



CARING FOR CHILD SURVIVORS OF SEXUAL ABUSE GUIDELINES

SECOND EDITION



Cover Photo: UNICEF/Jill Connelly/Democratic Republic of the Congo, 2010

Published by UNICEF Child Protection Section (GBViE) Programme Division
3 United Nations Plaza New York, NY 10017

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Suggested citation: United Nations Children's Fund (UNICEF) and International Rescue Committee (IRC), "Caring for Child Survivors of Sexual Abuse Guidelines", Second Edition, UNICEF, New York, 2023.

This publication was possible thanks to the partnership with the Deutsche Gesellschaft für Internationale Zusammenarbeit (GIZ) GmbH, under the generous support of the Bundesministerium für Wirtschaftliche Zusammenarbeit (BMZ).

ACKNOWLEDGEMENTS

In 2012, the United Nations Children's Fund (UNICEF) and the International Rescue Committee (IRC), developed the first edition of the Caring for Child Survivors of Sexual Abuse (CCS) Guidelines with support of an interagency technical review panel comprised of gender-based violence and child protection experts. The Guidelines aimed to respond to a gap in global technical guidance on providing a model of quality care for children and families affected by sexual abuse in humanitarian settings.

After more than ten years of implementation and based on requests from field-level service providers, UNICEF and IRC, with the support of the German Corporation for International Cooperation GmbH (GIZ) and with generous funding from the German Federal Ministry of Economic Cooperation and Development (BMZ), initiated the revision of the Caring for Child Survivors materials and tools. Extensive field consultations were carried out with over 250 experts worldwide, consultations that provided the guiding thread for the revision process and the development of the new guidelines and training package.

The new guidance includes both revisions and content additions based on practitioner feedback, the most recent evidence and learning. The second edition aims to bring a stronger focus on gender inequality, intersectionality, as well as the connections between the best interests of the child and a survivor-centered approach.

The revised Guidelines were drafted by Jennifer Lee (IRC), Gretchen Emick (IRC), Elisabeth Roesch (UNICEF), Meghan O'Connor (UNICEF), under the leadership of Alexia Nisen (UNICEF), Caroline Masboungi (UNICEF) and Catherine Poulton (UNICEF). In this task, they were supported by the UNICEF and IRC teams in South Sudan (UNICEF/IRC), Afghanistan (UNICEF), Yemen (IRC) and Nigeria (IRC) who participated in the testing and review of content. These pilots greatly contributed to keep the voice of the frontliners at the heart of the revision process.

UNICEF and IRC would also like to thank the members of the Advisory Board for their time and engagement: Samar Abdelrahman, Tamara Akinyi Obonyo, Amel Amir Ali, Cristina Baron Porras, Lauren Bienkowski, Lourdes Carrasco, Leigh-Ashley Lipscomb, Stefanie Lorin, Kloelupho Mongkhonphob, Luz Angela Obando Montenegro, Tamalar Paw, Fabian Alberto Pacheco, Castañeda, Colleen Dockerty, Abigail Erikson, Yang Fu, Marcio Gagliato, Emily Krasnor, Joyce Mutiso, Kate Rougvie, Maria Semaan, Albert Wambua, Dr. Ajwang Warria, Mu Wee.

Several experts from within UNICEF and IRC, in addition to the Advisory Board, shared their knowledge and experience: Dorcas Ahinfowe Erskine, Caoimhe Bhaird, Emmanuelle Compingt, Ahmed Ghanem, Tasha Gill, Farah Hammoud, Afrooz Kaviani Johnson, Anna Koehorst, Sinéad Murray, Salimata Ndoye, Sunita Palekar Joergensen, Aditi Shrikhande Chemba Raghavan, Lorenza Trulli from UNICEF and Jerry Abdala Kulelemba, Yvonne Agengo, Annalisa Brusati, Cat Byrne, Sarah Cornish-Spencer, Patricia Gray, Mehreen Jaswal, Meghana Kulkarni, Sophia Ngugi, Tizita Tekletsadik, Pauline Thivillier from IRC.

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INTRODUCTION

Sexual abuse perpetrated against children is one of the most significant crises of our time.¹ Child sexual abuse is a significant risk factor for children, in common with other forms of child maltreatment.² Sexual abuse can have severe short- and long-term consequences on the physical, mental, social, emotional and economic well-being of children, families and communities.³ In emergencies, the threat of all forms of child abuse and gender-based violence (GBV), including child sexual abuse, is acute and widespread.

At the heart of all child sexual abuse cases is a child at a specific developmental and chronological point in their life who holds various social identities defined by the context in which they live. All these factors, combined with the individual experiences of the child, impact their risk, needs and ability to seek and access services following an incident of sexual abuse. This, along with the many professional disciplines involved in responding to child sexual abuse in any setting, makes responding to child sexual abuse challenging.⁴

The primary responsibility to protect and care for child survivors of sexual abuse lies with the State, including in humanitarian settings. When the State is unable or unwilling to take on this responsibility, it often sits with non-governmental actors in the GBV and child protection (CP) sectors. GBV and CP service providers should work with child survivors of sexual abuse (and caregiver/family where appropriate) to understand their needs and inform them of all available service options – a process called case management. As the main focal points of this process, caseworkers plan, seek, advocate for, coordinate and monitor the services a child (and/or caregiver/family) chooses to engage in, providing them with emotional support throughout the process.

The goal of the Caring for Child Survivors of Sexual Abuse (CCS) resources is to ensure that young and adolescent girl and boy survivors of sexual abuse (hereinafter referred to as “child survivors”) and their non-offending caregivers get the best possible care. It lays out standards for service providers and more specifically caseworkers to provide high-quality care to child survivors of sexual abuse and their non-offending caregivers so that they can ultimately recover and heal. The original guidelines and accompanying training materials were developed in 2012. After more than ten years of implementation, the United Nations Children’s Fund (UNICEF), in partnership with the International Rescue Committee (IRC) and with the support of the German Corporation for International Cooperation GmbH (GIZ), present this second edition with revisions and new content based on learning and practitioner feedback.

¹ Together for Girls, The Equality Institute and Oak Foundation, What Works to Prevent Sexual Violence Against Children: Evidence Review, 2019.

² Tischelman, A. C. & Geffner, R., ‘Forensic, Cultural, and Systems Issues in Child Sexual Abuse Cases – Part 1: An Introduction’. Journal of Child Sexual Abuse, 19(5), 2010, p. 485-490.

³ WHO, Responding to Children and Adolescents Who Have Been Sexually Abused: WHO clinical guidelines, World Health Organization, 2017.

⁴ Ibid.

THE CARING FOR CHILD SURVIVORS OF SEXUAL ABUSE RESOURCES

The Caring for Child Survivors of Sexual Abuse resources articulate the knowledge, attitudes and skills necessary for CP caseworkers, GBV caseworkers and other relevant service providers working with child survivors of sexual abuse (including non-binary children and adolescents).

The resource package includes these CCS Guidelines (the Guidelines) and the CCS Training (the Training). The Guidelines provide caseworkers and other relevant service providers with guidance on caring for child survivors of sexual abuse in humanitarian settings. The Training brings the content of the Guidelines to life and provides a space to dive deeper into the core knowledge areas, attitudes and skills through discussion and practical exercises. They should be used together – the Training has been designed to provide caseworkers with an opportunity for practical application of key concepts covered in the Guidelines.

The primary target audience for the CCS resources is staff who provide CP and/or GBV case management services in humanitarian settings. Any humanitarian actor with a specialisation in children, gender and health (in particular, clinical management of rape) can also benefit from the CCS resources. Other relevant service providers involved in the care of child survivors of sexual abuse, including health workers, legal actors and mental health professionals, can also benefit.

What has changed in the second edition?

This second edition integrates learning and feedback, strengthening the original CCS resources in the following ways:

- » centres awareness of gender inequality;
- » centres the best interests of the child and a survivor-centered approach;
- » promotes an intersectional approach;
- » provides updated CCS tools to reflect guidance changes;
- » provides links to new resources.

CARING FOR CHILD SURVIVORS THEORY OF CHANGE AND INTENDED OUTCOMES

The technical guidance outlined in this document draws from the CCS theory of change (see *Figure 1 below*). The CCS theory of change posits that child survivors can be supported in their recovery and healing from sexual abuse with child-centred compassionate and appropriate care and treatment. The theory of change outlines the key elements of care and treatment and the knowledge, skills and attitudes required for caseworkers and other relevant service providers to be able to provide such care.

CARING FOR CHILD SURVIVORS THEORY OF CHANGE

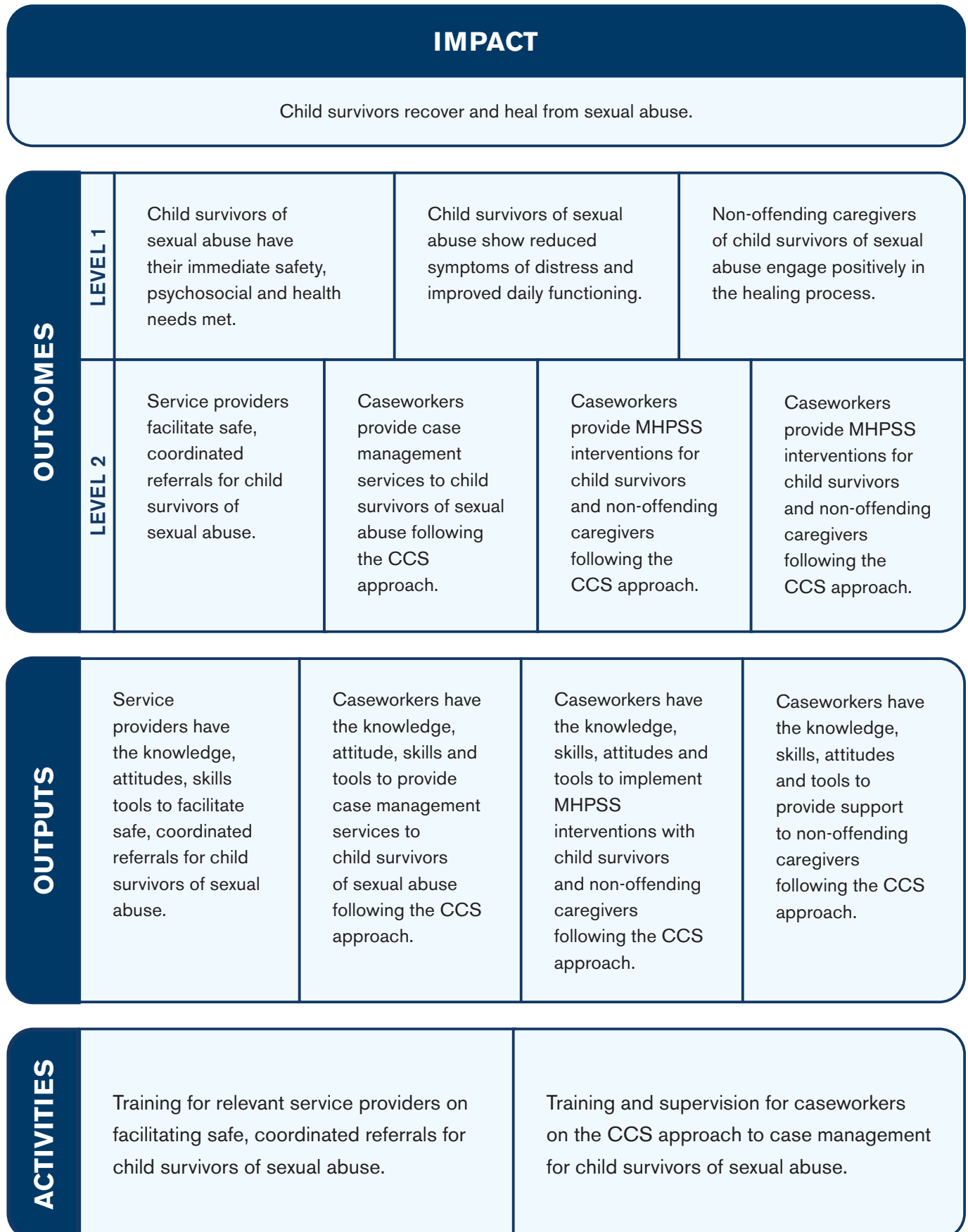


Figure 1: Theory of Change

USING THE GUIDELINES

While the Guidelines are grounded in a case management approach, they are not intended to replace or supersede existing CP or GBV case management approaches or existing government social services. Rather, they provide considerations specific to child survivors of sexual abuse that should be integrated into any existing case management services.

The Guidelines are:

- » designed solely to provide care and response services for child survivors of sexual abuse and to support their families;
- » a tool for providing case management and mental health and psychosocial (MHPSS) support for child survivors of sexual abuse and their families;
- » relevant to services for children under the age of 18, however they will need to be adapted to a child's age, developmental stage, gender and other characteristics;
- » designed for use in humanitarian settings where relevant services are in place and agencies (national systems or humanitarian) meet the minimum requirements for providing case management services.

Limitations of the Guidelines

The Guidelines do not:

- » address treatment of perpetrators or prevention of sexual abuse despite evidence that direct intervention at the community level contributes to safer communities;
- » address other forms of GBV affecting girls – such as child and early forced marriage, female genital mutilation, honour killings – or other forms of violence affecting children more generally, such as forced labour or recruitment;
- » serve as a training manual. A separate CCS Training Package accompanies these Guidelines, also available online;
- » address community-based interventions (such as integrating child survivors of sexual abuse into child-centred spaces or community-based interventions to combat social stigma and discrimination). However, they do offer suggestions for making appropriate referrals to agencies that might support such interventions.

Specific considerations for integrating the Guidelines into GBV and CP programmes

Prior to providing services to child survivors of sexual abuse, CP and GBV teams must have existing programming aspects and procedures in place and experienced case management teams. To enable safe disclosures of sexual abuse and appropriate confidential responses, field agencies implementing these Guidelines must have:

- » an understanding of national child protection systems and how all children, regardless of their origin and legal status, can access them;
- » an understanding of the alternative care options for children within the context and any limitations to those options, considering gender, age and developmental stage;
- » an understanding of laws and policies relating to children and GBV, including mandatory reporting laws and/or policies in the context;
- » an agency-specific protocol to ensure the best interests of the child and the safety and security of the caseworker and other staff involved in the case;
- » established CP and/or GBV case management services (whether through existing national systems or by humanitarian actors) that meet the standards outlined in this document;
- » access to established wrap-around services for sexual violence (health, safety/security, legal, etc.) and/or be working with local partners providing safe and accessible services to GBV survivors and/or children facing broader protection concerns;
- » access to safe spaces with activities and programming specifically for children of different ages (through CP agencies or national systems) or activities and programming specifically for adolescent girls (through GBV agencies or national systems);
- » an understanding of the existing programming for adolescent girls within the context to appropriately address the multiple and compounding risks and types of violence, including child sexual abuse, that adolescent girls may face.

In addition, it is critical that service providers understand the issue of child sexual abuse in local context. Service providers should understand:

- » the local attitudes, beliefs, norms, practices and capacities in relation to child sexual abuse, as well as to children and gender more broadly;
- » the laws and policies that could impact a child survivor of sexual abuse (for example, mandatory reporting, legal age of marriage for girls, legal age for consent, etc.) and the risks and benefits associated with these;
- » the factors and actors that protect or pose risks to girl and boy survivors of sexual violence, including those of diverse sexual orientation, gender identity, gender expression and sex characteristics (SOGIESC) and/or those with disabilities;
- » the protective capacities of individuals or groups in the community who may play an important role in a child's healing.

Organisations can also use the *Caring for Child Survivors Case Management Minimum Standards for Service Providers* to evaluate their operational readiness for providing case management services to child survivors of sexual abuse.

Required training and competencies

Agency staff should already be trained and able to demonstrate competency in:

- » GBV or CP case management, including [UNHCR's 'Best Interests Procedures'](#) for asylum seeker and refugee children;
- » basic MHPSS support skills.

When agencies plan to undertake the Training and scale up CCS services, programme supervisors should also consider the qualities and attitudes of staff that will provide those services (see *Chapter 2* and *Chapter 3*).

OVERVIEW OF THE CHAPTERS

While the Guidelines are grounded in a case management approach, they are not intended to replace or supersede existing CP or GBV case management approaches or existing government social services. Rather, they provide considerations specific to child survivors of sexual abuse that should be integrated into any existing case management services.

Chapter 1

Outlines the Caring for Child Survivors approach which includes the **guiding principles, foundational theories and approaches** to working with child survivors of sexual abuse. It specifically addresses how to apply a survivor-centred and child-centered approach to this work.

Chapter 2

Outlines the **core knowledge** areas that caseworkers must have prior to working with child survivors of sexual abuse and their families.

Chapter 3

Supports caseworkers to develop the necessary **attitudes** to work with child survivors of sexual abuse. It also supports caseworkers to identify, reflect on and address **biases** that may be harmful to child survivors in all their diversity.

Chapter 4

Introduces best practices in **communication** with child survivors of sexual abuse and their families, including guidance on how to communicate with children and trusted caregivers about the experience of sexual abuse. This chapter also explains verbal and non-verbal techniques that can be used to help child survivors feel safer and more comfortable expressing themselves.

Chapter 5

Provides **considerations for navigating key issues** throughout the case management relationship with a child survivor of sexual abuse. This chapter explores how the best interests principle can be used to work through these issues.

Chapter 6

Provides detailed guidance on the **key tasks that are part of each step of the case management process**. Specific attention is given to assessment and intervention areas that are part of the case management process for child sexual abuse.

Chapter 7

Provides an overview of **best practices related to coordination** of child survivor cases across multiple service providers, including coordination/collaboration between CP and GBV case management actors.

Chapter 8

Provides guidance on how to integrate **supervision for caseworkers** working with child survivors of sexual abuse into existing CP and GBV case management supervision systems and practices.

GLOSSARY OF TERMS

The terms and definitions used in this Glossary are not legal definitions and are not intended as such.⁵ Terms defined in other resources and/or more commonly understood have not been included.

Adolescence	The period between ages 10 and 19 years. It is a continuum of development in a person's physical, cognitive, behavioural and psychosocial spheres. Can be subdivided into pre-adolescence (9–10 years), early adolescence (10–14 years), middle adolescence (15–17 years) and late adolescence ⁶ (18–19 years).
Adolescent	Any person between the ages of 10-19 years. The term 'adolescent' is not intended to replace the use of 'children' in the Guidelines, but provides an additional term to describe specific ages, maturation and life stages of individuals aged 10-19 years.
Caregiver	The person who is exercising day-to-day care for a child or children. He or she is a parent, relative, family friend or other guardian. This may apply to foster parents, including those who 'adopt' a child informally as well as those who do so formally. The term does not necessarily imply legal responsibility. In the Guidelines the term caregiver is used to also indicate a biological parent.
Case management	A systematic process in which a trained and supervised caseworker assesses the needs of a client and, when appropriate, the client's family. He or she then arranges, and sometimes provides, coordinates, monitors, evaluates and advocates for a package of multiple services to meet the specific client's complex needs. ⁷
Caseworker	An individual, employed by a service-providing agency, who provides case-management services to clients. Caseworkers are trained in client-centred case management, and they are supervised by senior programme staff. They adhere to a specific set of systems and guiding principles designed to promote safety, well-being, hope and healing for their clients. Caseworkers are also referred to as social workers, case holders, child protection workers and gender-based violence workers.

⁵ In an effort to ensure consistency, to the extent possible, some definitions have been taken directly from the IASC Guidelines on Gender-Based Violence Interventions in Humanitarian Settings. Other sources are referenced accordingly.

⁶ Despite late adolescence being the age of legal adulthood in most settings, it is included here because the ages of 18-19 are still characterized by a developing set of skills, particularly around critical reasoning, understanding, and decision-making.

⁷ National Association of Case Workers, [NASW Standards for Social Work Case Management](#), NASW, Washington DC, 2013.

Child	Any person under the age of 18. ⁸
Child development	The psychological, social, emotional, cognitive and physical changes that human beings undergo from birth to adulthood. Many scholars have identified different stages of child and youth development, which refer to the periods of time or age ranges during which changes are expected to take place. The ages associated with these changes will vary across individuals, and as such, stages of development are best understood on a continuum rather than a fixed timeline. ⁹
Child safeguarding	Preventative measures within an agency to protect children from deliberate or unintentional acts that increase risk of harm and ensure that the agency and its programmes are safe for children.
Child sexual abuse	There is no set definition of child sexual abuse. Therefore, these guidelines use: <i>Any form of sexual activity, physical or not, with a child, perpetrated by an adult or by another child who has power over the child. Child sexual abuse often involves body contact, but not always.</i>
Child survivor	A person under the age of 18 who has experienced an act of sexual abuse.
Cisgender	People whose gender identity and gender expression corresponds with the sex they were assigned at birth.
Gender expression	The actions, mannerisms (ways of speaking, walking, hand gestures, etc.), preferred activities, and ways of dressing associated with your gender. Gender expression does not always reflect a person's gender identity. One does not have to have a diverse sexual orientation, gender identity or sex characteristics to have a diverse gender expression. <i>See also SOGIESC.</i>
Gender identity	Each person's deeply felt internal and individual experience of gender, which may or may not correspond with the sex they were assigned at birth or the gender attributed to them by society. Gender identity includes people who identify as non-binary or other genders beyond male/female or man/boy and woman/girl. <i>See also SOGIESC.</i>

⁸ [Convention on the Rights of the Child \(1989\)](#) Treaty no. 27531. United Nations Treaty Series, 1577, pp. 3-178.

⁹ International Rescue Committee, Child and Youth Protection and Development Sector Framework. A guide to Sound Project Design and Consistent Messaging, IRC, January 2012.

Gender-based violence

An umbrella term for any harmful act that is perpetrated against a person's will, based on socially ascribed (gender) differences between males and females. It encompasses a range of human rights violations, including sexual abuse of children, rape, domestic violence, sexual assault and harassment, trafficking of women and girls and several harmful traditional practices, including forced, early marriage.¹⁰

Grooming

Any actions taken by a perpetrator to establish emotional connections with a child and their caretakers to enable abuse.

Inclusion

The process by which efforts are made to ensure equal opportunities – that everyone regardless of their background can achieve their full potential in life. Such efforts include policies and actions that promote equal access to services as well as enabling participation in the decision-making processes that affect their lives. Source: UNDESA.

Intersectionality

A feminist framework which illustrates how interlocking systems of oppression impact individual's and groups' experiences of violence and discrimination. These interlocking forms of oppression are rooted in identities like race, class, age, disability, sexual orientation, gender identity and gender expression, ethnicity and religion. As such, a person's multiple identities will result in unique experiences of oppression and privilege.

LGBTI

Lesbian, gay, bisexual, queer, transgender and intersex people. This term is rooted in Western understandings of sexuality. Other terms may be more applicable and appropriate across contexts. See *a/so SOG/ESC*.

Mandatory reporting

State laws and policies which mandate certain agencies and/or persons, including teachers, social workers and health staff, to report actual or suspected child abuse (e.g., physical, sexual, neglect, emotional and psychological abuse, unlawful sexual intercourse).

¹⁰ Inter-Agency Standing Committee, [Guidelines for Gender-Based Violence Interventions in Humanitarian Settings: Focusing on Prevention of and Response to Sexual Violence in Emergencies](#), IASC Task Force on Gender and Humanitarian Assistance, 2005.

Non-binary	An umbrella term for gender identities and/or expressions that are neither male nor female; refers to identities outside the gender binary. <i>See also</i> SOGIESC.
Non-offending caregiver	A parent of caregiver who has not sexually abused or directly participated in the sexual abuse of their child. ¹¹
Paedophilia	A specific disorder where there is a preference for sexual activity with a prepubescent child or children. More information on the criteria for diagnosis can be found by referring to the footnote. ¹²
Perpetrator	A person who directly inflicts or supports violence or other abuse inflicted on another against his/her will.
Service provider	Agencies charged with providing direct services to children and/or survivors of gender-based violence. These professionals include caseworkers, social workers, health workers, child protection workers, legal actors and mental health professionals.
Sexual exploitation and abuse	Any actual or attempted abuse of a position of vulnerability, differential power or trust for sexual purposes. This includes profiting monetarily, socially or politically from the sexual exploitation of another. ¹³
Sexual orientation	The capacity of an individual to experience emotional, affectional and sexual attraction to, and engage in intimate relationships with, individuals of a different gender, the same gender, or with individuals across multiple genders. <i>See also</i> SOGIESC.
SOGIESC	Sexual orientation, gender identity and expression, and sex characteristics. Often used as an umbrella term to represent groups of people with diverse identities, the Guidelines use the term 'people with diverse SOGIESC' to refer to groups of people, while referring to individuals with a specific identifying term: lesbian, gay, transgender, queer, intersex or non-binary.

¹¹ Vaughan-Eden, V., LeBlank, S.S. & Dzumaga, Y., 'Succeeding with non-offending caregivers of sexually abused children' in [Handbook of Interpersonal Violence and Abuse Across the Lifespan: A Project of the National Partnership to End Interpersonal Violence Across the Lifespan](#), Eds. R. Geffner, J.W. White, L.K. Hamberger, A. Rosenbaum, V. Vaughan-Eden & V.I. Vieth, p. 1-20, Springer Cham. 2020.

¹² World Health Organization, [The ICD-11 – Classification of Mental and Behavioural Disorders: Diagnostic criteria for research](#), WHO, Geneva, 2022.

¹³ Secretary-General's Bulletin, [Special measures for protection from sexual exploitation and abuse](#), United Nations Secretariat, ST/SGB/2003/13, 9 October 2003.

Survivor/victim

A person who has experienced gender-based violence. The terms 'victim' and 'survivor' can be used interchangeably, although 'victim' is generally preferred in the legal and medical sectors, and 'survivor' in the psychological and social support sectors. "Child survivor" is used throughout these Guidelines.

Transgender

An umbrella term for people whose gender identity and/or gender expression differs from the sex they were assigned at birth.
See also SOG/ESC.

Chapter 1

THE CARING FOR CHILD SURVIVORS APPROACH

CHAPTER OVERVIEW

This chapter introduces a specific approach to case management of young and adolescent girl and boy child survivors of sexual abuse in humanitarian settings informed by best practice in gender-based violence (GBV) and child protection (CP) case management. Referred to as ***the Caring for Child Survivors (CCS) approach***, it includes:

- » theoretical foundations upon which a specific approach to case management for child survivors of sexual abuse is built;
- » guiding principles for implementing case management with child survivors of sexual abuse.

Associated tool

CCS Case Management Minimum Standards for Service Providers

INTRODUCTION

Exact definitions of case management vary slightly across the humanitarian field – depending on the discipline from which they originate.¹⁴ The primary model adapted by the CP and GBV sectors in humanitarian aid contexts is social work case management, which is defined as:

“A method of providing services whereby a [professional] social worker assesses the needs of the client and the client’s family, when appropriate, and arranges, coordinates, monitors, evaluates and advocates for a package of multiple services to meet the specific client’s complex needs.”¹⁵

Child sexual abuse is a complex issue that demands a multi-faceted, multi-disciplinary response to best meet a child survivor’s needs and support their healing. **The CCS approach is a specific approach to case management for child survivors of sexual abuse that is rooted in the best practices of GBV and CP case management.** It articulates important theoretical foundations and guiding principles to provide a lens (or set of lenses) and process through which

¹⁴ Minimum Standards for Child Protection in Humanitarian Response defines case management as “the process of assisting individual children and families through the coordination of service provision and management of information by designated caseworkers.”

¹⁵ National Association of Case Workers, [NASW Standards for Social Work Case Management](#), NASW, Washington DC, 2013.

caseworkers carry out case management with child survivors of sexual abuse. Lastly, the CCS approach also defines a specific set of core knowledge, attitudes and skills required of caseworkers in order to effectively implement case management with child survivors of sexual abuse.

THEORETICAL FOUNDATIONS OF THE CCS APPROACH

The CCS approach to case management draws on theoretical foundations from GBV and CP practice. These foundations acknowledge the nature of child sexual abuse as a disempowering experience of distress that results in shame and stigma among other consequences and thus requires a response that is both empowering and compassionate.

Client-centred

Client-centred case management means that caseworkers engage the client (and, when appropriate, other members of the family) in all aspects of case management. They tailor services to the client's needs, preferences and goals. Being client-centred in CCS case management requires caseworkers to combine child-centred and survivor-centred approaches.

A child-centred approach entails organising and delivering services and making decisions in a way that centres young and adolescent children's needs and best interests. A child-centred approach is, by nature, child-friendly and seeks to facilitate participation of the child in their care and treatment. It involves engaging young and adolescent girl and boy children in services in ways that are accessible and appropriate for them based on their age, development and other factors that impact their capacity for decision-making. A child-centred approach seeks to explore and build on a child's protective factors and address risk factors, including the child's and non-offending caregivers' strengths. The child-centred approach is informed by the guiding principles of the [Minimum Standards for Child Protection in Humanitarian Action](#) and [Inter Agency Guidelines for Case Management & Child Protection](#).

The survivor-centred approach comes directly from GBV services and is rooted in the empowerment of women and girls. A survivor-centred approach upholds four guiding principles – safety, confidentiality, respect and self-determination, and non-discrimination – to create a supportive environment that puts the survivor at the centre of the healing process and trusts the survivor as the expert of his/her own life. This approach seeks to do no harm while facilitating the survivor's recovery. A survivor-centred approach can and should be used with child survivors of sexual abuse to the extent possible based on their age, development and in accordance with decisions and services that are in the child's best interests. The survivor-centred approach is described further in the [Interagency GBV Case Management Guidelines](#) and the [GBV Minimum Standards](#).

Person-in-environment

A person-in-environment framework (also known as a socio-ecological framework) recognises that the client cannot be separated from their environment. It recognises that clients' needs are influenced by the context in which they live their daily lives. How clients access, receive and experience services will also be informed by their environment. It recognises that systemic injustice and oppression underlie many challenges clients face. When applied to the issue of child sexual abuse, caseworkers must understand and acknowledge the ways in which incidents of child sexual abuse intersect with other forms of interpersonal violence, experiences of distress as well as systemic, societal forms of violence and oppression.

Power analysis

There are four types of power that society restricts or enables access to, based on individual identities.¹⁶ A power analysis recognises that child sexual abuse is by definition an abuse of power (power over). It is inherently tied to the power imbalances associated with being a child as well as the dynamics of sexual violence which are rooted in the power differential between the survivor and perpetrator. From there a power analysis means that caseworkers consistently examine how a child survivor of sexual abuse is being influenced by, navigating and accessing power dynamics, including in the helping relationship.

The four types of power

Power within: Internal sense of confidence, self-esteem and dignity inherent to self.

Power over: Authority, control or coercion – abuse is always a form of 'power over'.

Power with: The strength in collective action – power that comes from working together as a group for change.

Power to: Power that comes from learning new skills, increasing capacity and the process of teaching and learning.

Strengths-based perspective

Rather than focus on a client's diagnosis or problems, the caseworker elicits, supports and builds on the resilience and potential for growth and development inherent in the child survivor of sexual abuse. Identifying and building upon a child survivor's strengths is a way of giving power and control back to the child survivor of sexual abuse and therefore a critical component of the caseworker's role in aiding the child towards recovery and healing.

When used together these frameworks encourage caseworkers to bring a gender-sensitive, child-centred, intersectional lens that responds holistically to a child survivor of sexual abuse.

¹⁶ Definitions are adapted from: <https://raisingvoices.org/women/sasa-approach/>

GUIDING PRINCIPLES OF THE CCS APPROACH

The CCS approach is also made up of specific guiding principles that represent best practice from both the CP and GBV sectors which should guide how caseworkers work with child survivors of sexual abuse:

Prioritise the physical and emotional safety (short- and long-term) of the child survivor of sexual abuse and support non-offending caregivers and family members when seeking services.

Promote the best interests of the child survivor of sexual abuse. The child's well-being is paramount throughout their care and treatment. This means evaluating risks to the child and non-offending caregivers and identifying their strengths and protective factors, discussing the possible positive and negative consequences with them to inform decision-making, and taking the least harmful course of action available. All actions should ensure that the child's rights to safety and ongoing development are never compromised.

Seek informed consent/informed assent before providing services. Align this to the child's evolving capacity, which may be impacted by both environmental factors (disability, access to education, etc.) and their experience of child sexual abuse. Adverse experiences, especially recent events, may temporarily impact a child's ability to consent. If a caseworker believes this to be the case, it is recommended to reaffirm consent or assent further in the case management process.

Ensure confidentiality of services and accept how and with whom the child (and non-offending caregiver as appropriate) wishes to share their story. This means ensuring:

- » the confidential collection of information during interviews;
- » sharing information on a need-to-know basis with those involved in a child survivor's care, in line with international standards, and only after obtaining permission from the child survivor and/or non-offending caregiver;
- » storing case information securely.

Facilitate meaningful participation of child survivors in service delivery, including involving them in decision-making. Article 12 of the [Convention on the Rights of the Child](#) states that children who are capable of forming their own views have the right to express those views freely in all matters that affect them, and that the views of children should be given due weight in accordance with the age and maturity of the child. Child survivors and their non-offending caregivers are the experts on their own lives and have the right to participate in decisions that affect their lives. If a caseworker is not able to follow the child's wishes, they should always

respectfully explain the reason, talk through any concerns the child may have, and continue to support the child as the decision is implemented. Meaningful participation will look different across age, level of maturity and gender:

- » younger children have limited cognitive ability to understand their options, and to assess the risks and benefits of decisions. This may also apply to some children with disabilities that impact cognition;
- » as children's capacity evolves, they should also have more input and more trust to know what they need in their own life and for their recovery. Children in adolescence and older adolescence can contribute substantially to decision-making and safely make many of their own decisions;
- » girls are disadvantaged in terms of social power and influence, control of resources, control of their bodies and participation in public and private family life.

Treat every child survivor fairly and equally. Offer the same quality of care and treatment to all children, according to their unique needs. Each child survivor will have different needs based on their social identities, life experiences, how the abuse was perpetrated, who the perpetrator was in relation to the child, how long the abuse went on for, etc.

Treat children with respect, kindness and empathy. Children who disclose sexual abuse require comfort, encouragement and appropriate support from caseworkers. Caseworkers should believe children who disclose sexual abuse and never blame them in any way for the sexual abuse they have experienced. A fundamental responsibility of caseworkers is to make children feel safe and cared for as they receive services, and to respect them as clients.

Recognise each child's and family's uniqueness. Each child and family has different strengths, resources and ways of coping. Caseworkers should work with them to strengthen coping mechanisms that are in the best interests of the child. Caseworkers should identify and build upon the child and family's natural strengths as part of the recovery and healing process. They should identify the factors which promote children's resilience and build on those during service provision. Children who have caring relationships and opportunities for meaningful participation in family and community life and who see themselves as strong will be more likely to recover and heal from abuse.

Understand each child's social identities and individual experiences. Caseworkers should also understand their own attitudes, beliefs and biases about children and adolescents, gender and gender equality and sexual abuse, because these can have a helpful or harmful impact on the child's ability to recover and heal from sexual abuse.¹⁷

Chapters 2–4 outline specific knowledge areas, attitudes and skill sets (respectively) that are based in the theoretical foundations and guiding principles of the CCS approach. Chapters 5–8 provide guidance on applying the CCS approach in direct case implementation.

¹⁷ Perry, B., *The Boy Who Was Raised as a Dog and Other Stories from a Child Psychiatrist's Notebook: What traumatized children can teach us about loss, love, and healing*, Basic Books, 2007.

CCS CASE MANAGEMENT MINIMUM STANDARDS FOR SERVICE PROVIDERS

Must be in place	Comments
1. Case management staff trained on CCS and who meet the knowledge, attitude and skills requirements are present in service-provider agencies.	
2. Supervision system for caseworkers providing care to child survivors.	
3. Safe, locked filing space to keep child records confidential.	
4. Referral system for children is documented and functioning.	
5. A private room is available for meetings with children and caregivers.	
6. Informed consent and confidentiality forms and procedures are adapted for child survivors.	

Should be in place	Comments
1. Case management forms are adapted and used for child survivors.	
2. Child-centred materials (such as toys, art materials, dolls) are available in counselling rooms for case management staff to use with child survivors.	
3. Sexual abuse educational materials are adapted and available for child survivors.	
4. Child supplies (such as clothes) are available at the case management service location.	
5. Defined psychosocial interventions offered as part of case management.	

Chapter 2

CORE KNOWLEDGE AREAS

CHAPTER OVERVIEW

This chapter outlines the core knowledge required for caseworkers working on child sexual abuse to apply and complement other professional knowledge and skills. The content draws on global information about the scope, dynamics and impacts of child sexual abuse on young and adolescent girl and boy survivors.¹⁸ Users should adapt the content to local contexts and populations as needed.

Associated tool

CCS Knowledge Assessment tool

INTRODUCTION

Accurate and full knowledge about child sexual abuse is central to delivering appropriate care and treatment to child survivors of sexual abuse and their families. Without accurate knowledge, service providers may perpetuate harmful beliefs that can cause further emotional distress and prevent healing. Caseworkers must have a comprehensive understanding of child sexual abuse and how to share accurate information with children and caregivers so that they can:

- » help children understand and manage the impact of sexual abuse through child-centred education and information sharing;
- » help families heal by educating them about child sexual abuse and supporting the affected child and their non-offending caregivers;
- » educate service providers who share misinformation about sexual abuse with children, families and/or community members.

¹⁸ The information explained in this section combines data from multiple resources. Three main resources are the National Child Traumatic Stress Network (www.nctsn.org); Stop it Now: Together We Can Prevent Child Sexual Abuse (www.stopitnow.com); and Levine, P., Trauma through a child's eye. North Atlantic Books, 2007.

KNOWLEDGE AREA 1: DEFINITION OF CHILD SEXUAL ABUSE

Sexual abuse is an abuse of power over a child and a violation of a child's right to life and healthy development through trusting relationships, among others. No universal definition of child sexual abuse exists.¹⁹ These Guidelines consolidate multiple definitions of rape, sexual abuse and child sexual abuse to define child sexual abuse as:

“Any form of sexual activity, physical or not, with a child, perpetrated by an adult by another child who has power over the child.”

Child sexual abuse **often involves body contact, but not always**. Child sexual abuse involving physical contact can include sexual kissing, touching, and oral, anal or vaginal sex. Examples of acts of sexual abuse that involve physical contact or touching include:

- » rape, either through:
 - penetration of the vagina, anus or mouth with a penis or another body part (such as fingers or tongue);
 - penetration of the vagina or anus with an object;
- » touching a child's genitals or private parts for sexual purposes;
- » making a child touch someone else's genitals or play sexual games.

Sexual abuse does not require penetration, force, pain or even touching. If an adult engages in any sexual behaviour (for example, inappropriate sexual language directed at a child, looking at a child's private parts, and/or showing private parts to a child) such behaviour is considered sexual abuse. Specific acts of sexual abuse that do not involve contact or touching include:

- » showing pictures of naked men and/or women to a child for the adult's sexual pleasure or interest;
- » deliberately exposing an adult's genitals to a child for the adult's sexual pleasure or interest
- » photographing a child in sexual poses;
- » encouraging a child to watch or listen to sexual acts;
- » watching a child undress or use the bathroom for the adult's sexual pleasure or interest;
- » forcing a child to witness rape and/or other acts of sexual violence.

Non-physical contact can be perpetrated in person or via technology. Technology, particularly internet access, chat forums, and social media platforms have increased the avenues for sexual abuse as well as the types of sexual abuse. Coercing or forcing a child to produce or share sexual images or videos of themselves online, photographing children or videoing them and then sharing online, or even documenting and posting or livestreaming physical acts of sexual abuse have all increased in recent years, particularly in the context of COVID-19 and increased unguided access to internet and social media.²⁰

¹⁹ World Health Organization, Social Change and Mental Health, Violence and Injury Prevention, Report of the Consultation on Child Abuse Prevention, pp. 13-17, Geneva, 29-31 March 1999.

²⁰ Whole of Syria GBV AoR, [Voices from Syria](#), 2022.

Child sexual abuse is a form of child maltreatment and of gender-based violence.

Gender and age-based power imbalances and inequalities drive the perpetration of child sexual abuse.²¹

In particular, patriarchal social norms emphasise male sexual entitlement, normalise sexual violence and allow for children, particularly girls, to be treated as possessions (evidenced by practices such as bride price and dowry).²² These norms also restrict women's and girls' control over their sexuality, emphasising 'purity' (the need to remain virgins), dependency and submissiveness. Both incest and paedophilia are forms of child sexual abuse shaped and perpetuated by patriarchal systems and harmful masculine ideologies.²³

KNOWLEDGE AREA 2: SCOPE OF THE PROBLEM

Sexual violence perpetrated against children is one of the most significant crises of our time, affecting children of all ages and genders across all country contexts.²⁴ It is imperative that those responding to child sexual abuse in their communities are aware of the occurrence and characteristics of child sexual abuse both globally and locally. Statistics vary between countries and reports, but available data suggests:

- » child sexual abuse (including perpetration through technology) occurs more often than reported;
- » girls are up to three times more likely than boys to experience sexual violence;²⁵
- » the majority of perpetrators of sexual violence are men;²⁶
- » a meta-analysis of online sexual abuse towards adolescents found that 12 per cent of adolescents experienced online solicitation and 20 per cent experienced unwanted online sexual exploitation;²⁷
- » children are often sexually abused in their own homes. An overview of studies in 21 countries found that 7–36 per cent of women and 3–29 per cent of men reported sexual victimisation during childhood. Most of the abuse occurred within the family circle;²⁸
- » perpetrators of child sexual abuse are most likely known to the child, most commonly as a family member, other relative, friend or other adult in a relationship of trust;²⁹

²¹ Haristi, R. & Adriany, V., 'Toxic masculinity in sexual violence against children in Indonesia: From a feminist point of view', *Early Childhood Education in the 21st Century* (1st ed.), Routledge, 2019.

²² Ibid.

²³ Kelly, R.J & Lusk, R., 'Theories of pedophilia' in W. O'Donahue & J. Geer (eds.), *The Sexual Abuse of Children: Theory and Research Volume 1*, Routledge, 1992.

²⁴ Together for Girls, The Equality Institute, & Oak Foundation, *What Works to Prevent Sexual Violence Against Children: Evidence Review*, 2019.

²⁵ United Nations Children's Fund, [Action to End Child Sexual Abuse and Exploitation: A review of the Evidence](#), UNICEF, 2020.

²⁶ Barth, J., Bermetz, L., Heim, E., Trelle, S. & Tonia, T., 'The current prevalence of child sexual abuse worldwide: a systematic review and meta-analysis', *International Journal of Public Health*, 58(3), 2013. DOI 10.1007/s00038-012-0426-1;

²⁷ Finkelhor, D., Shattuck, A., Turner, H.A. & Hamby, S.L., 'The lifetime prevalence of child sexual abuse and sexual assault assessed in late adolescence', *J Adolescent Health*, 55(3), 2014. doi: 10.1016/j.jadohealth.2013.12.026. Epub 2014 Feb 25. PMID: 24582321.

²⁸ Radford, L., Allnock, D. & Hynes, P., [Preventing and Responding to Child Sexual Abuse and Exploitation: Evidence Review](#), UNICEF, 2015.

²⁹ Madigan, S., Villani, V., Azzopardi, C., Laut, D., et al. 'The prevalence of unwanted online sexual exposure and solicitation among youth: A meta-analysis', *Journal of Adolescent Health*, 63(2), 2018.

²⁰ Howe, D., *Child Abuse & Neglect: Attachment, Development, and intervention*, Red Globe Press, London, 2005.

²⁵ Radford, L., Allnock, D. & Hynes, P., *idem*, UNICEF, 2015.

- » globally, girls who marry before the age of 15 are 50 per cent more likely to face physical or sexual violence from an intimate partner, and married girls are more likely to describe their first sexual experience as forced.³⁰ (Whether the sexual experience is described as forced or not by married girls, it is still considered sexual abuse as girls cannot consent within the context of these unequal relationships and particularly if they are under the age of 15);
- » as girls and boys enter older adolescence (ages 15–17), rates of sexual violence increase for girls and to decrease for boys, highlighting the intersecting roles of gender, age and developmental stage on the sexual victimisation of children. These factors also influence the impact of sexual violence on children.³¹

KNOWLEDGE AREA 3: PERPETRATORS OF CHILD SEXUAL ABUSE

Who perpetrates child sexual abuse?

Characteristics of perpetrators vary across local cultures and contexts. However, the vast majority of perpetrators are men.³² While women also may perpetrate sexual abuse, it is far less common (and often includes non-physical acts of sexual abuse, such as coercion of girls into sex work).³³ Perpetrators of sexual abuse can be family members (fathers, grandparents, siblings, uncles, aunts, cousins, etc.). They can also be neighbours, religious leaders, teachers, health workers or anyone else with close contact to children. Because of this, children can be sexually abused more than once and over long periods of time. Although statistics show it is less common, children can also be sexually abused by someone they do not know. In humanitarian settings this may include humanitarian workers perpetrating sexual exploitation and abuse against children in the populations they serve.

How do perpetrators abuse power?

One feature is always present in the sexual abuse of children: abuse of power over a child for sexual purposes. Children are in a natural and legal position of dependence on their caregivers and other adults. Adults who perpetrate child sexual abuse have greater power than children in terms of authority, physical strength and size and influence.³⁴ Perpetrators also usually have greater knowledge and understanding than children of the legality and appropriateness of sexual behaviour based on factors such as age, developmental stage, intelligence, disability and social status. Perpetrators may also be in a position of privilege relative to the child and their family, creating further imbalance in power between the child and perpetrator. Perpetrators can and

³⁰ <https://www.girlsnotbrides.org/themes/violence-against-girls/>

³¹ Finkelhor, D., Shattuck, A., Turner, H.A. & Hamby, S.L., 'The lifetime prevalence of child sexual abuse and sexual assault assessed in late adolescence', *J Adolescent Health*, 55(3), 2014. doi: 10.1016/j.jadohealth.2013.12.026. Epub 2014 Feb 25. PMID: 24582321.

³² Deblinger, E., Mannarino, A. P., Cohen, J.A., Runyon, M.K. & Heflin, A.H., *Child Sexual Abuse: A Primer for Treating Children, Adolescents, and their Nonoffending Parents (2nd ed.)*, Oxford University Press, 2015.

³³ Gerke, J., Rassenhofer, M., Witt, A., Sachser, C. & Fegert, J. M., 'Female-perpetrated child sexual abuse: Prevalence rates in Germany', *Journal of Child Sexual Abuse*, 29(3), 263-277, 2020.

³⁴ Deblinger, E., Mannarino, A. P., Cohen, J.A., Runyon, M.K. & Heflin, A.H., idem, Oxford University Press, 2015.

do seek out positions of trust, increased power, and increased access to children to enable a strategy of sexual abuse called grooming (see more below).

How do perpetrators victimise children?

Three styles of engagement are commonly used by perpetrators to victimise children:

- » use of threats, force and violence by the perpetrator against the child;
- » seizing an opportunity to abuse (usually a one-time incident);
- » grooming.

It is important to note that other ways to perpetrate child sexual abuse may be less easily defined and may be harder to recognise as abuse. This can be particularly true as adolescent girls age and beliefs about what is appropriate for them change (for example early marriage may be culturally acceptable but still represents a form of child sexual abuse.)

Grooming is a strategy commonly used by perpetrators in person and/or online to sexually abuse children. Grooming involves a complex process through which a perpetrator pursues a trusting relationship with a child that allows him to engage the child in sexual activities.³⁵ The process generally involves the perpetrator identifying a child, putting himself in a situation that will give him access to the child, developing an exclusive or 'special' relationship with the child, and then slowly sexualising the relationship with the child. During the grooming process, perpetrators often cultivate an emotional relationship with the child so that the child becomes more compliant to the wishes of the perpetrator and confused about the abusive nature of the relationship.³⁶ Grooming minimises the likelihood of disclosure because children have complex and conflicted feelings toward their abusers, and feel they had a part to play or are responsible for their sexual abuse. Perpetrators can also groom other significant people in the child's life, including parents, caregivers, and other family members with the same aim of maintaining the abuse and decreasing likelihood of reporting or help seeking.

³⁵ Ibid.

³⁶ Cashmore, J. & Shackel, R., '[Gender differences in the context and consequences of child sexual abuse](#)', Current Issues in Criminal Justice, vol. 26:1, 2014.

KNOWLEDGE AREA 4: CHILDREN AND SEXUAL ABUSE DISCLOSURE

'Disclosure'³⁷ refers to the act of making the child sexual abuse known. A child's capacity to disclose that they have been sexually abused is impacted by several factors including the child's age, developmental stage, sense of safety, available resources and other factors relevant to a particular context, such as gender issues and social and cultural norms. A child's decision to disclose sexual abuse is never done in isolation – it is always made in a social context.

Often, disclosure of sexual abuse is a process – it is rarely linear and sequential. Children may first 'test the waters' to see how adults or peers react to hints about their sexual abuse.³⁸ Based on how the adults or peers react, the child survivor of sexual abuse decides whether to fully disclose or not. Adults who react with anger, blame, disbelief, shock or other harmful responses may cause a child to stop talking and/or deny that the sexual abuse happened.

Child survivors of sexual abuse also often delay their disclosure of sexual abuse for weeks to years after the incident took place. This is particularly the case for child survivors who feel responsible for the abuse or who were sexually abused by a family member. Many children do not disclose their experiences of sexual abuse until they become adults.³⁹ Children may experience significant psychological distress as a result of actively keeping their sexual abuse a secret, and they may be torn between wanting and not wanting to tell someone they trust.⁴⁰ Service providers are responsible for responding to child sexual abuse disclosure with compassion, calmness and care.

More detail on how to respond to disclosures of sexual abuse is provided in *Chapter 4*.

³⁷ The information in this section draws on three key resources: [National Child Traumatic Stress Network, Stop it Now!](#), and Levine, P., *Trauma through a child's eye*. North Atlantic Books, 2007.

³⁸ Tracy, N., [Warning Signs of Child Sexual Abuse](#). HealthyPlace, Retrieved 2 June, 2023.

³⁹ Deblinger, E., Mannarino, A. P., Cohen, J.A., Runyon, M.K. & Heflin, A.H., [Child Sexual Abuse: A Primer for Treating Children, Adolescents, and their Nonoffending Parents \(2nd ed.\)](#). Oxford University Press, 2015.

⁴⁰ Ibid.

Identification of child survivors

Many child protection workers are trained to identify or actively seek out children experiencing or at risk of abuse. This is because younger children or smaller children are often not able to protect and seek services for themselves. However, in cases of sexual abuse, such identification is not recommended because it can:

- » put the child survivor at further risk of harm, such as retaliatory violence from the perpetrator and/or his family and community members;
- » replicate victimisation and patterns of power and control that the child experienced at the hand of their perpetrators;
- » compromise the child survivor's right to consent/assent and confidentiality.

While actively seeking out cases of child sexual abuse is not recommended, caseworkers and other relevant service providers must be able to recognise signs and symptoms of a child who is at risk of or has already experienced sexual abuse. If a child is believed to be at risk of or experiencing child sexual violence, caseworkers and other relevant service providers must find a safe way to engage with the child (and/or non-offending caregiver depending on the child's age/developmental stage) so that they feel safe enough to disclose.

Types of disclosure

Child sexual abuse can be directly or indirectly disclosed.

- » **Direct disclosure:** Occurs when the child survivor of sexual abuse or the child survivor's family members/friends directly and purposefully informs someone else (for example, service provider, community member, peer) about the sexual abuse. Recent research indicates that children usually disclose to their mothers more than any other adults or peers.⁴¹
- » **Indirect disclosure:** Sometimes referred to as 'accidental disclosures'. Occurs when someone witnesses child sexual abuse, or when someone (for example, doctor, nurse, non-offending caregiver) becomes aware of the sexual abuse after recognising in the child a consequence of the abuse (for example, sexually transmitted infection, pregnancy).

Direct and indirect disclosures can occur with or without the child's consent/assent. For example, children may tell their caregivers that they have been sexually abused, and the caregivers may then disclose the abuse to service providers without the agreement of the child. This is considered direct and involuntary disclosure. However, children can also willingly share information about sexual abuse to trusted adults or service providers themselves. This is considered direct and voluntary disclosure.

⁴¹ Ibid.

Voluntary and involuntary disclosure becomes a necessary consideration when service providers begin care and treatment for an individual child. How the sexual abuse was discovered and disclosed, the number of people the sexual abuse was revealed to, how the child reacted to the revelation of the sexual abuse, and the number of people who spoke with the child following the disclosure may affect a child's willingness to share what happened to them. Some children may be ready to communicate about the sexual abuse and receive help, while some children may be afraid to do so. Every child's experience is different and should be normalised.

Common reasons why young and adolescent children do not disclose sexual abuse

- » **Fear of consequences:** Many children are afraid to tell an adult about abuse because they feel physically threatened, or because they believe they will be taken away from their families. They may fear being blamed for shaming the family or involving outside authorities. The fear of the consequences may be greater than fear of the abuse itself.
- » **Fear of dismissal:** Children are often afraid that adults will not believe them. They are afraid that their parents, community leaders, clan members, religious leaders and others will dismiss their claims and refuse to help. The perpetrator may compound this fear by convincing the child that no one will believe them or that they will get into trouble if they speak out, etc.
- » **Manipulation:** The perpetrator may trick or bribe the child (for example, give the child a gift in exchange for non-disclosure). The perpetrator will often make the child feel embarrassed or guilty about the abuse. Sometimes the perpetrator will blame the child, saying he or she invited the abuse.
- » **Self-blame:** Children may believe the sexual abuse is their fault or they may think the abuse is deserved (for example, the child may think it was their fault for inviting the perpetrator to their place or for being in the wrong place at the wrong time). A child may feel that they allowed the abuse and should have stopped it. In no case is a child ever responsible for the sexual abuse they experience.
- » **Protection:** The child may want to protect the perpetrator and/or family in some way, especially if the perpetrator is close to the child and their family.
- » **Age:** Children who are very young may be unaware they have experienced sexual abuse. They may think that the abuse is normal, particularly if the abuser is someone the child knows and trusts. Younger children may also have linguistic or developmental limitations that prevent disclosure.
- » **Disability:** Children may be unable to disclose the abuse if they are unable to speak to or otherwise reach out to a service provider.

All disclosures of all sexual abuse must be heard with respect and believed. Caregivers, service providers and adults have the responsibility to hold the perpetrator responsible for the abuse and not the child.

KNOWLEDGE AREA 5: NEEDS OF CHILD SURVIVORS

A child's recovery from sexual abuse requires both immediate response to critical needs and longer-term responses and support. Some of these needs include:

- » **Physical and emotional safety needs:** This requires services providers to mobilise crisis intervention support through case management services. Children's access to timely healthcare is ensured through immediate response services. These critical first responses set the stage for addressing longer-term needs and facilitating a holistic recovery and path to healing.
- » **Psychological needs:** Children will need support to feel safe and trusting of adults again, to understand their feelings about the abuse, and to cope with adverse reactions (flashbacks of the abuse, obsessive thoughts of the abuse, and other emotional challenges). A strengths-based approach to engage children can identify who they felt safe with before the abuse, which adults know about the abuse that have responded in supportive ways and working with these adults to understand the impacts the child may be experiencing.
- » **Social needs:** Experiences of sexual abuse are isolating and alienating for many children. Children (and families) will need help to recover and heal from the impacts of sexual abuse on the family and familial relationships. Children thrive on routine and consistency – ensuring that they can go back to school, participate in community events, etc. will assist in strengthening a sense of normalcy. If supportive, trusted adults and peers are identified, working with the child to engage in these relationships can address social needs.
- » **Care arrangements:** Children will need a secure place to recover if abuse happened in the home and they cannot return. Identifying care arrangements with the child, to the extent possible, to minimise the loss of control and to empower them to voice their opinions on who they feel safest with may reduce chances of tension, re-victimisation and incidents of the child running away from care arrangements.
- » **Legal/justice needs:** Children have a right to justice and may need support while the legal investigation and the prosecution of their cases occur. Justice systems are often dysfunctional; even in the highest-functioning justice systems, a child may be subjected to victim-blaming attitudes from police, lawyers, judges and others involved in the system. Identify critical structural issues that may exist and that a child and their family may experience within the justice system. Being open and honest about potential experiences within the justice system, as well as any mandatory reporting requirements, can help a child to feel empowered and more secure when engaging in this system.

- » **Other protection interventions:** Children who are separated, unaccompanied or who face other protection risks require targeted protection interventions. These children may have been surviving on their own, without support for months or even years when they engage in services. One way a caseworker can integrate a strengths-based approach is to acknowledge this and the decisions they have made that have helped them to survive with so little support. Working with them to identify and engage with other protection interventions acknowledges the ways they have made decisions and respects what they have been able to do without support.

KNOWLEDGE AREA 6: GENDER AND CHILD SEXUAL ABUSE

Child sexual abuse is gendered and thus facilitated by pre-existing gender inequalities. Girls typically report rates of sexual abuse two to three times higher than boys, with some exceptions in certain settings.⁴² While many of the impacts and barriers that girls and boys face are similar, they may experience them differently and the social implications and reactions to their abuse may vary. Girls and boys may have different risk factors, experiences of child sexual abuse and access to services, and they often experience different short- and long-term impacts.⁴³ Cultural beliefs and stereotypes unique to each context also play a significant role.

Gender dimensions impacting girls

Sexual abuse of girls is rooted in gender inequality.⁴⁴ Patriarchal social norms emphasise male sexual entitlement, normalise sexual violence and allow for girls to be treated as possessions. The patriarchal systems that uphold gender inequality also result in compounding forms and experiences of gender-based violence for many girls as they age.

Girls' experience of sexual abuse of girls may be affected by:

- » discriminatory gender norms, which significantly contribute to violence at the individual and societal levels; this violence is also used to reinforce gender inequality⁴⁵;
- » manifestations of gender inequality (such as lack of access to resources, imposing strict beliefs about appropriate behaviour and restricting girls' agency in relationships);

⁴² United Nations Children's Fund. [Action to end child sexual abuse and exploitation: A review of the evidence](#). UNICEF, New York, 2020.

Barth, J., Bermetz, L., Heim, E., Trelle, S. & Tonia, T., 'The current prevalence of child sexual abuse worldwide: a systematic review and meta-analysis', International Journal of Public Health, 58, 2013.

Finkelhor D, Shattuck A, Turner HA, Hamby SL. [The lifetime prevalence of child sexual abuse and sexual assault assessed in late adolescence](#). J Adolesc Health, 2014 Sep; 55(3): 329-33.

⁴⁴ Ligiero, D., Hart, C., Fulu, E., Thomas, A. & Radfort, L., [What Works to Prevent Sexual Violence Against Children: Evidence Review](#). Together for Girls, 2019.

⁴⁴ Haristi, R. & Adriany, V., 'Toxic masculinity in sexual violence against children in Indonesia: From a feminist point of view', Early Childhood Education in the 21st Century (1st ed.). Routledge, 2019.

⁴⁵ United Nations Children's Fund, [Gender Dimensions of Violence Against Children and Adolescents](#). Strategy paper, UNICEF Child Protection Programme Division, 2020.

- » violence used to maintain gender inequality (such as early marriage, female genital mutilation and intimate partner violence, etc.);
- » increasing risk of sexual violence combined with other forms of gender-based violence, including early marriage, intimate partner violence, female genital mutilation and other culturally specific forms of harmful practices as girls age;⁴⁶
- » experiencing blame for the sexual abuse by parents and communities; this can lead to harmful 'solutions' including child, early and forced marriage to the perpetrator of the abuse;⁴⁷
- » particular risk of sexual abuse in school settings, including sexual abuse by teachers⁴⁸ and potential early cessation of education due to perceived or real threats of sexual abuse (such as harassment, presence of armed actors, distance to school);⁴⁹
- » reproductive consequences of sexual abuse including pregnancy; the pressure to marry becomes particularly acute if a girl becomes pregnant because of sexual violence.⁵⁰ In some cultures, girls who experience sexual violence also face the risk of 'honour killings' at the hands of family members.⁵¹

Girls may not disclose their experiences of sexual violence nor seek services for a variety of reasons, including:

- » stigma and blame;
- » risks of experiencing further violence;
- » restricted mobility (for example, requiring permission or accompaniment to access services);
- » family members who wish to keep others from finding out about the abuse due to stigma, shame and often as a means of protecting the girl's perceived value and worth.

When adolescent girls seek services for experiences of sexual violence, they may only have access to reproductive health services designed for adult women, and may also face judgement and harmful attitudes, beliefs and behaviours from service providers. This results in multiple barriers to care, low rates of care seeking by girls and their non-offending caregivers, and the potential for unaddressed needs and gaps in services even when girls do seek care.⁵²

⁴⁶ Ligiero, D., Hart, C., Fulu, E., Thomas, A. & Radfort, L., [What Works to Prevent Sexual Violence Against Children: Evidence Review](#). Together for Girls, 2019.

⁴⁷ United Nations Children's Fund, [Gender Dimensions of Violence Against Children and Adolescents](#). Strategy paper, UNICEF Child Protection Programme Division, 2020.

⁴⁸ Inter-agency Network for Education in Emergencies (INEE), [Mind the Gap: The State of Girls' Education in Crisis and Conflict](#), 2021.

⁴⁹ Global Working Group to End School-related Gender-based Violence, [Briefing paper: Addressing school-related Gender-based Violence is critical for safe learning environments in refugee contexts](#), 2016

⁵⁰ United Nations Children's Fund, [Gender Dimensions of Violence Against Children and Adolescents](#). Strategy paper, UNICEF Child Protection Programme Division, 2020.

⁵¹ Ibid.

⁵² World Health Organization, Responding to Children and Adolescents Who Have Been Sexually Abused, WHO Clinical Guidelines, World Health Organization, 2017.

Service providers must be aware of how gendered dimensions of sexual abuse may affect a girl's willingness and ability to disclose and seek services. Caseworkers should:

- » acknowledge that girls' risk of being sexually abused increases as they age;
- » recognise that sexual abuse of girls often combines with other forms of gender-based violence; this is particularly true for adolescent girls who experience child sexual abuse in the context of marriage and intimate relationships;
- » recognise that girls prefer to speak with female service providers, which should be the default for girls;
- » recognise there can be internal (individual) and external (social) barriers to receiving care. Social stigma, including fear of being blamed, as well as restrictions on girls' movements and autonomy may make it difficult to seek support;
- » recognise that external barriers to receiving care include the risk of further violence. Girls across contexts risk further violent acts, including forced marriage to the perpetrator, physical punishment, and even death ('honour killings') if the abuse becomes known.

Gender dimensions impacting boys

Boys' experiences of sexual abuse may be influenced by:⁵³

- » seeing themselves as less than male (emasculatation);
- » concerns about feeling powerless and thus flawed;
- » fear of being labelled as sexually interested in males (homosexual);
- » beliefs that no matter what, all sexual activity is appropriate for males.⁵⁴ Particularly, if experiencing abuse from a female perpetrator, both the boys themselves and service providers may view this abuse as 'less damaging' or even as a neutral or positive experience;⁵⁵
- » gender norms that prize self-reliance and 'strength' for men and boys, leading boys to avoid seeking external help for issues, including child sexual abuse.⁵⁶

For these reasons, boys, especially adolescent boys, may be less likely to disclose and/or speak about their abuse experiences. Service providers must be aware of how harmful beliefs may affect a boy's willingness to disclose. They should:

- » acknowledge that boys can be sexually abused;
- » recognise that sexual abuse of boys can take many forms;⁵⁷ in conflict settings it can include genital violence, such as castration and penile amputation and forced rape of others;

⁵³ Bergstrom, S., Butler, T., L. & Karp, C.L., Treatment Strategies for Abused Adolescents: From Victim to Survivor, Interpersonal Violence: The Practice Series), Volume 19, SAGE Publications, 1997.

Ligiero, D., Hart, C., Fulu, E., Thomas, A. & Radfort, L., [What Works to Prevent Sexual Violence Against Children: Evidence Review](#). Together for Girls, 2019.

⁵⁴ Bergstrom, S., Butler, T.L. & Karp, C.L., Treatment Strategies for Abused Adolescents: From Victim to Survivor, Interpersonal Violence: The Practice Series), Volume 19, SAGE Publications, 1997.

⁵⁵ Ibid and Cashmore, J. & Shackel, R., 'Gender differences in the context and consequences of child sexual abuse' Current Issues in Criminal Justice, vol. 26:1, 2014.

⁵⁶ Murray, L., Nguyen, A. & Cohen, J., 'Child sexual abuse', Child and Adolescent Psychiatric Clinics of North America, 23(2).

⁵⁷ Touquet, H., Chynoweth, S., Martin, S., Reis, C. et al. 'From "It rarely happens" to "It's worse for men"', Journal of Humanitarian Affairs, 2(3), 2020.

- » understand that sexual abuse does not cause homosexuality, which carries additional stigma, mistaken beliefs about the effects of sexual abuse may make it more difficult for boys abused by an adult male to disclose;
- » recognise that boys should ideally be offered a choice of a male or female service provider;
- » recognise there can be internal (individual) and external (social) barriers to receiving care, including the fear of being labelled homosexual, as well as issues related to victimisation and masculinity;
- » recognise that criminalisation of homosexuality increases fear of seeking services and chances of facing legal consequences if the abuse becomes widely known or reported to legal authorities;
- » accept that male child survivors of sexual abuse have the same needs for care, support and treatment as female child survivors of sexual abuse – to feel safe, cared for, believed, encouraged and assured that seeking help and/or acknowledging sexual abuse is the right thing to do.

KNOWLEDGE AREA 7: AGE, DEVELOPMENT AND CHILD SEXUAL ABUSE

The age and development of a child, along with their gender and other parts of their identity, will impact both their risk of experiencing child sexual abuse and their ability to access services. Service providers should understand how girls and boys may react differently to sexual abuse based on several factors, including their age, developmental stage and cultural context. As girls and boys age and experience more and longer impacts of gender norms and beliefs, these norms become more ingrained. Adolescents usually are significantly more aware of gender norms and expected behaviour, attitudes and beliefs. Therefore, as boys and girls reach adolescence, the impacts, signs and symptoms, particularly emotional and behavioural, may differ more significantly across genders. Across ages, sudden physical, emotional or behavioural changes can be signs of abuse. While it also varies across age and development, the ability and willingness to disclose sexual abuse and its consequences is covered more fully in *Knowledge Area 4*.

It is important to believe reports of sexual abuse no matter what is observed about the child. Some signs of sexual abuse, particularly those that are emotional or behavioural, can emerge months or years after the incident(s). For example, signs may emerge during later periods of stress, such as the loss of a loved one or other adverse event, or when entering intimate relationships.

Risk factors for abuse according to age

Ages 0–5 years

- » Perpetrators almost always likely to be adults known to the child;⁵⁸
- » children in this age range may not know that what is happening is abuse and may not be able to disclose (pre-verbal children);
- » toddlers are particularly susceptible to grooming;
- » infants and toddlers have limited physical strength to fight or run away.

Ages 6–9 years

- » As children move into this age range, they are still most likely to experience abuse from someone known to them in a position of trust;
- » children in this age range are also still very susceptible to grooming tactics by perpetrators.

Ages 10–14 years

- » Children in this age range may begin to experiment with sex or be targeted for sex as they begin to become aware of their sexuality;
- » a wider range of social circles opens them up to abuse from acquaintances and ‘stranger’ perpetrators in addition to closer known perpetrators (parents, other relatives, friends);
- » easy access to internet and mobile technology increases the risk of abuse because of the additional access adults and peers have to groom and/or harass adolescents;⁵⁹
- » in some contexts, the risk of child marriage increases as the child reaches puberty opening adolescent girls up to risk of sexual abuse within marriage in addition to early marriage as a risk itself.

Ages 15–17 years

- » Increased risk of sexual abuse by peers for girls, both within and outside of consensual relationships;
- » increased risk of sexual abuse by peers for boys who are close in age to them, including cousins, siblings, other relatives or, if living in an institution, peers residing in that institution;
- » increased risk of co-occurring violence as a girl ages, which often includes sexual abuse;
- » aging out of the home through marriage or working outside of homes as live-in carers increases risk of sexual abuse and sexual exploitation.

⁵⁸ Radford, L., Hynes, P. & Allnock, D. [Preventing and Responding to Child Sexual Abuse and Exploitation: Evidence review](#), UNICEF, 2015.

⁵⁹ Ibid.

Signs of abuse according to age

The signs of abuse - whether emotional, psychological, social or physical - will also vary according to age. The tables below summarise the impact of sexual abuse and the emotional, psychological and physical signs according to age groups.

Table 2.1: Infants and toddlers (ages 0–5 years)

Emotional, psychological and social signs	Physical signs
Ages 0-3 years: » crying, whimpering, screaming more; » clinging or unusually attaching to caregivers; » regressive behaviours; » change in eating or sleeping habits that is not linked to typical development; » difficult to soothe; » communicates emotional pain as physical pain.	Ages 0-3 years: » difficulty sleeping; » new or unexplained marks or bruises, especially in genital area; » pain, discoloration, sores, cuts, bleeding/discharge in genitals, anus, mouth; » sexually transmitted infections.
Ages 3-5 years: All of the above and: » refusing to leave 'safe' places or afraid to go to specific places; » displaying knowledge or interest in sexual acts inappropriate to their age or sexualised behaviour.	Ages 3-5 years: All of the above and: » soiling accidents, bed wetting (after having mastered these skills).
Other	
» may hint at issues with comments like "I don't like him" rather than direct disclosures;⁶⁰ » may mimic sexual behaviours they have been exposed to during abuse.⁶¹	

⁶⁰ Fontes, L.A. & Plummer, C. 'Cultural Issues in Disclosures of Child Sexual Abuse', Journal of Child Sexual Abuse, 19(5), 2010.

⁶¹ National Center on The Sexual Behavior of Youth, [Childhood Sexual Development](#). Accessed on 2 June, 2022.

Table 2.2: Younger children (ages 6–9)

Emotional, psychological and social signs	Physical signs
» similar reactions to children aged 3–5 years; » fear of particular people, places or activities or of being attacked; » regressive behaviours; » suddenly refusing to go to school; » touching their private parts – more than a previous typical exploration and/or in inappropriate settings; » avoiding family and friends or generally keeping to themselves; » refusing to eat or wanting to eat all the time; » fear, sadness or may be more likely to exhibit aggressive behaviours and anger.	» new or unexplained marks or bruises, especially in genital area; » weight gain/loss; » pain, discoloration, sores, cuts, bleeding/discharge in genitals, anus, mouth; » soiling accidents, bed wetting; » sexually transmitted infections; » pregnancy for girls who have begun ovulation.
Other	
» sexually explicit, planned or aggressive sexual acts or stated sexual fantasies; » putting objects in the vagina or anus, putting one's mouth on others' sexual body parts and pretending toys are having sex (may occur rarely in children who have not been sexually abused);⁶² » may be unable to concentrate, resulting in a decline in school performance.	

Adolescence⁶³ is often described as a time of transition into adulthood, which can be a very trying time because they are no longer viewed as a child, but they are not truly regarded as an adult. In the context of child sexual abuse, adolescent girls and boys face particular challenges that are specific to their developmental stage:

- » in general, adolescents tend to place more importance on peer groups and 'fitting in'. This can complicate their efforts to come to terms with sexual abuse given the high level of stigma and shame that sexual abuse carries across communities;
- » both adolescent girls and boys may be reluctant to discuss their feelings or may even deny any emotional reactions to the sexual abuse, in part because of their desire to fit in and avoid the shame and stigma associated with sexual abuse;

⁶² Ibid.

⁶³ While the globally recognized definition of adolescents is age 10-17, these guidelines focus on children below age 18.

- » adolescent girls may have fewer connections with others outside of their families, further limiting their ability to disclose to someone with whom they feel comfortable;⁶⁴
- » boys overall are unlikely to seek out services. Girls, meanwhile, may have more worries about violent reactions to disclosing abuse and may be hesitant to trust service providers given societal and cultural consequences for survivors.

The tables below further subdivide the signs of abuse affecting adolescents into the signs of abuse affecting younger adolescents (ages 10-14 years) and older adolescents (ages 15-17 years).

Table 2.3: Younger adolescents (ages 10–14 years)

Emotional, psychological and social signs	Physical signs
» depression (e.g., feeling sad, lack of energy, not wanting to do things that are normally enjoyed, unexplained physical symptoms, poor sleep); » suicidal ideation or self-harm; » flashbacks of abuse; » avoidant behaviour, withdrawal; » angry, confrontational, disobeying or disrespecting authority; » drug and/or alcohol use; » problems in school; » disordered eating.	» difficulty sleeping; » weight gain/loss; » pain, discoloration, sores, cuts, bleeding/discharge in genitals, anus, mouth; » sexually transmitted infections; » for girls, reproductive health concerns including fistula, unwanted pregnancy and other.
Other	
» may play games that include sexual aspects; » if talking about abuse, more likely to speak about abuse if non-contact abuse, abuse from a stranger and/or perceive parents to be caring and supportive; » if talking about abuse, more likely to speak with peers than adults.	

⁶⁴ O'Connor, M. & Tanner, S., [A safe place to shine: Creating opportunities and raising voices of adolescent girls in humanitarian settings](#), International Rescue Committee, 2017.

Table 2.4: Older adolescents (ages 15–17 years)

Emotional, psychological and social signs	Physical signs
» depression (e.g., feeling sad, lack of energy, not wanting to do things that are normally enjoyed, unexplained physical symptoms, poor sleep); » suicidal ideation or self-harm; » self-harming behaviour; » flashbacks of abuse; » avoidant behaviour, withdrawal; » drug and/or alcohol use; » anger, disobeying or disrespecting authority; » problems in school or avoidance of school; » disordered eating; » if talking about abuse, more likely to speak with peers than adults; » if talking about abuse, more likely to speak about abuse if non-contact abuse, abuse from a stranger and/or perceive parents to be caring.	» difficulty sleeping; » weight gain/loss; » pain, discoloration, sores, cuts, bleeding/discharge in genitals, anus, mouth; » sexually transmitted infections; » for girls, reproductive health concerns including fistula, unwanted pregnancy and others.
Other	
» low self-esteem/negative sense of self, identity confusion, challenges in emotional expression and emotion regulation; » feeling distant or cut-off from other people; » issues with developing or maintaining a sense of autonomy from others;⁶⁵ » cultural views of male sexuality may impact boys' ability to recognise experience as abuse and worry about being perceived as homosexual because of the abuse;⁶⁶ » blame, particularly for girls, as well practices fuelled by the need to 'reclaim honour' (e.g., early forced marriage, violent punishment, honour killings).	

It is important to note that children react to sexual abuse in a variety of ways. A child may not exhibit any of these behaviours, but this does not mean that they are not experiencing abuse. Conversely, just because a child is exhibiting some of these signs, we do not immediately assume abuse. Signs should trigger further exploration with the child and their non-offending caregivers, as appropriate.

⁶⁵ Bukowski, W.M., 'Sexual abuse and maladjustment considered from the perspective of normal developmental processes' in W. O'Donahue & J. H. Greer (eds.), *The Sexual Abuse of Children*, Routledge, 1992.

⁶⁶ Ibid.

KNOWLEDGE AREA 8: INTERSECTIONALITY AND CHILD SEXUAL ABUSE

The term intersectionality is defined as:

“A framework for understanding that people experience overlapping (that is, intersecting) forms of oppression, discrimination, and marginalisation based on their co-existing identities (for example, inequality based on gender and/or ethnicity).”⁶⁷

To ensure an intersectional approach, caseworkers should seek to understand how a child's layered social identities create a unique lived experience for that child, impact vulnerability to sexual abuse, and affect a child's access to services.

A social identity is a person's sense of who they are based on group membership(s) (for example, girl, boy, refugee, child, student, mother). All people have intersecting social identities whereby no one identity can be looked at in isolation. For example, a child is not simply a child, but may also be a student, refugee, girl, eldest sibling, Muslim, etc. All individuals have social identities that are put into social categories (for example, race, ethnicity, sexuality, gender) which are subject to the influences of structural forces (for example, racism, heterosexism, patriarchy) which shape, create, and reinforce each individual's status and experience (for example, power, privilege, oppression) in any given community. To provide quality services that meet the specific needs of clients – including child survivors of sexual abuse – it is critical to understand the interaction of their social identities in context.

The following identities are highlighted because of the specific dynamics impacting risk, vulnerability and experiences of child sexual abuse in humanitarian settings. However, caseworkers may find others equally important depending on the context. Caseworkers can best support children when they have examined their own biases and beliefs related to different identities, understand the barriers these children face, and ensured services are respectful, supportive and accessible.

⁶⁷ Inter-Agency Standing Committee (IASC), [Minimum Standards for Gender-Based Violence in Emergencies Programming](#), UNFPA, 2019.

Children with disabilities

Children with disabilities face significantly higher risk for sexual abuse compared to children without disabilities of the same age and gender. Children with physical disabilities are 2.9 times more likely, and children with mental disabilities (intellectual or neurological) are 4.6 times more likely, to be survivors of sexual violence compared to children without disabilities.⁶⁸ Depending on the type of disability a child has, they may be less able to express themselves and disclose to others the abuse they are experiencing, more susceptible to grooming tactics (for example, if a child has certain mental disabilities). Adolescent girls with disabilities may be less able to advocate for their sexual and reproductive health needs and wishes because of biases and stereotypes (for example, that they are unable to understand, do not have sexual desires, and do not know what is best for them, etc).

Children with disabilities may also face drastically different responses to their abuse,⁶⁹ including being less likely to be believed when they disclose experience(s) of sexual abuse because of beliefs about their intellectual capacity, even if their disability doesn't affect intelligence. Further, adaptations and accessibility needs vary depending on a child's disability.

Accessibility and reasonable accommodation

Case management teams have a responsibility to fully support children with disabilities to the extent possible.

Accessibility to services from both physical standpoints (ramps, safe location, positioned away from areas of concern like bars, cinemas, cafes, police or security stations, etc.) and communication and attitude standpoints (caseworkers have examined their attitudes and beliefs about people with disabilities, understand how to adapt communication, etc.)

Reasonable accommodation should be provided to ensure a child's participation. This may include readily available sign language interpreters, easy to read forms, a personal assistant for the child, allowing more time and space to explain concepts and options and for the child's questions and concerns about them.

⁶⁸ Jones, L., Bellis, M., Wood, S., Hughes, K., et al., 'Prevalence and risk of violence against children with disabilities: a systematic review and meta-analysis of observational studies'. The Lancet, 380, 2012.

⁶⁹ Watters, L. & Orsander, M., Disability-Inclusive Child Safeguarding Guidelines. Able Child Africa, 2021.

Young and adolescent children with diverse sexual orientation and gender identities

Children who identify as diverse SOGIESC⁷⁰ are at risk of persecution, discrimination and violence as a result of their real or perceived sexual orientation, gender identity or gender expression. Transgender and non-binary people's experiences vary greatly throughout different cultures. In some cultures, third-gendered people are accepted and hold important roles. Intersex people may or may not have diverse sexual orientations or gender identities. They are included here because they share common concerns with people of diverse SOGIESC about harm arising from gender norms.

Children who identify as diverse SOGIESC often begin experiencing violence at young ages as they begin expressing themselves in ways considered non-normative for their gender or sex.⁷¹ This violence, often perpetrated by their own family members, may start with attempts to control their behaviour. Other forms of violence, including bullying, may come from peers, classmates, teachers and others in their lives. Children identify as diverse SOGIESC are at high risk of being rejected by their families and forced to leave home or forced into high-risk livelihood activities like commercial sexual exploitation. These children may also experience forms of child sexual assault (for example, forced marriage or 'corrective rape'), which are seen as a way to 'correct' their identity into those considered normative.⁷²

Children who identify as diverse SOGIESC may be less likely to seek services, particularly if their parents or caregivers are perpetrating the physical and emotional abuse. If parents are supportive and non-offending, the child may still be reluctant to seek services because of discrimination and prejudice from the community and service providers. They may also fear legal consequences if the legal framework criminalises persons of diverse SOGIESC and/or activities.⁷³

Children of diverse SOGIESC have higher rates of attempted suicide and suicide than heterosexual (cis-gender) children⁷⁴ and need trusted adults who can speak to their experiences of discrimination and child sexual abuse.

⁷⁰ This resource uses the terms lesbian, gay, bi-sexual, transgender, queer, and intersex (LGBTQI) when speaking about specific child survivors. It uses the term diverse SOGIESC (sexual orientation, gender identity and gender expression) when speaking generally about this population. However, other culturally specific terms may be more appropriate in local contexts.

⁷¹ Roth, D., Blackwell, A., Canavera, M. & Falb, K., [Cycles of Displacement: Understanding Violence, Discrimination, and Exclusion of LGBTQI People in Humanitarian Contexts](#), International Rescue Committee, 2021

⁷² Ibid.

⁷³ Ibid and UNFPA, [International Technical and Programmatic Guidance on Out-of-School Comprehensive Sexual Education: An Evidence-Informed Approach for Non-Formal, Out-of-School Programmes](#), UNFPA, New York, 2020.

⁷⁴ Roth, D., Blackwell, A., Canavera, M. & Falb, K., Ibid.

Racial/ethnic/Indigenous identities

When children experience child sexual abuse, their race, ethnicity or Indigenous identity may impact how they are perceived as survivors, what services they receive and how they receive those services. Particularly for Indigenous children and refugee/asylum seeking children living in contexts where they are discriminated against based on race or ethnicity, barriers to care may be acute. Children from an oppressed race or ethnicity may be specifically targeted for sexual abuse as perpetrators may believe they are easier to groom because of their experiences with discrimination.

Racism that children and families experience in their communities and fear of discrimination, particularly by service providers, can represent concrete barriers to reporting.⁷⁵ Girls from an oppressed race or ethnicity may be deprived of being treated as children and viewed as less innocent, less needing of protection and more adult-like (that is, adultification)⁷⁶ or portrayed as responsible for their own sexual abuse. Children from an oppressed race or ethnicity often also experience discrimination and racism from service providers and systems of care (for example, being less likely to be identified as needing services in the first place,⁷⁷ given lower priority or urgency in receiving services). Indigenous children face distinct barriers to services as health and response services very rarely work to integrate traditional care, healing practices or medicines into the offered care.⁷⁸ Understanding Indigenous cultural beliefs, traditional practices and important paths to healing can be a critical enabler for Indigenous children and their families to seek care. Additional belief and attitude work related to race, ethnicity and Indigenous people is covered in *Chapter 3*.

⁷⁵ Warrington, C., Beckett, H., Ackerley, E., Walker, M. & Allnock, D., Making Noise: Children's Voices for Positive Change After Sexual Abuse. Children's Experiences of Help-Seeking and Support After Sexual Abuse in the Family, University of Bedfordshire & Office of the Children's Commissioner, 2016.

⁷⁶ Koch A. & Kozhumam A., 'Adultification of Black children negatively impacts their health: Recommendations for health care providers', Nursing Forum, 57(5), 2022.

⁷⁷ Ackerley, E. & Latchford, L., 'Applying an intersectional lens to sexual violence research and practice' in Helen Beckett and Jenny Pearce (eds), Understanding and Responding to Child Sexual Exploitation, 1st edition, Routledge, 2017.

⁷⁸ UNFPA, [International Technical and Programmatic Guidance on Out-of-School Comprehensive Sexual Education: An Evidence-Informed Approach for Non-Formal, Out-of-School Programmes](#), UNFPA, 2020.

KNOWLEDGE AREA 9: RISK AND PROTECTIVE FACTORS THAT INFLUENCE THE IMPACT OF CHILD SEXUAL ABUSE

In addition to internal factors related to a child's identity – there are external risk and protective factors that can influence the impact of sexual abuse on child survivors.

Risk factors directly related to the perpetration of the abuse

The perpetrator of the abuse: Effects are generally worse when the perpetrator is a parent, step-parent or trusted adult, rather than a stranger. This will impact a child's ability to trust adults, as well as impact their feelings of safety and security with adults.

Extent of physical violence: The level and degree of distress that the child experiences will be impacted by several factors, including experiences of physical violence. If serious physical violence is involved, the emotional and health consequences can be more serious for the child. This may be mitigated by other protective factors, including presence of strong support systems, quick access to appropriate healthcare, and the absence of other factors.

How long the abuse went on: The longer the duration of the abuse, the more serious the emotional and health consequences can be for the child.

Responses to a child's disclosure of sexual abuse: The response the child received when they disclosed is critical. Doubting, ignoring, blaming and shaming responses can be extremely damaging – in some cases even more than the abuse itself.

What happens after the abuse: If a child receives the appropriate care and support, they will suffer less. However, if a child is blamed and shamed by the community or family, or does not receive help, this will have a negative impact on the child's ability to heal, feel safe and continue a healthy progression of development.

Resilience as a protective factor

Long-term recovery also requires caseworkers to work with a child and non-offending caregivers to recognise protective factors and build resilience. Resilience refers to the ability of children and their families to deal with, and recover from, adversity and crisis. A child's resilience results from both individual characteristics and coping mechanisms (innate and acquired) and the protective factors in a child's environment. These innate and acquired characteristics and mechanisms include biological, physical and psychological traits and health, as well as skills and knowledge. Children use these characteristics to defend themselves against violations of their rights and to cope with and recover from adversity.

External or environmental factors also influence a child's resilience. The external conditions that enable children to endure and recover are known as protective factors. At the family level, these protective factors include positive attitudes and involvement on the part of parents or caregivers, family cohesion, adequate housing and stable and adequate income. At the community level, protective factors include involvement in community life, peer acceptance, supportive mentors and access to quality schools and healthcare. It is essential for service providers to build on both a child's individual coping mechanisms and protective environmental factors that support the healing and recovery of children following sexual abuse.

Resilience is not static. It can be influenced and strengthened. Working with child survivors of sexual abuse requires service providers to be able recognise and build upon their resiliencies to help them cope with the impacts of sexual abuse. Caseworkers can work with the child and non-offending caregivers to increase protective factors and reduce risk factors within the child's environment.

KNOWLEDGE AREA 10: IMPACT OF SEXUAL ABUSE ON CAREGIVERS

When non-offending caregivers first find out about their child being sexually abused, they will experience a wide range of feelings that will vary based on their own systems of support and resilience, their current experiences, stress, adverse events and any child sexual abuse they might have experienced themselves. The following are common emotional reactions to a child disclosing sexual abuse:

- » anger, disbelief, shock, worry, deep sadness and fear;
- » betrayal, confusion and disbelief;
- » insomnia, change of appetite or other physical complaints;
- » confusion about what to do or where to seek help;
- » shame and blame themselves for not paying attention to their child's behaviours;
- » feeling they have failed as parents and have not protected their child;
- » wondering why their child chose to disclose to others and not them directly;
- » conflicting emotions, especially if the accused perpetrator is someone that is a trusted and close friend or family member;
- » wanting the problem to 'go away' or not even realising that sexual abuse can cause harm and that their child needs care;
- » becoming angry toward the child or scolding or beating the child;
- » prioritising or feeling pressure to prioritise family honour and relationships at the expense of the child survivor of sexual abuse.

Caregivers need support in coping after a disclosure of child sexual abuse because they suffer emotionally and because the child needs the caregiver's support and attention to facilitate their own healing. They also need to be aware that believing their child is crucial for their child's recovery. Therefore, responding to cases of child sexual abuse requires service providers to have strategies and skills for positively involving non-offending caregivers in the child's healing and recovery.

Several factors will impact both a caregiver's reactions and their ability to respond and support their child

For example, intimate partner violence is a risk factor for child abuse and if a mother is experiencing violence from a partner who is also perpetrating child sexual abuse, she may be unable to safely leave the situation and remove her children from the home. If a maternal caregiver also has a history of child abuse, emotions from her experiences as a child may surface, impacting her ability to respond in a caring and supportive manner. For these reasons, service providers must be careful to not blame non-offending caregivers, particularly female caregivers, for sexual abuse.

Developing additional knowledge areas and adapting to context

There may be additional knowledge areas related to child sexual abuse in the setting where services are being offered that are important for staff to know. In addition, information about sexual abuse may vary from one setting to another, based on the population receiving services. For this reason, managers and supervisors are encouraged to build on and/or adapt the knowledge areas outlined in this chapter.

CARING FOR CHILD SURVIVORS KNOWLEDGE ASSESSMENT

Date:

Staff name:

Supervisor:

PURPOSE

This tool allows supervisors to determine if a gender-based violence caseworker or a child protection caseworker has sufficient technical knowledge to work with child survivors of sexual abuse.

GENERAL INSTRUCTIONS

1. Use this CCS Knowledge Assessment tool in a discussion with the staff in a quiet and private location.
2. Inform the caseworker that this tool is being used to assess areas where further capacity building is needed. It is not a performance evaluation tool. Explain that the caseworker will receive a score to determine if they meet the overall knowledge requirements.
3. Ask the staff person to share their knowledge on the 20 topic areas in the tool. Compare their responses with the 'Criteria' column and score each as follows:
 - **Met (2 points):** If the individual answers the question correctly and fully.
 - **Partially met (1 point):** If the individual answers at least 50 per cent of the question. For example, if the question is, "Name four signs and symptoms of abuse" and the caseworker can only name two.
 - **Not met (0 points):** If the individual is unable to answer the question.
4. Once the assessment is complete, total the scores and discuss the outcome with the caseworker including any capacity building needed.

ASSESSMENT QUESTIONS

Knowledge competency area	Comments	Met (2 points)	Partially met (1 point)	Not met (0 points)
1. Explain the general definition of child sexual abuse.	Need to make these main points for full score: 1. Must be able to describe who is considered a child (boy or girl under 18). 2. Must talk about using power over a child for sexual purposes. 3. <i>Will likely start to describe specific acts of sexual abuse which you can also count as points towards the question below.</i>			
2. What are examples of sexual abuse that involve touching (contact)?	Needs to be able to name at least two examples for full score: 1. Forced anal, vaginal or oral sex. 2. Touching a child's breast, buttocks or anus in a sexual way. 3. Forcing a child to touch private parts of another person for sexual purpose.			
3. What are examples of sexual abuse that do NOT involve touching (non-contact)?	Needs to be able to name at least five examples for full score: 1. Forcing a child to watch sexual movies, read stories or look at sexual images. 2. A person showing their sexual parts to a child for sexual purposes (for example, masturbating in front of a child). 3. Taking pictures of a child in sexual positions. 4. Making a child watch sexual acts on purpose. 5. Talking to a child in a sexual way. 6. Inappropriately watching a child undress or go to the bathroom (because the person is sexually gratified by doing this).			
4. What are the common types of sexual abuse in your work setting?	This answer key should be developed in your context.			
5. Who are possible perpetrators of sexual abuse?	Need to be able to make these main points for full score: 1. Children are most often abused by people the child knows and trusts. 2. Also mention that children can perpetrate sexual abuse against other children. 3. Strangers can also sexually abuse. 4. Other fact that is specific to context.			

6. Why might a child not tell anyone about sexual abuse?	Need to be able to identify at least six reasons for full score: 1. Fear of being hurt. 2. Threatened by perpetrator. 3. Fear of being blamed. 4. Not knowing what happened was abuse. 5. Protecting family/parents. 6. Shame and guilt. 7. Manipulation (given something in exchange for not telling). 8. Additional reason specific to population/cultural context.			
7. Why is it important to know how sexual abuse was first found out (that is, disclosed)?	Need to be able to identify these three points for full score: 1. To know whether or not the child was 'willing' for the sexual abuse to be disclosed. 2. To know if the child told someone already, to identify this person as a possible person of trust. 3. To know whether or not the primary caregiver is aware, as this will affect how the care and treatment is coordinated with the family.			
8. List the common signs and symptoms of sexual abuse for children aged 0–5 years.	Need to be able to identify at least five signs and symptoms for full score: 1. Crying, whimpering, screaming that is not usual behaviour. 2. Trembling, fearful. 3. Not wanting to separate from caregivers, may be more attached than normal. 4. May not want to leave places they feel safe. 5. Sleeping problems. 6. Problems developing, such as losing ability to talk.			
9. List the common signs and symptoms of sexual abuse for children aged 6–9 years.	Need to be able to make these main points for full score: 1. Fear of particular people, places or activities. 2. Behaving like a baby (e.g., going to the bathroom in bed or wanting parents to dress them). 3. May refuse to go to school. 4. Touching their private parts a lot. 5. Feelings of sadness. 6. Nightmares (very bad dreams) or problems sleeping. 7. Stay alone and away from family or friends. 8. Eating problems, such as not wanting to eat or wanting to eat all the time. 9. Additional reactions that are common to population/cultural context.			

10. List the common signs and symptoms of sexual abuse for children aged 10–17 years.	Need to be able to list at least six signs and symptoms for full score: 1. Depression, sadness, crying. 2. Nightmares. 3. Problems in school (hard to concentrate). 4. Withdrawing from friends and community activities. 5. Anger and fighting. 6. Think about the abuse all the time, even when they don't want to. 7. Thoughts of wanting to die; attempted suicide. 8. Additional reactions that are common to population/cultural context.			
11. What are common social consequences of sexual abuse for a child?	Need to be able to identify at least four consequences for full score: 1. Shunned by family and/or community. 2. Blamed by family/community. 3. Stigmatisation and being 'outcast'. 4. Seen as a 'bad girl' or a 'homosexual boy'. 5. Other culturally relevant reason.			
12. What are common health consequences of sexual abuse for a child?	Need to be able to identify at least eight health consequences for full score: 1. Injury (bruises, broken bones, vaginal injuries). 2. Disease/infection. 3. Chronic infections. 4. Chronic pain. 5. Gastrointestinal problems. 6. Sleep disorders. 7. Unwanted pregnancy. 8. Unsafe abortion. 9. STIs including HIV. 10. Menstrual disorders. 11. Pregnancy complications. 12. Gynaecological disorders.			
13. What are considerations specific to girl survivors?	Need to name #3 and two other considerations for full score: 1. Girls' risk of being sexually abused increases with age. 2. Girls experiencing sexual abuse are often experiencing other forms of gender-based violence. 3. Disclosure can often lead to other forms of GBV such as honour killing, forced to marry perpetrator, restricted movement, forced to drop out of school. 4. Girls will likely need to speak to a female service provider. 5. Adolescent girls will likely need access to reproductive healthcare.			

14. What are considerations specific to boy child survivors?	Need to name three considerations for full score: 1. Sexual abuse of boys can take many forms. 2. Boys may have an even harder time than girls disclosing. 3. Boys may experience deep shame and/or fear that sexual abuse causes homosexuality. 4. Sexual abuse does not cause homosexuality. 5. Other points that are relevant to the cultural context.			
15. In addition to gender and age, what other identities should a caseworker be aware of and consider when working with a child survivor?	Need to name two of the first four examples and one context-specific example for full score: 1. Disability status. 2. Race. 3. Ethnicity. 4. Sexual orientation, gender expression and gender identity. 5. Identity specific to context (e.g., particular tribe). 6. Identity specific to context (e.g., particular religion).			
16. What are the factors that can make sexual abuse more serious?	Need to be able to list at least five factors for full score: 1. Age of the child survivor at the time of the abuse. 2. If violence was used. 3. How long the abuse went on (longer is worse). 4. The relationship the child has to the perpetrator (closer relationship is worse). 5. What happened after the abuse. For example, was the child believed and helped? (not believed is worse). 6. Other factor specific to context.			
17. What are some common feelings caregivers may have after hearing about their child being sexually abused?	Need to list at least five feelings below for full score: 1. Blaming themselves for the abuse. 2. Fear for their child's health and safety. 3. Guilt and shame. 4. Anger at their child. 5. Misunderstanding their child, for example, thinking child is lying. 6. Other points that are relevant to the cultural context.			

18. What can help to promote children's coping and healing?	Need to list at least five factors for full score: 1. Caring and timely support. 2. Family and social support and care. 3. Ability to continue with education and other activities the child was involved in prior to the abuse. 4. Psychosocial interventions that help the child understand and manage their reactions to the abuse. 5. Individual capacity of the child. 6. Religious or spiritual beliefs. 7. Other that is specific to the context.			
19. Why is it important for you, and other service providers to have knowledge about child sexual abuse?	Need to identify at least three of these reasons for full score: 1. Because it is the role of caseworkers to share accurate information with children and caregivers. 2. To educate the community accurately about child sexual abuse. 3. To educate child survivors and family members about sexual abuse. 4. To help a child understand what has happened to them and validate their experiences.			
20. EXTRA QUESTION FOR PROGRAMME ADAPTION				
TOTAL POINTS QUESTIONS 1-20				
TOTAL SCORE				

EVALUATING KNOWLEDGE COMPETENCY

30–40 points: Scores in this range indicate that the caseworker has **met** the core knowledge requirements and is able to work independently with children and families with ongoing supervision.

16–28 points: Scores in this range indicate that the caseworker has **partially met** the core knowledge requirements, but additional training is needed to build accurate and complete knowledge about child sexual abuse issues. The caseworker should be monitored very closely if working on child sexual abuse cases. A capacity building plan should also be put into place. This may include one-on-one mentoring sessions, additional training opportunities, shadowing fellow staff members, among other capacity building activities.

0–14 Points: Scores in this range indicate that the caseworker has **not met** the core knowledge requirements. They have insufficient knowledge to work on child sexual abuse cases. A capacity building plan should be put into place. This may include one-on-one mentoring sessions, additional training opportunities, shadowing fellow staff members, among other capacity building activities. Following additional training, the tool should be re-administered.

Final evaluation:_____ **Met**_____ **Partially met**_____ **Not met****OTHER OBSERVATIONS AND COMMENTS****CAPACITY BUILDING PLAN (if needed)****SUPERVISOR SIGNATURE** _____**STAFF SIGNATURE** _____

Chapter 3

CASEWORKER ATTITUDES AND BIASES

CHAPTER OVERVIEW

This chapter outlines how caseworkers can identify and address harmful attitudes and biases such that they can better address the needs of child survivors of sexual abuse and their non-offending caregivers. It identifies:

- » supportive attitudes caseworkers need to appropriately respond to children who are at risk of or who have experienced sexual abuse;
- » harmful myths about child sexual abuse and responses to such myths;
- » how caseworkers can identify and mitigate their own biases related to the different identities of child survivors of sexual abuse.

Associated tool

CCS Attitude Assessment tool

INTRODUCTION

Across societies and cultures there are often deeply embedded values and beliefs about children and child sexual abuse that serve to implicitly condone perpetration and silence and shame survivors. Caseworkers, whether conscious or subconscious may hold some of these harmful values and beliefs, which inherently influence the way in which they work with a child survivor of sexual abuse. These values and beliefs – which comprise a service provider's attitudes – have a direct impact on a child's likelihood of disclosing sexual abuse and the child's pathway to healing and recovery.⁷⁹

⁷⁹ Perry, B., *The Boy Who Was Raised as a Dog: And Other Stories from a Child Psychiatrist's Notebook. What Traumatized Children Can Teach Us About Loss, Love, and Healing*, Basic Books, 2007.

Before working with child survivors of sexual abuse, caseworkers must reflect on their attitudes about children and child sexual abuse. This process can be supported through the CCS Attitude Assessment which can be used as a self-assessment tool or administered by a supervisor. Using this tool, supervisors can support caseworkers to identify harmful attitudes and biases they may have and facilitate a process of reflection and learning (see Chapter 8: Supervision and Staff-Care). Training exercises can also facilitate a process of self-assessment, reflection and learning (see *Module 3 of the CCS Training*).

ESSENTIAL ATTITUDES FOR CCS

As part of the CCS approach, there are essential attitudes caseworkers must have and demonstrate to effectively support child survivors of sexual abuse.

Attitudes about children

- » Children have inherent strengths and coping mechanisms, which caseworkers should build on;
- » Children are the future of our communities and countries, but they also have skills and energy to contribute in the present moment;
- » Children – in particular girls – should not be subject to child, early and forced marriage and other harmful traditional practices that pose a major risk to their physical, mental and emotional health;
- » Children have a right to:
 - healthy development;
 - live a life free from violence and must be protected from harm;
 - care, love and support;
 - be heard and be involved in decisions that affect them;
 - information to be shared in a way they understand;
 - equitable treatment, free from discrimination based on their gender, age, sexuality and if they are living with a disability, etc.

Attitudes about children who experience sexual abuse

- » Children tell the truth about sexual abuse;
- » Children are not at fault for being sexually abused;
- » Children can recover and heal from sexual abuse;
- » Children should not be stigmatised, shamed, blamed or ridiculed for being sexually abused;
- » Children need reassurance that their feelings and reactions are normal and that they have strengths and skills to recover and thrive;
- » Children have the right to privacy and the opportunity to decide how they tell their story and to whom;

- » Children need to understand what happened to them and the services that are available and accessible at an appropriate level for their age and development;
- » Children – in particular older adolescents – are not adults. They still need support, care and safety in similar ways to younger children to recover from and heal from sexual abuse;
- » Children – including adolescent girls – need safe spaces and activities with peers, not restriction and fewer socialisation opportunities as they age;
- » Children – in particular girls – should not be forced to marry their abusers.

Addressing harmful attitudes and beliefs

Caseworkers working with child survivors of sexual abuse play an important role in addressing harmful myths about child sexual abuse which can impact child survivors' access to and process of healing. Addressing such myths with the child and their family and other service providers can help to lift blame and shame from the child survivor and family, destigmatise services for child sexual abuse and open more pathways to healing.

As part of training and supervision caseworkers should also identify local myths specific to the culture(s) of their clients and how to best respond to them. Table 3.1 lists some of the most pervasive and potentially harmful attitudes and myths common across many cultures. The table also provides the accurate information and potential responses that caseworkers can share with child survivors of sexual abuse and their caregivers when these myths/attitudes surface during the case management process.

Table 3.1: Potentially harmful attitudes and myths about child sexual abuse

Attitude/ belief	Information that can be shared with child/caregiver
It is shameful or improper to talk about any aspect of sexual and reproductive health with children. These are adult topics.	» Teaching children that it is ok to discuss these issues and giving them the language to do so can equip them to recognise and disclose abuse;⁸⁰ » Views around purity and virginity may make it less acceptable for girls to discuss sex or have knowledge of sexual and reproductive health.
Child sexual abuse is not a common problem.	» While no definitive prevalence rate for child sexual abuse worldwide exists, meta-analyses⁸¹ show that 7–12 per cent of boys and 18–20 per cent of girls worldwide report experiencing child sexual abuse.

⁸⁰ Kenny, M.C. et al., 'Child sexual abuse: From prevention to self-protection', Child Abuse Review 17(1):36–54, January 2008.

⁸¹ Murray, L.K., Nguyen, A. & Cohen, J.A., 'Child Sexual Abuse', Child and Adolescent Psychiatric Clinics of North America, 23(2), 321–337.

Children lie or make up stories about abuse. We can't trust them to be telling truth about the abuse.	» Children rarely lie about abuse and should be trusted when they disclose; » Children with certain identities are less likely to be believed than others. For example, a girl with a disability may face more scrutiny or doubt because of myths and norms related to gender and disability.
Only a stranger would abuse a child. No one known and trusted by the family would do something like that.	» Statistics demonstrate that children are most likely to be abused by a family member, relative or family friend; » Understand: men benefit from 'believability' over children, particularly girls, due to patriarchal values and the perceived worth of men/boys above women/girls in many cultures. Perpetrators can and do use this to their advantage when denying abuse.
Some girls cause the abuse (by the way they dress or behave).	» Children are never responsible for or cause the abuse they have experienced; » This attitude is pervasively directed at girls and shifts the blame to them rather than the perpetrators. This shift in blame helps reinforce harmful solutions like child early forced marriage to the perpetrator.
Adolescent boys cannot be sexually assaulted.	» Adolescent boys can and do experience child sexual abuse; » This belief is often rooted in beliefs that adolescent boys are always seeking sexual experiences and always enjoy sexual experiences, therefore negating their ability to be survivors of assault. This belief can be particularly entrenched if the perpetrator is a woman.
If a man abuses a boy, that automatically means the boy is gay/a homosexual.	» A pervasive myth that many boy survivors themselves may believe, this myth often prevents boys from seeking out services. Sexuality is not created or changed by experiences of abuse; » Homosexuality is often responded to with violence, so the perception that a boy who experiences child sexual assault is gay could make him more vulnerable to other forms of violence as well.
A girl's value lies in her purity; therefore, if she is sexually abused, she no longer has value to the family or community.	» This belief is rooted in norms that tie women and girls' worth to perceived chasteness and seek to control women and girls' actions, including their experiences of sexuality; » Investment in girls increase the overall well-being of families and communities.

If a boy is abused, they will end up abusing other children or become perpetrators later in life.	» Most children who experience child sexual abuse will not become perpetrators; » This belief can lead to victim blaming, stigmatisation and harmful treatment of survivors. By anticipating that they will become abusers themselves, focus may shift to preventing this or viewing the survivor in a negative light rather than their healing and recovery.
If a child survivor does not show emotional, psychological, behavioral, or physical signs of distress, they are fine and always will be.	» Healing and recovery are not linear. A child may have signs and symptoms that a caregiver or caseworker does not recognise, or they may not currently be exhibiting disruptive signs and symptoms of abuse; » Stress, further experiences of abuse and violence, drastic changes to their routine or environment, and even shifting into adolescence or adulthood may bring up signs and symptoms years after abuse has occurred.

Other harmful attitudes and behaviours

Children and caregivers often hold intense blame and shame around these experiences. The thought of child sexual abuse happening in the community usually elicits resistance from individuals and the community as it is a particularly difficult experience for many to accept.

Resistance can look like:

- » **Denial:** Refusing to acknowledge something as truth or an issue. Example: "Nothing happened to my child. They are lying for attention".
- » **Minimising:** Seeing something as less serious than it is in reality. Example: "This happens to many girls. She should be happy that he finds her beautiful".
- » **Justification:** Asserting that something is reasonable or acceptable. Example: "A girl of 13 can be married".
- » **Victim blaming:** Stating that the child is at fault for the violence they experienced. Example: "She should not have been alone with that man. Why did she go with him?"
- » **Comparing victimhood:** Shifting focus to another group that also experiences violence. Example: "This doesn't happen that often. Boys being forced into fighting happens so much more. We have to focus on that".
- » **Remaining silent:** Ignoring or keeping quiet when child sexual abuse occurs, especially if it is accepted in the community. Example: Dismissing the child when they disclose – "Men are like this. It happened to me as well, we should not mention it."

- » **Reinforcing norms:** Behaviour that supports or strengthens power inequality, harmful traditional beliefs and attitudes, myths about child sexual abuse, or harmful/violent solutions to child sexual abuse. Example: Supporting a community leader's suggestion that restricting adolescent girls' access to school and community will prevent child sexual abuse. Supporting or assisting in the forced marriage of the child survivor to the perpetrator.

EXAMINING CASEWORKER BIAS

In addition to examining their attitudes about children and child sexual abuse, caseworkers must also acknowledge and reflect upon biases they may have that may be more related to the multiple and intersecting identities of a child and family with whom they are working. While examining biases is not particular to caseworkers working on child sexual abuse, there are ways in which a child survivor's identities require a caseworker to work in a particular way so that a child's needs are met. The process of examining biases can be done through supervision and may also be facilitated by training. It is recommended that caseworkers – with the support of supervisors:

- » examine personal beliefs about sexual and reproductive health needs of children, comprehensive sexual education and appropriate behaviour and relationships for children and adolescents;
- » explore any personal limitations or exceptions to the belief that all children are worthy of respect and quality services (for example, how a child's behaviour or a particular identity may impact this belief);
- » develop processes to enable children to voice their opinions, state their needs and actively participate in their own recovery, in line with the belief that children have the right to self-determination to the extent possible based on age and development;
- » recognise and acknowledge how gender and age impact experiences of and responses to child sexual abuse;
- » understand how some child survivors of sexual abuse may not have access to services or may be less visible to caseworkers because of the different forms of oppression they face or specific characteristics of their identities;
- » develop a sense of which identities face particular challenges, barriers or forms of discrimination in the local context.

Specific considerations for young and adolescent girl survivors

Caseworkers should:

- » reflect on their personal beliefs about and experiences with gender inequality;
- » examine which girls are the most marginalised in the culture and what factors put them at particular risk of marginalisation. Specific groups of girls that may be at particular risk will vary across contexts but may include age-specific groups of girls, married girls, girls of diverse ethnicities or religions, girls with diverse sexual orientations and gender identities and girls with disabilities;
- » cultivate understanding of how girls thrive within the cultures and communities that often oppress them in multiple ways;
- » focus on identifying opportunities, informal or formal networks and spaces for girl survivors to engage with other girls and role models;
- » challenge social norms and attitudes that condone male violence and dismiss sexual abuse against girls.

For an explanation of why girls may need specific support, see *Chapter 2 (Knowledge Area 6)*.

Specific considerations for young and adolescent boy survivors

Caseworkers should:

- » reflect on their personal beliefs about and experiences with gender-based expectations;
- » recognise how gender inequality and patriarchal values harm boys in different ways to girls;
- » understand barriers to service seeking, including legislature that criminalises same-sex sexual relations;⁸²
- » understand harmful beliefs that caseworkers may hold around people of diverse SOGIESC and boys as survivors;
- » understand ways in which boys have internalised harmful beliefs about sexuality, relationships and masculinity.

For an explanation of why boys may need specific support, see *Chapter 2 (Knowledge Area 6)*.

⁸² Chynoweth, S.K., Buscher, D., Martin, S. & Zwi, A.B., 'A social ecological approach to understanding service utilization barriers among male survivors of sexual violence in three refugee settings: a qualitative exploratory study', Conflict and Health vol. 14, art. 43, 2020.

Specific considerations for child survivors with disabilities

Caseworkers and supervisors can:⁸³

- » examine personal attitudes about disabilities by answering questions such as:
 - how do you treat people with disabilities?
 - what were you taught about people with disabilities as a child?
 - what were you taught about people with mental disabilities and how do those myths impact your views now?
- » understand that disabilities result primarily from societal barriers rather than from the impairment of the child;
- » consider and recognise the barriers to inclusion for children with disabilities, and promote accessibility and inclusion:
 - assess their own services and use reasonable accommodation to remove communication and physical barriers;
 - assess referral services for safety and attitudes regarding children with disabilities;
 - be aware of the ways a child's condition may impact their sexual and reproductive health needs (for example, some conditions may cause puberty to begin earlier while others delay it).

For an explanation of why children with disabilities may need specific support, see Chapter 2 (Knowledge Area 9).

Specific considerations for working with child survivors who identify as LGBTQI

Caseworkers can:⁸⁴

- » examine their own beliefs and bias towards people of diverse SOGIESC people and address myths and harmful attitudes and beliefs they may hold about them, by answering questions such as:
 - do you know any members of the diverse SOGIESC community?
 - how do you treat them?
 - what perceptions or stereotypes do you have of them?
 - what were you taught about people of diverse SOGIESC when you were a child? How does that inform your views now?
- » be aware of the legal status of people of diverse SOGIESC in the context and risks for reporting sexual abuse of these children;
- » engage in available training and capacity building offered by local LGBTQI organisations;

⁸³ UNFPA, [International Technical Guidance on Sexuality Education: An Evidence-Informed Approach](#), UNESCO, UNAIDS, UNFOA, UNICEF, UN Women & WHO, January 2018.

⁸⁴ Ibid.

- » seek to understand the different needs of transgender girls and transgender boys, which frequently differ from cis-gender girls and boys.

For an explanation of why children with diverse sexual orientation, gender identity and gender expression may need specific support, see *Chapter 2 (Knowledge Area 8)*.

**Specific considerations for working with child survivors
who identify as Indigenous, a person of colour, or an ethnic minority**

Caseworkers can:⁸⁵

- » recognise the impact of marginalisation and oppression on cultures and communities and how that may impact the casework relationship by answering questions such as:
 - do you come from a community/culture that has historically been the oppressor of the child's community? If yes, do you understand the reasons why a child survivor of sexual abuse and their non-offending caregivers may not view you as a safe person or an ally who can be trusted?
 - if you come from a different culture/community from the child, what were you taught about people of the child's race/ethnicity when you were a child? How does that impact your views of the culture/community now?
 - if you come from the same culture/community of the child, how do your experiences of oppression and marginalisation impact your work?
- » understand the ways self-determination and participation in the case management process may be particularly important for these children and their families when they exist in societies that minimise, restrict or otherwise hinder their ability to fully utilise their traditional beliefs, practices and ways of living;
- » identify traditional healing practices, beliefs and customs that are empowering and non-stigmatising that can potentially be integrated into the case management process and relationship with the child survivor of sexual abuse.

For an explanation of why children with these identities may need specific support, see *Chapter 2 Knowledge Area 9*.

⁸⁵ Ibid.

Recognising other identities

Similar questions for self-reflection and actions to take can be done for any identity a child may hold. Supervisors should also assess what other important identities child survivors hold in the context and seek to take relevant steps to (1) address harmful attitudes and (2) cultivate positive attitudes in regards to these children. The work of addressing personal bias and cultivating positive attitudes in order to do no harm is continual. Caseworkers and supervisors should expect this self-reflection work to be an ongoing, evolving process.

THE ROLE OF SUPERVISORS IN EXAMINING ATTITUDES AND BIASES

Supervisors play a critical role in ensuring caseworkers hold or develop the required attitudes and have gone through processes of self-reflection on their bias. At a minimum, supervisors should:

- » promote space for self-reflection about myths, harmful beliefs, and risks associated with these;⁸⁶
- » promote understanding of children's rights as survivors of sexual assault, including non-discrimination and self-determination⁸⁷ (to the extent possible based on age and maturity);
- » create a safe supervisory space to examine social and cultural taboos around sex and sexual abuse with caseworkers, recognising that many may have internalised these taboos;
- » work with caseworkers to understand power imbalances within the culture and their own power in the case management relationship;⁸⁸
- » promote a whole-child approach for child survivors of sexual abuse by actively cultivating understanding of the impacts of different forms of discrimination on their experiences of abuse, seeking services and interacting with caseworkers.⁸⁹

⁸⁶ Sawrikar, P., 'Service providers' cultural self-awareness and responsible use of racial power when working with victims/survivors of child sexual abuse: Results from a program evaluation study in Australia', Children and Youth Services Review vol. 119, December 2020.

⁸⁷ Smith et al., 'Clinical care for sexual assault survivors multimedia training: a mixed-methods study of effect on healthcare providers' attitudes, knowledge, confidence, and practice in humanitarian settings', Conflict and Health vol. 7, art. 14, 2013.

⁸⁸ Ackerly, E. & Latchford, L., 'Applying an intersectional lens to sexual violence research and practice' in Helen Beckett & Jenny Pearce (eds) Understanding and Responding to Child Sexual Exploitation (1st edition), Routledge, 2017.

⁸⁹ Ibid.

CARING FOR CHILD SURVIVORS ATTITUDE ASSESSMENT

Date:

Staff name:

Supervisor:

PURPOSE

This tool allows supervisors to determine if a gender-based violence caseworker or a child protection caseworker demonstrates a child-centred attitude that suggests they will provide compassionate and appropriate care and treatment to child survivors of sexual abuse.

GENERAL INSTRUCTIONS

1. Use this assessment tool after the caseworker receives training on child sexual abuse and before the caseworker starts to work directly with children. Administer the tool regularly to gauge any changing attitudes and beliefs in caseworkers working with child survivors.
2. This is a self-administered tool. Ask the caseworker to complete the CCS Attitude Assessment tool on their own and to return it to you when finished. Do not provide them with the notes on 'Interpreting the results of the CCS Assessment tool'.
3. Ask the caseworker to answer the questions honestly.
4. Explain that the 14 questions assess the caseworker's underlying feelings and beliefs about children and sexual abuse. Ask the individual to circle one number in each row, reflecting how much they agree or disagree with each question.
5. Total the value of the circled scores in each column and then calculate the total score for all four columns.

ASSESSMENT QUESTIONS

Statements	Individual Scoring			
	Strongly agree	Somewhat agree	Somewhat disagree	Strongly disagree
1. Children have a right to contribute to decisions that affect them.	4	3	2	1
2. Some girls cause sexual abuse by the way they behave or how they dress.	1	2	3	4
3. Children should keep silent and not talk about sexual abuse.	1	2	3	4
4. Sexual abuse is always the perpetrator's fault.	4	3	2	1
5. Children who are sexually abused are dirty and ruined.	1	2	3	4
6. It is my responsibility to hold adults and caregivers accountable when they blame children who have experienced sexual abuse.	4	3	2	1
7. Sexual abuse does not cause homosexuality.	4	3	2	1
8. Making a child feel shame and guilt after sexual abuse is sometimes okay.	1	2	3	4
9. It is my responsibility to believe a child when they disclose that they have been sexually abuse.	4	3	2	1
10. Children purposefully make up stories about being sexually abused.	1	2	3	4
11. Children can be sexually abused by a close relative.	4	3	2	1
12. Children with disabilities can contribute to decision-making related to their care.	4	3	2	1

13. It is my responsibility to be aware of my own beliefs and values about sexual abuse and to talk to my supervisor if I find that I am blaming or judging children.	4	3	2	1
14. Children who are sexually abused cannot go on to live a normal life.	1	2	3	4
Total the value of the circled scores in each column and then calculate the total score for all four columns.				
TOTAL SCORE				

EVALUATING ATTITUDE

Answers can range from 1 to 4.

- » **56–46 points:** The caseworker has child-centred attitudes – they have positive beliefs and values for working with children.
- » **45–35 points:** Scores in this range indicate some troubling attitudes that may be harmful to children. Supervisors should use their discretion in allowing staff to work on child sexual abuse cases and may want to consider capacity strengthening the staff person before they work independently with child survivors.
- » **34 points or below:** Scores in this range indicate that a caseworker is not ready to work with sexually-abused children. Managers and supervisors should work independently with an individual who scores below 34 to address negative beliefs and attitudes and identify remedial actions.

Chapter 4

COMMUNICATION SKILLS

CHAPTER OVERVIEW

This chapter covers best practices for communicating with young and adolescent girl and boy child survivors of sexual abuse in a way that builds a trusting, safe and supportive relationship between the caregiver and the child. It provides considerations based on age and developmental stage, gender and disability. Lastly, it includes strategies for addressing common communication challenges with child survivors of sexual abuse.

Associated tool

CCS Communication Skills Assessment tool

INTRODUCTION

Given the nature of child sexual abuse, children and their caregivers will likely be in crisis when caseworkers meet with them. Shame, feelings of self-blame, fear of not being believed and of what will happen once they disclose what they have experienced are all emotional barriers that will make talking about the experience of child sexual abuse difficult for children and their caregivers. Depending on their age, some children may not understand what has happened to them. From the very beginning, caseworkers must create a safe, supportive and caring environment. Communication is an essential part of establishing a trusting, safe and supportive helping relationship with the child and caregiver. They may experience fear, embarrassment or shame about the abuse, which affects their willingness and ability to talk to caseworkers.

Furthermore, as discussed in *Chapter 3*, evidence shows that caseworkers and other service providers can impact a child's healing based on how they respond to a child's disclosure of abuse⁹⁰ – in other words, what caseworkers say and how they say it can have a positive or negative impact on a child's healing process. If a child discloses sexual abuse and perceives they are being blamed for the abuse by the service provider, the child may experience deeper levels of shame, anxiety and sadness. This may result in the child refusing to share further information

⁹⁰ Perry, B., *The Boy Who Was Raised as a Dog, and Other Stories from a Child Psychiatrist's Notebook: What Traumatized Children Can Teach Us About Loss, Love, and Healing*. Basic Books, 2007.

even denying the abuse altogether in subsequent interviews because they do not feel safe. When a service provider communicates belief, care and empathy, the child survivor is more likely to engage further, thus enabling the provider to offer appropriate care and treatment. When caseworkers effectively use compassionate communication to provide child-centred care, the relationship between the caseworker and child has the additional function of supporting psychological healing from sexual abuse-related impacts. Given how essential and important communication is for working with child survivors of sexual abuse, caseworkers must possess specialised skills in child-centred communication that focuses on building trust and creating positive, healing interactions.

BEST PRACTICES FOR COMMUNICATING WITH CHILD SURVIVORS

Effective communication helps the caseworker:

- » develop a caring and compassionate relationship with the child and caregiver;
- » share important information to children and families in a way they accept and understand;
- » gather crucial information in a sensitive way that can be used to guide care and treatment.

The communication guidelines and best practices outlined below can help caseworkers and other service providers cultivate this sense of safety for child survivors of sexual abuse and their caregivers. While specific communication techniques will need to be adapted according to a child's age and developmental stage, these core communication skills are an essential part of the CCS approach. While intended for caseworkers, they can also be useful for other service providers working with child survivors of sexual abuse.

The **goal of communication** between a caseworker and child is to **establish a trusting, safe and supportive helping relationship**. The helping relationship is a relationship of trust that empowers the child and caregiver(s) to feel cared for and respected by the caseworker. Every meeting with child survivors and family members are opportunities for service providers to strengthen the helping relationship.

Prepare a safe, confidential and child-centred space

Choose a safe location: Meetings with children should take place in a confidential, safe and child-centred atmosphere. A child-centred atmosphere can include child-centred toys and materials or a space to sit comfortably on the floor. For older adolescents, spaces for younger children may not be appropriate and spaces for adults may not either. Caseworkers should offer options of spaces where efforts have been made by child protection and gender-based violence practitioners to provide inclusive safe spaces and activities so that girls, boys and their female/male caregivers can choose where they feel most comfortable to attend case management

support sessions. It is recommended to see child survivors of sexual abuse in locations other than their homes. This is both because the perpetrator may live in the home and because parents, caregivers and other family members may not know about the abuse or may engage in victim blaming behaviours if they do know about the abuse.

Set appointments at opportune times of day:

Earlier in the day (or other quieter times) can be helpful for children's ability to concentrate. A case management office may be private but still susceptible to loud noises from activities within the space, or noises from busier times of day in the surrounding neighbourhood. If this is the case, see if you can set appointments for these children during quieter times of day.

Assess your space: Before working with child survivors of sexual abuse, all caseworkers should assess their space to ensure it is child centred.

- » are there smaller chairs/tables or mats for children to sit at as culturally appropriate?
- » are there culturally appropriate toys like dolls, games and art supplies available?
- » are there times when relatively few adults are in the space?

Adjust communication based on age and development: Adjust communication to be simple, clear and reflect the understanding of the child. Use creative, play-based communication techniques as much as possible and as age appropriate. Ensure that you leave plenty of time for children to ask questions. *See Table 4.1* for examples for age- and development-based adjustments.

Ten communication guidelines and best practices

1. Prepare a safe, confidential and child-friendly space.
2. Be nurturing, comforting and supportive.
3. Provide reassurance.
4. Help children feel safe.
5. Explain to the child why you want to speak with them and what they can expect.
6. Do not distress the child further.
7. Speak so children understand.
8. Pay attention to non-verbal communication.
9. Use child-centred non-verbal techniques.
10. Respect children's opinions, beliefs, and thoughts.

Be nurturing, comforting and supportive

Give children the choice to have a trusted adult with them: To the greatest extent possible during any case management session, children should have the option to have an adult they trust with them, especially very young children and children who may feel anxious with or afraid of a service provider. If the parent(s) or caregivers are non-offending and children want them in the room, they should be included. On the other hand, some children will hesitate to communicate in front of parents and caseworkers will need to consider talking with them alone.

Be mindful of touch: Communicating with care does not need to involve touch. Younger children may demonstrate disrupted boundaries and be overly affectionate with the caseworker quickly, or on the contrary, be reluctant to be touched.

Demonstrate safe boundaries with the child while not engaging in overly physical affection: Communicate with the child about their life, school, family and other general topics before finding out more about their experience(s) of abuse, using non-verbal (see Section 9) as much as possible and relevant. This helps the service provider gauge the child's capacity to be verbal, helps a child feel at ease with the service provider, builds trust and maintains comfortable pacing of the conversation.

Maintain equality: Sit at the same height as the child; keep your eyes aligned with the child's eyes. Try not to bend over or look down at the child, or squat to look up into the child's face. These strategies promote a sense of respect for the child and reinforce feelings of trust.

Support the caregiver: Infants and toddlers (0–5 years) should not be interviewed directly about their abuse. They have limited verbal communication skills and are unlikely to make any disclosures about abuse. The non-offending parents/caregivers should be the primary sources of information about the child and suspected abuse. Even older children and adolescents will benefit from support to the caregiver. A caregiver's emotional state will impact the child's emotional state and ability to communicate. Appropriate support to the caregiver can impact older children's and adolescents' comfort in communicating about a difficult subject.

Provide reassurance

Children need to be reassured that they are not at fault for what has happened to them. Caseworkers must therefore believe child survivors of sexual abuse and communicate this.

Use healing statements: Healing statements, such as “I believe you” and “It's not your fault”, are essential to communicate at the outset of disclosure and throughout care and treatment.

Emphasise perpetrator responsibility: Find opportunities to tell survivors that they are brave for talking about the abuse and that they are not to blame for what they have experienced. Tell the child that they are not responsible for the abuse.

Examples of healing statements

1. I believe you (builds trust)...
2. I am glad that you told me (builds a relationship with the child)...
3. I am sorry this happened to you (expresses empathy)...
4. This is not your fault (non-blaming.)...
5. You are very brave to talk with me and we will try to help you (reassuring and empowering)...

Create an accepting environment: Reassure them about their thoughts and feelings and that it is acceptable to not know an answer or be unsure. Make sure they know that it is ok to ask questions and create space for them to do that throughout your conversation.

Keep in mind gendered barriers to reporting and seeking services, as these will also impact trust building with girl and boy survivors in varied ways. Children who identify as LGBTQI may also need more time and consistent reassurance of their safety with the caseworker based on previous experiences and treatment at the hands of their family members.

Help children feel safe

Caseworkers are responsible for ensuring that children's emotional and physical safety are safeguarded during all communication, particularly during direct interviews about experiences of sexual abuse. The following actions can help create a feeling of safety, which is essential for children expected to share personal and painful experiences with caseworkers:⁹¹

- » **offer children the opportunity to have a trusted adult present** during case management sessions;
- » for younger children who wish to see you alone, **offer to speak to non-offending caregivers** after you initially see to the child;
- » **do not force a child to communicate to, or in front of, someone they appear not to trust.** If adolescents appear to not trust someone, speak to them alone and ask them if there are reasons to be concerned about the person. Trust what they tell you;
- » **do not include the person suspected of abusing the child** in any case management sessions;
- » **tell the child the truth, even when it is emotionally difficult.** If you don't know the answer to a question, tell the child, "I don't know". Honesty and openness develop trust and help children feel safe;
- » **do not make promises you cannot keep.** A child may communicate that they have something they need to tell you and that they want you to keep it a secret. The child's trust has most likely been broken already by someone close to him or her. It is important to reassure them that they can trust you, **but also to inform them that you might need to share some of the information they provide for you to keep them safe.** If the child discloses that he or she is being hurt and is unsafe, you must tell others who need to know, and the child should know that you cannot keep this information confidential;
- » **ask for permission to speak.** Ask children older than seven years for permission to speak with them. Use as many open-ended questions as possible;
- » **avoid multiple-choice or yes/no questions,** which can be confusing and lead the child to give inaccurate responses;

⁹¹ This section draws heavily from: IASC, Training Manual on Caring for Survivors, UNICEF, 2010.

- » **empower children.** After children describe events or occurrences in their lives and talk about their reactions, reassure them that they “did the right thing” by telling another person about these events. It may be helpful to allow them the opportunity to explore their ideas and solutions. For example, you might say, “What would you tell other kids to do if they were in the same situation?” If they are unable to reply, you can offer them paper and crayons and see if they want to draw their ideas.

Explain to the child why you want to speak with them and what they can expect

Caseworkers should routinely explain the purpose of the meeting, why they want to speak with them, and what will be asked of the child and their caregiver in child-centred terms. Accurate and truthful information can be empowering to children and facilitates their involvement in subsequent decision-making. For example, tell the child about other people (“families”, “kids your age”, “people like you”) who have had the same kind of thing happen to them and how they have found it helpful to talk to others.

Do not cause further distress

Children respond to and cope with abuse in different ways. Many children become visibly emotional when communicating about their abuse. Others communicate about their experience in a way that may seem ‘emotionally distant’ or calm. These are all normal reactions. Regardless of how a child presents, it is important that caseworkers respond in a supportive manner, and are able to support if a child begins to feel overwhelmed during a session. Caseworkers should:

- » **ensure a solid rapport exists** before asking about their experiences;
- » **gather sensitive information** from caregivers or other service providers to reduce the child retelling their story multiple times;
- » **shorten session times based on age and development.** All children are likely to need breaks, shorter assessment periods or a combination of tactics when discussing their experiences of abuse. However, children have limited attention spans and will only be able to focus on a given topic for a certain amount of time. Caseworkers can integrate play and follow a younger child’s lead across topics and thoughts rather than pushing the child to stay on topic;
- » **adjust tone and pace.** Using a calm, comforting tone at a slower pace will be important for child and adolescent survivors:
 - slower pace and a calm tone will help younger children to engage in the conversation. These children are experiencing new emotions that they will not fully understand during this time of life. When experiencing abuse during this stage, the likelihood of experiencing intense emotions with a limited understanding and no prior experience of them increases. Helping young children to understand the emotions they are experiencing can be a powerful healing aspect of the case management relationship;⁹²

⁹² Kolucki, B. & Lemish, D., [Communicating with Children. Principles and Practices to Nurture, Inspire, Excite, Educate and Heal](#). UNICEF, November 2011.

- older children and adolescents will benefit from communication that reflects the depth of their experiences and emotions. As children enter adolescence, their emotions will become more complex as will their ability to reflect on their experiences and resulting emotions. Caseworkers should mirror this in their communication.

Monitor any interactions that might upset or further distress the child. Do not become frustrated or angry with a child, pressure or force a child to answer a question that he or she is not ready to answer, pressure or force a child to communicate about the sexual abuse before they are ready, or have the child repeat their story of abuse multiple times to different people.

Speak so children understand

Make every effort to communicate appropriately with children based on their age and developmental stage. Table 4.1 gives examples of explaining case management to children of different age ranges.

Table 4.1: Explaining case management to children

Age group	Communication adjustment	Example
0–3 years	Communicate details with the caregiver directly. Address children older than 18 months from a perspective of informing them about each next step of what will happen.	To the caregiver: “I am a caseworker here at [name of organisation]. I work with children and caregivers to help them address their needs. Today, if you agree, we will talk about what happened to your child and what you think would be the most help to them and you. Do you have questions right now?” To the child (if older than 18 months): “Your mum and I are going to talk for a little bit right now. Would you like to play with this toy or this toy while we talk?”
3–5 years	Choose simple, concrete words with a comforting tone.	“My job is to listen to children and to help children the best I can.”
6–9 years	Use simple language and explanations that give space for them to ask questions.	“I’m someone who listens to and helps children best I can. I have helped many children who have had similar experiences to you. We can work together to figure out how to make some of the things you’re worried about better.”

10–14 years	Ask questions and solicit feedback to demonstrate respect for their ideas.	“I am a caseworker here at [name of organisation]. I work with children to help them feel safe. We are going to talk today about what happened and what you think you need to feel safe. Do you have questions so far?”
10–14 years	Ask questions and solicit feedback to demonstrate respect for their ideas.	“I am a caseworker here at [name of organisation]. I work with children to help them feel safe. We are going to talk today about what happened and what you think you need to feel safe. Do you have questions so far?”
15–17 years	Talk respectfully and present options or different perspectives.	“I am a caseworker here at [name of organisation]. I work with children and people your age to help them address their needs”. Today, if you agree, we will talk about what happened to you and what you think would be the most help to you. Do you have questions right now?”

- » **Younger children** respond best to simple language in short periods of time. As children move to ages 3–5 years, they will respond more to questions and find them engaging.
- Be aware of what children can understand. Even children as young as 12 months can understand a lot so it is important to explain critical aspects of what is happening, even if they do not have the language skills to respond to you.
 - Use imaginative play, songs and repetition to engage with young children. Intersperse these strategies with questions and discussion of what happened to them.
 - Keep in mind that these children may communicate about the abuse through additional ways like drawing or using a doll to represent themselves.
 - Choose the right words. Children, especially those under the age of six, take words literally, so the service provider must use concrete language. For example, if you ask a young child, “Did he drive you away in his car?” the child may answer “No” if the actual vehicle was a truck.
 - Clarify words and phrases. Younger children also use the same word or phrases to refer to more than one body part or sexual act. Thus, the service provider must take the time to clarify the words and phrases used by children to ensure an accurate understanding of children’s statements.

» **Older children:** Children aged 6–9 years can engage in conversations for longer periods of time and hold their attention longer.

- Use clear, simple language and explanations, direct questions and give the child time to think through their answers;
- Don't lead the child's answer. For example, do not say, "Did he put his hands on your breasts?" Or if using a doll to help a child communicate what happened, do not point to the breasts on the doll and ask, "Did he touch you here?" Instead, ask the child to show you where they were touched. Examples of useful questions or statements are "Has anyone ever touched you in a way that makes you confused or frightened?" "Share with me how you were touched", "Tell me what happened next", "Use your own words. It is okay to go slowly".

» **Younger adolescents:** Younger adolescents (10–14 years), even when they have not experienced abuse, are going through significant emotional, physical and cognitive changes in their lives. The experience of sexual abuse heightens this. Further, cultural expectations significantly alter the experience of adolescence. Adolescents in cultures characterised by individuality and independence seeking will experience exploration of their identity and the boundaries of their families as part of their quest for independence. Adolescents in cultures that view puberty as the bridge to adulthood may find themselves working or supporting their families in other ways, with little time for friends. Speaking to these children should be characterised by both a recognition of the developmental changes they are experiencing and how their culture views the period of adolescence.

- Solicit their opinions, wants and needs during the case management process.
- Reflect and integrate their views and opinions on the services they receive and their needs.
- Recognise that children within this age group may already have significant responsibility and experiences commensurate with adulthood, aside from their experiences of abuse.

Married adolescent girls

Because married girls and girls who are mothers are usually not dependent on or receiving support from parents / caregivers, communication with them should reflect their experiences, the decisions they are already making, the responsibilities they already have, and that they are usually treated by the community as 'adults.'

Communication should reflect a survivor-centred approach that places additional weight on the girl's opinions and decisions when working to ensure her best interests. More information on married girls and decision-making can be found in [Chapter 5](#).

- » **Older adolescents:** As children enter the 15-19-year age range, they develop stronger cognitive reasoning skills and their ability to analyse complex issues increases. It is important to remember that adolescent girl survivors in this age range may already be married, experiencing intimate-partner violence or other additional forms of gender-based violence, or already have children of their own.
 - Speaking with older adolescents in ways similar to speaking with adults can help a caseworker convey respect and build trust with the older adolescent.
 - With unmarried adolescent girl survivors, the opinions and decisions of her non-offending caregivers must also be taken into account. Communication methods will need to reflect the importance of her opinions and priorities and those of her non-offending caregivers.
 - With older adolescent boys, reflect understanding and acceptance of them and their experiences. Acknowledge resistance and fears about how community members perceive them.
 - Adolescents marital status may change cultural expectations about the extent to which caregivers will be involved in decision-making.

- » **Children with disabilities:** When working with children with disabilities, ways of speaking may need to be adjusted to ensure understanding. However, do not make assumptions about skills, cognitive capacity or the needs of a child survivor with disabilities (*see Chapter 2* for more information about working with children with different types of disabilities). Ask for advice on ways you can better communicate.⁹³
 - With the youngest children, you can ask them and their non-offending caregivers.
 - As children with disabilities reach older ages, ask them directly and take their advice on how they like to be addressed and ways to communicate with them.
 - Children with hearing impairments may use sign language, writing, reading lips or a combination of these depending on both their impairment and their ability to read and write.⁹⁴ Ask which they prefer and be prepared to immediately provide any of these methods.
 - Children with intellectual impairments (cognitive or mental impairments may both result in intellectual impairment) can learn and understand new things, with adjustment. Speak in short, clear sentences, similar to the short sentences you use with young children. Allow extra time for questions and clarification or to communicate their answer. Use aids like dolls, pictures or drawing materials to help convey meaning. Do your best to identify quiet areas with minimal outside distractions⁹⁵ as distractions impact all children but may be especially hard for children with intellectual impairments to maintain focus. Be prepared to use assistance through a support person that is not a caregiver, for example, an interpreter for sign language. When an additional support person is used, follow best practices for

⁹³ Women's Refugee Commission & International Rescue Committee, "[Tool 6: Guidance on communicating with persons with disabilities](#)" in Building Capacity for Disability Inclusion in Gender-Based Violence Programming in Humanitarian Settings, A Toolkit for GBV Practitioners, June 2015.

⁹⁴ Ibid.

⁹⁵ Ibid.

- working with interpreters - maintain focus on the child and address questions and comments to them directly, rather than to the interpreter.
- When communicating with child survivors with physical disabilities, take care that you are not making assumptions about their intelligence or cognitive abilities based on their having a physical disability. Often, despite no cognitive impairment, children with physical disabilities will notice when others are speaking excessively slow or make other adjustments that indicate the speaker doubts their intelligence.

Pay attention to non-verbal communication

It is important to pay attention to both the child's and your own non-verbal communication during any interaction. Children may demonstrate that they are distressed by crying, shaking or hiding their face, or changing their body posture. Young children may be particularly prone to crying, shaking, hitting themselves or other forms of non-verbal communication to demonstrate that they are upset, overwhelmed or dysregulated. This non-verbal communication is in line with the limits to their verbal communication.

- » Pay attention to smaller, more subtle signs from children of all ages. These may include fidgeting, wringing hands, tapping feet or legs or shifting side to side in a seat. Children may begin looking away to other parts of the room or down at their hands. They may begin taking longer pauses to resist answering;
- » Pay attention to your own non-verbal communication. If your body becomes tense or if you appear to be uninterested in the child's story, they may interpret your non-verbal behaviour in negative ways, thus affecting their trust and willingness to talk.

Use child-centred non-verbal techniques

Techniques like art, drawing, using dolls, etc. can increase a child's feelings of comfort and safety in communication. Children who have been sexually abused can benefit from child-centred non-verbal techniques to facilitate information sharing throughout all stages of the child's care and treatment process. Non-verbal methods of communication offer many benefits:

- » children may feel less threatened using non-verbal methods than sitting in a room talking;
- » children may find it easier to express emotions through drawings or stories, especially younger children and children not used to expressing emotions or answering questions;
- » children express emotions, thoughts, ideas and experiences both during and after the non-verbal communication activity.

Children of all ages can benefit from a service provider who has several methods for giving and receiving information. Children who are younger and/or not responsive to verbal communications, in particular, can benefit from the option of communicating using art and other materials. With appropriate training caseworkers can use these materials through non-directive or directive techniques.

Non-directive techniques: These apply when a service provider encourages a child to use available materials but does not provide explicit instructions. These can help a child feel at ease and facilitate conversation in a less threatening manner. For example:

- » engage children in non-directive techniques at the beginning of a meeting, allowing the child to relax and engage in a fun and creative activity without being told what to do;
- » invite children to draw a picture or tell a story but do not give specific directions about what they might draw or say. 'Drawings and play can be a useful starting point for conversations about what the child is thinking and feeling. However, it is important that caseworkers do not make assumptions and inferences based on what a child draws alone, as this can lead to inaccurate conclusions (for example, a caseworker may misinterpret the use of dark colours as representing negative emotions, when in fact a particular child may associate dark colours with safety, or the dark coloured crayon may simply have been the nearest at hand). It is important that the caseworker asks open questions and checks their understanding with the child;
- » have simple dolls, puppets or toys available. They can be offered to play with during meetings and can provide a simple way to start interacting with a young child and building trust. During this time, the caseworker should let the child guide the interactions with the dolls and follow the child's lead in playing with them.

Directive techniques: These apply when a caseworker asks a child to participate in a specific art-based or other creative activity. These techniques can be useful to gather information about specific areas of a child's life. For example:

- » have a child draw their family (anyone living in their house). This can be an effective way to find out who lives with the child. Once the child draws the picture, caseworkers can ask additional questions about the family such as: To whom is the child closest? Who is he or she scared of? With whom does he or she get along? What do family members do during the day?
- » have a child draw their daily activities. This can be an effective way to find out what the child's day is like. For example, is he or she in school, out of school? Who does he or she spend time with? Does he or she describe certain friends or activities?
- » have a child draw their safety circle. The child draws a circle and puts inside the circle what and who makes him or her feel safe. This can be an excellent way to identify safety concerns the child may have. The caseworker can take this activity a step further and have the child draw the things outside of the circle that scare them (the circle being the symbolic boundary of safety). This can provide additional information about the child's perception of risk (what and whom) and safety (what and whom);
- » use tools to find common language. For children four years or older, it can be useful to have dolls and or drawings to define common terminology for body parts. Studies have shown that children use many different names for private parts,⁹⁶ and many young children do not know which parts of the body are considered private.⁹⁷ Young children tend to use a wider range

⁹⁶ Cheung, K.F.M., Stevenson, K.M. & Leung, P., "Competency-Based Evaluation of Case-Management Skills in Child Sexual Abuse Intervention", *Child Welfare*, 70, no. 4, 1991, pp. 425–435.

⁹⁷ Ibid.

of words to refer to body parts and sexual acts than do older children. In these cases, a doll can be used to help develop a common understanding of the word the child is using and what body part the child is referring to. This can be useful during assessment as caseworkers gather basic information about what happened to the child.

Respect children's opinions, beliefs and thoughts

Children have a right to express their opinions, beliefs and thoughts about what has happened to them as well as any decisions made on their behalf. Caseworkers are responsible for communicating to children that they have the right to share (or not to share) their thoughts and opinions.

To build rapport with the child, it will be important to explore the child's ideas and opinions about what happened to them, their experiences of the abuse and its aftermath, and how these experiences have impacted them. Depending on the age, gender, maturity and other aspects of a child's identity, it may also be important to them to explore their beliefs and thoughts about:

- » sexual assault and sexual assault survivors;
- » perpetrators of abuse and the person(s) who perpetrated abuse on them;
- » themselves and their experience of abuse, particularly: how the abuse has impacted their identity and how they perceive themselves;
- » what their cultural and/or religious beliefs are about abuse and survivors;
- » how they are applying their cultural and/or religious beliefs to themselves and if there is any conflict, hurt or tension between those beliefs and their experience as a survivor;
- » others' beliefs and opinions about survivors and sexual abuse, particularly:
 - what do they agree with? What do they disagree with?
 - how do the beliefs and opinions of others impact their relationships?
- » other's (especially caregivers) beliefs and opinions about themselves personally as a survivor of abuse, particularly:
 - how do others' beliefs and opinions impact their relationship with that person?
 - do others' beliefs or opinions put them at risk for further violence?
- » what they think should happen, what they need and what would most help them.

These conversations are important to have and may be the only opportunity for the child to share such thoughts with someone safe and supportive. They are not easy conversations to have. The caseworker has to navigate these conversations with the child in line with their maturity and development while balancing the sensitivity of the tensions and emotions they may bring up. See Chapter 5 for more detailed guidance on assessing maturity and working within a child's evolving capacity.

ADDRESSING COMMON COMMUNICATION CHALLENGES

Children who become overwhelmed

Child survivors may have experienced sexual abuse that they may not fully understand, depending on their age, maturity, awareness and cultural taboos and beliefs about sex and sexuality. They may also understand some of what happened to them but believe harmful myths about sexual abuse. They may hold beliefs about how others will react and treat them. Children may be overcome with feelings of fear when discussing their experiences of abuse⁹⁸, and caseworkers should stop if the child appears distressed. If the child becomes distressed caseworkers should do the following:

- » if seeing the child alone, reassure the child that it's normal to feel distressed when thinking and talking about these things. Use healing statements to express appreciation for their trust and courage and trust in sharing how they are feeling. Then offer to get a trusted parent, caregiver or other support person;
- » support the child (and their caregiver) through feelings of distress and provide mental health and psychosocial interventions (*see Chapter 6*) to support returning to a state of calm;
- » once they are calmer, end the session. Making sure the child feels safe to leave. Communicate that sharing their story was brave and it is normal for them to feel such big emotions. Encourage the child and caregiver to use some of the practices that helped calm them;
- » schedule another time to see the child/ caregiver. (Note that follow-up conversations with children who become distressed are not considered 'multiple interviews').

Children who refuse to communicate

It is normal and common that some children will not want to communicate about the abuse they have experienced. Following the communication principles, children who refuse to speak should not be forced to do so. Caseworkers need to create an environment in which the child feels comfortable enough to disclose information about the abuse. They also need to communicate with the adults the child trusts to determine if there are any urgent medical or safety issues that need to be addressed. In addition, they should work with other adults in the child's life to coach them on gathering information that may help in understanding the situation.

Caseworkers should watch closely for reasons why the child refuses to speak. For example:

- » is there someone in the room who seems to make the child reluctant to speak?
- » does the child stop speaking when left alone with the caseworker, indicating he or she is afraid to talk without another trusted adult present?

⁹⁸ In *Chapter 7*, the guidelines offer suggestions the practice of multiple interviews has been shown to cause additional harm to child survivors.

- » are they not speaking because the environment around them is not safe or private, or because they are not ready to trust the caseworker? If a child does not want to build trust with a particular caseworker, it is not that person's fault. Find other ways to help the child, such as referrals or talking with family members.

Many other factors may influence why a child refuses to speak about sexual abuse, including fear of consequences (being forced to marry the abuser, for example) and shame. The caseworker may want to be proactive in addressing these fears to provide the child survivor with some reassurance that they will be properly helped. If a child never speaks about the abuse, caregivers can often provide adequate information for the child to receive care.

It may be that a particular child is just not comfortable with a certain caseworker because of their sex, age or another factor. In that case, the caseworker should find another person within their agency to work with the child.

Most importantly, caseworkers do not need to have information about the abuse the child experienced immediately. Psychosocial support can be provided to children and their caregivers overtime in order to support the child and build trust overtime.

Children, memory and emotion

- » The experience of abuse can affect a child's ability to remember what happened and pass on information during an interview.
- » Children may not connect emotionally with the story they are retelling in the same way adults might.
- » Children may have no emotional reaction at all, while others will react emotionally in a way that mimics the person talking with the child.

Therefore, it is important for service providers to remain calm, in control and comforting.

Children who do not acknowledge their experience of sexual abuse

In most child sexual abuse cases, particularly involving younger children, someone other than the child will refer them for help. There may be times when an adult suspects or has witnessed a child being sexually abused and has disclosed this information to a caseworker without the child's permission or knowledge. There may also be times when a child initially discloses about an experience of sexual abuse, but then denies it in a subsequent meeting.

If sexual abuse has been disclosed by a third party, a child may be more likely to initially deny the abuse. Child survivors may also recant disclosures of sexual abuse if their caregivers or other trusted adults in their lives tell them not to talk about it, or if they see that the disclosure has caused significant distress to their caregivers. The child may fear consequences of speaking out if the perpetrator has threatened the child to stay silent.

In some situations, there may be age-appropriate sexual attraction between adolescents that a parent is concerned about. While it may be upsetting to the parents it is not necessarily an act of sexual abuse.

In any of these situations, the role of the caseworker is not to determine whether abuse has occurred, but to establish a relationship where the child feels safe enough to disclose abuse.

Caseworkers should use the following strategies in addressing allegations of abuse that the child survivor denies:

Stay neutral: Do not confirm or deny what the child is saying. Let the child know that you are not there to judge but to listen, understand and help.

Get more facts: Communicate separately with the child and the person who has referred the child. Ask questions that provide a bigger picture of what may be happening: What is the age of the child and the alleged perpetrator? What is their relationship? What is the relationship between the person who reported the case and the child?

Be patient: It is normal that children may not be willing or able to talk about sexual abuse because of the associated shame or stigma. Do not force children to talk about sexual abuse. Caseworkers need to meet children at their current capacity to share and communicate.

Continue to support the child: Caseworkers can still support the child by providing mental health and psychosocial support and working with caregivers to support their child.

CARING FOR CHILD SURVIVORS COMMUNICATION SKILLS ASSESSMENT

PURPOSE

This tool allows supervisors to determine if a gender-based violence caseworker or a child protection caseworker has the communication skills required to work with child survivors of sexual abuse.

GENERAL INSTRUCTIONS

1. Use this CCS Communication Skills Assessment tool in a discussion with a caseworker in a quiet and private location.
2. Inform the caseworker that the tool is being used to assess areas where further capacity building is needed. It is not a performance evaluation tool. Explain that the caseworker will receive a score to determine if they meet the overall communication competency requirements.
3. Ask the caseworker to explain or describe the 15 concepts in the tool. Compare their responses with the 'Criteria' column and score each as follows:
 - **Met (2 points):** If the individual answers the questions correctly and fully.
 - **Partially met (1 point):** If the individual answers at least 50 per cent of the question.
 - **Not met (0 points):** If the individual is unable to answer the question.
4. Once the assessment is complete, total the scores and discuss the outcome with the caseworker, including any capacity building needed.

ASSESSMENT QUESTIONS

Child communication and engagement skill	Comments	Met (2 points)	Partially met (1 point)	Not met (0 points)
1. Give some examples of healing statements child survivors should hear from a service provider throughout care.	Need to list at least four statements for full score, including #1 and #2: 1. I believe you. 2. This is not your fault. 3. I am very glad you told me. 4. I am sorry this happened to you. 5. You are very brave for telling me and I will try to help you. 6. Other culturally appropriate healing statement.			

2. Describe how you should begin an intake and assessment session with a child.	Need to at least say the importance of starting with general questions and building some trust before asking: 1. Warm welcome. 2. Start with general questions. 3. Ask the child if they know why they are speaking with you. 4. Explain the child's rights (allowed to not answer a question or stop at anytime, etc). 5. Offer the child a toy or something to hold on to (if available). 6. Offer encouraging statements along the way.			
3. Describe how to use your body language (such as eye contact, position of your body) to help a child feel safe and comfortable.	Need to explain four ways body language would be adapted for full score: 1. Sit on the floor with a younger child. 2. Use appropriate eye contact. 3. Friendly expression on face. 4. Soft, gentle voice. 5. Other culturally appropriate thing to do.			
4. Describe how you would explain a health referral to a child survivor aged of 10–12 years.	Should include both points for full score: 1. Accurate description of healthcare services (includes risks/consequences). 2. The child's rights during the healthcare treatment and examination.			
5. Describe how you would explain a protection referral to a child aged of 10–12 years.	Should include all the following points for full score: 1. Accurate description of the protection services (includes risks/consequences). 2. Explaining what will happen when the protection staff talk to the child. 3. Explaining what the child and family's rights are during the police interviews.			
6. Explain how to find out how a child is feeling using child-centred materials (drawings, toys, etc.).	Need to list at least 3 points for full score: 1. Draw pictures of faces that represent different feelings and ask the child which one is the closest to how they feel. 2. Ask the child to draw a picture about the feeling in their mind and heart. 3. Ask the child to use colours to represent their different feelings. 4. Other idea/activity that the caseworker has that would be good to try.			

7. What are some important choices you should offer to children before talking with them about their abuse experience?	Need to provide at least three choices for full score: 1. The choice to have a caregiver or trusted person in the room. 2. The choice of where to have the conversation. 3. The choice to decide when to have the conversation. 4. If possible, the choice to have either a male or female interviewer – this is more specific to boy child survivors. It is always best practice for girls to be interviewed by female counsellors as they are almost always abused by men.			
8. If a child is under the age of 5 years, who should you talk to find out what happened to the child?	Must make both points for full score: 1. First, the person who brought the child in. 2. The child's caregiver (if appropriate).			
9. What are some key healing statements to say to a non-offending caregiver/parent who is distressed by their child's sexual abuse?	Need to name at least four statements for full score: 1. This is not your fault (if that is true). 2. We can help you and your child get better. 3. This happens to other children too. 4. You are not a bad parent because this happened. Sexual abuse is the fault of the perpetrator. 5. Other statement that is culturally relevant.			
10. What is the maximum amount of time you should interview a child about their sexual abuse?	Correct answer 1. Depends upon the age of the child, between 30 minutes to one hour.			
11. What is the difference between interviewing a 7-year-old and a 17-year-old?	Need to name at least two points for full score: 1. 17-year-old can understand what has happened more 2. 17-year-old will have more capacity to offer ideas, opinions about what should happen. 3. 17-year-old will be more concerned about social impacts and stigma of abuse.			

12. If a child refuses to talk to you (and is not disabled or hearing impaired) what are three things you should evaluate as the service provider?	Need to name at least two points for full score: 1. Is there somebody in the room the child does not feel safe speaking in front of? 2. Are you acting in a way that is making the child uncomfortable? 3. Is the interview place safe for the child to speak?			
13. Give an example of how you would respect a child's view, beliefs and opinions.	Need to name at least two points for full score: 1. Ask the child what their thoughts are about a particular action 2. Tell the child in the beginning and throughout communication with them that they have the right to share how they feel and think. 3. Create space for the child to talk. 4. Additional point relevant to the context.			
14. Describe how a caseworker's attitude and beliefs about sexual abuse impact communication with children.	Need to name at least two points for full score: 1. When caseworkers have the right attitude and belief, they communicate in a genuine and caring way. 2. They are more committed to caring for the child. 3. They provide accurate and non-judgemental information and counselling. 4. Other point that the interviewer feels is right.			
15. EXTRA QUESTION FOR COUNTRY PROGRAMME ADAPTION				
TOTAL POINTS QUESTIONS 1-15				
TOTAL SCORE				

EVALUATING COMMUNICATION SKILLS

20–30 points: Scores in this range indicate that the individual has **met** the core communication skill requirements and is able to work independently with children and families, with ongoing supervision.

10–18 points: Scores in this range indicate that the individual has **partially met** the communication skill requirements, but additional training is needed to build knowledge and skills on child-centred communication. The staff person should be monitored very closely if working on child sexual abuse cases. A capacity building plan should also be put into place. This may include one-on-one mentoring sessions, additional training opportunities, shadowing fellow staff members, among other capacity building activities.

0–8 Points: Scores in this range indicate that the individual has **not met** the core communications skills requirements to communicate with child survivors. Additional training and support should be provided, and the tool should be re-administered after further training. A capacity building plan should also be put into place. This may include one-on-one mentoring sessions, additional training opportunities, shadowing fellow staff members, among other capacity building activities.

Final evaluation:_____ **Met**_____ **Partially met**_____ **Not met**

OTHER OBSERVATIONS AND COMMENTS (Note any direct observations of the individual that is important to include in the communication assessment).

CAPACITY BUILDING PLAN (if needed)

SUPERVISOR SIGNATURE _____

STAFF SIGNATURE _____

Chapter 5

KEY ISSUES

CHAPTER OVERVIEW

This chapter describes key issues caseworkers need to navigate when providing case management to child survivors of sexual abuse. Thoughtful application of the principle of the best interests of the child is required to navigate key issues, such as: decision-making, the process of obtaining informed consent/assent, upholding confidentiality and its limits, and mandatory reporting. While all of the guiding principles set out in *Chapter 1* should guide the actions of the caseworker, the best interests of the child is specifically highlighted because of its significance in guiding the decisions and actions of the caseworker as they navigate these particularly challenging issues.

Associated tools

Gaining informed consent and informed assent

Assessment guidelines based on age and developmental stage

INTRODUCTION

Service providers have the responsibility to uphold children's best interests throughout case management, which includes promoting actions that are in the child's best interests and advocating with others to do so. In case management of child survivors of sexual abuse, actions that promote children's best interests are those that:

- » protect the child from potential or further emotional, psychological and/or physical harm;
- » reflect the child's wants and needs;
- » empower children and families;
- » examine and balance benefits and potentially harmful consequences;
- » promote recovery and healing.

Determining which courses of action are in the best interests of a particular child requires the caseworker to:

- » carry out a careful evaluation of the child's situation;

- » hold meaningful discussions with the child and caregivers about what they believe is in the child's best interests; and
- » seek the least harmful course of action.

Throughout the case management process caseworkers will encounter issues that require careful analysis and thoughtful decision-making in order to fulfil their roles and more particularly to uphold the best interests of the child based on their unique characteristics, set of circumstances and available support. Across contexts, the most challenging of these issues are:

- » engaging the child in decision-making;
- » gaining informed consent/assent;
- » upholding and navigating limits to confidentiality;
- » navigating mandatory reporting requirements.

Guidance for approaching each of these issues and how they intersect with each other is discussed below.

KEY ISSUE 1: ENGAGING CHILD SURVIVORS IN DECISION-MAKING

Engaging a child survivor of sexual abuse in decision-making is essential to the CCS approach. A collaborative decision-making process is important because the dynamics of sexual abuse are such that an adult – likely a trusted one – has already violated the child's trust and undermined any sense of agency. When children are provided the space to express their needs and feel heard and understood by adults, they can begin to rebuild a sense of trust in others and begin to regain or build a sense of agency.

However, a variety of concerns, fears, cultural beliefs and social norms prevent child survivors from having the opportunity to participate in decisions relating to their care and the services they receive. Furthermore, there are often legal parameters in place that require that certain decisions about a child's care and treatment are made by an adult (*see Key Issue 2: Informed Consent and Assent*). Nonetheless, children have the right to participate in their care and treatment in many different ways, including contributing to certain decisions by expressing their views and opinions. Engaging young and adolescent children in decision-making is a multi-faceted process in which the caseworker has to consider the following throughout the case management process:

- » **Age and developmental stage.** The age and developmental stage of the child affects their ability to contribute to decision-making.;
- » **Type of decision.** Some decisions must be made by the caregiver, but there will be others that do not require this. (For example, whether/who the child wants to have with them while they speak with a caseworker). To the extent possible, caseworkers should maximise opportunities to provide children with options that empower them to make decisions, even if they seem like small decisions;

- » **Degree of decision-making.** A child can contribute to decisions being made even if they are not ultimately the decision maker. In critical care and treatment decisions, hearing the views and opinions of a child survivor of sexual abuse can help a caseworker evaluate what decisions are in the best interests of the child.

Caseworkers can actively facilitate children's participation in decision-making by:

- » assessing a child's maturity and capacity to make decisions in a culturally appropriate manner. *Table 5.1* lays out general guidance with respect to age and maturity for decision-making. Additional aspects of maturity that can be assessed include the child's:
 - development and ability to express a choice;⁹⁹
 - capacity for understanding;
 - appreciation of circumstances;
 - reasoning ability.
- » integrating a child into their case management process from a rights-based perspective;
- » listening to children's thoughts, ideas and opinions affecting their care and treatment;
- » providing children with information about what is happening and offer them ample opportunities to express their thoughts;
- » ensuring full participation of a child in the case management process in alignment with age, development and ability.

Decision-making and girls who are married

Girls who are in early marriages, particularly those who are adolescents, should be considered able to make decisions for themselves (unless an assessment of maturity indicates otherwise). Husbands of these girls may want to have significant influence and/or control of their decision-making, but this is never appropriate. Caseworkers should ensure that married girls understand their right to decision-making and why it is not appropriate for their husbands to be involved in their care and treatment (particularly if the girl is seeking services for sexual violence perpetrated by her husband). Caseworkers working with girls who are married, particularly those who are younger, can support the girl to identify another trusted adult who can play a supportive role through the case management process. Lastly, caseworkers must be aware that girls in early marriages may have significant needs that go beyond responding to sexual violence within the marriage. More information on how service providers can safely work with married girls can be found in the [Girl Shine Early Marriage Package training](#).

⁹⁹ This includes expressing a choice through reasonable accommodation practices in addition to verbally expressing a choice.

Table 5.1: Suggested maturity for decision-making based on child's age

Child's age	Maturity for decision-making
8 years and younger	Children in this age group have the right to give their opinion and be heard. They may be able to participate in the decision-making process to a certain degree, but caution is advised to avoid burdening them with decisions beyond their ability to understand.
9–12 years	Children in this age group can meaningfully participate in the decision-making process, but maturity must be assessed on an individual basis.
13–14 years	Children in this age group are presumed to be mature enough to make a significant contribution to decision affecting their care.
15 years and older	Generally, children in this age group are mature enough to make their own decisions, without the input of a caregiver. However, this depends on the local laws regarding the age of consent.

KEY ISSUE 2: GAINING INFORMED CONSENT AND INFORMED ASSENT

Informed consent is the voluntary agreement of someone who has the maturity, capacity and legal authority to consent. Informed consent requires a child and/or caregivers/legal guardians to have full understanding of:

- » services and options available to the child and their families or caregivers;
- » potential risks and benefits of services;
- » how information is collected and used;
- » confidentiality and its limits.

Informed assent is the expressed willingness to participate in services. Informed assent becomes important in child sexual abuse cases because legally and/or developmentally children may not have the capacity to provide consent. From a healing perspective, informed assent is also important in sexual abuse cases because the process helps children to regain or build agency. Informed assent requires child-centred communication methods to enable children to understand as much as possible to agree to participate in services. While they may not fully understand the aspects of service delivery listed above, efforts must still be made to explain services in a manner that is appropriate to a child's development.

Caseworkers must obtain informed consent/informed assent from the child survivor of sexual abuse and non-offending caregiver to begin case management services; the caseworker will also need to repeat the informed consent for each service to which the child survivor of sexual abuse and/or caregiver is referred – even if the service will be provided by the same agency. Services needed beyond the case management service should be agreed with the child survivor of sexual abuse and non-offending caregiver during *Step 3: Case Action Planning*. The informed consent/assent process requires that caseworkers explain to the child and non-offending caregiver what the services entail, including possible benefits and risks:

- » give the child and non-offending caregiver all possible information and options available so they can make choices, using different formats and exploring different means to give consent;
- » inform the child and caregiver that their information may need to be shared with others and for what purposes;
- » explain how their information will be safely and securely stored;
- » explain what will likely happen to the child when engaging in services;
- » explain the benefits and risks of services;
- » explain to the child and non-offending caregiver that they have the right to decline or refuse any part of services;
- » explain the limits of confidentiality.

Determining informed consent and assent

Before engaging in the informed consent process caseworkers must know:

- » the person(s) responsible and legally able to provide informed consent for care and treatment of a child in the local context;
- » the age at which a child can independently consent to care and treatment in the local context;¹⁰⁰ how to assess a child's evolving capacity to determine if a child is able to provide informed assent or informed consent (within the set policies of the agency and laws of the country);
- » the mechanisms for third-party individuals (including governmental bodies, community-based mechanisms, national or international NGOs, other trusted adults) to provide consent if parents, caregivers or other legal guardians are not available or if they are a suspected perpetrator.

Table 5.2 sets out general guidance for informed consent and assent according to different age groups. Note that each context may have its own legal guidance which must be followed. *Gaining informed consent and informed assent* provides more detailed guidance by age and stage.

Table 5.2: Overview of informed consent/assent for different age groups

Age group	Child	Caregiver	If no caregiver or not in child's best interests	Means
0–5 years	Not applicable	Informed consent	Other trusted adult's or caseworker's informed consent	Written consent
6–11 years	Informed assent	Informed consent	Other trusted adult's or caseworker's informed consent	Oral assent Written consent
12–14 years	Informed assent	Informed consent	Other trusted adult's informed consent or child's informed assent. Child's view should take due weight according to maturity level.	Written assent Written consent
15–17 years	Informed consent/ Informed assent	Obtain informed consent with child's permission	Child's view should take due weight according to maturity level.	Written consent

¹⁰⁰ Depending on the age at which a child can give consent, parents and non-offending caregivers may not need to give consent for services. Laws in most contexts, however, state the age of consent to be at least 16 years or older, therefore requiring that a legal guardian (e.g., parents/caregivers) provide informed consent for the child to receive services.

As a child's capacity evolves, informed assent and consent should be re-assessed and re-affirmed. Caseworkers should therefore assess and reassess maturity as needed beginning with less complex subjects and decisions and moving to more complex ones as the child demonstrates understanding. Particular points in the case management process involving decisions that are within the child's capacity present opportunities to seek informed assent or consent again.

Consent for children with disabilities

Caseworkers should always assume that all children with a disability (including those with intellectual disabilities) have the capacity to provide informed consent or informed assent in line with the age group recommendations. It is the caseworker's responsibility to:

- » ask the non-offending caregiver or another trusted adult or family member for guidance on communicating with the child;
- » adjust communication using a range of styles;
- » ask the child if there is someone they would like to support them with communication;
- » make decisions based on the best interpretation of the child's will and preferences as appropriate to their age, development and understanding.

Just because a child survivor has a communication-related disability (such as a hearing impairment or verbal impairment) does not mean that they cannot communicate or comprehend what is being explained to them.

When informed consent becomes challenging

Seeking informed assent and informed consent may be further impacted by dynamics with caregivers. For example, a non-offending caregiver may not want to give consent for services for reasons such as stigma, fear, and/or shame. Additionally, the only caregiver culturally permitted to give consent may also be the perpetrator of the sexual abuse, or the child survivor may be unaccompanied, without a legal guardian. Examples of other common challenges are:

- » the non-offending female caregiver cannot or does not believe she can give informed consent as she is not the head of the household;
- » there is no official legal guardian, non-offending caregiver, other trusted adult or specific agency that can act as the decision maker for a child;
- » a non-offending caregiver is present in the child's life but disclosure of sexual abuse to the caregiver would almost certainly result in additional violence or death (that is, honour killing) of the child;
- » adolescent girl and boy survivors are mature enough to make their own decisions and provide informed consent, but either do not want to tell/involve their non-offending caregiver(s) in the process or their non-offending caregivers have legal authority and do not consent to services;

- » adolescent survivors are accompanied by a young adult friend/neighbour/family member who does not have the legal authority to provide informed consent on behalf of the survivor who is under the legal age to consent or under the age of a set policy.

In situations such as these or others in which gaining informed consent presents challenges, caseworkers should consider:

How urgent is the decision regarding care? When the child survivor of sexual abuse is at imminent risk of danger and/or has urgent health needs and the non-offending caregiver refuses to give informed consent for health services, caseworkers should immediately involve a supervisor. Ideally, supervisors will have already developed a protocol for such situations. It may be beneficial for the caseworker (along with their supervisor) to carry out case consultations with other gender-based violence or child protection actors, including relevant national protection actors, in order to seek input on the course of action that will ultimately uphold the child's best interests.

If the caregiver is refusing consent, what are the driving factors for doing so? If a non-offending caregiver is reluctant or refuses to consent to services for their child initially or throughout, it is important to understand their underlying concerns. A caregiver may not want to consent because of shame, stigma, security/retaliation and/or fear. They may feel the child needs to be disciplined or they may be in denial about the abuse. They may not believe the incident is abuse. They may be seeking to protect the offender who is a relative or friend or has powerful influence in the community. They may also face practical barriers to engaging in services, like insufficient funds to travel to the centre or conflicting priorities (for example, collecting water or searching for food).

In the absence of an urgent health or safety need, the caseworker should:

- » engage with the non-offending caregiver to better understand their refusal or hesitancy;
- » identify critical barriers to giving informed consent;
- » assess if those barriers can be addressed, removed or the risk associated with them reduced;
- » create a plan to address barriers with the non-offending caregiver before seeking informed consent again.

What is the age of the survivor and their capacity for consent? In situations in which children are old enough or determined to have the capacity for decision-making, they can give their own consent without the consent of the caregiver. To assess a child's comprehension and capacity to make the decision at hand, caseworkers should consider the child's ability to:

- » comprehend and reflect back key pieces of information in relation to the decision;
- » think and make choices with some degree of independence;
- » evaluate the possible benefits and risk that accompany the decision.

What are the legal parameters for consent within the context? There may be contexts where there are legal determinations as to the age of consent and processes that must be followed. In other contexts, there may not be such legal frameworks in place, permitting the caseworker to make a determination or in some cases act on behalf of the child. That is particularly likely if no other formal procedures exist to determine what is in the child's best interests.

KEY ISSUE 3: UPHOLDING AND NAVIGATING LIMITS TO CONFIDENTIALITY

Upholding confidentiality is one of the guiding principles of protection and health services. It requires caseworkers to **collect information in safe ways, protect all information gathered about survivors and agree to share only on a need-to-know basis and after gaining the explicit permission of the child and their caregiver.** Explaining confidentiality and the limits to it usually happens within the informed consent/informed assent procedures of Step 1 Introduction and Engagement in the case management process. However, upholding confidentiality and its limits is a priority throughout the case management process.

Confidentiality protocols and decisions are more straightforward when working with adult survivors, as adults are legally empowered to make decisions for themselves. Working with children, especially younger children, requires not only understanding the legal limits to confidentiality, but also how caregivers should be involved, and how to balance the best interests of the child.

Ethical limits to confidentiality, whether adult or child, exist to ensure safety when the survivor is:

- » at risk of hurting or killing themselves;
- » at risk of being hurt or killed by someone else;
- » at risk of hurting or killing another person;
- » injured and in need of immediate medical attention.

Working with children, especially younger children, requires understanding additional legal limits to confidentiality and the reasons for these limits, including to safeguard the child from further abuse and prevent the perpetrator from harming others. Additional limits to confidentiality for children may apply when mandatory reporting laws and prevention from sexual exploitation and abuse (PSEA) policies exist. Discussed more in [*Key Issue 4*](#), information about mandatory reporting and how it impacts limits to confidentiality must be explained in advance to a child and their caregiver.

Caseworkers must be clear and consistent with children and caregiver about the limits to confidentiality. Caseworkers should have a standard set of agency-specific confidentiality protocols that guide all staff providing care to children. Decisions about how best to protect the confidentiality of the child and their access to support services are an ongoing element of the case management process. In the context of case referrals, caseworkers should discuss with the child and caregivers which information they would choose to share with other service providers and how to share such information, including the possible risks and benefits. If a child needs protection – for example, they are being stalked and at risk of imminent harm – it may be useful, if considered safe, to provide information to local law enforcement agencies, to protect the child. How much and what to share should always be discussed and decided with both the child and the caregiver, in line with legal requirements.

Unless legally mandated, decisions to break a child's confidentiality should always be guided by the best interests of the child. And even in such cases, the best interests of the child and other guiding principles should inform how this is done. If confidentiality needs to be broken, to the extent possible the caseworker should inform the child in advance and explain why confidentiality must be broken, discuss potential impact on the child's physical and psychological safety, including how it impacts the child's trust in the caseworker.

PSEA policies and reporting

In humanitarian settings, organizations usually have PSEA policies. These require the organisation's personnel to report known cases of sexual exploitation and abuse perpetrated by humanitarian actors. **PSEA policies, which may also be referred to as safeguarding policies, are different than legally codified mandatory reporting requirements that are discussed in the next section.**

Each organisation will have its own procedure for reporting, managing and investigating reported cases of sexual exploitation and abuse. These policies should include measures that allow for confidential reporting and be informed by survivor-centered, best interests and do no harm principles.

Caseworkers should understand their organisation's policies on PSEA and if they are required to report PSEA, to whom and how investigations will be handled. This information should be integrated into their informed consent procedures in which they explain the limits to confidentiality. Caseworkers should uphold the best interests of the child in reporting PSEA.

Explaining confidentiality

The caseworker's role is to explain the concept of confidentiality and its limits to child survivors of sexual abuse and their non-offending caregivers, ensure understanding, and safely apply the principle of confidentiality in a way that upholds the best interests of the child survivor of sexual abuse.

To explain confidentiality and its limits to child survivors of sexual abuse in a dignifying manner, caseworkers must have the language skills to communicate with children of different ages and respect the fundamental truth that children's experiences and stories belong to them. After explaining confidentiality to children, caseworkers should ask the child a few questions to make sure the child understands what has been said. Questions such as "Can you tell me what I should do if I thought that someone was hurting you?" or "Can you tell me what my job is?" will help assess the child's comprehension.

Caseworkers should include children in decision-making about how, what and with whom to share information in line with existing protocols. Limits to confidentiality should be communicated during informed-consent procedures.

Sample script for explaining confidentiality to an 8-year-old survivor

My job is to talk to children and help them with problems they face. I care about you and what happened to you, and I want to keep you safe. What you tell me is between you and me, unless there is something that you tell me that worries me or if you need help that I cannot give you. If I am worried about your safety, I may need to talk to someone who can help you. If we need to get you more help in order to check your body or talk to someone who can help keep you safe, we will talk together about that other person, and decide what we should say. My job is to try and make sure that you are not hurt anymore, so we may need to also get help from other people to keep you safe and healthy. Does this sound okay with you?

Sample script for explaining confidentiality to a 12-year-old survivor

My job is to talk to children and help them with problems they face. Although most of what we talk about is between you and me, there may be some problems you might tell me about that we would have to talk about with other people. For example, if I can't help with you a problem you have, we will need to talk to other people who can help you. Or if I find out that you are in very serious danger, I would have to tell [appropriate agency] about it. If you tell me you have made plans to seriously hurt yourself, I would have to inform your parents or another trusted adult. If you tell me you have made a plan to seriously hurt someone else, I would have to report that. I would not be able to keep these problems just between you and me because I want to be sure that you are safe and protected. If there comes a time where we must talk to other people, you and I will talk together about it first. Do you understand that it's okay to talk about anything with me, but there are other things we must talk about with other people?"

These scripts represent the most basic scenario of explaining confidentiality. In cases of child sexual abuse, urgency, fear and a desire to protect the child can sometimes lead to caregivers and caseworkers violating the child's confidentiality. For example, a service provider may be so focused on the child obtaining healthcare that they contact healthcare providers before talking with the child and their caregiver about a health referral. It is important that caseworkers stay grounded and are well versed in confidentiality and why it is critical for child survivors of sexual abuse. Only then are caseworkers also able to do no further harm and help others understand the importance of confidentiality.

KEY ISSUE 4: NAVIGATING MANDATORY REPORTING REQUIREMENTS

Mandatory reporting laws typically require public service providers, such as doctors, nurses, police, social workers and teachers, who regularly work with children **to report suspected or known cases of child maltreatment** to specific agencies. Depending on the context, reports may be made directly to the police, to government child protection agencies, or to specific departments within justice systems. Where mandatory reporting laws exist in relation to child abuse, the ultimate objective is to protect children from harm and ensure action is taken by proper authorities when abuse is known or suspected.¹⁰¹

In GBV work, mandatory reporting is almost always considered harmful because it usually involves going against the expressed wishes of an adult survivor or compelling an adult survivor to report to authorities to access a needed service which most often has safety implications. With children, this is not always the case. There are some scenarios when mandatory reporting may be beneficial and of added benefit for the child and their non-offending caregivers. For example, in a setting with well-established social services and justice mechanisms, mandatory reporting could result in much-needed additional support for a child survivor of sexual abuse and their non-offending caregivers.

Implementing mandatory reporting

In order to safely and effectively implement mandatory reporting requirements, caseworkers must:

- » have an accurate understanding of the mandatory reporting laws/policies in their context; Specifically:
 - whether the mandatory reporting laws apply to caseworkers, health staff, other service providers (for example, in some contexts, mandatory reporting laws may require health staff to report but not caseworkers);
 - how these laws/policies impact the child and their non-offending caregivers;
 - how to explain laws/policies to the child and their non-offending caregivers;
 - potential risks to mandatory reporting for all child survivors (for example, police ill-trained/not trained on child sexual abuse, punitive actions for child and/or non-offending caregiver, broken or fractured legal system with little likelihood of justice, etc.);
 - potential risks to mandatory reporting for child survivors that may be identity specific (for example, discriminatory practices against refugee children, sexual stereotyping that results in re-victimisation for particular adolescent girls by police or others in justice system, specific harmful practices like honour killing or child, early or forced marriage);
 - who the caseworker should go to if the risks outweigh potential benefits to mandatory reporting.

¹⁰¹ Mandatory reporting laws also exist for incidents of rape and sexual abuse of adults but are more common across contexts for child sexual abuse.

- » analyse specific criteria to determine whether reporting is in the child's best interests, and document and report this information to supervisors;
- » explain mandatory reporting requirements to children and caregivers at the outset of service delivery. This should happen as part of the informed consent process in Step 1 Introduction and Engagement (*see sample script in Chapter 6*).

If a mandatory report is required, caseworkers must share the following information at the start of the first meeting with a child survivor and non-offending caregiver:

- » the agency/person to which/whom the caseworker will report;
- » the specific information being reported;
- » when and how the information must be reported (written, verbal, etc.);
- » the likely outcome of the report;
- » the child's and family's rights in the process.

Children, particularly older children (adolescents), and caregivers should be part of the decision-making process on how to address mandatory reporting in the safest and most confidential way. This means caseworkers should seek and consider their opinions and ideas on how to make the report. This does not mean the caregiver and child can decide whether a report is made; rather, they can help decide how and when the report is made.

The best interests of the child should always be the primary consideration when taking actions on behalf of children, even in the context of mandatory reporting laws. The most beneficial/least detrimental course of action for the child, and the least intrusive one for the family, should be employed as long as the child's safety is assured.

Developing organisational policy on mandatory reporting

In settings where laws, policies, guidelines and systems exist, service providers should have established procedures in place for reporting suspected or actual abuse before providing services directly to children, as well as guidance on what to do if reporting might put the child at greater risk of harm. Best interest of the child, survivor-centred and do no harm principles should inform the development of such policies.

Supervisors should assess whether a mandatory reporting law or policy exists in the setting. If yes, they should establish procedures based on these key questions:

- » who is required to report cases of child abuse?
- » who are the officials designated to receive such reports?
- » when is the obligation to report triggered (for example, with suspicion of abuse?)
- » what information needs to be shared?
- » what are the reporting regulations regarding timing and other procedures?
- » how is confidentiality protected?
- » what are the legal implications of not reporting?
- » when should mandatory reporting procedures be re-evaluated? (At periodic times during the year? After certain events that may change the landscape for mandatory reporting?)
- » Is the mandatory reporting law specific to child abuse or is it specific to sexual violence, or both?
- » is there a PSEA reporting mechanism? What is the requirement for reporting under that mechanism?

GAINING INFORMED CONSENT AND INFORMED ASSENT

The age at which parental consent is needed to provide services to a child depends on the laws of the country. When a child is under the age of legal consent, caregiver consent is required. In the absence of any clear laws or adherence to laws, as a general rule children under the age of 15 years require caregiver consent.

INFANTS AND TODDLERS (AGED 0–5 YEARS)

Informed consent for children in this age range should be sought from the child's caregiver or another trusted adult in the child's life, not from the child. If no such person is present, the service provider (caseworker, child protection worker, health worker, etc.) may need to provide consent for the child, in support of actions that support the child's health and well-being.

Very young children are not sufficiently capable of making decisions about care and treatment. For children in this age range, informed assent will not be sought. The service provider should still seek to explain to the child all that is happening, in very basic and appropriate ways.

YOUNGER CHILDREN (AGED 6–11 YEARS)

Typically, children in this age range are neither legally able nor sufficiently mature enough to provide their informed consent for participating in services. However, they are able to provide their informed assent or willingness to participate. Children in this age range should be asked their permission to proceed with services and actions which affect them directly. This permission can be provided verbally by the child and documented as such on the informed consent form. For children in this age range, written parental/caregiver informed consent is required, along with the child's informed assent. If it is not possible to obtain informed consent from a parent or caregiver, then another trusted adult, identified by the child, who can be safely brought into care and treatment decisions should be approached to consent for the child.

YOUNGER ADOLESCENTS (AGED 12–14 YEARS)

Children in this age range have more advanced cognitive development, and, therefore, may be mature enough to make decisions on and provide informed assent and/or consent for services. In standard practice, the caseworker should seek the child's written informed assent to participate in services, as well as the parent/caregiver's written informed consent. However, if it is deemed unsafe and/or not in the child's best interests to involve the caregiver, the caseworker should try to identify another trusted adult in the child's life to provide informed consent, along with the child's written assent. If this is not possible, a child's informed assent may carry due weight¹⁰² if the caseworker assesses the child to be mature enough, and the caseworker can proceed with care and treatment under the guidance and support of their supervisor. In these situations, caseworkers should consult with their supervisors for guidance.

OLDER ADOLESCENTS (AGED 15–17 YEARS)

Older adolescents, aged 15 years and above, are generally considered mature enough to make decisions. In addition, 15-year-olds are often legally allowed to make decisions about their own care and treatment, especially for social and reproductive healthcare services. This means that older adolescents can give their informed consent or assent in accordance with local laws. Ideally, supportive and non-offending caregivers are also included in care and treatment decision-making from the outset and provide their informed consent as well. However, decisions for involving caregivers should be made with the child directly in accordance with local laws and policies.

If the adolescent (and caregiver) agrees to proceed, the caseworker documents their informed consent using a client consent form or by documenting on the case record that they have obtained verbal consent to proceed with case management services.

¹⁰² Due weight refers to the proper consideration given to the child's views and opinions based on factors such as their age and maturity.

ASSESSMENT GUIDELINES BASED ON AGE AND DEVELOPMENTAL STAGE

Talking with child survivors requires caseworkers to consider several factors, including the child's age and stage of development.

The level of a child's development is influenced by many factors besides age. The environment has an important impact, as do education, culture, nutrition, access to healthcare, social and family interactions, as well as war and violence and their consequences (for example, psychosocial and mental health problems, displacement).

When talking with children about sexual abuse, caseworkers limit the discussion time to:

- 30 minutes for children under 9 years;
- 45 minutes for children aged 10–14 years;
- One hour for children aged 15–17 years.

INFANTS AND TODDLERS (0–5 YEARS OLD)

- » **Do not talk to** children in this age range directly about their abuse. They have limited verbal communication skills and are unlikely to make any disclosures about abuse.
- » The non-offending caregivers should be the primary sources of information about the child and suspected abuse. Other significant adults in the child's life, particularly people who have provided care, should be consulted, including the person accompanying the child.

YOUNGER CHILDREN (6–9 YEARS OLD)

- » Children in this age range **can be directly assessed** by caseworkers. If possible and with the informed consent of the non-offending caregiver and informed assent of the child, the caseworker can also gather information about the abuse from trusted sources in the child's life.
- » Children in this age range may have a difficult time answering general questions. This may result in children saying, "I don't remember" or "I don't know", or they may give vague responses such as, "the man did a bad thing", but fail to share more.
- » Caregivers/parents or someone the child trusts can be involved in the interview as long as the child requests that the adult be present (and the adult is not a suspected abuser).
- » Children in this age range benefit from a mixture of both verbal and art-based communication techniques. Children in this age range shouldn't be asked questions that involve abstract ideas like justice or love. They tend to think in concrete (literal) terms.

YOUNGER AND OLDER ADOLESCENTS (10–17 YEARS OLD)

- » Children in this age range **can be directly assessed** by the service provider. Open-ended questions can produce important information about sexual abuse;
- » Caregivers/parents or someone the child trusts can be involved as long as the child requests that adult to be present (and that adult is not a suspected abuser);
- » Adolescents have more capacity for analytical thought and reflection, but caseworkers should remember that children in this age group are also still developing cognitively, emotionally, physically, etc.

Chapter 6

CASE MANAGEMENT WITH CHILD SURVIVORS

CHAPTER OVERVIEW

This chapter provides guidance on how to implement the six steps of case management for child survivors of sexual abuse. It reviews the key tasks of each step and articulates how the CCS approach to case management is applied in each step.

Associated tools

Safety Planning

CCS Mental Health and Psychosocial Assessment

Healing Education

Relaxation Training

Coping Skills

Problem Solving

OVERVIEW OF STEPS OF CASE MANAGEMENT

As introduced in *Chapter 1*, case management for child survivors of sexual abuse draws from both gender-based violence and child protection case management practice. In the CCS approach to case management, the primary role of the caseworker is to:

- » support and advocate on behalf of the child and family;
- » be the child's and family's main point of contact for assessment of needs;
- » support care and treatment goals and plan interventions to meet needs; and
- » provide, coordinate and follow up on the provision of services. Caseworkers do this by following a step-by-step process.

The steps and key tasks involved in each step (outlined in Table 6.1) are largely similar to those used in GBV and CP case management with small differences to reflect the particularities of working with with child survivors of sexual abuse.¹⁰³

Table 6.1: Key case management steps

Step	Caseworker Tasks
Step 1: Introduction and Engagement	» greet and comfort the child; » gain informed consent/assent for case management services (this includes explaining confidentiality and its limits and mandatory reporting requirements if present).
Step 2: Assessment	» gather information about the child and the nature of the abuse; » assess the needs of the child and/or caregiver.
Step 3: Case Action Planning	» develop the case action plan with the child and/or caregiver; » gain informed consent/assent for referrals to other services.
Step 4: Implement Case Action Plan	» assist and advocate for children to obtain quality services; » provide direct interventions, if appropriate (MHPSS); » complete any mandatory reporting procedures; » lead coordination of care.
Step 5: Follow-up	» follow-up on the case and monitor progress; » implement a revised action plan (if needed); » continue to provide MHPSS support.
Step 6: Closure and Evaluation	» assess for and implement case closure procedures; » conduct a service evaluation.

¹⁰³ In refugee contexts, UNHCR and implementing partners will implement case management for child sexual abuse within the context of [UNHCR's Best Interests Procedures \(BIP\)](#).

STEP 1: INTRODUCTION AND ENGAGEMENT

The initial case management step of introduction and engagement starts when the caseworker first meets with the child survivor of sexual abuse and/or the child's caregiver. During this step, the caseworker needs to:

- » greet and comfort the child;
- » gain informed consent/assent for case management services.

Greet and comfort the child

This is the caseworker's first chance to develop rapport with a child and their caregiver and begin to develop the basis for a trusting relationship. The caseworker's knowledge, attitudes and communication skills will become the basis for how the caseworker engages the child and caregiver and ultimately the extent to which they are able to establish rapport.

As discussed in *Chapter 4: Communication Skills*, caseworkers should be prepared to adjust the physical environment and their style of communication to create a setting that maximises comfort and communicates compassion to the child. As part of this first step, caseworkers should:

Introduce yourself: Caseworkers are in a different position than other adults likely regularly present in children's lives (parents/caregivers, teachers, etc) in that a key part of their role is to ensure the child's safety and well-being. Being clear about who you are and what your role is can help signal to the child that the caseworker will have a different relationship with the child. Caseworkers can be brief but clear for example: "My name is Asha and my job is to help girls and boys when they feel sad or have any problems. The name of my organisation is Safe Places. My job is to keep you safe, listen to you and give you information about how to get help if you need it."

Make the child feel at ease and provide options: From the outset of engagement, the caseworker can help the child feel at ease by giving them options - where and how to sit, offering for them to hold particular toys or other objects that the child seems to be initially curious about.

Observe the child: During these initial moments, caseworkers should observe the child and the caregiver and their interactions. This may allow the caseworker to begin to assess the child's maturity, age and development as well as the caregiver's support to the child.

Gain informed consent/assent for case management services

As discussed in *Chapter 5*, the process of gaining informed consent/assent first happens at the outset of the initial meeting with a child survivor of sexual abuse and their caregiver. After greeting the child and ensuring they are as comfortable as possible, caseworkers should begin the informed consent process to allow children and caregivers to provide their permission to participate in case management. In this first step, caseworkers need to explain:

- » the caseworker's role and responsibilities in case management;
- » what case management includes (for example, listening to problems, identifying needs, helping to meet needs) as well as clarify the benefits and limitations of services;
- » what confidentiality means, and how, on occasion, confidentiality cannot be kept (including conditions for which mandatory reporting is required);
- » how the child survivor's information will be safely and securely stored (this includes any case forms and database systems being used);
- » ways in which the client information will be used (data collection, information sharing for case management);
- » caseworkers should always offer children and caregivers the opportunity to ask questions or share concerns during this discussion.

A sample script for the informed consent process is below and can be adapted based on age, and developmental stage:

Sample script: Informed consent/assent for a child client

Hello *[name of client]*.

My name is *[name of staff]* and I am here to help you. I am a caseworker and my role is to help children who have experienced difficulties. I work for *[insert organisation]* and many children benefit from receiving our services. Today we may talk about why you are here so that we can discuss how I can help you and if there is other help that you need I can connect you to these services.

It is important for you to know that I will keep what you tell me confidential, including any notes that I write down during case management. This means that I will not tell anyone what you tell me or any other information about your case, unless you ask me to, or it is information that I need to share because you are in danger. There are sometimes I may not be able to keep all the information to myself for safety reasons.

- » If I find out that you are in very serious danger, I would have to tell *[insert appropriate agency here]* about it.
- » Or, you tell me you have made plans to seriously hurt yourself, I would have to tell *[caregiver]* your parents or another trusted adult.
- » If you tell me you have made a plan to seriously hurt someone else, I would have to share that *[with my supervisor or agency]*.
- » *[Mandatory reporting requirements if they apply in your local setting]*

I would also like to share with you that you have choices as we work together.

- » You do not have to answer any question that I ask you. You can stop me or ask me to slow down at any time.
- » You can speak with me alone or with your *[insert caregiver]*. This is your decision.
- » You can ask me any questions you want to, or to let me know if you do not understand something I say.
- » You can tell me that you do not want me to help you and that is ok. I will share with you some other options for help. .
- » If you do not want me to write anything down you can tell me.

Do you have any questions? *[Allow for time to answer any questions the child and caregiver may have before moving forward to obtain their informed consent/assent to proceed].*

May I have your permission to continue to help you?

- » **If YES**, ask the child and caregiver to sign the informed consent/assent form.
- » **If NO**, provide information about other services in the community.

STEP 2: ASSESSMENT AND STEP 3: CASE ACTION PLANNING

Once the caseworker has engaged the child and non-offending caregiver in services the caseworker can move onto Step 2: Assessment. Good case management rests on good assessment. The assessment informs the caseworker's analysis of what services may be needed to address the needs of the child survivor of sexual abuse. The process of discussing with the child and/or caregiver the recommended services and actions occurs in Step 3: Case Action Planning. Because these two steps are so interrelated and most often interwoven in the case management process guidance is provided for them together in this section.

In Step 2, the caseworker will:

- » gather information about the child and the nature of the abuse;
- » assess the needs of the child/caregiver.

In Step 3, the caseworker will:

- » with the child (and caregiver), develop the case action plan based on assessment;
- » gain informed consent/assent for referrals to other services.

Overview of assessment

The goal and purpose of the initial assessment is to safely and slowly assess the child's situation – and their experience of sexual abuse – to help identify the child's and caregiver's potential immediate and eventually, longer-term needs. During assessment, which is Step 2 of the case management process, the caseworker will gather information from the child and non-offending caregiver in order to:

Understand the context for the child and the abuse:

- » child's family composition and current living situation.
- » understanding what has happened to him/her.
- » understanding who the perpetrator is and whether they can access the child.
- » understanding if the child has already received care and treatment.

Assess the child's potential needs concerning:

- » immediate safety risks and needs.
- » appropriate medical care and treatment.
- » the child's MHPSS well-being and functioning.
- » the child's/family's desire to pursue legal/justice services.
- » other relevant needs.

Understand the context of the child: After establishing initial rapport with the child and obtaining informed consent (Step 1: Introduction and Engagement), the caseworker should seek to understand more about the child and their situation and why the child/caregiver are seeking services.

Some guiding questions that caseworkers should consider for developing a context or understanding of the child and their situation are:

- » how old is the child?
- » what is the family situation? Does the child have parents/caregivers? Does the child live with the caregivers? Is there a caregiver with the child now? Does the child have someone in their family that they trust?
- » what is the child's current living situation?

Note that some of this information may already have been gathered during Step 1: Introduction and Engagement.

The purpose of beginning the assessment session within these main assessment areas is to first learn basic, yet essential, context (that is, understanding) for the child. It also allows the caseworker to begin an assessment with questions that are not as threatening and/or scary as it may be for the child to be asked directly about the abuse he or she has experienced.

Supportive approach to assessment

While it is often necessary for caseworkers to gently inquire about the child's experience of sexual abuse during this step, **it is not necessary to elicit every single specific detail about the sexual abuse**. Very detailed questions about the child's sexual abuse should be asked once a safe and trusting relationship has been established between the caseworker and the child survivor, and only when the child is ready and wants to share such details.

Caseworkers should carefully follow the communication best practices from Chapter 4 for asking questions and watch the child closely for any signs of discomfort. If the child expresses verbally or non-verbally that he/she is not comfortable answering questions or telling you information about his/her experiences, caseworkers are advised to respect the child and stop. Many children, given proper time and space to develop trust in the caseworker, will open up to share about what happened. It may be necessary for the caseworker to explain to the child that "we can always come back to this at a later point" if he/she is not ready to answer a specific question and then redirect the conversation to a less threatening topic.

If caseworkers are unable to obtain necessary information need to repeat an assessment, they should explain this to the child in order to mitigate the child's fears that they are being asked more than once because they are not believed.

Understand the context of the abuse: Gathering certain information about the child's experience of abuse is vital to determining the urgency of the child's health and safety needs. Overall, the areas of focus for caseworkers in order to understand what happened include:

- » **Nature of abuse:** In other words, what happened? While caseworkers do not need to ask many details about the violence, it is crucial to find out if physical force was used and whether there was vaginal/anal penetration. Immediate medical care and treatment is highly indicated in these circumstances.
- » **Date(s) of the last incident:** Knowing the last incident date is essential to analysing the urgency of a medical referral and for accurately informing the child and caregiver about medical options. Different medical treatments are available depending on the date of the last incident.¹⁰⁴
- » **Who the perpetrator is and their access to the child:** What is the relationship of the perpetrator to the child survivor and their family? In other words, does the closeness of this relationship have implications for safety? Or to cause further distress/ harm to the child?
 - Where is the perpetrator (if the child/family knows) and can the perpetrator access the child easily?
 - What is the occupation of the perpetrator (their position - and level of power - could raise safety concerns)?
 - How many perpetrators are involved (this information may be gathered in additional sessions/interviews with a child survivor as part of their overall care and treatment)?
- » **Whether the child has already received care** and treatment services.
- » **Other information** shared by the child.

Assessment: Safety

Determining the child's current safety is the most important assessment area that must be discussed before the child leaves the first and subsequent meetings with the caseworker. The caseworker's priority is to assess with the child/ caregiver the child's personal safety needs, including physical and psychological safety in their home environment, community, and safety/ support systems. In cases of child sexual abuse, especially if the sexual abuse happened at home or with a family member, caseworkers should ask the child (if aged six years or older) about their safety concerns privately. This allows the child to speak without a parent/caregiver in the room and may elicit more information than would have been obtained otherwise. If a child refuses to speak with the caseworker alone and/or the child and caregiver appear upset or agitated, the caseworker should use their judgement and determine whether to proceed with the safety assessment jointly.

The most important question for caseworkers to answer during the safety assessment is whether the child is safe from further abuse. Information gathered during the initial assessment phase about the perpetrator will help answer this question. In addition the caseworker should evaluate:

¹⁰⁴ Note: the child may have a history of abuse. Questions related to the child's past history of abuse should be asked after immediate needs related to the current incident of violence have been resolved. Children should not be forced to recount every incident of abuse during an initial interview, as this can cause emotional and psychological distress.

- » **The child's sense of personal safety in the home environment.** Sample questions include:
 - "Does anyone at home scare you?"
 - "When you are at home do you worry that you will be hurt?"
 - "Does the person who hurt you visit your home?"
- » **The child's sense of personal safety in the community environment.** Sample questions include:
 - "When you are walking to school, do you fear anything or anyone?"
 - "Do you ever feel scared outside of your home... [if yes, 'where?']?"
 - "What is it like at your school?"
 - "Do you feel safe at school?"
- » **The child's identified safety/support systems.** Sample questions include:
 - "Who do you feel safe with?"
 - "When you have a problem, who do you talk to?"
 - "Who do you trust at home?"

Special considerations for safety assessments

When the perpetrator is a close male family member: In cases of child sexual abuse involving a close male relative, caseworkers should be alert for other kinds of violence, including intimate partner violence, physical abuse and/or serious neglect.

When the perpetrator is an adolescent girl's husband: In cases of child sexual abuse where an adolescent girl is married, caseworkers should be aware of the level of control and input into decision-making the husband and his family may be traditionally afforded. They should also consider the possibility of long-term, intimate partner violence that extends beyond the particular incident(s) of marital rape or other forms of sexual abuse the girl may be seeking services for. Specific considerations include:

- » what other forms of violence may be present in the home;
- » who the girl lives with in addition to her husband;
- » if the girl is a mother, her safety concerns for her children as well as any fears around how seeking services might impact separation from her children;
- » who, if anyone, can be identified as a trusted adult for her;
- » what her relationship with and access to her parents is like – are they likely to be supportive to her seeking services?

When the survivor is a very young child: In cases of child sexual abuse involving very young children, the perpetrator is most often known to the child and may have ease of access to them, even after a non-offending caregiver seeks services. In addition, the caregiver may not know who the perpetrator is or even that their child was sexually abused when they seek services. They may seek services because they feel they need support with the child's subsequent behaviours and not recognise the underlying cause of these behaviour.

Case action planning: Safety

Safety planning is an empowering approach to support the child and engage them in problem solving and planning based on their own strengths and protective factors. Based on the safety risks identified for the child and/or caregiver, the caseworker and the child and/or caregiver will jointly develop an action plan that includes referrals to protection and security agencies supplemented with an individual safety plan (as part of *Step 3: Case Action Planning*). If a child is not safe, an action plan must be in place before the child and caregiver leave the first meeting. Caseworkers may have to assess whether alternative care arrangements are necessary, first pursuing options with other family members or friends (if safe to do so) and then through state or other organisation's temporary shelter services.

Safety planning tools can help support the caseworker in making safety planning visual, tangible and concrete. These Guidelines provide examples of *Safety planning tools* for older and younger children

As part of *Step 5 case follow-up* the safety plan should be revisited as safety risks increase or decrease overtime.

Assessment: Health/medical needs

Rape and sexual abuse result in physical, mental and sexual and reproductive health consequences for children. The impact of sexual abuse in childhood can be long term and lead to poorer health outcomes in adulthood. Untreated, sexual abuse can be life threatening or cause chronic health issues. Therefore, determining whether a medical referral is needed is of primary and crucial importance in the assessment. Caseworkers are responsible for assessing the child survivor's immediate health needs, explaining to the child survivor and non-offending caregiver(s) about available health services regardless of when the incident occurred, referring the child survivor of sexual abuse to health services after obtaining informed consent/assent, and accompanying the child survivor and non-offending caregiver to health services as needed.

An effective health assessment requires understanding the type and quality of health services available, the laws with respect to accessing health services (that is, any mandatory reporting requirements), and what the survivor can expect in terms of the delivery of health services. Furthermore, the caseworker must be aware of the time-sensitive nature of certain types of health services. During the initial phases of assessment, when gathering information from the survivor and/or caregiver about the circumstances of the sexual abuse, caseworkers should be listening for the following:

- » nature of the assault - if the assault included physical contact and more specifically vaginal or anal penetration it is more likely to require immediate attention;
- » presence of injuries and/or complaints of pain which can indicate physical contact and penetration;
- » timing of the assault - whether the most recent assault occurred within 72–120 hours.

Caseworkers may also have to ask follow-up questions during this part of the assessment in order to determine whether and how urgent a medical referral is needed.

The following are potential urgent medical needs that require immediate attention:

Risk of HIV: If the nature of the most recent assault included physical contact and more specifically vaginal or anal penetration and it occurred within 72 hours, the survivor can be referred for medical care to receive HIV post-exposure prophylaxis within 3 days (72 hours). HIV testing can be done as early as 6 weeks after assault and should be repeated 3–6 months after the incident.

Risk of pregnancy: If the assault include vaginal penetration, the risk for unwanted pregnancy can be reduced if a survivor is referred for medical care to receive emergency contraception within 5 days (120 hours). Pregnancy testing can be done one week after the assault. In case pregnancy has resulted from the assault, the possible options should be discussed, in line with the local legislation.

Risk of other STIs: For both girls and boys there is the risk of sexually transmitted infections (STIs). STIs including chlamydia, gonorrhoea, syphilis and genital herpes should be treated with antibiotics and if left untreated may cause chronic illness or infertility. While there is not a time limit for receiving presumptive STI treatment, the sooner it is provided the more effective.

Clinical care for child sexual abuse

Depending on the circumstances of their abuse, some child survivors may require clinical care in order to treat and mitigate the immediate physical consequences of sexual violence.

Clinical care protocols and services for child sexual abuse should follow the [*WHO's Clinical Management of Rape and Intimate Partner Violence Survivors*](#) (2020) guidance. The guidance sets out standards of care that should be available and provided to survivors of sexual violence and IPV in humanitarian settings. It is intended for use by qualified health-care providers (medical doctors, clinical officers, midwives and nurses) who are working in humanitarian emergencies or other similar settings.

Caseworkers can advocate with health providers that a child survivor access such services, knowing prior to making a referral the quality of such services and explaining what the child can expect. Caseworkers can also alert supervisors when they become aware of health workers not following protocols and best-practices for clinical care (e.g. reporting a case to authorities prior to providing health care where this is not legally stipulated).

Acute injury or pain: Depending on the severity and nature of the injury (that is, broken bones, wounds or internal injuries), urgent medical attention may be indicated for medical stabilisation and treatment. Some serious and life-threatening injuries are not easily detected as they may not be physically visible or associated with pain (for example, internal bleeding to the stomach or brain, fistula, etc.).

Evidence collection: If the survivor requests evidence collection for legal purposes, it is important that a medical examination be arranged and recorded as soon as possible (within 72 hours). Note that evidence collection should not be carried out if there are no clear forensic procedures or the capability for the evidence to be analysed.

Other medical needs that may require treatment:

- » risk of hepatitis B and tetanus for which vaccinations and prophylaxis can be provided if there has been risk of exposure and vaccinations are not up to date;
- » incontinence of urine or stool may indicate severe complications resulting from injury, such as fistula- or rectal-sphincter damage requiring surgical attention;
- » a physical and/or external genital exam may be necessary to assess injuries. A physical exam may also be reassuring to the survivor to ensure that they are fine physically, not internally injured and free of infections.

During assessment, the caseworker should also seek to understand:

- » if the child has already been to health services and what they received;
- » ongoing needs for medical care and treatment for this incident including follow-up appointments.

Case action planning: health and medical care

Case action planning in response to medical needs focuses on providing information to the child and/or their caregiver about the services available, how those services may address the needs identified, the potential risks/ consequences of accessing such services, and what the survivor can expect when receiving the service.

Child survivors and their caregivers state that receiving clear information and explanations of processes, respect for privacy and confidentiality, non-judgemental responses that communicate belief and prioritise the child or adolescent's safety and needs are critical aspects of receiving healthcare.¹⁰⁵ Caseworkers have a role to place facilitating access to health services by preparing the survivor and their caregiver for the service and obtaining informed consent for a referral.

¹⁰⁵ Broadus-Shea, E. et al., 'A review of literature on good practice considerations for initial health system response to child and adolescent sexual abuse', Child Abuse & Neglect, 116, 2021.

Providing information: Caseworkers should be able to explain to the caregiver and survivor in a child-centred way that:

- » the most comprehensive sexual health services can be received within 72 hours of a sexual abuse incident;
- » some (but not all) services can be received within 120 hours of a sexual abuse incident;
- » even weeks or months after abuse occurred, it is important to offer a referral to health services as only some services are time sensitive;
- » for any physical examinations, including a forensic examination for the purposes of evidence collection, the child has the right to:
 - choose who else is present in the room while the examination takes place;
 - choose who carries out the examination (male or female examiner);
 - choose where the exam is done - e.g., on the lap of a trusted caregiver, on a chair, on the examination table;
 - receive explanations of what will happen before each step occurs;
 - provide informed consent/assent for various processes and steps of the examination;
 - stop the examination at any point.

Sample script for preparing a child for health services (specifically some aspects of clinical care)

When you go to the clinic, you will see a [insert clinical care focal point for the context]. Your [non-offending caregiver or other identified support person] can go with you and stay with you while you see the [focal point], but the [focal point] may want to speak with you alone for a few minutes. The healthcare worker will explain everything to you, they will ask you some questions to get to know you better, learn more about what happened, and learn how to provide you the best medical care. They might ask to examine you, to look at your body to see if you are healthy and well. It will not hurt. They might offer you medicines to help you stay healthy. Do you have any questions about who you will see or what will happen at the health clinic?

Navigating common challenges with

medical referrals: Part of the caseworker's role is also to discuss the potential risks and concerns that may exist when accessing healthcare services. For example, common risks and possible barriers to seeking and receiving care include:

- » the attitudes, beliefs and bias of healthcare workers about survivors of sexual abuse;
- » lack of training in child-led and survivor-centred principles;
- » limited recognition or ability to meet the unique needs of diverse child survivor of sexual abuse;
- » problematic mandatory reporting laws and procedures.

Depending on the quality of health services, caseworkers may need to prepare the child and/or the caregiver that health staff may not be trained in how to provide services in a child-centred manner. The caseworker should discuss with the child/caregiver how to address that. For example:

- » can the caseworker accompany the survivor?
- » is there someone else who can accompany who feels confident advocating for the child's care?
- » would there be a point at which the child and/or caregiver could decide to stop the services?

Mandatory reporting: In some contexts, mandatory reporting laws require

documentation to be completed and submitted to law enforcement before receiving healthcare. Some laws penalise healthcare workers with loss of licences or ability to practice medicine if they do not report. Even when these laws have exemptions or have been repealed, healthcare workers may still be operating under the belief that they have to report. In these instances, it is important that caseworkers inform the child and caregiver prior to making a referral and discuss possible consequences of a mandatory report and make a safety plan related to it.

Healthcare worker attitudes towards adolescent girls

Just like other service providers, healthcare workers may hold certain bias towards adolescent girls which could result in particularly problematic actions and further harm to these survivors. Adolescent girls may face blame and shame from both parents or caregivers and healthcare providers. Stigma associated with sexual activity can result in healthcare providers and parents or caregivers being resistant to providing adolescent girls with all available reproductive health services when seeking CMR services. Bias on the part of the healthcare worker may also be coupled with customary practices that support child early and forced marriage to the perpetrator as well as subjecting girls to virginity tests. If a healthcare worker supports these practices, this could increase the risk of the healthcare worker involving traditional justice, community leaders or police against the adolescent girl's and her caregiver's wishes or best interests.

Caseworkers should discuss with the adolescent girl and her non-offending caregiver the potential attitudes, bias and potential harm that may be caused by the healthcare team in these situations.

Evidence collection may be required as part of mandatory reporting laws. For example, a law may mandate that evidence collection must be completed to receive full medical attention. Children and caregivers affected by such laws need to know this ahead of time unless the need for emergency services prevents discussing this.

Assessment: Psychosocial needs

Mental health and psychosocial support (MHPSS) are critical to ensuring children who experience sexual abuse can heal and continue to build coping mechanisms that can help in their recovery. In humanitarian contexts, MHPSS programmes for survivors, families and communities should use an integrated approach aimed at supporting child resilience.¹⁰⁶ An integrated approach recognises the importance of MHPSS activities that promote resilience and support coping strategies for children, their families and their communities, while acknowledging that specialised mental health services might not always be available. Caseworkers may be both the first service providers to see child survivors of sexual abuse and the service providers with the most experience and training to respond to MHPSS needs. Therefore, the MHPSS interventions they provide (at level 2 of the MHPSS pyramid: Community and family supports and level 3: Focused, non-specialised support) pyramid are critical supports in the child survivor's recovery.

MHPSS interventions should address the mental, emotional, social, and spiritual needs of child survivors and their caregivers/families. They should build internal and external resources for children and their caregivers/families to cope with adversity.

Case management, when using a survivor-centred approach, promotes mental health and psychosocial well-being and can be considered a form of MHPSS. When caseworkers provide non-judgemental assistance, validation and support to access resources, they can positively impact a survivor's recovery.¹⁰⁷ Caseworkers are well-placed to provide basic MHPSS interventions to child survivors and their caregivers, following the initial case management process. Lastly, case management is also an important method for helping survivors access other MHPSS programmes and resources in their community.

Conducting the CCS mental health and psychosocial needs assessment

After the initial assessment and actions to address immediate needs like safety and health have taken place, caseworkers can begin to assess more specific mental health and psychosocial needs. Caseworkers can use the *CCS Mental Health and Psychosocial Needs Assessment* tool to better understand the child's social and family environment, psychological well-being and strengths.

¹⁰⁶ Inter-Agency Standing Committee, [Guidelines on Mental Health and Psychosocial Support in Emergency Settings](#), IASC, 2007.

¹⁰⁷ Garcia-Moreno, et al., 'The health-systems response to violence against women', *The Lancet*, 385, No. 9977, 2014.

Before conducting the mental health and psychosocial assessment: Caseworkers must determine the capacity of children to participate in a mental health and psychosocial assessment based on their capacity to understand what is happening and their willingness to participate. However, generally mental health and psychosocial assessments can be conducted with children aged eight years and older. Caseworkers will also need to decide whether - and how - to involve children's caregivers or other trusted adults in the assessment. Analysing who, if anyone, is best suited to participate in the child and family assessment depends on specific information likely to have been discovered during the initial stages of case management. For example, a caseworker might consider the presence of:

- » a supportive, non-offending caregiver/parent;
- » the person who referred the child for services, taking into consideration the person's relationship with the child;
- » people identified by the child directly as trusting adults in the child's life, or people who spend significant time with the child.

The *CCS Mental Health and Psychosocial Assessment* tool guides the caseworker to understand the child's situation regarding:

- » home and social contexts, including an assessment of the parent/child relationship;
- » day-to-day well-being and functioning;
- » caregivers' feelings and beliefs toward the child and sexual abuse;
- » child and family strengths;
- » opportunity to assess further safety issues (as part of ongoing intervention).

Detailed guidance and considerations are included in the tool annexed.

Case action planning: MHPSS interventions

There are common and effective interventions that caseworkers can provide to help children with the MHPSS difficulties discovered during the assessment process, and which do not require extensive training and expertise in mental healthcare. They include:

- » healing education;
- » relaxation training;
- » coping skills identification and training;
- » problem solving.

Each of these interventions requires dedicated human and financial resources, as well as some degree of skills training and supervisory support for providers (note: supervisors do not need to be mental health specialists to be able to provide the right supervision). These interventions will also typically be a supplement to generalised case management, rather than a replacement. They are usually integrated into the case management process.

Table 6.2 provides an overview of each intervention, who it targets, its goals and the required training and supervision to implement the intervention. Instructions for implementing each intervention can be found in the tools at the end of this Chapter.

Table 6.2: MHPSS interventions

Intervention	Target	Goal	Required training	Supervision
<u>Healing education</u> ¹⁰⁸	Children aged 5–6 years and above depending on maturity; caregivers.	Understand the impact of sexual abuse. Learn how to stay safer in the future and how to cope with emotional and physical reactions provoked by abuse.	High level technical knowledge about child sexual abuse. Training 1–3 days, depending on existing skills and experience.	Include in ongoing supervision sessions. Specific checks into capacity strengthening plans.
<u>Relaxation training</u>	Depending on exercise, children aged 2 years and older; caregivers.	Cope with stress and reduce physiological symptoms, such as racing or pounding heart, difficulty sleeping or concentrating, anger, anxiety, etc. ¹⁰⁹	Practice sessions that include an explanation of the exercise and what it aims to do, a demonstration of the exercise, practice time and reflection.	Supervision of practice sessions. Check in during regular supervision about implementation.
<u>Coping plan</u>	Children 10 years old or older. Depending on maturity and ability, a younger child can, in partnership with caregiver.	Children identify and develop their own internal coping mechanisms, including skills to calm themselves, recognise when they need to reach out for support, and skills to manage difficult emotions.	Practice with supervision.	Observation and feedback through practice. Reflection on implementation.

¹⁰⁸ IRC and UNICEF, [Caring for Child Survivors of Sexual abuse: Guidelines for health and psychosocial service providers in humanitarian settings](#), IRC and UNICEF, 2012.

While the technical term is "psychoeducation", for "healing education" was developed as part of the pilot of the original CCS Guidelines because it was easier to translate and understand in other languages. CCS Second Edition continues to use "healing education" for consistency.

¹⁰⁹ McNeil, D.W. & Lawrence, S., '[Relaxation Training](#)' in M. Hersen & W. Sledge (Eds), *Encyclopedia of Psychotherapy*, Elsevier Academic Press, 2002.

<u>Problem solving</u>	Children (10 years old or older). Depending on maturity and ability, a younger child can, in partnership with caregiver.	Individuals with tools to identify and solve problems that arise from life stressors, to improve overall quality of life. ¹¹⁰	Practice with supervision.	Observation and feedback through practice. Reflection on implementation.
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Other activities: Each of the interventions presented in this section can be done with minimal additional resources, time and training. However, that is not true for all MHPSS activities that a case management team may find useful and wish to implement with child survivors of sexual abuse. Several resources exist to support teams in appropriately integrating MHPSS services into programmes. For CP and GBV actors working with child survivors, these include:

- » The Minimum Standards for Gender-Based Violence in Emergencies.
- » Minimum Standards for Child Protection in Humanitarian Action.
- » The [Mental Health and Psychosocial Support Minimum Service Package](#).

¹¹⁰ Nezu, A.M., Maguth Nezu, C. & D'Zurilla, T., [Problem-Solving Therapy: A Treatment Manual](#), Springer Publishing, 2012.

STEP 4: IMPLEMENTATION

During this step, the caseworker will:

- » assist and advocate for children to obtain quality services;
- » provide direct interventions, if appropriate (mental health and psychosocial);
- » complete any mandatory reporting procedures in line with the best interests of the child;
- » lead coordination of care.

Once the initial assessment and case action planning steps are complete, it is time to implement the action plan. Typically, children and families require assistance with accessing other services (for example, referrals for safety interventions and medical care). In many settings, caseworkers will directly provide MHPSS and similar services, as well as link children and families with other agencies.

Assist and advocate for children to obtain quality services

Based on the action plan created between the child and caseworker, the caseworker will carry out their responsibilities related to helping obtain the necessary services. There are many different ways the caseworker can assist the child and caregiver with obtaining services. Typical actions include:

- » accompanying children/caregivers to the police, health and other service providers;
- » advocating on behalf of the child. Some common examples are advocating:
 - with police and security personal to take protective measures;
 - for compassionate and quality medical care and treatment;
 - for children's views and opinions to be taken into consideration in actions that affect their life and well-being.
- » meeting with service providers (for example, health workers) to explain what happened and provide information about the abuse so the child is not forced to repeat their story (which information the caseworker shares should already have been discussed with child during case action planning).

Provide direct interventions (mental health and psychosocial)

For case management agencies also providing direct MHPSS interventions, caseworkers conduct MHPSS interventions during this step. Direct MHPSS interventions like those described in the previous section are interventions provided by the caseworker directly to the child and/or family.

Complete mandatory reporting procedures

Part of the caseworker’s responsibility is to complete any mandatory reporting procedures that are required in a particular setting. Mandatory reporting requirements should already have been discussed with the child and caregiver as part of the informed consent process and during case action planning. The child and caregiver must be fully aware of the process, procedures and protocol. As discussed in *Chapter 5*, decisions on mandatory reporting should be made with the child and caregiver and in line with best interests, survivor-centred and do no harm principles. Risk mitigation measures and safety planning related to mandatory reporting should already be in place with the child and caregiver before any reporting is implemented.

Lead coordination of care

It is the role of the caseworker to lead the coordination of the child’s care. Coordination activities may include directly arranging access to services; reducing barriers to obtaining services; establishing linkages; and other activities recorded in progress notes. Coordination strategies specific to CCS case management and which should take place at an organisational / sectoral level are elaborated on in *Chapter 8: Coordination*. However, there are specific mechanisms caseworkers can use in order to coordinate care at the case level, such as:

- » **Case consultations:** A useful mechanism to seek support and guidance from a supervisor, senior caseworker or another provider on a particular issue in a case (such as compounding CP or GBV issues). They are especially useful when the case would benefit from expert consultation that is beyond the scope of the team providing case management.
- » **Case conferences:** Create a regular opportunity for multiple service providers to review case plans for complex and/or high-risk cases. They can be especially helpful to address situations where a child’s needs are not being met; to identify or clarify ongoing coordination issues amongst service providers; and to provide the child with more holistic, coordinated and integrated services.

Table 6.3 outlines the details of these mechanisms in terms of participants, timing and privacy and data protection issues.

Table 6.3: Characteristics of case consultations and case conferences

Type of meeting	Case consultation	Case conference
What is the purpose?	To seek support and guidance from a supervisor, senior caseworker or another provider on a particular issue in a case. Especially useful when the case would benefit from expert consultation that is beyond the scope of the team providing case management.	To create a regular opportunity for multiple service providers to review case plans for complex and/or high-risk cases. Can be especially helpful to address situations where a child's needs are not being met; to identify or clarify ongoing coordination issues amongst service providers; and to provide the child with more holistic, coordinated and integrated services.
Who participates?	The child's caseworker, the supervisor and at least one caseworker or supervisor from the other sector.	The child and/or their caregiver (if appropriate), the caseworker, the supervisor and at least one staff member or supervisor from each of the other departments – or organisations – providing services to the child and their family.
	<i>There should NOT be any individuals at the consultation or conference that are not directly involved in the child survivor's case.</i>	
When does it happen?	As often as necessary. Often initiated early in the case management process. Can be particularly helpful when a child and/or their caregiver do not wish to be referred for additional services, but their needs go beyond the expertise of the primary caseworker.	Regularly through the case management process. The primary caseworker, or if needed, a direct supervisor is responsible for scheduling these regular meetings, inviting participants (ensuring sufficient notice), setting an agenda and facilitating the meeting.
Identifying data shared?	No. The case should be discussed in general terms (e.g., "the child", "the female caregiver", rather than names or other identifiers).	Yes, because the survivor and/or their caregiver are present and all participants in the meeting must already be actively involved in the case management process.

STEP 5: CASE FOLLOW-UP

During this step, the caseworker will:

- » follow up on the case and monitor progress;
- » implement a revised action plan (if needed);
- » continue to provide mental health and psychosocial and mental health support.

Case follow-up visits allow the child and the caseworker to update each other on actions taken since the first meeting and ensure the child has received needed services and to assess any improvement in the child's situation. Follow-up visits also provide the opportunity for the caseworker to re-assess the child's safety situation, assess for any new urgent needs that may have arisen since the last meeting, and discuss longer-term needs and care.

Regular follow up also helps the caseworker to continue to build trust with the child survivor of sexual abuse and non-offending caregiver, which often helps child survivors of sexual abuse and non-offending caregivers to disclose additional aspects of the sexual abuse and/or new issues. Child sexual abuse can be very isolating, so regular follow up helps to instill a sense of connection and hope in child survivors and their non-offending caregivers.

For follow-up visits, caseworkers should agree upon times and mechanisms with the child and caregiver during the initial assessment and case action planning process. Follow-up meetings should take place in a location where the child is comfortable and confidentiality can be protected. They should include a specific time, date and place based on individual needs.

STEP 6: CASE CLOSURE AND EVALUATION

In this step, the caseworker will

- » assess for readiness for case closure and implement case closure procedures;
- » evaluate services through client feedback.

Assess for and implement case closure

Case files should generally be closed when:

- » the case plan is complete and satisfactory, and follow up is finished;
- » there has been no client contact for a specified period (for example, more than 30 days);
- » the child client and caseworker agree that no further support is needed.

Case closure is an opportunity for caseworkers to revisit the case action plan with child survivors of sexual abuse and non-offending caregivers and to discuss whether the case management goals have been met. The caseworker should facilitate a discussion with the child survivor and non-offending caregiver in a manner appropriate to the child survivor's age and developmental stage on whether their goals have been met and if additional services are needed. Caseworkers, together with the child survivor and non-offending caregiver, must think about whether closing the child survivor's case is in the child survivor's best interests.

When cases are very complex, and especially where risks are very high, it is likely that a case will remain open for a long time. This is an issue that needs discussion and planning with the case management supervisor to ensure that services are not compromised by an organisational need to close a case before all issues have been worked through.

In contexts where caseworkers may see the child survivor of sexual abuse only one time, they must prioritise the assessment and case action planning steps and provide as much information as possible to the child survivors. The caseworker will need to thoroughly document the information provided to the child. The caseworker should keep the case file open for a period of 30 days, and then close the case if there is no contact with the child client after 30 days.

In contexts where follow up is possible, cases should not be closed until the last follow up is satisfactory. This usually happens when the child's and family's needs are met and/or their (normal or new) support systems are functioning. It is important to make sure that case closure is child centred and that the child is ready for the case to be closed. When a case is closed, the caseworker should give the child (and caregiver, as appropriate) assurances that they are welcome to contact the caseworker in the future if necessary. Caseworkers should document when a case is closed and the specific reasons for doing so.

Evaluate case management services through client feedback

Evaluation is one way for caseworkers to receive feedback from child survivors of sexual abuse and non-offending caregivers they have supported. The purpose of a client feedback is to improve services and better meet the needs of child survivors in the future. It should not be used as a staff-performance tool. Most often, service evaluations are completed through an interview with the child survivor and non-offending caregiver by a staff member other than the child's caseworker. In some cases they can complete a written questionnaire. In general, the guidelines for directly involving and interviewing child survivors as part of a service evaluation are:

- » if the child is 9 years old or younger and the caregiver was actively and positively involved in the child's care and treatment, only the caregiver should be interviewed;
- » if the child is 10–12 years old, and the caregiver was actively and positively involved in the child's care and treatment, caregivers should be interviewed. However, children at this age should also be asked for their opinion about the care they received; they can be included in the interview with the caregiver or interviewed separately. This should be decided on a case-by-case basis;
- » if the child is 14–18 years old, they are able to be interviewed directly about their opinion of services provided. If appropriate, a separate interview with the child's caregiver may be useful, if they were actively and positively involved in the child's care and treatment. Generally, adolescents should provide permission to the caseworker before the child's caregiver is approached.

As with all services, caseworkers are required to obtain permission from the child survivor of sexual abuse and non-offending caregiver to conduct the service evaluation. Caseworkers should inform child survivors that all responses will be confidential and that interview does not include questions about their case; it serves only to obtain information about the services they have received. If the child survivor can read and write and would like to complete the questionnaire on their own, this is also acceptable.

SAFETY PLANNING TOOLS

A safety plan is a tool that a caseworker and the child (and their family members if appropriate) create to reduce the risk of harm. The plan is created together with the child and includes identifying safe places and people. It also outlines ways children can seek safety in different situations. Below are tools that caseworkers can use to facilitate discussions about safety and safety planning with children of different ages.

Safety Planning Table

The safety planning table uses the categories of: patterns related to the child's safety, the child's responses to unsafe situations, supportive people in the child's life, and safe places the child is already accessing or can access. The caseworker can discuss these topics with the child using the questions as a guide—first assessing safety and then using that information to support safety planning. The first table can be used with older children. The second table is a condensed version that can be used with younger children.

Topic	Assessing safety	Safety planning
Patterns	» Can you tell me about some of the times you feel unsafe? » Are you in a specific place? » Is it a certain time of day? » Are you alone? If not, who is with you? » Have you noticed anything in particular that comes before that (violence)?	» Is there a way you can avoid ... [location] without getting in to trouble? » Is there an adult who you trust who could be with you ...[at the time or in the place identified]? » Is there anything we could do to make you feel safer at home/school etc?
Response	» What do you usually do if you are in danger or feel scared » What do you tend to do in that situation? » Does that strategy work well for you? » Is there anything else you would like to do? » Do you have a phone or access to the phone of a neighbour, friend, family member etc? » Are you able to keep your money/phone in a safe place?	» Do you have credit on your phone? » Do you know anyone who would let you borrow their phone? » If there is trouble, you can call... » Do you have a friend who could safely help you to access [insert location or service]? » Are you able to carry your important things (e.g. documents, money, photos) with you in case you need to move quickly?
Supportive people	» Who do you speak to or get the attention of if you are in danger? (e.g. neighbour, friend, family member, staff) » Is there anyone you trust who knows about the abuse? » Is there anyone who could speak to (the perpetrator) about their violence without you getting in trouble?	» Is there anyone nearby who you go to for help and advice? » Is there someone nearby who you would feel comfortable going to if you did not feel safe? » You can contact me if you don't feel safe. Would you like that?

Safe places	» Where do you go if you are in danger? » Is there a place you would like to go to but have not yet?	» Is there a place you could go to if you don't feel safe? » Do you know of any safe spaces nearby? (e.g. neighbour, community leader, child friendly space etc.) » How would you get out of the home if there was danger? » Is there a particular day or time when you are able to leave the house and move more freely? (i.e. less likely to be observed) » Do you have any sisters or brothers who could help you (or you would want to help) if you were in danger? » Would you ask for help (or help) any of your brothers and sisters to come with you?
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For use with younger children

Topic	Assessing safety	Safety planning
Supportive people	» Do you have a friend who is very kind? What do you like about them? » Who do you talk to when you feel worried? » Do you have a neighbour here who you trust?	» If you were worried or upset, who would you like to help you? » If you were worried or upset, could you go to...(i.e. trusted adult such as neighbour or parent of a friend).
Safe places	» Do you have a favourite place round here? » Where do you go if you feel worried or unsafe? » Do you know where the....is? (insert safe space such as child protection space, community leader, police etc.)	» If you were worried or upset, would you go to...(identified safe space)? » Would you need any support to get to your safe space? (e.g. from neighbour or older sibling/ friend). » Shall we draw a map of the path from your home to your favourite/safe space?

SAFETY CHECKLIST

The safety checklist helps identify specific actions children can take when they feel unsafe. They document the plan and/or memorize specific actions such as numbers, code words, etc. This is appropriate for ages 10 or above (or more generally with children that can read and write easily).

If there is a problem or I do not feel safe...	
I can call someone using these phone numbers	
I can use this alert word	
I can go to these people	
I can go to these places	
I can leave my home by doing these things	
I can carry these things with me	
I can help (or ask for help from) my sisters and brothers by	

Community map

The community map helps the caseworker gain a better understanding of the child's community; outline risks and protective factors in the community; and identify unsafe and safe people and places. It can be used with children ages 4-12.

In this exercise, the caseworkers asks the child to:

- » draw a small house in the middle of the paper;
- » draw all the places and people they visit around the house and label them;
- » mark each of the places they like with their favorite color;
- » mark each of the places they do not like with a different color.

The caseworker then discusses the drawing with the child to understand the child's drawing and ways in which the child marked people and places. The caseworker can use this information to help the child understand and work with risk and protective factors.

SAFETY CIRCLE

The safety circle can be used to gain a better understanding of what items, people or places make a child feel safe or unsafe; identify people children can go to when they feel unsafe; and identify places children can go when they feel unsafe. It can be used with children ages 3-12.

In this exercise, the child draws a circle and puts inside the circle what and who makes him or her feel safe. This can be an excellent way to identify safety concerns the child may have. The caseworker can take this activity a step further and have the child draw the things outside of the circle that they are scared of/ make them feel unsafe (the circle being the symbolic boundary of safety). This can provide additional information about the child's perception of risk (what and whom) and safety (what and whom).

CARING FOR CHILD SURVIVORS MENTAL HEALTH AND PSYCHOSOCIAL ASSESSMENT

Instructions:

The Caring for Child Survivors Mental Health and Psychosocial Assessment (CCS MHPSS Assessment) can be administered as a stand-alone assessment multiple times throughout the CCS case management process. It should not be administered when the child survivor first discloses, needs immediate medical attention, or expresses that they are in physical pain. Usually, the first opportunity will be in the second or third meeting with the child and non-offending caregivers.

For Supervisors:

If your agency does not have a general psychosocial assessment you can integrate this assessment into your existing case management approach and tools once staff are trained on how to use it. If your agency has a general psychosocial assessment that case workers have received training for and have experience using, components of this assessment can be integrated into the agency's existing tool. At minimum, the following should be included:

- » main worries/problems;
- » family and living situation;
- » social support;
- » child functioning assessment;
- » child and family strengths.

Case action planning for MHPSS can be integrated into existing action planning forms.

For Case Workers:

As you, the child survivor, and non-offending caregivers work together and address immediate health and safety needs, you may have opportunity to more deeply explore and address the psychosocial needs of the child. You may also identify psychosocial needs for the caregiver, however, these will need to be addressed through a referral to another case worker. When administering the MHPSS assessment:

- » do ensure you take appropriate time, take breaks, and move at the pace of the child;
- » anticipate the potential for both the child and the non-offending caregiver may find some questions difficult to answer, bring up hard emotions and painful situations;
- » use developmentally appropriate methods of communication and questioning, including playing games, drawing, and other methods. Be sure to always discuss drawings to avoid inaccurate interpretations;
- » when action planning, focus on strengths, resiliencies and ways to enhance these in addition to addressing concerns, sources of stress, etc.

Consider the following guidance for each of the main sections of the tool.

Part 1: General Assessment of the Child:

- » consider if it will be useful to find out from caregivers what they perceive as the main problems and concerns;
- » if possible, assess main problems with the child and caregivers separately so that both are able to share freely with the caseworker;
- » pay attention to whether the child's and caregiver's main concerns/worries are the same or different;
- » if the concerns/worries are different, the caseworker should discuss the child's concerns with the caregiver to promote communication and understanding between the child and caregiver;
- » record the perceived main concerns of both the child and caregivers in **Part I: General Assessment**.

Part 2: Family and Social Context:

- » seek to assess the child's family, social, spiritual, and community situations to better understand the broader environment around the child;
- » focus on specific data on the child's living situation (where do they eat and sleep? How many people live in the home? etc) as well as the child's lived experience in order to build off what is already known from the initial assessment;
- » consider key questions around lived experience, including:
 - who did the child trust the most in the family before the abuse happened?
 - who does the child trust after the abuse? Is the child happy at home? Does the child have basic needs met (food, clothing, education, protection)?
 - is the child treated differently from other children in the family? If yes, how so?
 - when is the child able to play freely?
- » when considering the wider environment, including social and spiritual aspects of community, assess:
 - what areas of the child's social support have diminished following the abuse?
 - what activities can the child increase, resume, or begin? What support do they need to engage in these activities?
 - what areas of the child's social support remain strong?
 - what resources, including religious leaders/community, may be sources of support?
- » record important details and facts in **Part II: Family, Social and Spiritual Context**;
- » in the section **Other Notes**, the caseworker can record additional details that are important but not specific to the family, social and spiritual contexts.

Part 3: Overall Functioning:

- » look at a child's behaviours, feelings, and expressions of somatic or "physical" complaints;
- » seek to identify changes that may have occurred since the incident of sexual abuse and/or the disclosure of abuse;
- » recognize that the assessment points included here are not exhaustive but represent common changes observed in children who experience abuse.

Use an age/development adjusted version of the specific statement:

- » "I am going to read some sentences to you. Please tell me how TRUE these sentences are about you. Think about how true these things are since _____ [describe abusive event... e.g., you were raped]."
- » Explain that the child should do their best to answer "yes" or "no" to the statements being read. Ensure reasonable accommodations are made to assist the child in being able to answer yes or no. If the child is unable to give a yes or no answer, indicate "unsure" in the comments section.

Part 4: Caregivers' Feelings and beliefs:

- » recognize that it may not be possible to safely assess caregivers' feelings and beliefs. But if possible, caregivers' feelings should be assessed;
- » caregivers' perspectives can provide insight into the support (or lack of) the child is receiving;
- » ask a series of questions and create space to share their views, feelings, opinions, and questions freely – do this part of the assessment without the child present.

Use the following key questions as a starting point for the assessment of the caregivers' feelings and beliefs:

- » **what is your understanding of the abuse/what happened?** This question helps the caseworker understand how much the caregiver knows and understands about what happened. The caseworker should watch out for statements of blame directed toward the child;
- » **what are your feelings about the abuse/situation?** This question explicitly asks caregivers what their feelings are about the sexual abuse. Here the caseworker should attempt to evaluate the caregivers' own level of emotional distress and their feelings toward their child. Caseworkers should ask whether caregivers' feelings have changed toward their child since the abuse;
- » **what changes have you noticed in your child since the abuse?** Oftentimes, reports of children's emotional distress come from adults in the child's life who notice behavior changes. This question also provides caseworkers with more information about the caregivers' perspectives on their child;
- » **what do you think will help your child right now?** Identifying what caregivers think is useful and important to help their children heal and recover. Supportive caregivers know their children well and their ideas about how to support their children's healing should be asked and integrated into psychosocial care plans;
- » **what are your main worries and needs right now?** This question provides an opportunity for caregivers to share their personal worries and fears while alerting the caseworker to additional needs/ worries that may impact the child.

Record answers to these questions in **Part IV: Caregiver Assessment**

Part 5: Child and Family Strengths:

- » recognize that children and families are resilient, and the majority of child survivors will recover with appropriate support;
- » assess both the child's strengths and the family's strengths.

Caseworkers should help children identify their own strengths, such as:

- » their courage;
- » their positive personality characteristics;
- » their pride.

Questions such as, "With all that has happened, what makes you smile, even just a little?" can help children identify aspects of their lives that give them hope. If a child cannot identify a strength or area of pride, the caseworker should reinforce what they personally have identified in the child.

Caseworkers should also help caregivers identify family strengths, including:

- » personal strengths as a caregiver like supporting their child, advocating for their child's needs, protecting their child and seeking services for them, handling family problems, and encouraging their child's hopes and dreams;
- » attachment to the child – strong and supportive attachments between caregivers and the child are vital to the child's recovery;
- » family capacities, hopes, and dreams – learn how caregivers traditionally solve problems, what capacities they have currently (supportive friends, extended family, a nonviolent home, etc.);
- » social support – connectedness to community and larger networks;
- » Jobs and financial assets.

Record the main points of this discussion in **Part V: Child and Family Strengths.**

Once these areas are assessed, the caseworker will analyze the information and choose, in collaboration with the child, psychosocial interventions based on the main problems identified. This process and actions taken can be documented within an existing case action plan or in **Part VI: Psychosocial Evaluation and Action Planning.**

Survivor Code:

Incident ID:

CARING FOR CHILD SURVIVORS MHPSS ASSESSMENT

Caseworker code:

Date:

Time:

PART I: MAIN PROBLEMS/WORRIES

For this section, case workers should use questions and/or drawing activities with children get a sense of what their main problems and concerns are following the experience of abuse. In this box, case workers should write down the current status of the child based on his or her own words.

PART II: FAMILY, SOCIAL & SPIRITUAL CONTEXT

Family & Living Situation: *Guidance for assessment: where does the child live (sleeps, eats, hangs around); who lives in the house and visits frequently; number of siblings, does the child appear happy in the home? Is the child able to play freely and where? Does the child appear afraid and/or not close to with parents/guardians, siblings; Is the child treated differently to other children in the family?*

Social Support <i>(friendships, school, participation in social and community life)</i>	Spiritual/religious:
Other Notes: <i>(e.g. safety risks identified, etc)</i>	

PART III: Child Functioning Assessment

DIRECTIONS: The caseworker should ask the child survivor these questions in a private, confidential room. Say: I'm going to read some sentences. Please tell me how TRUE these sentences are about you. Think about how true these things are since _____ [describe abusive event...e.g., you were raped]

<i>There can only be the X mark in one column.</i>	YES	NO	COMMENTS
1. I don't see my friends as much as I used to.			
2. I have stopped my daily activity (e.g. school).			
3. I am having fights with people more than I used to.			
4. I am having a hard time going to sleep or staying asleep.			
5. I am having body aches, stomachache, headache or other aches.			
6. I worry that something bad is going to happen.			
7. I am feeling sad and hopeless.			
TOTAL SCORE:			

PART IV: Caregiver Assessment (if possible)

What is your understanding about the abuse and what happened?	
What are your feelings about the abuse and what happened?	
What changes have you noticed with your child since the abuse?	
What do you think will help your child right now?	
What are your main worries and needs right now?	

PART V: Child & Family Strengths**Child Strengths/Protective Factors**

(things the child enjoys doing, positive relationships to caregivers, people they trust and who support them, able to solve problems, feel hopeful, laugh, etc)

Caregiver & Family Strengths/Protective Factors

(strong and positive relationship with their child, other family members; able to cope with stress; social and community support; job/income)

PART VI: Evaluation & Action Planning (for the caseworker to complete only)

Assessment Questions	YES	NO	N/A	Action Plan for Intervention (include, what is the action, who is responsible and timeframe)
1. Did the child report having problems functioning (See functioning items 1-3). If yes: interventions required: 1. Problem solving 2. Healing education 3. Relaxation training				
2. Did the child report feeling anxious or worried (See Functioning items 4-6). If yes: interventions required: 1. Relaxation training 2. Healing education Problem solving (if needed)				
3. Did the child report having negative feelings (See Functioning items 6-7). If yes: interventions required: 1. 3-Step Coping 2. Healing education 3. Relaxation training				

List the strengths (child and family) that can support the child's healing. (school, activities, sense of humor, etc).	
Other areas of need identified during the assessment that require intervention (direct and/or referral) (if not addressed above)	
Identified Need:	Action Plan (include what action, who will do what, and timeframe).

Next Follow Up Appointment scheduled for (date/time)_____

HEALING EDUCATION

OVERVIEW

Healing education involves a caseworker providing specific, accurate information about sexual abuse and related topics to child clients and family members.¹¹¹ Knowledge empowers children and helps survivors and family members to heal.

Caseworkers should provide information about:

- » the facts about sexual abuse, to increase the child's sense of understanding of what they experienced;
- » how to stay safe in the future.

In addition, healing education sessions specifically for caregivers help caregivers provide the best support to children affected by abuse.

CONSIDERATIONS FOR PROVIDING HEALING EDUCATION

- » healing education involves discussing sensitive topics with children; hence it might be better suited for adolescents (10 years old or older) and caregivers;
- » this intervention can be implemented individually or in groups with survivors and children and adolescents at risk';
- » it is recommended to have same-sex facilitators and same-sex groups, especially for adolescents;
- » adapt methods for providing healing education for children and families to the local culture to ensure information is relayed in the most culturally appropriate way possible;¹¹²
- » healing education can be provided even if a child does not disclose what happened to them, as this intervention provides general information about sexual abuse rather than a child's specific experience.

¹¹¹ IRC and UNICEF, [Caring for Child Survivors of Sexual Abuse: Guidelines for Health and Psychosocial Service Providers in Humanitarian Settings](#), IRC and UNICEF, 2012.

¹¹² Ibid.

INSTRUCTIONS FOR PROVIDING HEALING EDUCATION

Step 1: Make an appointment with the child (and caregiver if appropriate):

Ask the child and caregiver if they are willing to participate in a special healing education session. Explain that you would like to share information with them that can help them understand and manage what has happened. Assure them that the session will take place in a private space and will last no longer than one hour.

The time available to work with a child will depend on your relationship with them, the family's willingness to engage and the context of the situation. Work with your supervisor to find ways to structure and deliver the healing-education sessions that cover key information.

Step 2: Conduct the sessions:

Determine how many additional sessions you can schedule with the child based on their needs and the opportunities for follow-up appointments. If there are opportunities to meet regularly with the child, aim to schedule at least three sessions to provide healing education and support. If only one session is likely, cover as much information as possible in that session.

HEALING EDUCATION SESSION TOPICS

Healing education covers three main topics:

- » Topic 1: What every child and family should know;
- » Topic 2: Body safety and safety planning;
- » Topic 3: Caregiver's role in children's healing process.

Topics 1 and 2 involve both the child and the caregiver and may be covered in one or two sessions. Topic 3 should be conducted in a separate session with the caregiver only.

Topic 1: What every child and family should know:

Children and caregivers need to have accurate facts about child sexual abuse. Always explain that child sexual abuse is not the child's fault and they are not to blame. Indeed, understanding sexual abuse is important for the child's and family's healing and recovery process. This is why we start with facts about sexual abuse when providing healing education to children and caregivers. The key facts and information to cover in the first session are:

- » what is child sexual abuse?
- » why it happens and who perpetuates it?
- » how children may feel after sexual abuse (common reactions)?
- » children's tendency to remain silent about abuse (***especially important for caregivers***).

What is child sexual abuse?

Key information in simple language:

- » child sexual abuse is when an adult or someone older than you touches or rubs your private parts or makes you engage in sexual activity or witness sexual acts. Sometimes the older person asks you to touch their private parts. Sexual abuse is also when someone talks sexually to you, makes you watch sexual videos or look at sexual pictures, or does sexual things in front of you;
- » sexual abuse is always wrong, and it's always the fault of the person who did this to you.

Adapt this information section to include information specific to the local context.

Why it happens and who perpetrates it?

Key information in simple language:

- » sexual abuse happens to a lot of children. It happens to boys and girls of all different ages. It doesn't matter whether you're rich or poor, sexual abuse happens to lots of different children all around the world;
- » the important thing to remember is that being sexually abused is not your fault; it's not about what you look like or anything that you did;
- » the person who did this to you may be someone you know, like your relative or a close family friend. Or they could be a complete stranger;
- » most of the time children are sexually abused by someone they know and trust.

How children may feel after abuse (common reactions)?

Key information in simple language:

- » children have many different feelings when they are sexually abused and after sexual abuse. The different feelings can be hard to understand. It's ok for children to have lots of different feelings about the abuse;
- » some children feel really mad at the person or afraid of him. Some children feel sad and don't want to talk to anyone. Some children even feel guilty about what happened;
- » all these feelings are okay and common;
- » sometimes these feelings can affect how children behave. Some children feel scared after being abused, and don't want to sleep alone or don't like to be alone;
- » some kids feel mad a lot and they get into lots of fights. Some kids feel really sad and just want to cry all the time;
- » it really helps to talk about all of these feelings.

Children's tendency to remain silent about abuse

Key information, especially for caregivers:

- » there are lots of reasons why children might not tell an adult when they have been abused;
- » sometimes, the person who abuses the child tells the child that it's "a secret" and that they shouldn't tell anybody;

- » sometimes the person makes threats and says things like, “If you tell anyone, I’ll hurt you” or “I’ll hurt your family”;
- » the person who hurt your child may even tell your child that no-one will believe them if they tell;
- » sometimes, children don’t tell because they’re ashamed or embarrassed or afraid that they’ll get in trouble;
- » it’s important for you to understand what happened is not your child’s fault. Your child needs support and acceptance from you;
- » you may have many feelings about your child being sexually abused. We can talk about your feelings and how to support you as well.

Topic 2: Body safety and safety planning:

In addition to regular and consistent safety assessments, hold a separate session with children and caregivers on body safety and safety planning. Children need to build the communication skills and the confidence to respond to potentially abusive or distressing experiences. While personal safety skills training does not guarantee the child will be 100 per cent safe, it may help children feel more in control and confident to respond to threats when they occur. Key concepts to cover in this session are:

- » be attentive and knowledgeable;
- » be cautious and prepared;
- » be assertive.

Be attentive and knowledgeable

Teach children about possible dangers in their environment and help them pay attention to their intuitions. It is helpful if children can recognise danger signs that indicate heightened risk, and to have children rehearse how they might respond to danger. These discussions may also have taken place in the standard case management.

Be cautious and prepared

As part of overall safety education, talk with children about what to do if/when they feel unsafe. Have children practice proper responses to danger or potential violence through role playing, etc. This can increase the child’s self-confidence and efficacy in handling a potential threat. When teaching a child about safety planning, discuss the following:

- » help the child name some adults that make him/her feel safe (if the child is having difficulty, ask about specific people, such as a teacher, a caregiver, a sibling, a friend). Once the safe people are identified, encourage the child to tell those people if they feel worried or unsafe (as part of safety planning, these people should be involved/included in a session to formally acknowledge them as ‘safe people’ in the child’s life);
- » help the child name places that make them feel safe, especially those places they would go if they didn’t feel safe at home;

- » map out a plan with the child and practice how the child would respond if they felt unsafe. What would they do? What would they say? It is important to have children practice saying “No!” to an adult who is doing anything to make them feel uncomfortable. Role playing is very useful to help children practice saying “No”.

Be assertive

Start with a review about what is okay and not-okay touching. Children should practice what they would do if they experience touching that is not okay. It is helpful to explain the following points to the child:

- » nobody should touch your private parts in a sexual way; even if it is someone you know and love;
- » if you feel funny, strange or uncomfortable about the way someone’s touching you, you should tell that person, “No!”
- » give children techniques (run, hide, ask for help, call out, scream) to use in response to inappropriate touching or behaviours. Make sure to help the child identify a trusted adult whom they can confide in if anyone threatens them again.

During this session, it is important to develop the child’s confidence and skill in protecting their bodies.

Be wary of sending the message that if abuse happens again, it is the child’s fault. Sexual abuse is always the fault of the perpetrator, and children who have been taught how to better protect their bodies may still experience abuse. If they do, it is not because the child was unassertive or ill-prepared enough to protect themselves. It is because the perpetrator has more power over the child and the child is in no way responsible for any abuse.

Topic 3 (caregiver session): Caregiver’s role in children’s healing process:

Organise a caregiver session to allow caregivers to share their understanding and feelings about sexual abuse. Caregivers play an essential role in children’s healing and recovery. In fact, healing is facilitated when children are supported by friends and family in their home and community environment. Caregivers are under a lot of stress after sexual abuse occurs. They may feel guilty for a variety of reasons, such as not protecting the child. They may feel anger because they feel the child has brought them shame and/or anger at the perpetrator. They may also feel confused about what to do next; and many other tumultuous emotions.

During the caregiver session, allow the caregiver to express their feelings and voice their concerns without judgement. However, you should challenge caregivers if they appear to blame the child for the abuse or if they take judgmental attitudes toward the child. Key topics to cover during the session are:

- » the role of caregivers in children’s healing;
- » what caregivers should watch for and how they can help;
- » the care services available for the caregiver.

The role of the caregiver in children's healing

- » caregivers play an essential role in children's healing. Many children recover from the impact of sexual abuse when they have support from their mothers, fathers and families;
- » caregivers need to encourage the whole family to lend support to the child. The family should treat the child with compassion and make the child feel loved;
- » children should continue to go to school, play and 'be children' after sexual abuse. Sexual abuse should not prevent the child from continuing to develop and engage in child appropriate activities.

What caregivers should watch for and how they can help

- » after sexual abuse, children may feel shy, embarrassed, scared, angry or sad. If caregivers notice their child is behaving differently (for example, refusing to go to school, to see friends, or other changing behaviours), they should talk to their child and seek help for them;
- » caregivers can help children by not blaming them for the abuse, making them feel comfortable and happy at home;
- » caregivers can help children by acknowledging and validating their feelings and reactions, responding to their needs, and allowing them time and space to come to terms with the experience in their own way;
- » caregivers should protect the child and make sure they will not be harmed by the perpetrator or anyone else;
- » caregivers should encourage their child to go back to school and resume daily activities;
- » caregivers should not discuss the abuse with neighbours or other people. Caregivers should not discuss the child's sexual abuse in front of the child (unless the best interests of the child indicates that the caregivers talk about the abuse with a medical doctor, legal counsellor or caseworker);
- » caregivers should always reinforce that sexual abuse is always wrong, and always the perpetrator's fault.

The care services available for the caregiver

Caregivers, especially if they are mothers, may blame themselves for the sexual abuse. Caseworkers need to support mothers and not blame them for the sexual abuse.

- » caregivers may also experience strong reactions after sexual abuse happens in their family. They may feel sad, angry, depressed, scared or confused. This is okay. It is normal for people affected by sexual abuse to experience these emotions;
- » caregivers may blame themselves for the abuse. But sexual abuse is always the fault of the perpetrator. It is not the child's fault and it is not the caregiver's fault;
- » caregivers should talk to friends or other trusted people or seek additional support if they are having a hard time in their daily life because of their reactions to the sexual abuse;
- » offer support to the caregiver to discuss their feelings about their child's sexual abuse and to find better ways to cope with the impact of the abuse:
 - make the caregiver aware of additional services and supports available for them and their child;
 - facilitate referrals to any services the caregiver wishes to receive.

TIPS FOR CASEWORKERS

Managing potentially harmful statements:

Listen carefully to the thoughts and feelings expressed by the child and caregiver. During this process, the caregiver may make statements that may be harmful for children to hear (for example, the caretaker may appear to blame the child for the abuse and misdirect their anger toward the child). To prevent that, arrange a separate session with the caregiver preferably before meeting with the child to address any beliefs that are potentially harmful for children and which could serve as obstacles in the healing process.

Gear information to the child's level of understanding:

Always adapt communication techniques (and to some extent the information shared) to the child's age and developmental stage. For example, with younger children, provide basic information through drawings, play and role playing. For older children, written materials are useful. This gives them the opportunity to understand things on their own and then ask questions to engage in dialogue.

Include supportive caregivers:

A child survivor should be provided healing education together with a caregiver, so long as the child is comfortable, and the caregiver is committed to supporting the child. It creates an opportunity for the caseworker to state openly to both the child and caregiver that the abuse is not child's fault.

Holding separate sessions with caregivers is also important as it allows the caseworker to address any harmful beliefs and misconceptions the caregiver may have and discuss strategies for the caregiver to repair with the child if they have already communicated harmful statements or carried out harmful actions. Depending on the age and developmental stage of the child, individual sessions with the child can also be useful to discuss feelings they may have towards their caregiver's reactions and statements.

If the caregiver becomes angry:

If a caregiver becomes angry or begins to blame the child during the session, politely ask them to leave. While anger is a normal human emotion and may be important to the caregiver's healing process, it is not good to continue a session with a child and their caregiver, if a caregiver is unable to control their feelings and reactions. Use any remaining time to address with the child what has just happened with the caregiver and reiterate key messages; The child is not to blame for the abuse nor are they to blame for their caregiver's reactions. Then address this with the caregiver and set up a time for an individual session to discuss this in more depth. In an additional caregiver session(s), work with the caregiver to shift their harmful beliefs and manage their anger by channelling it in more positive directions, especially in front of the child.

Ending the session:

Before the session is finished, review the information you have discussed with the child and caregiver. Ask both parties what they believe has been most helpful in the session. It is also important to ask the child and the caregiver if they have any questions about the information provided during the session. Before the child and the caregiver leave, offer them the chance to join another healing education session the following week, if appropriate.

RELAXATION TRAINING

OVERVIEW

Caseworkers can teach children ways to cope with stress and reduce physiological symptoms, such as racing or pounding heart, difficulty sleeping or concentrating, anger, anxiety, etc. Research suggests children tend to express stress in physical ways. For example, children can report physical symptoms – such as headaches, stomach aches, nausea, non-descript aches and pains – when they are experiencing emotional stress. Hence, children can benefit from understanding the link between emotional stress and its impact on the body. By learning techniques to relax the body, children can gain tools to help reduce their physical symptoms.

KEY CONSIDERATIONS

Techniques should vary based on the individual's needs, preferences and age and should be adapted to the local context. Consider:

- » saying a prayer;
- » watching a candle flicker;
- » dancing and singing;
- » breathing exercises;
- » any other technique that can help a child relax their body and mind, including those described in this annex.

The variety of relaxation exercises that can be provided means that certain exercises can be adjusted for even very young children (2 years old or older). Simple breathing exercises can be modelled for young children and done with them. Guided imagery or other more complex relaxation techniques may be more suitable for children aged 6 years and older. Supervisors and caseworkers should review various techniques and resources to determine which techniques are most applicable to the context and likely to be accepted and used by children and their caregivers.

INSTRUCTIONS FOR RELAXATION TECHNIQUES

Caseworkers can teach children new ways to cope with stress to reduce negative reactions. With basic relaxation techniques, the steps to provide them will follow a similar pattern. Most relaxation exercises can be done with three to four key steps.

Step 1: Explain the exercise:

Provide a simple explanation of the exercise and what it aims to do. If there is the potential for discomfort or difficult emotions to arise from the exercise, explain this from the beginning. For example, say, “We are going to do a type of special breathing today. This type of breathing is meant to help us feel calm when we get upset. Sometimes when we first start practicing this type of breathing, it might make us feel strange or nervous. When you try this, if it makes you feel uncomfortable, you can always stop breathing this way and return to the way you’re breathing right now”.

Be sure to modify descriptions of relaxation exercises to the development and maturity of the child. For example, for a young child, you could say, “We are going to do a breath called deep belly breathing. With this breath, we want to take in as much breath as we can to blow our bellies up like a balloon. Then we will empty our belly balloons as slow as we can”.

Step 2: Demonstrate the exercise:

Always demonstrate the exercise first so that the caregiver and child can see it before practicing. You may need to exaggerate the exercise for demonstration practices, particularly if it is a type of breath or an exercise without much movement.

Step 3: Have the child (and caregiver) practice the exercise:

Ask the child and caregiver to practice the exercise. This may include doing the exercise with them or giving them verbal instructions as they practice. For example, say, “We are going to breathe in through our noses for a count of three and out through our mouths for a count of three. We will do this three or four times. Then we will try to breathe in and out for a count of four. Are you ready to start?”

“Breathe in through your nose for a count of three... two... one. Now breathe out through your mouth for a count of three... two... one. Repeat this three times”.

Step 4: Have the child practice at home:

Relaxation exercises take practice. Ask children and caregivers to practice exercises at appropriate times. Tie practice to what the exercise is specifically trying to accomplish for that child. Ask children to start by practicing two or three times when they feel safe, when they can practice without interruption, or when they feel ready to practice. You should also ask the child to try to remember how these practice sessions feel and what they feel after they practice. Tell the child that you will check in about their homework at their next session. As children get more comfortable with the exercises and have ideas about which relaxation exercises they like and work for them, ask them to use these exercises when they are feeling upset, overwhelmed or with other difficult emotions the child has identified as being something where they are needing support.

This annex provides guidance on two relaxation techniques. It also provides some additional resources for other relaxation exercises. The relaxation techniques described in this section are:

- » controlled belly breathing;
- » body relaxation.

CONTROLLED BELLY BREATHING

Controlled belly breathing is a useful technique to help children and adults manage anxiety and stress. It's usually taught to help children cope with stressful thoughts and overwhelming feelings. The goal of controlled belly breathing is to have children focus on their breathing so that they breathe deeply and slowly. They also learn that there are strategies that can help them cope with feelings of tension or anxiety. Finally, they learn that by concentrating on their breathing patterns, they can distract themselves from unpleasant thoughts or images. One advantage of a tool like controlled belly breathing is that caseworkers can demonstrate it to children and can also monitor closely their progress in using the strategy correctly. When teaching controlled belly breathing to children, follow three steps:

Step 1: Explain the technique:

Explain to the child why they should learn a breathing technique. For example, say, "Today we're going to learn a way to help ourselves calm down and manage our nervousness and upset feelings. I'm going to show you a breathing activity that can help you calm your mind and your body. When we get upset, we tend to breathe faster and not as deeply. This does not allow enough air into our lungs, which can make our body feel out of control. Doing this breathing exercise when you are upset will help you get more air into your lungs. Controlling your breathing will help your body and mind relax. It's also something you can do anytime and anywhere".

Step 2: Demonstrate the technique:

Show the child how to breathe in and out slowly. The directions for controlled breathing are:

- » get into a comfortable position (either lying down or sitting comfortably);
- » concentrate on breathing, inhaling and exhaling through the nose. Place one hand on your stomach and one hand on your chest. When inhaling, the hand on the stomach should move up, and when exhaling it should move down. The hand on the chest should not move.

Step 3: Have the child practice belly breathing:

- » some children might like to lie on the floor with a small toy or object on their belly. With each breath, the object should move up and down. You can also ask the child to imagine that their belly is a balloon;
- » praise the child's as they practice the technique. Once the child has tried a few breaths, instruct the child to breathe more slowly on the exhalations than on the inhalations. It can help to count during breaths, by saying, "First take slow deep breaths in through your nose. Count in one...two...three and watch your stomach, not your shoulders, rise. Then breathe out one...two...three...four...five and watch your stomach fall";
- » once the child is able to get into a breathing rhythm, have them choose a word to say silently while they exhale. Good examples are 'calm' or 'safe'. Instruct the child to try to think only about their breathing and this word. As other thoughts come into their head, the child should try to picture them floating away;

- » ask the child to practice controlled breathing every day at home, for a few minutes or longer if they can. Children can practice while they are falling asleep at night or at another time that is right for them. Older children can record these home practices on a form and discuss with you later. Help the child decide when/where the homework will be done, trying to identify likely barriers to practicing on their own. Initially, the practice sessions should be done when the child is calm and can concentrate, not at times of stress and anxiety.

Include the caregivers:

Parents can be taught controlled belly breathing to help their children learn and practice these skills at home. In addition, parents often benefit from these skills themselves, given the high levels of stress they may be experiencing. The same controlled breathing technique taught to the child can be taught to the parent. To help reinforce the skill, children can be involved in teaching their parents the technique in session.

BODY RELAXATION

Children and adults can use this tool as a way to relax their bodies and decrease muscle tension. This is helpful for children and adults who have trouble falling asleep or who have physical symptoms of anxiety. Body relaxation is usually taught by having people alternate between tensing and relaxing their muscles. Focusing on this difference teaches children how to recognise tense feelings and neutralise them. There are many ways to teach children relaxation skills, some of which depend on the child's age. This annex explains some of them, but always be creative when helping children learn to relax. Games, dance, music and other activities can be used to teach the technique.

Step 1: Explain body relaxation

Explain what body relaxation is and why it is important. For example, say, "Sometimes we all feel a little scared or nervous. When we have these feelings, our bodies can get tense or tight. This is an uncomfortable feeling; sometimes it even hurts. To help get rid of these tense feelings, we're going to help you learn to relax your body. This can help you feel looser and calmer".

Step 2: Lead the child through body relaxation exercise

Caseworkers should be trained in (and know how to practice) body relaxation to make sure they can demonstrate it effectively. Caseworkers can guide children in body relaxation techniques by following these directions:

1. Have the child sit or lie in a comfortable position. The child should get as comfortable as possible. Have the child close their eyes if they would like.
2. Tell the child, "Take a deep breath in and out through your nose. Do this again. I'm going to ask you to tighten and relax specific muscles in your body. Concentrate on how your muscles feel, specifically the difference between tight and relaxed. After tightening, a muscle will feel more relaxed".

3. Say to the child:

- First concentrate on the large muscles of your legs. Tighten all the muscles of your legs. Feel how tight and tense the muscles in your legs are right now. Hold it for a few moments more ... and now relax. Let all the tension go. Feel the muscles in your legs going limp, loose and relaxed. Notice how relaxed the muscles feel now. Do you feel the difference between tension and relaxation? Enjoy the pleasant feeling of relaxation in your legs.
 - Now focus on the muscles in your arms. Tighten your shoulders, upper arms, lower arms and hands. Squeeze your hands into tight fists. Make the muscles in your arms and hands as tense as you can. Squeeze harder ... and harder ... hold the tension in your arms, shoulders and hands. Feel the tension in these muscles. Hold it for a few moments more...and now release. Let the muscles of your shoulders, arms and hands go limp. Feel the relaxation as your shoulders lower into a comfortable position and your hands relax at your sides. Allow the muscles in your arms to relax completely.
 - Focus again on your breathing – slow, even, regular breaths. Breathe in and relax. Breathe out the tension. Breathe in and relax. Breathe out the tension. Continue to breathe slowly, in and out.
 - Now tighten the muscles of your back. Pull your shoulders back and tense the muscles along your spine. Arch your back slightly as you tighten these muscles. Hold ... and relax. Let go of all the tension. Feel your back comfortably relaxing into a good and healthy posture.
 - Turn your attention now to the muscles of your chest and stomach. Tighten and tense these muscles. Tighten them further ... hold this tension ... and release. Relax the muscles of your chest and stomach.
 - Finally, tighten the muscles of your face. Scrunch your eyes shut, wrinkle your nose and tighten the muscles of your cheeks and chin. Hold this tension in your face...and relax. Release all the tension. Feel how relaxed your face is!
 - Try to think about all the muscles in your body. Notice how relaxed your muscles feel. Allow any last bits of tension to drain away. Enjoy the relaxation you are feeling. Notice how calmly you breathe, how relaxed your muscles are. Enjoy this relaxation for a few moments.
4. When the child is ready to return to the usual level of alertness and awareness, have them slowly reawaken their bodies. They can wiggle their toes and fingers, swing their arms gently or stretch out their arms and legs.
5. Encourage children to practice this at home before they fall asleep.

Explaining body relaxation to younger children:

Younger children will not be able to follow detailed instructions, so be creative when teaching them body relaxation techniques. For example, you might compare a body to a noodle or uncooked bean (or another food that is more appropriate in the local setting). Say, “Have you ever seen beans before they are cooked? What do they look like? They are very stiff. How about beans after they’re cooked, what are they like? They are soft and mushy. Let’s pretend we are cooked and uncooked beans! First, we’ll pretend to be uncooked beans and be very tense and strong and stand up very straight. And then we’ll be cooked beans, loose and relaxed and soft. Let’s try again [repeat here, having the child follow you]. Let’s be uncooked beans ... okay, now cooked beans ... then uncooked beans” Then, pause a few seconds and say, “Cooked beans ...” [can repeat several times].

Include caregivers:

Parents can be taught body relaxation to help their children practice these skills at home. In addition, parents benefit from these skills themselves, given the high levels of stress they may be experiencing. The same body relaxation techniques taught to children can be taught to their parent. To reinforce the skill, children can help teach their parents in session.

ADDITIONAL RELAXATION TRAINING RESOURCES

Resource	Key Exercises
Exercises for Grounding, Emotional Regulation & Relaxation ¹¹³	The 'Draw a safe space' tool has been tested with young children to create a personally meaningful visual representation of a safe place that the child can go to in their mind when they feel stressed. This can also be used with older children through a guided imagery exercise.
Let's Get Grounded: A toolkit for survivors ¹¹⁴	This workbook has explanations of three types of grounding exercises (physical, mental and soothing) and provides simple ideas and exercises for each. Not all will be appropriate to every context, but several options are provided for each type of grounding.
Resources for Resilience website	The Resources for Resilience website has several short YouTube videos called 'Rapid Resets' that can be used with children in settings with widely available wireless internet connection and adequate bandwidth.
Save the Children	Offers several relaxation exercises that can easily be done with children, facilitated by caregivers.

¹¹³ National Center on Domestic Violence, Trauma & Mental Health, Exercises for Grounding, Emotional Regulation & Relaxation for Children and Their Parents, NCDVTMH, 2014.

¹¹⁴ Arizona Coalition to End Sexual and Domestic Violence, Let's Get Grounded: A Toolkit for Survivors, ACESDV, no date.

COPING SKILLS

OVERVIEW

The after-effects of sexual abuse can be hard for child survivors. They may feel ashamed and sad. They may refuse to attend school and spend large amounts of time by themselves. They may have a hard time finding the right people and resources to help them cope with the impact of sexual abuse. However, caseworkers need to remember that children are strong, and that it's possible for them to heal, recover and live happy and healthy lives.

This intervention focuses on helping children identify and develop their own internal coping mechanisms, including skills to calm themselves, to recognise when they need to reach out for support, and to manage difficult emotions. A coping plan should identify external social support and activities that build on the child's interests and strengths. In this way, the child is encouraged to participate in positive activities that they enjoy. The more engaged and supported a child's life is, the better their mood and the more likely they are to return to normal functioning (going to school, playing with friends, talking with others, etc.) A coping plan includes:

- » social support that makes a child feel safe and that their emotional needs are being met;
- » activities that build on their interests and strengths;
- » exercises that build on internal skills and social and emotional competencies.

Through such a coping plan, caseworkers can encourage children to participate in positive activities that they enjoy.

KEY CONSIDERATIONS

This intervention can be practiced individually and/or (partially) together with the child's non-offending caregivers, if the child and caregiver agree.

This intervention can build on the intake and the psychosocial assessment, where protective and risk factors have been identified. Any child survivor will benefit from a caseworker who considers these factors and is able to integrate actions to strengthen protective factors into the coping plan.

The intervention implies some cognitive, emotional and verbal skills, so it is better suited for adolescents (10 years old or older). Depending on maturity and ability, a younger child can still benefit from a coping plan that is developed in partnership with the non-offending caregivers.

INSTRUCTIONS FOR COPING SKILLS EXERCISE

Step 1: Identify safe people and self-comforting actions:

Ask the child, “When you are feeling this way [for example, scared, sad, etc.], who can you talk to?” Have the child list people they feel comfortable talking with.

Ask “When you are feeling this way, what makes you feel better? What do you do to feel better?” Always validate the feelings the child identifies.

Step 2: Identify the activities the child enjoys:

Building on the child’s strengths, ask, “How do you feel when you do those things?” Help the child identify positive feelings (for example, happy, relaxed, etc.) they have when engaged in pleasurable individual, family and community activities.

Step 3: Develop a plan with the child:

Building off the child’s answers, develop a plan with the child to engage people, activities, interests, skills, competencies and other strengths they have identified, to help them when they need support. Ask caregivers to support the child in carrying out the plan. Follow-up with the child and caregiver at the next meeting to find out if they have tried the plan and whether or not it is helping the child to feel better.

Some useful activities to help a child identify their own strengths and interests include:

- » talk/draw/play games with the child to help them identify their interests and the people they feel safe with and supported by. Be sure the child knows how to locate these people;
- » talk/draw/play games with the child to learn about their faith and their spiritual beliefs. If appropriate and aligned with their wishes, help the child reconnect to faith if they are feeling isolated;
- » talk/draw/play games with the child to help them identify what they can do when they feel sad, anxious, upset, etc. Find out what kind of activities make them feel better and who are their friends and ‘safe people’;
- » encourage the child and help them recognise their own strengths. Praise them. Children need to see themselves as capable human beings who deserve love, happiness and protection.

Use a case action plan to note strengths, coping skills a child will work on, social activities and sources of support rather than creating an additional form for the case plan.

PROBLEM SOLVING

OVERVIEW

Problem solving is an intervention that provides individuals with tools to identify and solve problems that arise from life stressors, both big and small, to improve overall quality of life.¹¹⁵ Problem solving is very practical, as it mainly focuses on the present, rather than delving into past experiences. Indeed, there are many types of problems that abused children will face, and it is likely that not all these problems are directly related to the sexual abuse the child experienced.

During the psychosocial assessment, a child may report difficulties or problems they face in their day-to-day lives. The child may find themselves struggling to feel accepted by a parent or friends, or they may have problems going back to school. Other contributing factors can be:

- » money stressors at home;
- » alcoholism at home;
- » the child has not been going to school for a long time;
- » the child is engaged in harmful work;
- » the child is living on the street.

Caseworkers assess a child's main problems throughout the psychosocial needs assessment. They use this information to help a child take steps to solve the most important problems they face. Follow the steps below to help a empower a child to solve problems they face, while supporting them fully in the problem-solving process.

KEY CONSIDERATIONS

Problem-solving plans can take different formats. A caseworker and child can use drawings or symbols rather than words to describe the problem, goals and steps toward solving the problem, making it suitable for children 6 years old and older.

The various formats of problem-solving plans can be contextualised for many different settings, including the majority of humanitarian settings. However, even in the most resource-abundant settings, not all problems may have a solution. In humanitarian settings where resources and referrals are limited, a caseworker should identify with the child which problems feel the most important to solve while also being realistic about the ability to fully resolve these issues.

¹¹⁵ Nezu, A.M., Maguth Nezu, C. & D'Zurilla, T., [Problem-Solving Therapy: A Treatment Manual](#), Springer Publishing, 2012.

The various formats of problem-solving plans can be contextualised for many different settings, including the majority of humanitarian settings. However, even in the most resource-abundant settings, not all problems may have a solution. In humanitarian settings where resources and referrals are limited, a caseworker should identify with the child which problems feel the most important to solve while also being realistic about the ability to fully resolve these issues.

Problem solving, as described here, is specifically designed to be used with child survivors as part of the case-management process. However, if working with the non-offending caregiver of a young child or a child who cannot extensively participate in decision-making, WHO's Problem Management Plus (PM+) manual¹¹⁶ is designed for working with adults and can be adapted to contexts. PM+ may also be more appropriate with older adolescents and married adolescent girl survivors. If using PM+ with a non-offending caregiver, caseworkers should still involve the child survivor to the extent possible in providing input on their problems, potential solutions and their priorities. This will depend on the age, development and capacity of the child.

INSTRUCTIONS FOR PROBLEM SOLVING

Step 1: Identify the problems which concern the child the most:

Ask questions such as, "What worries you the most right now?" or "What problems do you have right now?" (This information should be in the first section of the assessment). Some children may have a hard time answering such questions. Refer also to information gathered during the initial assessment.

For example, say, "When we first talked, you mentioned that you are not going to school right now, but this is an activity that you enjoy. Can you tell me more about why you are not in school?"

Depending on the problems identified, assess which problems are directly related to the sexual abuse and work with the child on a plan to address these problems. Also consider problems of broader concerns related to the well-being of the child. Support the child to identify strategies to address these issues and/or refer the child for further required services and support that are beyond your capacity.

Step 2: Prioritise the problems:

If multiple problems are identified during the assessment, hopefully some of them can be addressed through the stress reduction, healing education and coping skills interventions (see *Healing Education, Relaxation Training, Coping skills*); otherwise, additional referrals need to take place to ensure appropriate additional support for the child. Work with the child to prioritise problems that concern the child the most and can be addressed at some level of intervention. Based on these problems, decide whether a referral for further support is needed or whether the problem can be addressed through these mental health and psychosocial support (MHPSS) interventions. For example, if a child is worried they are being blamed by family for the abuse, conduct a healing education intervention with the caregivers and work with the child to identify other

¹¹⁶ World Health Organization, [Problem Management Plus \(PM+\): Individual psychological help for adults impaired by distress in communities exposed to adversity](#), WHO, 2018

actions to solve this problem. In other situations, a referral may be needed. For example, if the child is living without an adult caregiver, ensure that a child protection caseworker is involved. For direct interventions, generally caseworkers should keep the problems limited to three or fewer and be sure that concrete actions can be taken towards solving the problems.

A ranking exercise is an option to help the child prioritise the problems they are experiencing. This starts with a free listing of all problems faced by the child and identified during the assessment. The caseworker and/or child can write/draw each of these or use a symbol for each problem (for example, a book to represent school) and place these on a table or the floor. Then ask the child to identify which three to five problems they consider to be the biggest. If the problems are written or drawn, the child can mark the key problems. If the problems have been symbolised, the child can lift the key problems and place them in another site.

The child might prioritise problems which you do not consider to be the most important problems, but it gives insight to the experience of the child and should not be denied. The next step here could be for you to rank three to five problems from your perspective. There might be overlaps, which should be the areas that need to be addressed. In situations where you might have prioritised different problems, discuss these differences and why these were prioritised. If the differences are minimal, all problems can be included in the problem-solving plan. If the differences include many problems, a further ranking can take place based on the combined child's and caseworker's initial ranking.

Step 3: Develop a problem-solving plan with the child:

Problem solving requires some simple steps. The first step is to identify the problem. The second step is to identify a goal (in other words, what the child's life would be like with the problem solved). The third step is to brainstorm all possible solutions to the problem and those that can be accomplished by the child, caregiver, caseworkers or others who can offer help. Problem-solving steps must be concrete and specific.

AN EXAMPLE OF PROBLEM SOLVING

Case description:

Alisha is worried that her father is going to be angry when he comes home and finds out she was raped. Alisha is worried that her father will throw her out of the house. Until now, Alisha has had a good relationship with her father and her mother is supportive of her. Furthermore, Alisha indicated that she has problems at school, as her classmates ignore her and she is excluded from the recreational activities happening in and around school – this has been happening for a long time.

Main problems:

- » Alisha's father will punish her for being raped.
- » Alisha is not included in recreational activities by her classmates.

Alisha's goals:

- » Alisha to be accepted and not blamed by her father and to live happily at home.
- » Alisha to be accepted by her classmates and to take part in recreational activities.

Possible solutions (brainstormed by the caseworker and Alisha together):

- » Alisha shares her fears with her mother.
- » Caseworker and Alisha's mother sitting with the father to explain the situation to him.
- » Involve someone whom the father respects and trusts to help tell the father what happened.
- » Have a backup plan for Alisha in case her father does force her to leave home.
- » Help Alisha cope with the constant worry about her father.

Problem-solving plan:

Based on the possible solutions brainstorm, Alisha and the caseworker agree actions to solve the problem (Table 1). There are different ways to help children develop a plan to address their stated problems.

Table 1: Alisha's problem-solving plan

Problem	Goal	Solutions	When	Who
Alisha's father will punish her for being raped.	Alisha's father to accept her and not blame her.	Discuss Alisha's fear.	Next week.	Caseworker, Alisha's mother and Alisha.
		Meet father with support person.	When he comes home.	Caseworker and Alisha's mother.
		Provide education to father to help him accept and understand what happened.	When he comes home and three times after the initial meeting.	Caseworker and Alisha's mother as she wishes.
		Make backup plan.	Next meeting.	Caseworker and Alisha.
Alisha not included in recreational activities	Alisha's classmates to accept her and invite her to participate in activities.	Referral to school teacher.	Today.	Caseworker.
List additional problems here				

Chapter 7

COORDINATING CARE FOR CHILD SURVIVORS

CHAPTER OVERVIEW

Good coordination amongst service providers is essential, particularly in cases of child sexual abuse given the complexity, interdisciplinary nature of the response and inherent levels of risk. The chapter includes coordination best practices for working with child survivors of sexual abuse. It outlines:

- » strategies for coordination and collaboration between gender-based violence and child protection actors;
- » strategies for multi-sectoral coordination;
- » best-practice examples.

Associated tools

[Addressing Co-Occurring and Multiple Forms of Violence](#)

[Coordination with Government Agencies on Child Sexual Abuse](#)

CCS COORDINATION BETWEEN GENDER-BASED VIOLENCE AND CHILD PROTECTION ACTORS

Good coordination and collaboration between GBV and CP service providers is critical to compassionate and effective care and support of child survivors of sexual abuse. Not only are GBV and CP actors the primary sectors with the capacity to provide case management services in response to child sexual abuse, they are also the likely first entry points for children and/or their caregivers seeking support. Coordinated service delivery from GBV and CP actors can mitigate the risk of:

- » contradictory or confusing information to the child and/or their caregivers;
- » re-experiencing the distress of the abuse due to multiple interviews;
- » loss of trust in the service providers and their capacity to assist;
- » delays in services provision that have lasting impacts on the child;
- » having limited access to and choice in service provider.

Such coordination and collaboration relies on a foundation of mutual trust and agreed upon mechanisms for service delivery and communication. One aim of the Guidance is to increase the capacity of GBV and CP actors in addressing CCS so that survivors have better access and choice. The strategies below can facilitate coordination and collaboration between GBV and CP actors.

Develop coordination agreements

Coordination agreements are formal documents which outline key principles and different roles and responsibilities of service providers when responding to cases of child sexual abuse. These can take various forms, including:

- » dedicated Standard Operating Procedures (SOPs) for child survivors of sexual abuse;
- » provisions for child survivors in broader GBV and/or CP SOPs;
- » context-specific case management guidelines;
- » service-level agreements between two or more partners/teams;
- » simple guidance notes developed collaboratively by the relevant actors.

The purpose of these agreements is to provide step-by-step guidance on how to support child survivors of sexual abuse, considering contextual specificities, availability and capacity of different actors, and differential needs and potential risks for survivors.

Given their context-specific nature, the content and structure of coordination agreements for case management of child survivors of sexual abuse will vary. However, at a minimum, coordination agreements should address:

Referral pathway for child survivors

Consider developing a specific referral pathway for child survivors when:

- » entry points are substantially different for child and adult survivors or where there are specific legal requirements to be followed (in cases of a child);
- » there are concerns about other actors and sectors training, knowledge and/or attitudes concerning child survivors;
- » specific mandatory reporting criteria only impact certain actors (for example, when laws only specify that health actors have a specific mandatory reporting requirement).

In these situations, a referral pathway specific to child survivors can note specific issues or concerns that are not applicable to adult survivors accessing GBV services or children accessing CP services. Referral mechanisms for cases of child survivors should be aligned to other GBV and/or CP referral mechanisms in each context. This includes the use of relevant referral forms or other tools to facilitate the safe and confidential sharing of information within the case-management process and to avoid the need to interview the child and/or their caregiver multiple times.

- » underlying principles when supporting survivors of child sexual abuse (*see Chapter 1*);
- » services/support that each partner can provide (including locations where each service is available);
- » minimum standards for staff competencies (*see Chapters 2,3,4*);
- » criteria and considerations for determining a primary caseworker to each case and differentiation of roles (*see section below for more information*);
- » mechanisms for referral, follow up and information sharing;
- » outline of any relevant mandatory reporting laws and how these will be addressed in the specific context;
- » coordination arrangements specific to cases of co-occurring violence where a non-offending caregiver is receiving support from another primary caseworker (for example, a situation where a child's primary caseworker is part of the CP team and the caregiver's primary caseworker is part of the GBV team, or different caseworkers within the GBV team are working with a mother and her child). *See the tool Addressing co-occurring and multiple forms of violence* for more information.

Coordination agreements between CP and GBV actors can be made by the two coordination bodies (for example, CP and GBV working groups or AORs), two agencies that are primary focal points GBV/CP service provision, or even two teams within the same agency that focus on respectively on GBV or CP services. The development on these can be facilitated through one or multiple coordination workshops engaging GBV and CP caseworkers, supervisors and team leaders. Such workshops can be added to the end of a Caring for Child Survivors training or can be organised as a stand-alone activity. Examples for facilitating this process can be found in IRC's [Caring for Child Survivors of Sexual Abuse \(CCS\) Operational Guidance Package](#).

Best practice: Developing specific SOPs in Pakistan

The UNICEF Country Office in Pakistan developed dedicated *Standard Operating Procedures for CP and GBV Actors Responding to Child Sexual Abuse* in 2022. The purpose of the SOPs is to “guide how child protection and GBV actors coordinate with each other to provide quality and holistic care to boy and girl survivors of sexual abuse.” The SOPs outline key terms and guiding principles for CP- and GBV-related child sexual abuse service delivery. They detail the differential needs of boy and girl survivors of child sexual abuse and the responsibilities of key sectors to respond within the multi-sectoral model according to the gender of the survivor. Specific guidance is provided on how to obtain informed consent or assent, how to meet mandatory reporting requirements and understand their inherent risks, and how to conduct referrals and safely share information. Developing dedicated SOPs for child sexual abuse, in this context, enabled a deeper analysis of the differential needs of boy and girl survivors of sexual violence, as well as providing detailed guidance on how to respond to different challenging scenarios, such as when no GBV and/or CP actors are available.

Identify criteria/considerations and roles for a primary caseworker

One aspect of a coordination agreement between GBV and CP actors is to set criteria for determining a primary caseworker in case of child sexual abuse and defining the roles of that caseworker. Both actors bring complementary skills and knowledge to the CCS case management process. However, best practice requires that a primary caseworker is assigned to each case to avoid duplicating efforts or confusing the child and their caregiver, and to streamline referrals and follow up.

Considerations for determining who is the most appropriate primary caseworker will depend on the context, but should consider the following:

Preference of the survivor and/

or their caregiver: The child or adolescent's desires in terms of where or from whom to receive services should be honoured to the extent possible unless there is a risk of causing harm (for example, because of a lack of knowledge and/or skills or because their preferred location or organisation is unable to provide a safe and confidential space).

Organisational and caseworker's skills and knowledge on how to support child and/or adolescent survivors of sexual abuse:

The organisation should have substantial experience in providing GBV and/or CP case management services, including to children. It is strongly recommended that the individual caseworker should, at a minimum, have received training on GBV or CP case management, and comprehensive Caring for Child Survivor training.

Considerations for girl survivors

In some cases, and in some settings, one service provider might be able to support children of all genders. Similarly, it may be appropriate for GBV providers to work with older girls (if they have not been trained to work with young children), and for CP providers to work with infant and young girls (e.g., 0-9 years of age).

In these settings, it is important to consider what training and awareness on myths, biases, and discrimination towards girl survivors CP caseworkers have undergone (see [Chapters 2 and 3](#), and associated tools). If discrimination and bias remain deeply embedded in the culture, it may still be safer for GBV providers to be the main service provider for girl survivors regardless of girls' ages and GBV actors' training on age and development.

Availability of quality supervision and support for the primary caseworker: Clinical or supportive supervision for the primary caseworker is essential. In particularly complex cases, joint supervision by both a CP and a GBV supervisor might be appropriate.

Gender of caseworkers: Children should always be offered a choice of male or female service provider. Most children, particularly girls, are likely to feel more comfortable speaking to a female provider, and in many contexts a female provider will be essential for girl survivors. When a male provider is requested, CP programmes may be better placed to provide support as they often have a mix of female and male caseworkers, whereas most GBV caseworkers are women.

Availability of safe, comfortable and confidential spaces for the survivor and their caregivers to receive support: Given the high risk of stigmatisation when one is identified as a survivor of sexual violence, and the ensuing safety risks, reducing the possibility of any survivor being identified as such must be a key criterion when establishing the confidential location/space for service delivery.

For refugee children involved in refugee case processing (registration, refugee status determination, durable solutions), considering many of the decisions related to refugee case processing will require the best interests procedure (BIA/BID), it may be beneficial to the case to be handled by a CP caseworker in order to avoid duplication of assessment and services.

In addition, differentiating the role of the primary caseworker in relation to others is essential. The primary caseworker should lead the case management process and as such be responsible for:

- » conducting the initial intake and assessment;
- » developing the action plan;
- » conducting regular follow up with the survivor and their caregiver;
- » initiating and following up on referrals;
- » reporting abuse to the authorities if required and appropriate.

Best practice: Determining primary caseworker for child survivors in Syria

In northwest Syria, female case managers working in GBV programs expressed discomfort at the idea of meeting alone with older adolescent boys (above the age of 15) due to social norms and safety concerns. It was also noted that older adolescent boy survivors were more uncomfortable discussing their experiences of sexual abuse with female case workers than with their male counterparts, as prevalent social norms consider discussions around sexuality between members of different genders to be highly inappropriate and offensive. As a result, male CP case workers are normally assigned primary responsibility for cases of male adolescent survivors of sexual abuse, while continuing to collaborate with GBV and other actors during the case management process.

MULTI-SECTORAL COORDINATION

Given the complexity of child sexual abuse cases, coordination with a range of other actors and service providers beyond the GBV and CP sectors is likely to be required during case management (if the child and/or caregiver give consent). These actors might include healthcare providers, MHPSS service providers, members of the judiciary and law enforcement agencies, teachers, childcare providers, governmental social workers and statutory bodies. Coordination should also extend to organisations and community groups that have specific expertise to support children and/or caregivers who experience specific forms of marginalisation.

Primary caseworkers are likely to be working with a range of actors who have limited or no knowledge of how best to support child survivors of sexual abuse and who might hold different attitudes towards sexual violence against children. For example, in contexts with mandatory reporting requirements regarding child abuse or child sexual abuse, actors might hold different views on their role in reporting these cases to the authorities and might even hold different legal responsibilities to report. When mandatory reporting presents potential risks for the safety and well-being of the child and/or their caregiver, these differing positions can cause substantial tension between actors involved in the case management process. The strategies below can ensure that the survivor and/or their caregiver are able to access services, but also to ensure they do so safely and without further risk of violence, discrimination or stigmatisation.

Accompaniment

When referring a child for services, the primary caseworker can accompany them (if the child has provided consent and it is safe to do so) as they access different services or meet with a different provider. During the meeting, the caseworker can advocate for the survivor, supporting their decisions and encouraging them to ask questions or express any concerns they might have about the service. The caseworker should be careful to not 'replace' the survivor or speak on their behalf during interactions with other service providers.

Follow-up

After completing a referral, the primary caseworker can take the opportunity of following up with the other service provider to provide additional context, address any harmful attitudes or beliefs that might exist, and support the other service provider to better understand the phenomenon of child sexual abuse and how to support the survivor safely and effectively.

Case conferencing

Primary caseworkers can use case conferences as an opportunity to disseminate key messages about child sexual abuse and how best to support a child and their caregiver in order to address harmful attitudes and beliefs and provide on-the-job coaching to other actors with less experience in supporting child survivors of sexual abuse.

Capacity strengthening

Formal and informal capacity-strengthening strategies for actors who might come into contact with child survivors of sexual abuse include:

- » trainings (from basic child-centred communication to a full Caring for Child Survivors training);
- » focused orientation sessions (for example, through the GBV Blended Curriculum);
- » app-based learning;
- » on-the-job mentoring and coaching sessions;
- » joint supervision sessions.

Sector-level coordination and advocacy

Leveraging coordination mechanisms at the sectoral level (for example, cluster/sector or sub-cluster/sub-sector level) can be very effective in developing intersectoral agreements and shared policy positions on key issues that might affect case management of child survivors of sexual abuse, such as mandatory reporting, referral mechanisms or consent and assent procedures. Sectoral-level coordination forums can also support individual actors in advocating for changes in sectoral or organisational policies that are harmful to child survivors of sexual abuse and/or their caregivers.

Coordination with Government agencies on child sexual abuse provides more guidance on coordinating with government actors on child sexual abuse.

Best practice: Multi-sectoral coordination

Supporting good practice in child survivor care in Syria: In northwest Syria, the practice of certain reproductive health actors to report cases of sexual violence, and especially sexual violence against children, to local law enforcement agencies or other authorities risked exposing survivors to stigmatization, retaliation and other forms of violence. To uphold the principle of 'do no harm', the GBV Sub-Cluster in Gaziantep worked closely with the Sexual and Reproductive Health Technical Working Group to produce a Joint Recommendation on Mandatory Reporting in northwest Syria. The purpose of the joint recommendation was to clarify existing legal requirements, outline the potential risk of reporting without the consent/assent of the child, and encourage all health providers to follow a safe referral approach to GBV case management organisations.

Migrant and refugee response in Italy: In Italy, UNICEF, UNHCR and IOM adapted and translated the interagency [GBV Pocket Guide](#) to provide a simple framework for all governmental and non-governmental actors working with migrants and refugees on how to deal with disclosures of GBV and/or other forms of violence. The adapted [Pocket Guide on How to Provide First Aid to Survivors of Gender-Based Violence](#) includes a section on supporting child survivors of violence, which presents key terms and definitions and step-by-step guidance (following the psychological first aid framework of 'Prepare, Look, Listen and Link') on how to support a child, including an unaccompanied child, who might have experienced GBV.

Simple do-and-don't lists accompany each section, with a section also on Italian mandatory reporting.

INFORMATION SHARING

In line with the principles for good coordination, information sharing within the context of dealing with survivors of child sexual abuse should be based on a strict interpretation of the principles of informed consent and assent and 'need to know' and should be aligned with the Child Protection Information Management System and the GBV Information Management System. When details of a specific case should be shared exclusively with individuals (rather than organisations) who are directly involved in supporting the survivor and/or their caregiver, the information shared should be the minimum required by the receiving service provider for the specific purpose of providing a service or otherwise supporting the child and/or their caregiver.

Referral mechanisms for cases of child sexual abuse should be designed with the utmost regard for the safety and confidentiality of the survivor and their caregiver. For instance, hard-copy referral forms should never include identifying information and electronic referral forms should be protected via a unique password (not shared with any other case/referral form) or other single-use encryption method.

Individual-level data, even if it does not include identifying details, should never be shared with individuals, actors and/or organisations that are not directly involved in the provision of services to the survivor. The only exception to this rule occurs when mandatory reporting requirements are in place, which must be communicated to the survivor and/or their caregiver in advance (*see Chapter 5*).

Coordination with health actors

Case workers will often need to closely coordinate with health actors because of the critical need for health services for child survivors. This close coordination enables the best chances for accessing health care in a timely manner and for ensuring the critical and unique healthcare needs of child survivors are met in child-led and survivor-centred ways.

Accompaniment: When referring a child or adolescent survivor for health services, the survivor and/or their non-offending caregiver may wish for the primary caseworker to accompany them. Accompaniment to health services may be useful for a child survivor because:

- » the caseworker can ensure the child accesses healthcare services within critical time frames for the clinical management of rape and reduce the chances of them being asked to repeat their story multiple times;
- » the caseworker may be able to ensure concepts and various procedures are explained in line with the child's development and capacity. This may be particularly important when children have an intellectual disability or other concern that impacts their development or capacity to understand;
- » the caseworker may be able to help explain concepts, procedures and importance of various health services to both the caregiver and the child in appropriate ways and provide a needed source of trust that may not be present with a health worker who they are meeting for the first time;
- » the caseworker may be able to offer comfort and support during physical examinations.

Follow-up: After completing a referral, the primary caseworker can follow-up with the health provider to ensure the child and caregiver have returned for any additional health care needs (such as returning for prophylaxis support or follow up)

Case conferencing: Primary caseworkers can use case conferences with health workers to:

- » increase their own understanding of healthcare services like HIV post-exposure prophylaxis, STI treatment, emergency contraception, vaccination against hepatitis B and tetanus;
- » discuss any concerns related to the best interests of the child, particularly if mandatory reporting laws exist for either or both the caseworker and health provider.

Case workers can access and review the following resources for more detailed information about responding to the health needs of child survivors:

- » WHO's [Clinical Management of Rape and Intimate Partner Violence](#), Part 6: Caring for Child Survivors;
- » WHO's [Responding to Children and Adolescents Who Have Been Sexually Abused](#).

ADDRESSING CO-OCCURRING AND MULTIPLE FORMS OF VIOLENCE

Coordination between GBV and CP services is especially important in situations of 'multiple forms of violence' – where a child is subject to sexual violence alongside other forms of violence and abuse and when there is 'co-occurring violence' – when multiple family members are exposed to violence by the same or multiple perpetrators, as in the case of a child being sexually abused by their male caregiver who also perpetrates intimate partner violence against the child's female caregiver. In these situations, the initial caseworker may not be trained or best suited to address an emerging issue or type of violence that is disclosed during the case management process and/or the caregiver may require their own caseworker to ensure that their individual needs are met outside of their engagement in the child's care. For example:

In situations of co-occurring violence, caseworkers will need to provide referrals to any additional family members disclosing other forms of violence. For example, if the female caregiver of a child survivor discloses intimate partner violence, she should be offered a referral to a GBV caseworker, one that is separate from the caseworker already working with the child survivor so that the caregiver can receive dedicated survivor-centered support.

The caseworker working with the child survivor should continue to engage and involve the caregiver in the child's care and treatment. The caregiver – with her own caseworker – has the opportunity for individual, direct support. This ensures that both the child and caregiver get the support they need. The two caseworkers will need to work together closely so that care to the child and caregiver is coordinated and that considerations related to their individual and collective safety remain paramount.

In cases where a child survivor is experiencing multiple forms of violence, it is possible that the caseworker may need additional assistance to help address needs that fall outside of their area of expertise. For example, if a GBV caseworker is supporting a child survivor who discloses that she is also experiencing child labour, the GBV caseworker may engage in case consultations with a CP caseworker to get information about how to address these additional needs.

In other cases, the caseworker may need to refer the child to another caseworker to work with the child on addressing a specific issue. This would call for case conferences as part of the coordination process. For example, when a GBV case worker is supporting a child survivor who discloses that she is also an unaccompanied minor, she may refer the child to a child protection service provider for reunification services.

Regular case consultations and/or case conferences – depending on the specific case circumstances – should be instituted as soon as possible in the case management process to enable an open yet safe and confidential channel of communication between case workers supporting each individual/family member. (*See Chapter 6*). Safety assessments for each survivor (that take into account all forms of abuse they are experiencing), will constitute the basis of discussion and decision-making, especially in situations where the individual needs and wishes of survivors are not aligned. Ensuring the safety of both children and adult survivors must be prioritized by all parties. Given the level of risk and complexity inherent in these cases, when both CP and GBV case workers are involved in providing services to the child survivor, the involvement of both GBV and CP case management supervisors is strongly recommended.

COORDINATION WITH GOVERNMENT AGENCIES ON CHILD SEXUAL ABUSE

Cases of child sexual abuse often require coordination with government agencies. While national level governments are responsible for the laws regarding child survivors (which can include policies for mandatory reporting), it is local government actors who implement national policy on a day-to-day basis. How local government actors implement such laws and policies directly impacts child survivor's access to and options for care. Thus, GBV and CP case management service providers will need to engage mostly with local government actors. In any setting, the case management service provider should understand the potential risks and opportunities associated with working with relevant government agencies. This is especially important if government actors enforce policies that are harmful to children, discriminate against specific groups of children, or may not be inclined to collaborate with humanitarian agencies. It is also important that service providers assess and understand differences that may exist across government sectors (for example, there may be differences in how local government representatives for women's and child protection / welfare engage versus law enforcement).

Considerations for case management service providers include:

- » **The legal frame:** To what extent policies, laws and practices are in place regarding child survivors, particularly mandated reporting laws or policies. Where they are in place, they should ideally focus on:
 - supporting the child and meeting their needs;
 - identifying cases and tracking trends;
 - punishment of the perpetrators rather than the survivors;
 - preventing child early forced marriage.
- » **The implementation:** To what extent and how do local government actors follow/ implement national level legislation and policy? Are there differences dependent on the sector of government?
- » **The ways of engagement with the local government:** Are there specific ways of working or procedures for the organization / programme to engage with local government agencies? Are some sectors easier to work with than others?
- » **The advocacy modalities:** How does advocacy with the government happen? Through humanitarian coordination mechanisms such as GBV or CP sub-clusters or sub-working groups? If not, is it possible for the agency to work with other agencies as a collective group to engage in advocacy work?
- » **Direct service provision:** Is the service provider authorized to work directly with child survivors in this setting? If no:

What barriers do child survivors face in trying to access local government agencies and their services?

- government policies and laws or practices/implementation of the policies?
- are common practices and implementation in line with the intentions of policies or law as written?
- staff attitudes and behaviours?
- staff capacity to respond to the needs and provide support?
- accessibility of government agencies by local community?
- other?

Once teams have answered these questions and others relevant to their context, they can develop actions and ways of working safely with local government in the specific context. If there is the willingness and interest on behalf of relevant government agencies to work collaboratively, case management service providers can work with government staff to address challenges and gaps in providing services to child survivors. On the other hand, if government agencies have policies, ways of working or other issues that put child survivors at risk for further harm, case management service providers can:

- » determine advocacy approaches (with others) to address concerns;
- » determine if working through and with local government agencies can mitigate challenges and open potential ways of working around harmful national policies;
- » determine if the case management team can work in a capacity strengthening or support role with relevant local government agencies.

Chapter 8

SUPERVISION AND STAFF-CARE

CHAPTER OVERVIEW

This chapter describes how to integrate supervision processes and specific content required for working with child survivors into existing child protection (CP) and gender-based violence (GBV) supervision practices.

Associated tools

CCS Case Management Assessment

CCS Case Review

Guidance for Integrating CCS Assessments

INTRODUCTION

Because of the complexity of child survivor cases and the risk of further harm, caseworkers working with child survivors of sexual abuse have specific supervision needs. This does not mean that entirely separate approaches and processes for supervision should be implemented for caseworkers working with child survivors. Most likely CP and GBV caseworkers will have child sexual abuse cases added to an existing caseload once they have the required training and demonstrate the requisite knowledge, attitudes and skills to work with child survivors. Supervision specific to child survivor cases should be integrated into these existing and ongoing supervision practices.

The Inter-Agency Guidelines for Case Management & Child Protection and the Inter-Agency GBV Case Management Guidelines have specific guidance on supervision that should form the basis of supervision for CP and GBV actors respectively. The primary goals of supervision in these existing practices are quality control of service delivery as well as support to the caseworker's professional growth and development. Recommended supervision practices from both these packages include:

- » regular individual supervision of a caseworker;
- » regular group supervision for caseworkers and supervisor to come together to support educational, professional development and administrative needs;
- » case conferences;
- » specific opportunities for further skill development through training or other capacity strengthening.

These practices use a supportive, compassionate and empowering approach to supervision that intends to model the way in which caseworkers should interact with their clients. The guidance that follows is built on the approach, process and content used in CP and GBV case management.

INTEGRATING CCS SUPERVISION AND CAPACITY STRENGTHENING

Once staff have completed the Caring for Child Survivors training, supervisors should integrate the following into existing supervision:

- » an initial capacity assessment;
- » capacity strengthening;
- » monitoring and re-assessment.

An initial capacity assessment following the *Caring for Child Survivors* training

Stand-alone *CCS Knowledge*, *CCS Attitude* and *CCS Communication Assessment tools* are available, should supervisors prefer to use more in-depth tools with caseworkers providing services to child survivors of sexual abuse. If teams have existing GBV or CP knowledge, skills and attitude assessments, additional questions specific to working with child survivors can be integrated (guidance on key questions to integrate can be found in the tools at the end of this chapter). Supervisors can also implement or integrate into existing assessments content from the *CCS Case Management Assessment tool* which is focused on the unique adjustments and additional aspects of providing case management to child survivors of sexual abuse.

Capacity-strengthening actions specific to working with child survivors of sexual abuse

Based on the initial capacity assessment, supervisors and caseworkers should discuss next steps for capacity strengthening: identify actions, a sequence for those actions and a timeline for completion, noting what must be priorities versus longer-term goals. These actions can be integrated into existing capacity-strengthening plans if those exist, or a new one specific to caring for child survivors of sexual abuse can be created. The CCS Case Review tool may be useful for supervisors as part of the capacity-strengthening process, particularly for caseworkers who have less overall case management experience or who struggled with the Caring for Child Survivors Training and post-test.

Monitoring and re-assessment

Returning to the capacity-strengthening plan at pre-agreed intervals (for example, at the end of every month) is an opportunity for the supervisor and caseworker to discuss the identified actions, progress towards them and reflections on successes and challenges. Supervisors can also periodically reassess caseworker knowledge, attitudes and skills with the same tools previously used to see if there has been improvement, doing so in a supportive rather than punitive manner. This provides an opportunity to see if a caseworker's knowledge changes over time and to identify new areas or information that should be included in ongoing learning through group supervision and case management meetings.

If safe to do and it does not disrupt the case management process, supervisors can observe caseworkers directly providing services to child survivors. This does not have to be long term or over multiple visits, but it is a helpful aspect of capacity strengthening when newly trained in caring for child survivors of sexual abuse. Direct observation allows supervisors to see how an individual applies knowledge about child sexual abuse in real time (supervisors can use the CCS Case Review checklist to support observation). If direct observation is not possible, supervisors can integrate into supervision questions on how knowledge was applied during casework or role-play a case with the caseworker.

SPECIFIC STRATEGIES FOR CCS SUPERVISION AND CAPACITY STRENGTHENING

Supervisors should ensure that caseworkers:

- » complete the Caring for Child Survivors Training;
- » complete key modules in either Child Protection Case Management Training or GBV Case Management training as outlined in the *Introduction*;
- » are assigned a smaller case load when initially seeing child survivors of sexual abuse – a maximum of 10–12 cases (ideally, caseworkers with no previous experience with other types of cases do not immediately work with child survivors of sexual abuse);
- » receive individual supervision of no less than 30 minutes per week and ideally 1 hour;
- » receive group supervision and/or case management meetings at least monthly (depending on workload and availability of the team) but ideally weekly;
- » receive capacity-strengthening assessment that includes knowledge, skills and attitude assessments and plans for addressing gaps through ongoing supervision;
- » receive cross-learning opportunities with other agencies who work with child survivors of sexual abuse.

As they gain more experience, supervision needs may decrease but caseworkers will still need:

- » individual supervision 1 hour per week, no less than 1 hour every two weeks;
- » group supervision and/or case management meetings weekly to monthly (depending on workload and availability of the team) but should not be less than monthly;
- » capacity-strengthening assessment that identifies and addresses priority areas of learning about child survivors for the caseworker;
- » cross-learning opportunities with other agencies and sectors who work with child survivors of sexual abuse;
- » refresher trainings, particularly on aspects of child protection or GBV if the caseworker does not have work experience in both case management programmes.

Supervisor experience for CCS

Supervisors need additional experience and competencies to support caseworkers working with child survivors. They need a strong foundational understanding of approaches to case management for child survivors and of the drivers of child sexual abuse. They need to be able to illustrate intersectional analysis and help caseworkers develop the skills to apply a survivor-centered, whole-child approach. Supervisors of caseworkers working with children need to have the following training and experience:

- » completed the Caring for Child Survivors training;
- » completed supplemental Child Protection training or Gender-Based Violence training, depending on prior experience;
- » at least 2 years' experience providing case management services to child survivors.

Topics to address in supervision for working with child survivors of sexual abuse

While not solely related to working with child survivors of sexual abuse, supervisors should be mindful of these issues and the particular ways in which they may surface for cases of child sexual abuse. The topics below here will also be topics that need to be addressed in supervision that may be particular to the dynamics of child sexual abuse cases.

- » **Addressing multiple forms of violence:** Many times, child survivors of sexual abuse are at risk of other forms of violence. This could result in the need for multiple services and sometimes more than one caseworker across different agencies. In such situations, case coordination is integral to maintaining effective services.
- » **Working with family systems:** Case workers who work with child survivors of sexual abuse need to work with both a child and their family. While this is familiar to CP caseworkers, it is not as common for GBV caseworkers and should be recognised within supervision processes.
- » **Identifying others who need services:** Caseworkers may also identify situations where a non-offending caregiver needs case management services or a child who has perpetrated sexual abuse needs case management services. Particularly when non-offending caregivers need services as well, the need for case consultations and case coordination increases.
- » **Recognising risk to other children in the home:** Other children in the home may be at risk of sexual abuse when a caseworker starts seeing a child survivor of sexual abuse, as the perpetrator may no longer have access to that child.
- » **Maintaining boundaries:** With child sexual abuse cases, many boundary issues may arise from multiple sources. For example, a caseworker may be pressured to provide case-identifying information and details.

- » **Staff well-being:** Working with child survivors of sexual abuse can have an emotional impact on caseworkers. For some, this may be more significant than for other cases. Because of this, boundaries are integral to both self-care and collective care for the team.
- » **Case load:** There may be workload requests that are not sustainable within the team or the larger agency. The caseworker themselves may overwork or have poor boundaries with a client because of the urgency and seriousness of the situation.

Specific topics for capacity strengthening

In addition to the above, capacity strengthening within the supervision process and as separate trainings may be needed on:

- » age and development impacts;
- » contextual dimensions of inclusion and diverse identities;
- » co-occurring violence:
 - mother is also experiencing GBV;
 - elder abuse is present in the home;
 - family experiences discrimination based on a specific identity;
 - child sexual abuse and children associated with armed forces and groups.
- » multiple forms of violence;
- » children who display harmful sexual behaviours;
- » mental health and psychosocial (MHPSS) support interventions relevant to child survivors of sexual abuse:
 - addressing suicidal ideation and safety planning;
 - deepening knowledge and experience with MHPSS interventions.
- » clinical management of rape procedures, as well as:
 - adjusted procedures and considerations for children and adolescents;
 - adjusted procedures based on type of incident experienced.
- » laws, government policies and traditional practices and justice mechanisms for child sexual abuse;
- » impacts of child sexual abuse on education, functioning, socialisation and strategies for reintegration;
- » community attitudes and behaviours towards child survivors of sexual abuse, their families and perpetrators.

SUPPORTING STAFF WELL-BEING

Studies show that caseworkers working with child survivors of sexual abuse experience heightened risk of different types of stress.¹¹⁷ Supervisors need to acknowledge that staff working on child sexual abuse may need additional support. While negative impacts of this work are serious and concerning, protective factors, including proper supervision and training provide ways to manage and mitigate those negative impacts. The strategies below can help supervisors create a supportive environment for their teams in general and in so doing can provide the necessary support for their staff working with child survivors of sexual abuse.

Enable a child-centred approach to be sustained:

- » provide time and space for caseworkers to reflect and learn in order to better meet children's needs and do no harm; working with child survivors of sexual abuse is complex and caseworkers will continue to develop competencies throughout their work.

Normalise empathy for and respect feelings of caseworkers:

- » recognise that the complexity of child abuse cases makes can lead to burnout and adverse impacts on well-being for caseworkers;
- » recognise that compassion fatigue impacts career longevity and financial stability for caseworkers and their own family;
- » create space for caseworkers to raise these concerns when they first experience them.
- » establish measures and processes for the supervisor to address caseworkers' concerns so the caseworker can continue doing this work;
- » promote self and collective care for caseworkers.

Enable open communication:

- » create an environment of open communication and supportive feedback amongst all members of the team;
- » create space for individual team members to raise their own concerns about outside factors and stressors that may impact their ability to maintain current case load;
- » promote respectful communication with the team;
- » schedule regular conversations about stress, factors currently creating stress in the context, and how those might impact work.

¹¹⁷ Crivatu, I.M., Horvath, M.A.H. & Massey, K., [The impacts of working with victims of sexual violence: A rapid evidence assessment](#), Trauma, Violence, & Abuse, 24(1), 2023.

Encourage team and self-awareness:

- » ensure awareness of team dynamics and how those may contribute to individual and collective stress;
- » create conversations around self-awareness and how the ability to recognise personal levels of stress, its fluctuations, and limits as professionals can help caseworkers to seek out help before experiencing more severe forms of stress;¹¹⁸
- » encourage, demonstrate and give space to practicing positive coping mechanisms;
- » acknowledge and validate caseworkers' experiences.

Encourage and explore professional boundaries:

- » understand the professional boundaries that are important for individual caseworkers, for the case management team and for the GBV or CP team;
- » create healthy boundaries around work hours, expectations and the limits of what is possible in the environment;
- » recognise and acknowledge limitations to services, referrals and operating environments. that make addressing the survivor's concerns harder, and sometimes impossible;
- » demonstrate healthy boundaries as much as possible for the team.

Establish clear roles and responsibilities:

- » implement clear and firm roles and responsibilities to ensure everyone on the team knows their roles, their limitations and who will support them in these roles;
- » promote caseworker safety - as a supervisor, a key responsibility is to recognise signs of stress, burnout and compassion fatigue and respond quickly and appropriately.

Establish a supportive structure:

- » regular individual supervision creates a dedicated space to raise concerns in private and to explore ways to address those concerns;
- » create an environment for caseworkers that is safe for learning, giving permission for staff to acknowledge what they do not know, be forthright with mistakes and work collaboratively to build skills. In addition, as well as one that recognises and addresses forms of stress caseworkers may be experiencing;
- » coordinate with human resources and programme managers/coordinators to ensure protocols for caseworkers showing signs of stress, burnout or compassion fatigue.

¹¹⁸ Ibid.

Set realistic expectations:

- » set realistic expectations around caseloads, time needed to complete paperwork, and continued learning and capacity-strengthening activities;
- » reduce caseloads as needed and possible to accommodate for personal situations that may be impacting a caseworker's overall experiences of stress;
- » consider buddy systems for check-ins/support among caseworkers.

Types of stress

Understanding the difference between functional stress and negative forms of stress can help caseworkers recognise when they might be experiencing stress that can impact their own well-being. Supervisors should therefore ensure that all caseworkers can recognise different types of stress and the warning signs of more severe forms of stress, both in themselves and in their colleagues¹¹⁹:

- » **Functional stress:** Stress associated with everyday decision-making and typical problem solving. Everyone experiences functional stress, which motivates productivity. It is a normal response that can be managed routinely.
- » **Cumulative stress:** Stress resulting from prolonged and unrelieved exposure to stressors. Cumulative stress is a common form of stress for humanitarian workers and when not recognised and proactively managed, it can lead to burn-out and compassion fatigue.
- » **Critical incident stress:** Stress that is caused by extraordinary events – almost everyone involved in the event will experience this stress. Because this stress is the result of an extraordinary event (for example, a tsunami, earthquake or other natural disaster) it is sudden, disruptive and creates a sense of vulnerability that did not exist before.
- » **Secondary traumatic stress**¹²⁰: Sudden adverse reactions that may occur when working with those who have experienced adverse experiences or traumatic events. This form of stress mirrors a survivor's and is generated from the survivor's experience, rather than the worker's direct experiences.
- » **Vicarious trauma**¹²¹: Stress resulting from witnessing or learning about others' experiences, which leads to changes to the worker's beliefs, frame of reference and world view. Vicarious trauma is a continuation of secondary traumatic stress and can lead to longer-term impacts for the worker and the need for their own supportive services as a client to work through these experiences.

¹¹⁹ The Alliance for Child Protection in Humanitarian Action. [Definition and Functions of Supervision within Case Management](#).

¹²⁰ Jenks, S.R. & Baird, S. (2002) [Secondary Traumatic Stress and Vicarious Trauma: A validation study](#).

¹²¹ Ibid.

CCS CASE MANAGEMENT ASSESSMENT

Date:

Staff name:

Supervisor:

PURPOSE

This tool allows supervisors to determine if a gender-based violence caseworker or a child protection caseworker has sufficient technical knowledge to work with child survivors of sexual abuse.

GENERAL INSTRUCTIONS

Use this CCS Case Management supervision tool in a discussion with a caseworker in a quiet and private location.

1. Before completing this assessment, confirm that the caseworker has demonstrated:
 - » in-depth knowledge about child sexual abuse (as evidenced by the *CCS Knowledge Assessment*);
 - » child-centred attitudes and beliefs (as evidenced by the *CCS Attitude Assessment*);
 - » communication skills standards (as evidenced by the *CCS Communication Skills Assessment*).

Record scores from these assessment tools in the box below.

2. Inform the caseworker that this tool is being used to assess areas where further capacity building is needed. It is not a performance evaluation tool. Explain that the caseworker will receive a score to determine if they meet the overall case management competency requirements.
3. 3. Ask the caseworker to explain or describe the 10 concepts in the tool. Compare their responses with the 'Criteria' column and score each as follows:
 - » **Met (2 points):** If the individual answers the questions correctly and fully.
 - » **Partially met (1 point):** If the individual answers at least 50 per cent of the question. For example, if the question is, "Name the guiding principles for working with child survivors" and the person can only name four.
 - » **Not met (0 points):** If the individual is unable to answer the question.
4. Once the assessment is complete, total the scores and discuss the outcome with the caseworker, including any capacity building needed

Caseworkers have already Met these Competency Assessments	Yes (input score)	No (input score)	Not Evaluated
Demonstrated in-depth knowledge about child sexual abuse (as evidenced by the CCS Knowledge Assessment)			
Demonstrated child friendly attitudes and beliefs (as evidenced by the CCS Attitude Assessment)			
Demonstrated communication skills standards (as evidenced by the CCS Communication Skills Assessment)			

ASSESSMENT QUESTIONS

Case management skills	Criteria	Met (2 points)	Partially met (1 point)	Not met (0 points)
1. What are the guiding principles for working with child survivors?	Need to list all guiding principles for full score. Need to list at least five principles for half score: 1. Prioritise physical and emotional safety. 2. Promote the best interests of the child. 3. Seek informed consent/assent. 4. Ensure appropriate confidentiality. 5. Facilitate meaningful participation in decision-making. 6. Treat every child fairly and equally. 7. Treat children with respect, kindness and empathy. 8. Recognise each child's and family's uniqueness. 9. Understand each child's social identities and individual experiences.			
2. What are the mandatory reporting requirements in this setting?	[Answer needs to be developed locally.]			
3. What are the limits to confidentiality in child cases?	Need to explain all three for full score: 1. If there are mandatory reporting laws in place. 2. The need to protect a child's physical and/or emotional safety. 3. If a child is at risk of harming another person (possibly homicidal) or themselves.			

4. Explain how informed consent/ assent procedures are adapted with children.	Need to include both key points for full score: 1. Based on the child's age and developmental stage. 2. Based on the presence/absence of supportive caregivers.			
5. In what ways can a caseworker promote a child's best interests?	Need to include at least three for full score: 1. Protect the child from potential or further emotional, psychological and/or physical harm. 2. Reflect the child's wants and needs. 3. Empower children and families. 4. Examine and balance benefits and potentially harmful consequences.			
6. When is informed consent/ assent sought during case management?	Need to state both for full score: 1. At the start of case management services. 2. For referrals to other services providers. This includes obtaining permission for collecting data (IMS) and using it in statistical reports.			
7. Explain the main areas of need that you must assess for a child survivor.	Need to name first three and one other for full score: 1. Safety and protection. 2. Health/medical care and treatment. 3. Psychosocial needs. 4. Legal/justice needs. 5. Other context specific.			
8. What are the steps of case management?	Need to name all six for full score (or at least four for half score): 1. Introduction and engagement. 2. Assessment. 3. Case action planning. 4. Implementing the case action plan. 5. Follow-up and monitoring. 6. Case closure and evaluation.			
9. What are examples of MHPSS interventions that caseworkers can provide, and how can they can help child survivors and their caregivers?	Need to name three and explain to get full score (Half score if at least two are named and explained): 1. Healing education (or psychoeducation): Provides specific, accurate information about sexual abuse and related topics. Helps understand impact and how to stay safe in future. 2. Relaxation training: Teaches strategies for managing physiological symptoms of stress. 3. Problem solving: Helps break down problems and develop concrete solutions. 4. Coping skills plan: Identifies child's sources and strategies to help them manage emotions.			

10. What are the main criteria for knowing when to close a case?	Need to name all three for full score (Half score if two are named): 1. The case plan is complete and satisfactory, and follow-up is finished. 2. There has been no client contact for a specified period (e.g., more than 30 days). 3. The child client and caseworker agree that no further support is needed.			
TOTAL POINTS QUESTIONS 1-10				
TOTAL SCORE				
EVALUATING CASE MANAGEMENT COMPETENCY 16-20 points: Scores in this range indicate that the staff person has MET the core case management requirements and is able to work independently with children and families with ongoing supervision. 8-14 points: Scores in this range indicate that the staff person has PARTIALLY MET the case management competency requirements, but additional training is needed to build knowledge and skills in case management. The staff person should be monitored very closely if working on child sexual abuse cases. A capacity building plan should also be put into place. This may include one-on-one mentoring sessions, additional training opportunities, shadowing fellow staff members, among other capacity building activities. 0-6 points: Scores in this range indicate that the staff person has NOT MET the requirements for sufficient knowledge and skills to provide case management to child survivors. A capacity building plan should be put into place. This may include one-on-one mentoring sessions, additional training opportunities, shadowing fellow staff members, among other capacity building activities. Following additional training, the CCS Case Management Assessment tool should be re-administered.		Final evaluation: _____ Met _____ Partially met _____ Not met		
OTHER OBSERVATIONS AND COMMENTS (Note any direct observations of the individual that is important to include in the case management assessment).				
CAPACITY BUILDING PLAN (if needed)				

SUPERVISOR SIGNATURE

STAFF SIGNATURE _____

CCS CASE REVIEW

Instructions for Supervisors:

Use this checklist as part of case supervision, within two weeks of a caseworker responding to a case of child sexual abuse. Review the caseworker's practice on an individual case by asking the caseworker if they completed the tasks listed for each step of case management. This checklist provides an opportunity to evaluate the caseworker's direct practice and to receive supervision from their supervisor.

Create a climate of trust, support and care				
Did the caseworker...	Yes	No	N/A	Supervisor comment
1. Stay calm and comforting throughout the child's care and treatment?				
2. Communicate with the child using simple, clear and non-blaming language?				
3. Tell the child they are strong and brave to have shared what happened, and that sharing was the right thing to do?				
4. Tell the child that they (the child) are not to blame for what happened?				
5. Appropriately include the child's ideas, views and opinions throughout the child's care and treatment?				
6. Not overwhelm the child with too much information?				
7. Establish a positive relationship with the child's non-offending caregivers (if possible)?				

Introduction/engagement and assessment				
Did the caseworker...	Yes	No	N/A	Supervisor comment
8. Explain to the child in simple, clear terms about case management services and confidentiality?				
9. Obtain informed consent and informed assent from the child and/or caregiver appropriately?				
10. Conduct a safe and supportive assessment (following the best practices for communication/ interviewing)?				
11. Collect only the details of the incident relevant to helping the child and the child's family?				
12. Assess the child's safety, health and psychosocial needs appropriately?				
13. Complete the correct forms and documentation?				
Case action planning and implementation				
Did the caseworker...	Yes	No	N/A	Supervisor comment
14. Develop an action plan based on the assessment of needs?				
15. Seek the child's views and opinions in decision-making, according to best practice?				
16. Involve the caregiver in the child's care and treatment action plan?				
17. Ensure the child's best interests (e.g., make sure any actions taken will safeguard physical and emotional safety) when planning action steps?				
18. Explain options for services to help meet the child's needs?				

19. Ask the child and caregiver how much information they would like to have shared during the referral process and how?				
20. Obtain informed consent/assent for referrals?				
21. Coordinate the child's needs through safe and appropriate referrals (e.g., accompany the child)?				
22. Implement mandatory reporting procedures (if applicable)?				
23. Implement additional psychosocial support (if appropriate)?				
24. Consult with supervisor on urgent safety concerns?				
25. Make a follow-up plan/appointment?				
26. Complete the correct forms and documentation?				
Case follow-up				
Did the caseworker...	Yes	No	N/A	Supervisor comment
27. Meet with the child at the requested time and location for follow-up appointment?				
28. Review the initial case action plan to assess the status of the child's needs being met?				
29. Re-assess the child's needs (focus on safety) to see if new issues or needs came up?				
30. Develop a revised action plan to meet the child's new needs?				
31. Obtain informed consent for any additional service providers who will be brought into the child's care and treatment?				
32. Make another follow-up appointment with the child and/or caregiver?				

33. Complete the correct forms and documentation?				
Case closure				
Did the caseworker...	Yes	No	N/A	Supervisor comment
34. Assess, with the child/caregiver, if all needs have been met and no further case management is needed?				
35. Review safety plan in place?				
36. Explain to the child and caregiver they can always come back for further services?				
37. Complete the appropriate case documentation?				
Overall case management provided				
Did the caseworker...	Yes	No	N/A	Supervisor comment
38. Follow the CCS Guiding Principles?				
39. Complete case management steps and procedures?				
40. Receive feedback and supervision from the case management supervisor?				

GUIDANCE FOR INTEGRATING CCS ASSESSMENTS

Supervisors have two options when integrating CCS competency assessments into their existing supervision and capacity-strengthening processes:

- » Use the three complete tools that assess core knowledge (*CCS Knowledge Assessment*), essential attitudes (*CCS Attitude Assessment*) and communication skills (*CCS Communication Skills Assessment*).
- » Integrate questions from these tools into existing caseworker assessments.

Assessing and Monitoring Knowledge:

If not using the complete *CCS Knowledge Assessment tool*, supervisors can include the following questions from that tool into their existing knowledge assessment tool.

Question	Suggested scoring	Required answers
1. Explain the general definition of child sexual abuse.	Need to make these main points for full score:	1. A child is a boy or girl under 18. 2. Power is used over a child for sexual purposes. 3. <i>Will likely start to describe specific acts of sexual abuse which you can count as points for Question 2.</i>
2. What are examples of sexual abuse that involves touching (contact)?	Need to make these main points for full score:	1. Forced anal, vaginal or oral sex. 2. Touching a child's breast, buttocks or anus in a sexual way. 3. Forcing a child to touch private parts of another person for sexual purpose.
3. What are examples of sexual abuse that do NOT involve touching (non-contact)?	Needs to be able to name at least five examples for full score:	1. Forcing a child to watch sexual movies, read stories or look at sexual images. 2. A person showing their sexual parts to a child for sexual purposes (e.g., masturbating in front of a child). 3. Taking pictures of a child in sexual positions. 4. Making a child watch sexual acts. 5. Talking to a child in a sexual way. 6. Inappropriately watching a child undress or go to the bathroom (meaning doing this because the person is sexually gratified by doing this).

4. List the common signs and symptoms of sexual abuse for children aged 0–5 years.	Need to be able to identify at least five signs and symptoms for full score:	1. Crying, whimpering, screaming that is not usual behaviour 2. Trembling, fearful. 3. Not wanting to separate from caregivers, may be more attached than normal. 4. May not want to leave places they feel safe. 5. Sleeping problems. 6. Problems developing, such as losing ability to talk.
5. List the common signs and symptoms of sexual abuse for children aged 6–9 years.	Need to be able to list at least six signs and symptoms for full score:	1. Fear of particular people, places or activities. 2. Behaving like a baby (e.g., going to the bathroom in bed or wanting parents to dress them). 3. May refuse to go to school. 4. Touching their private parts a lot. 5. Feelings of sadness. 6. Nightmares (very bad dreams) or problems sleeping. 7. Stay alone and away from family or friends. 8. Eating problems, such as not wanting to eat or wanting to eat all the time. 9. Additional reactions that are common to population/cultural context.
6. List the common signs and symptoms of sexual abuse for children aged 10–17 years.	Need to be able to list at least six signs and symptoms for full score:	1. Depression, sadness, crying. 2. Nightmares. 3. Problems in school (hard to concentrate). 4. Withdrawing from friends and community activities 5. Anger and fighting. 6. Think about the abuse all the time, even when they don't want to. 7. Thoughts of wanting to die; attempted suicide. 8. Additional reactions that are common to population/cultural context.
7. What are common health consequences of sexual abuse for a child?	Need to be able to identify at least eight health consequences for full score:	1. Injury (bruises, broken bones, vaginal injuries). 2. Disease/infection. 3. Chronic infections. 4. Chronic pain. 5. Gastrointestinal problems. 6. Sleep disorders. 7. Unwanted pregnancy. 8. Unsafe abortion. 9. STIs including HIV. 10. Menstrual disorders. 11. Pregnancy complications. 12. Gynaecological disorders.

8. What are some common feelings caregivers may have after hearing about their child being sexually abused?	Need to list at least five feelings below for full score:	1. Blaming themselves for the abuse. 2. Fear for their child's health and safety. 3. Guilt and shame. 4. Anger at their child. 5. Misunderstanding their child, for example, thinking child is lying. 6. Other reaction provided that is relevant to the cultural context.
9. What can help to promote children's coping and healing?	Need to list at least five factors for full score:	1. Caring and timely support. 2. Family and social support and care. 3. Ability to continue with education and other activities the child was involved in prior to the abuse. 4. Psychosocial interventions that help the child understand and manage their reactions to the abuse. 5. Individual capacity of the child. 6. Religious or spiritual beliefs. 7. Other that is specific to the context.

Assessing and Monitoring Attitudes:

If not using the complete *CCS Attitude Assessment tool*, teams should incorporate the following questions from that tool into their existing attitude assessment tool (or general assessment tool).

If the caseworker does not meet, or only partially meets the required attitudes (using the full tool or the questions below) for working with child survivors, discuss with the individual whether they feel ready to work with child survivors and their families before engaging in additional self-reflection and/or training. It may not be appropriate for the caseworker to work with child survivors until she or he undergoes personal reflection of the harmful values and/or beliefs discovered during the attitude assessment. If this is the case, supervisors will need to handle this conversation carefully and sensitively. In some settings, it may be required to discuss these results with a senior manager for advice on how to approach the conversation.

Statements	Individual Scoring			
	Strongly Agree	Somewhat Agree	Somewhat Disagree	Strongly Disagree
1. Some girls cause sexual abuse by the way they behave or how they dress.	1	2	3	4
2. Children who are sexually abused are dirty and ruined.	1	2	3	4
3. When adults and caregivers blame child survivors of sexual abuse for what happened to them, it is my responsibility to challenge them in a supportive manner.	4	3	2	1
4. Sexual abuse does not cause homosexuality.	4	3	2	1
5. A child may purposefully make up stories about being sexually abused.	1	2	3	4
6. It is my responsibility to be aware of my own beliefs and values about sexual abuse and to talk to my supervisor if I find that I am blaming or judging children.	4	3	2	1

Assessing Communication Skills:

If not using the complete *CCS Communication Assessment Tool*, teams should incorporate the following questions into their existing communication assessment tool (or general assessment tool).

Communication skill	Criteria for answering correctly	Met (2 points)	Partially met (1 point)	Not met (0 points)
1. Describe how you would explain a health referral to a child survivor between the ages of 10 and 12 years.	Should include both points for full score: 1. Accurate description of healthcare services (includes risks/consequences) and 2. What the child's rights are during the healthcare treatment and examination.			
2. Explain how to find out how a child is feeling using child-centred materials (drawings, toys, etc)	Correct answers can include any of the following ideas: 1. Draw pictures of faces that represent different feelings and ask the child which one is the closest to how he or she feels. 2. Ask the child to draw a picture about what is the feeling in their mind and heart. 3. Ask the child to use colours to represent the different feelings they have. 4. Other idea/activity that the caseworker has that would be good to try.			
3. What important choices should you offer children before talking with them about their abuse? experience?	Need to provide at least three choices to get full score: 1. The choice to have a caregiver or trusted person in the room. 2. The choice of where to have the conversation. 3. The choice to decide when to have the conversation. 4. If possible, the choice to have either a male or female interviewer – this is more specific to boy child survivors. It is always best practice for girls to be interviewed by female counsellors as they are almost always abused by men.			
4. If a child is under the age of 5, who should you talk to find out what happened to the child?	Must make the following two points for full credit. 1. First, the person who brought the child in for services. 2. The child's caregiver (if appropriate).			

5. What is the difference between interviewing a 7-year-old and a 17-year-old child?	Need to name at least two points for full credit: 1. 17-year-old has a greater understanding of what has happened 2. 17-year-old has more capacity to offer ideas and opinions about what should happen. 3. 17-year-old will be more concerned about social impacts and stigma of abuse.			
6. If a child refuses to talk to you (and is not disabled or hearing-impaired) what are three things you should evaluate?	Need to name at least two points for full score: 1. Is there somebody in the room the child does not feel safe speaking in front of? 2. Are you acting in a way that is making the child uncomfortable? 3. Is the interview place safe for the child to speak?			
7. Give an example of how to respect a child's view, beliefs and opinions when working with them	Need to name at least two points for full score: 1. Ask the child for their thoughts about a particular action. 2. Tell the child in the beginning and throughout any communication with them that they have the right to share how they feel and think. 3. Create space for the child to talk. 4. Additional point relevant to the context.			



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December 2023