departmental silos, unclear roles (especially HR, IOS, Ombudsman), and competing priorities hinder consistent decision-making.
- **Division of Labour (rated 65):** Responsibilities are well-defined in policy (e.g., PASM, accountability framework), but clarity and enforcement vary by level and region. Confusion remains in some areas, especially in field operations and emergency contexts.

**Conclusions on Pillar 2: Policy**
WHO has established a comprehensive and up-to-date policy framework to support the prevention and response to sexual misconduct, anchored by the 2023 Policy for PASM. The PASM policy is well-regarded**,** integrating the latest standards and unifying SEA and SH under a single framework. This innovative approach is seen as a key strength of WHO's policy landscape.

Supporting policies, including the Code of Ethics, Policy on Retaliation, Policy on Abusive Conduct**,** and the Legal Framework for Standards of Conduct, have been recently revised and broadly support PASM**,** reinforcing a shared commitment to accountability, ethics, and safeguarding. Together, these create a robust policy environment that supports the organization's PASM agenda.

Overall, the elements assessed all were rated as adequate. The key strengths include having a comprehensive primary policy (PASM) (rated 90), supporting policies (rated 80), integration into emergency operations (rated 78), and the accountability framework (rated 82).

Identified areas for improvement involved issues of implementation and the policy environment. This is further elaborated on under Pillar 3.

**Conclusions on Pillar 3: Implementation Management**
WHO has made measurable progress in implementing the PASM agenda across multiple operational areas, supported by a strong policy foundation, a dedicated department, earmarked core funding, and increased strategic attention at all levels of the organization. However, the overall picture of implementation management is mixed, reflecting both significant achievements and notable gaps that continue to limit full and effective execution. This is not unexpected as the successful

implementation of PASM requires organizational culture change, and that requires sustained effort, resources and leadership.

The strengths to date include implementation planning at HQ (rated 75), transparency and accountability measures (rated 88), institutionalized safeguarding (rated 79), capacity building efforts (rated 75), and the use of best practices and monitoring and evaluation (both rated 77).

Given the expansive nature of implementation, there are a number of areas for improvement identified:

- **Implementation of supportive policies (rated <50)** lags behind PASM and lacks dedicated planning, resources, and ownership.
- **Integration in emergency operations (rated 70)**, while structurally present, remains inconsistent and highly context-dependent, often constrained by politics, resources, or the limitations of Member State partnerships. There is a call for better operational coordination between the PRS Department and WHE.
- **Victim- and survivor-centred approaches (VSCA) (rated 65)** are not yet consistently operationalized, especially in field contexts, with key gaps in case management systems, and protection from retaliation.
- **Organizational culture change (rated 63)** while initiated, is fragile and not yet holistic. Broader ethical, behavioural, and gender-equal workplace reforms remain at preliminary stages.
- **End-to-end incident management system (rated 61)** still faces delays and fragmentation in case tracking and investigation.

**Conclusions on Pillar 4: Resources and Sustainability**

While considerable progress has been made and there are encouraging signs of PASM becoming institutionalized, there remains a risk that these gains could be eroded if momentum and organizational attention decline. At its core, PASM is about driving meaningful culture change, an effort that not only addresses sexual misconduct but also contributes to preventing other forms of inappropriate behaviour. Sustaining this progress requires a holistic, organization-wide approach that reinforces shared values, accountability, and a respectful workplace culture at all levels.

Given the current uncertain budgetary situation at WHO, the stocktaking does not make any recommendations in terms of resources except to reiterate that the PRS initiative is still fragile and while progress has been made, the sustainability of that change requires a continued, and deeper organizational culture change. That will take sustained effort, resources and leadership at all levels of the organization.

# 6.0 Recommendations

WHO's governance and strategy framework for PASM is strong and maturing, with exceptional leadership, a robust strategy, and formal mechanisms for emergency integration. However, coordination, role clarity, and compliance enforcement remain uneven, particularly at regional and country levels. To sustain impact, it is essential that WHO keeps focusing on collaboration, resources, and adapting efforts to country/mission realities in priority settings.

WHO's PASM and PASM-related policies are substantively strong, current, and well-aligned, but effectiveness is uneven due to implementation and contextualization gaps. Ongoing efforts should focus on strengthening awareness and implementation of accountability at all levels, improving operational clarity and implementing partner compliance, and ensuring policies are adapted and enforceable in diverse settings, particularly in emergencies.

The implementation management of WHO's PRS strategy is adequate with some areas for improvement.

Strong headquarters-led planning and transparency structures support progress, but these must be complemented by greater consistency, contextual adaptation, and operational integration, especially in humanitarian and partner-facing settings. The next phase of work must focus on continued institutionalization of knowledge and practices, accelerating and sustaining culture change, and closing gaps in victim/survivor support mechanisms to fully realize the ambitions of the PRS framework.

Based on the findings outlined above and throughout this report, the stocktaking exercise proposes the following recommendations:

1. **Assign a single unit with clear senior leadership for the full implementation of supporting policies (PAAC and PAR) using the same successful approach that was used for implementation of the Prevention and Response to Sexual Misconduct (PASM) policy**
   This recommendation should integrate the following components:
   a) consider best practices drawn from the implementation of the PASM policy and PRSEAH Strategy;
   b) consider effective and efficient use of resources in a constrained financial landscape;
   c) use a project management and change management approach as was used for the implementation of the PASM policy; and
   d) accelerate the organizational culture change strategy implementation to fully support the sustainability of this work.

2. **Prioritize Operational Coordination with WHE**
   Strengthen the operational coordination between the WHO Health Emergencies (WHE) Programme and the Prevention and Response to Sexual Misconduct department (PRS), at the three-levels of the Organization, particularly in implementing the PRSEAH components of the Emergency Response Framework (ERF). This would help avoid duplication, clarify roles and responsibilities, and ensure that high-risk contexts remain a top priority.

3. **Build on the effective risk management approach for minimizing risks in WHO's operations including by:**
   a) collaborating within the UN system to more clearly define the scope and limits of accountability for WHO and other UN agencies in relation to Implementing Partners and Member States;
   b) strengthening implementing partners' capacity for safeguarding from SEAH; and
   c) intensify support to host governments/Member States for safeguarding during joint WHO-government operations as per the Member States Accountability Framework for PRSEAH.

4. **Maintain Organizational Standing for PRS work**
   Retain the current structural positioning of the PRS Department for the short term (2–3 years) and maintain the current level of core resourcing for sexual misconduct prevention and response work. Doing so will continue to signal strong leadership and senior management commitment to PRS as an organizational priority.

5. **Plan for accelerated institutionalization of the PASM policy and PRS work**
   Ensure that the next phase of the PASM strategy includes a clear roadmap for transitioning PRS efforts into an integrated model of implementation monitoring and ensuring full institutionalization and accountability across the Organization.

6. **Strengthen IOS Resourcing for Investigations**
   Provide the Office of Internal Oversight Services (IOS) with adequate resources, capacity development and an effective case management system to reduce and monitor investigation timelines and integrate victim/survivor-centred approaches. Without improvements in this area, the sustainability of not only PASM, but broader organizational change efforts, will remain at serious risk.

**Annexes in Volume 2 (under separate cover)**

Annex A: Terms of Reference

Annex B: Stocktaking Tool

Annex C: Master Interview Guide

Annex D: List of Documents

Annex E: Online Survey