Management of Clinical and Community Sexual Violence and Exploitation Services for Children and Adolescents

A Companion Guide—DRAFT
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AIDSFree

The Strengthening High Impact Interventions for an AIDS-free Generation (AIDSFree) Project is a five-year cooperative agreement funded by the U.S. Agency for International Development under Cooperative Agreement AID-OAA-14-000046. AIDSFree is implemented by JSI Research & Training Institute, Inc. with partners Abt Associates Inc., Elizabeth Glaser Pediatric AIDS Foundation, EnCompass LLC, IMA World Health, the International HIV/AIDS Alliance, Jhpiego Corporation, and PATH. AIDSFree supports and advances implementation of the U.S. President’s Emergency Plan for AIDS Relief by providing capacity development and technical support to USAID missions, host-country governments, and HIV implementers at the local, regional, and national level.

Recommended Citation

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# ACRONYMS

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<th>Description</th>
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<tr>
<td>AIDSFree</td>
<td>Strengthening High Impact Interventions for an AIDS-free Generation</td>
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<tr>
<td>ART</td>
<td>antiretroviral therapy</td>
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<tr>
<td>GBV</td>
<td>gender-based violence</td>
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<tr>
<td>NGO</td>
<td>nongovernmental organization</td>
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<td>PEP</td>
<td>post-exposure prophylaxis for HIV</td>
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<td>PEPFAR</td>
<td>U.S. President’s Emergency Plan for AIDS Relief</td>
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<td>SGBV</td>
<td>sexual gender-based violence</td>
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<td>SWAGAA</td>
<td>Swaziland Action Group Against Abuse</td>
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<td>USAID</td>
<td>U.S. Agency for International Development</td>
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<td>WHO</td>
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Responsibility for any errors or misperceptions in the document lies fully with the authors.
INTRODUCTION AND OVERVIEW

Why this Guide?

Health providers/managers must recognize that what they do in the exam room is only the first part of service delivery, and that it is their responsibility to ensure the overall well-being of clients beyond the clinical exam.

Responding to the full needs of children and adolescents who have experienced sexual violence and exploitation can be daunting. How do we respond to something so sensitive that requires multi-sectoral support and funding in environments that have few resources?

The Management of Clinical and Community Sexual Violence and Exploitation Services for Children and Adolescents – a Companion Guide provides a basic framework, examples, resources, and contact information for health providers and managers to:

- Better understand and facilitate linkages with critical social and community services for comprehensive care for children and adolescents who have experienced sexual violence and exploitation beyond the clinical exam.
- Take additional steps to help children and adolescents receive the information and support they need.
- Contribute to shifting sociocultural norms that perpetuate a culture of violence and silence that can also increase HIV risk and vulnerability.

While the primary audience of this guide is health providers and managers, information contained within also provides guidance on the multi-sectoral systems needed for a coordinated response. Given this, the guide should also serve as a useful resource for government stakeholders as well as for community actors within the health, child welfare and protection, education, and legal/justice sectors. Intended as a general resource, the information in this guide should be adapted to country-specific contexts, resources, needs, and policies.

While there are many gaps, there are also many things the health and social welfare sector can do even with small amounts of funding. It is our hope this guide will provide inspiration for small steps a program can do. Still today, many countries lack national protocols for the delivery of services for children who have experienced sexual violence and exploitation. These include protocols for establishing services tailored to children and adolescent needs and ensuring follow-up care and referrals for psychosocial and community support services. There is limited to no global guidance for health facilities on how a referral system for children who have experienced sexual violence and exploitation should function, or what follow-up such a system
should include. There is almost no guidance on the short-and long-term needs of those who have experienced sexual violence and exploitation (including psychosocial needs, which largely are grouped outside ‘medical management’). To fill this gap and develop this document, this guide borrowed heavily from nongovernmental organizations (NGOs) that have developed promising guidelines and resources on various aspects of these integrated care needs.

This resource serves as a companion guide to the 2012 Clinical Management of Children and Adolescents Who Have Experienced Sexual Violence: Technical Considerations for PEPFAR Programs, which provides step-by-step guidance on the appropriate clinical/forensic care for children and adolescents who have experienced sexual violence and exploitation. Note this 2012 document focuses on clinical/forensic management and does not address in detail how providers can better understand and facilitate linkages with critical social and community services for comprehensive care for children and adolescents who have experienced sexual violence and exploitation.

How to Use this Guide

This guide can be read from beginning to end, or the reader can jump to the relevant section. Specific resources and tools are referenced throughout, providing practical implementation guidance meant to be contextualized within the local reality. External links to online resources are indicated by blue underline and internal hyperlinks to navigate within the document are indicated by red italics. Details on contact persons are included when available. The guide comprises the following sections:

Section 1: Background and Rationale provides a basic overview of the key issues, with a focus on the intersection of sexual violence and exploitation and HIV.

Section 2: Models for Integrated Service Provision summarizes the various integrated, comprehensive models.

Section 3: The Minimum Package is an overview of the minimum services that children and adolescents who have experienced sexual violence and exploitation need, and summarizes key considerations. It is an introduction, not a comprehensive explanation of each of these needs. This section also contains links to further reading and tools, and a chart with recommended minimum and aspirational standards.

Section 4: Roles and Coordination of Various Stakeholders describes the major service providers for children and adolescents who have experienced sexual violence and exploitation. This section is a general overview; the exact nature of the roles/responsibilities of each cadre varies from setting to setting, and will depend on the laws, protocols, and norms of the specific
environment. It is suggested programs develop their own, locally relevant job descriptions with roles and responsibilities for each cadre that is part of the overall response system.

**Section 5: Referral Pathways** suggests a generic pathway that programs can adapt to their contexts and provides a checklist for setting up a network. Because case management is a critical component of ensuring continuity of services for children and adolescents, this section also contains a brief summary on case management principles and resources for more information.

**Section 6: Case Management** offers a brief overview of the important case management process, case manager roles/responsibilities, and presents a basic flowchart that programs can adapt to their particular settings.

**Section 7: Guiding Principles** is an overview principles and suggestions to help ensure that the actions that service providers take on behalf of children are supported by standards of care that aim to benefit the child’s health and well-being.

**Section 8: Essential Steps for Long-Term Success** describes general, big-picture essential steps to reduce sexual violence and exploitation against children and adolescents.

**Section 9: Program Highlights** presents brief overviews of programs that are addressing the needs of children and adolescents who have experienced sexual violence and exploitation. It includes details and contact information for each program.
SECTION 1: BACKGROUND/RATIONALE

Sexual violence experienced as a child and adolescent can have a profound impact on core aspects of emotional, behavioral and physical health and social development throughout life (Together for Girls 2015)

Sexual violence and exploitation against children and adolescents is universally condemned but much more frequent than people realize. It is a global human rights violation of vast proportions, with severe immediate and long-term health and social consequences. National-level violence against children survey data from Together for Girls surveys show that about one in three girls and one in seven boys experience sexual violence as children in the home, school, care and justice institutions, workplace, and communities at large (Together for Girls 2015). Such instances happen in developed and developing countries, in emergency settings, and during peacetime.

Sexual violence and exploitation against children and adolescents differ from that of adults and cannot be handled in the same way. Such sexual violence and exploitation is unique due to young peoples’ economic dependence, weak social position (especially girls), and gender inequalities, such as high rates of gender-based violence (GBV) and severe consequences of the HIV epidemic on family and community structures. Similar to sexual violence and exploitation against adults, sexual violence and exploitation against children and adolescents are surrounded by a culture of secrecy, stigma, and silence because they are viewed as a private matter, especially when the perpetrator is a family member.

Girls who experience sexual violence are three times more likely to have an unintended pregnancy, and girls under 15 who have experienced sexual violence are five times more likely to die in childbirth (Together for Girls 2015). Various studies have established linkages between experiences of sexual violence during childhood and future engagement in sexual risk-taking behaviors, such as having multiple partners, using condom inconsistently, drug and alcohol abuse, and engagement in intergenerational and transactional sex (Lalor and McElvaney, 2010; Roemmele and Messman-Moore 2011; Richter 2014). A growing body of evidence has further established an association between sexual violence and increased vulnerability to HIV infection (Baral et al., 2012; Dunkle et al., 2004; Jewkes et al 2010; Machtinger et al 2012; Silverman et al. 2008). Even if a child or adolescent is not infected with HIV immediately after an act of sexual violence and exploitation, research indicates that s/he becomes more likely to contract
infectious and chronic diseases later in life (Jewkes, Sen, and Garcia-Moreno 2002; Jewkes 2010). Children may be at higher risk for HIV transmission than adults because sexual violence and exploitation against them is frequently associated with multiple episodes of violence, and might result in mucosal trauma (Weeks and Day 2013).

The psychological consequences of sexual trauma in childhood are diverse and highly individualized. There is no one response that is experienced by all: the diversity of emotional outcomes is evident in the variability in severity; timing (immediate to delayed impact); duration (short- to long-term); and types of consequences (e.g., psychological symptoms, maladaptive behaviors) (Yuan et al 2006). Research in adults strongly indicates an increased risk of a wide range of psychological morbidity associated with sexual violence (World Health Organization 2013) including post-traumatic stress disorder (PTSD), as well as the onset of depression, obsessive-compulsive disorders, sexual dysfunction, panic attacks, substance abuse, and suicidal ideation (Genvers and Abrahams 2014, World Health Organization 2013).

It is widely accepted that few child sexual violence and exploitation cases are reported to authorities. When children do disclose, it is often part of a longer-term process rather than a single event, and over a longer period of time as compared to adults (Day and Weeks 2012). This manner of disclosure can have important implications for medical management and the collection of forensic evidence, and poses different and important psychological, safety, and legal needs as compared to those who present immediately after a single violation.
Gaps in Providing an Adequate Response

Children and their caregivers face well-documented challenges to accessing and receiving quality clinical care and supportive and follow-up services:

| Delays in seeing a doctor at the facility | Doctors and nurses insufficiently trained to address the needs of children who have experienced sexual violence and exploitation | Public lack of awareness of health risks associated with sexual violence | Rape kit and HIV test kit stockouts | Lack of privacy at the health facility | Limited coordination and communication among health facility staff, police, and social workers | Lack of immediate or longer-term counseling and other psychosocial support | Poor follow-up care and referrals | Transport Costs |

While it varies from country to country, in sub-Saharan Africa it is commonly reported that doctors often avoid cases of sexual violence and exploitation against children because they are reluctant to be witnesses in court trials. This reluctance may reflect feeling intimidated by the process, lack of confidence in the justice system to protect witnesses, reports of witnesses treated poorly by judges, lawyers, and others involved in the process, or concern about the length of time that cases take in court. In many countries, it is mandated to assign a social worker to each case of a child who has experienced sexual violence and exploitation. In reality, there are severe human resource limitations in nearly all sub-Saharan African countries. When social workers are available, they are often unclear of their role and unequipped for short or long-term case management.

Multiple assessments and key informant interviews in various countries reveal serious concerns about the police services, including lack of sensitivity or professionalism, and corruption inhibiting the delivery of services. Many people expressed concern that the way police handle cases may cause secondary trauma for children and their caregivers, which may contribute to the reluctance to report cases. There is reported limited confidentiality and a limited sense of safety for children and their caregivers in police stations. In many settings, police receive no specialized service training and limited to no in-service training, particularly for counseling, and
there are few dedicated cadres currently specializing in sexual violence and exploitation against children at police academies.

For cases that do go to court, serious inadequacies in the system include absence of survivor advocates, witness shelters before trial, skilled and trained prosecutors (who have the will to bring perpetrators to justice), and efficient processing and resolution of cases. Plaintiffs face stigma and discrimination during the court procedures, including public intimidation as a result of indiscriminate media use of journalistic license and access to cases.

Involving civil society groups, NGOs, and faith-based organizations in a network of services can help fill these gaps by sending specialized advocates to contribute their expertise and skills. For example, civil society can play an important function by providing oversight for accountability and advocating for nurses to take a larger role, including having the mandate to conduct forensic exams and sign the medico-legal forms and testify in court (key informant interviews, Keesbury, J. and Thompson, J. 2010).
SECTION 2: MODELS FOR INTEGRATED, MULTI-SECTORAL RESPONSE

This section highlights various models for providing integrated, multi-sectoral services for children and adolescents who have experienced sexual violence and exploitation. The models generally suggest a mix of medical/forensic care, psychosocial care, legal advice, and other support services either on-site or via referrals.

Generally speaking the most common models are:

1. Services fully run and ‘owned’ by a health facility/hospital with either government or donor assistance, or a combination;
2. Services ‘owned’ by and physically located in a health facility/hospital, with clinical services largely provided by the health facility and supportive services provided by local NGOs;
3. Services ‘owned’ by an NGO but physically located in a health facility/hospital, with supportive services provided via referrals to NGO-services outside the facility;
4. Services ‘owned’ by an NGO but physically located inside a health facility/hospital, with supportive services provided largely by NGOs (and possible police) on-site; and
5. Non-medical services offered by an NGO and located in a stand-alone center, with referrals for medical care.

There are well-documented pros and cons associated with each of these models.

Evidence shows that integrated care models, in whatever form, should be established within a health institution where many survivors may present or identified through screening, and there is a concentration of senior health care providers responsible for developing and modifying protocols, training health care workers, and maintaining a database to guide future policies and areas where research may be needed (Choma 2012; key informant interviews). Successful models generally build on existing infrastructure instead of creating new structures/systems (Keesbury and Thompson 2010, key informant interviews). Hospitals are generally best equipped to provide 24-hour emergency services, treatment for serious trauma/injuries, and laboratory services, as well as specialized HIV services and providers who are authorized to complete required medico-legal documentation. At these larger facilities, services may be centralized in one location or offered throughout different sections of the facility (Keesbury, J. and Thompson, J. 2010).

Yet there are also important roles for smaller health centers/facilities to play: critically, these are frequently located close to the community and/or outside of urban areas where accessing
hospitals may be difficult. While they may not have the capacity to treat serious injuries, offer specialized care, or have antiretroviral therapy (ART) facilities available, let alone be staffed with qualified health personnel (usually doctors), when appropriately trained and equipped in areas such as crises counseling, emergency contraception, and PEP, these staff/facilities can offer important services to children and adolescents who have experienced sexual violence. This is an important consideration for rural communities, where hospitals may be far and clients may be within their 72-hour deadline for initiating PEP. Health centers can also provide follow-up care for clients who visit a larger facility for initial care but who cannot travel similar distances for follow-up (Keesbury, J. and Thompson, J. 2010).

Any decisions regarding the appropriateness of various models must apply to the particular setting and be informed by local needs and financial and human resource capacities. Ultimately, in resource-limited settings, there cannot be a single integrated model for all levels of care. The expectation that a national or even regional standard is possible is unrealistic and impractical. Rather, each level should have an adapted version of an integrated approach.

**One-Stop Centers**

The term “one-stop center” is often used to describe an integrated approach, although many models that self-identified as ‘one-stop centers’ vary in terms of actual services provided. What many of these models have in common is an integrated medico-legal and counseling approach, with large variation in how integrated the legal and other social service support is provided, and extent and quality of long-term follow up. How these services are delivered depends on the setting and resources available. In some integrated programs, all immediate and some follow-up services are physically co-located. Other programs have a referral network that ensures access to other essential services.

“One-stop centers” with limited referrals require multi-disciplinary staff and multi-sectoral collaboration to provide all of the services in one location. Regardless of the model, key

![Figure 1: One-Stop Center Key Elements](image)
elements to facilitating use are (see Figure 1) confidentiality, no or small fees for services, easily accessible (in terms of distance), and extended or around-the-clock operating hours (Munalula and Kanyengo 2011; Undie et al. 2012; key informant interviews). Given the dearth of rigorously evaluated programs, it is difficult to make a general statement about the efficacy of a particular self-designed one stop center model over another, or evaluate/compare the impact of these various models. But these elements have shown to be critical to serving children and adolescents who have experienced sexual violence and exploitation.

Stand-alone facilities can be stigmatizing when identified as a sexual violence-specific center, resulting in low uptake. This can be mitigated by housing such centers in a hospital or clinic, which provides a measure of anonymity to those arriving at the facility. Health facility-based, hospital-“owned” one-stop centers may be better suited for achieving the broadest range of health and legal outcomes for GBV survivors than are NGO-owned one-stop centers, because they have adequate infrastructure, supplies, equipment, and staff to offer clinical management of rape (or other kinds of violence) to survivors. Regardless of model, successful follow-up is both a critical and often lacking component.

**Standardized Nationwide Centers**

Some countries have sought to optimize a multi-sectoral approach and ensure consistency by implementing standardized, nation-wide models (also at times called one-stop centers). These (usually) government-supported models are often enshrined in local laws and policies, with some NGO involvement. Yet key informant interviews and a number of reviews suggest that even for country-standardized models, implementation varies greatly from location to location. Consistency in implementation requires monitoring organizational systems and actors involved; on-going training of leadership; consistency in facility structures and associated organizations; management of local politics, demonstrated commitment; and allocation of resources (Colombini et al 2012; key informant interviews).

**Ladderized Model**

The ‘ladderized’ model, demonstrated by the national *Women and Child Protection Units in the Philippines*, evolved to offer different services through various levels of the health care system. The minimum requirements for all Women and Child Protection Units are a trained physician and social worker available and permanently situated in a designated area preferably near the emergency room of the hospital. As illustrated in Figure 2, a Level 1 Women and Child Protection Unit provides minimum medical services in the form of medico-legal examination, acute medical treatment, minor surgical treatment, monitoring and follow-up, social work intervention such as safety (and risk) assessment, coordination with other disciplines (i.e., local
social welfare and development office, police, legal, NGOs), peer review of cases, proper documentation and record-keeping, and expert testimony in court. A Level II facility offers a trained physician, social worker, and a trained police officer or a trained mental health professional. In addition to the services of Level I, Level II also offers 24/7 coverage, social work interventions including case management and case conferences, additional police investigation or mental health services; and proper documentation and record-keeping using the Child Protection Management Information System (CPMIS). A Level III Women and Child Protection Unit includes at least two trained physicians; at least two trained and registered social workers; a registered nurse; a trained police officer; and a mental health professional. Services include those of Level II and long-term case management, availability of specialty consultations, and other support (i.e., livelihood, educational). While many countries do not yet have the capacity to have a trained physician or social worker available, the concept of developing a ladderized model based on local resource realities is promising for resource-limited settings.
Figure 2: Levels of Women and Children Protection Units

Administrative Order No. 2013-0011
Revised Policy on the Establishment of Women and Child Protection Units in All Government Hospitals
https://www.mindbank.info/item/4374
SECTION 3: THE MINIMUM PACKAGE

This section presents a ‘minimum package’ of services to meet the needs of children and adolescents who have experienced sexual violence and exploitation. It is intended as an introduction to the minimum package of services, and is in no way a comprehensive package. **Figure 3** presents an overview of the minimum package of a multi-sectoral response to children and adolescents who have experienced sexual violence and exploitation: medical/forensic, safety/protection, psychological, legal/justice, and other support that will vary by the context. Those who have experienced sexual violence and exploitation may require immediate response from service providers to mobilize crisis intervention support. Following the immediate crisis response, children and adolescents (and families) may require longer-term care and support to recover, heal, positively and fully engage in daily life, prevent further violence, and minimize HIV risk and vulnerability. The subsections below summarize what each service need entails.
### Figure 3: Framework of Needs

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<th>WELLBEING</th>
<th>IMMEDIATE RESPONSE</th>
<th>LONGER-TERM</th>
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| **Medical and Forensic Care and Treatment** | - Medical stabilization/treatment of acute injury or pain  
- Prevention of HIV transmission (PEP)  
- Prevention of Hepatitis B transmission (Hepatitis B PEP)  
- Prevention of pregnancy (emergency contraception where available)  
- Sexually transmitted infection prophylaxis  
- For those who become pregnant, offering referrals in countries where abortion is legal, to services for those that desire to terminate the pregnant, as well as support for pre-natal pregnancy services is essential  
- Evidence collection  
*See The Clinical Management of Children and Adolescents Who Have Experienced Sexual Violence: Technical Considerations for PEPFAR Programs for clinical management guidelines (medical/forensic management).* | - Follow-up visits, ongoing treatment and medication for sexually transmitted infections, HIV PEP, side effect management  
- Prenatal care services (those who become pregnant)  
- People living with HIV support group (those who contract HIV) |
| **Safety and Protection** | - Immediate safety assessment and action planning  
- Temporary care arrangements, including transportation | - Ongoing safety assessment (as needed)  
- Long-term care arrangements  
- Services for reintegration into family/household |
| **Psycho-social Support** | - Psychological risk assessment (suicidal/homicidal ideation)  
- Immediate psychosocial support (in tandem with medical/forensic management)  
- Immediate caregiver/family support | - Trauma-informed psychosocial support services (long-term counseling, rehabilitation); including GBV survivor support groups  
- Caregiver and family support – also aimed at addressing norms that facilitate GBV and HIV risk and serve as a barrier to services |
| **Legal/Justice** | - Legally empowered medical practitioner to complete and sign police forms  
- Police report process (support for statement-taking and documentation)  
- Legal assistance services for immediate justice system engagement (immediate referral for lawyers linked to safety assessment and action planning) | - Legal assistance services for justice system involvement (pre-court training/preparation, care and support during trial for child/adolescent and family) |
| **Other/Social Support** | - Basics such as clothing, hygiene, and sanitary items | - Economic security support  
- Education support (trauma-informed services that provide age-appropriate educational and development activities) |
Medical and Forensic Care and Treatment


**RESOURCES: CLINICAL MANAGEMENT GUIDELINES**

- *Service Specification for the Clinical Examination of Children and Young People Who May Have Been Sexually Abused*
- *RCGP Safeguarding Children Toolkit for General Practice*
Immediate (and ongoing) Safety Assessment and Action Planning

Safety interventions are actions taken to secure the immediate protection of a child who is being or has recently experienced sexual violence and exploitation. The question that should guide the providers is: *is the child in danger right now?* (Erickson 2011). A safety assessment consists of the systematic collection of information on threatening family conditions and current, significant, and clearly observable threats to the safety of the child or youth (U.S. Department of Health and Human Services, 2015). This includes engaging the child/adolescent (and family, in cases where there are non-offending family members) to address the following questions:

- Is there serious harm to a child?
- Is there an immediate threat of serious harm?
- Are protective capacities within the family to adequate to mitigate any threats of immediate serious harm?
- Is there a need for an immediate safety intervention or action?¹
- Is there involvement of social care services?

**Safety Decisions/Action Plan**

These questions and subsequent discussions will inform a safety decision. By making a safety decision, the provider is determining whether safety interventions are needed to protect a child. A safety decision of “unsafe” requires immediate safety intervention action; this plan may include in- or out-of-home options or some combination of both. As the NAPCWA states in its document, A Framework for Safety in Child Welfare Safety, “interventions are not expected to resolve or significantly diminish safety threats, provide rehabilitation, or address the conditions that must change to reduce the risk of

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future maltreatment. Safety interventions are actions to immediately control and mitigate the threat of serious harm to keep the child safe until the family’s own protective capacities are sufficient to provide necessary child protection.” (NAPCWA 2009).

Ideally the safety plan should incorporate all actions needed to control safety threats which, if continued, would result in the child being in danger of immediate or ongoing harm. Common features of a safety plan include:

- Children’s opinions and ideas are actively sought and considered
- The caregivers and family should, whenever possible, be involved in developing and implementing the safety plan
- Clearly specifying what the harm or immediate threat of harm is (e.g., perpetrator still lives at home)
- Description of the child’s vulnerability and the caregiver’s protective capacities
- A written safety plan developed by the caseworker and reviewed by his/her supervisor
- Details of how the intervention will work, i.e., how it will protect the child and any appropriate time frames
- Details of how the worker, designated partner, or private agency will monitor the plan’s effectiveness (NAPCWA 2009)

There are different approaches in attending to safety, with some prioritizing the family’s control over implementing safety plans and others promoting more direct intervention to ensure child welfare, continuity of care, safety, and access to support during a period where safety may be threatened. Common interventions include:

- Securing emergency, safer shelter either through the services provided by the facility, or those offered by an affiliated NGO or the government’s social welfare department
- Authorization of emergency food/cash/goods
- Involving the community police or law enforcement for protection monitoring
- Involving family or neighbors as safety resources (NAPCWA 2009)
- Providing a list of resources (sexual violence shelters, rape crisis centers, taxi/car services, support groups, mental health specialists, health care providers, law enforcement, addiction counselors, etc.).

**Emotional Safety**

There are also considerations of the child/adolescent’s emotional safety. Addressing threats to emotional safety can be as important as addressing physical safety concerns. After an assault, a child/adolescent may develop harmful coping mechanisms (such as substance abuse, cutting/self-mutilation, eating disorders, and increased risk-taking). Many victims experience
trauma-induced mental health conditions (like depression, anxiety, or suicidality), isolate themselves from friends and/or family, or feel unsafe (Victim Rights Law Center 2013). Be alert for children/adolescents who implicitly or explicitly mention that they are thinking of hurting themselves or taking their life. If, based on your conversation, you believe this may be a possibility, do not be afraid to ask directly if s/he is thinking about hurting her/himself. All staff should be trained to work with suicidal clients. Organizations should have internal policies and protocols for staff to follow if they determine a client is a danger to self or others. These policies should be consistent with victims’ privacy rights and the organization’s other privacy obligations (see Psychological Support Services section for more detail on addressing suicide).

**RESOURCES: SAFETY ASSESSMENT AND ACTION PLANNING TOOLS**

- Sample Safety Assessment Form
- Sample Suicide Question Form
- Sample Safety Action Plan

**Temporary Care Arrangements, Including Transportation**

Temporary care arrangements refers to a safe place where children/adolescents can stay in the immediate period after disclosure, whereby determinations can be made if it is safe for a child to return to home or if longer-term placement is necessary. Some facilities may offer short-term accommodations. In some settings, this determination requires the engagement of a government social worker who has a legal mandate to remove a child from their home. Transportation to the temporary care location should be part of the package of services, so the cost of getting there does not become a barrier.

**Ongoing safety assessment**

An ongoing safety assessment refers to ongoing monitoring and evaluation of the child’s safety by the caseworker and other collaborating partners (family members, case supervisor, child protection staff, community-based security, etc.) if needed (Erickson 2011). The purpose is to make sure the plan is actually keeping a child/adolescent safer, and to monitor if modifications or adjustments are needed. A safety review is a formal process to monitor the effectiveness of inventions applied in cases and evaluate the outcomes.

**Long-term care arrangements**

Long-term care arrangements may be necessary if multiple safety assessments continually indicate the home environment to be unsafe for the child. However, arrangements such as foster
homes, group homes, and long-term placements are generally considered to be a last-resort option.

**Services for reintegration into family/household**
There are many documents on reintegration from war/conflict but not finding references re: sexual abuse reintegration.

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**FURTHER READING: SAFETY AND PROTECTION**

- [Safety Planning with Adult Sexual Assault Survivors: A Guide for Advocates and Attorneys](#)
- For a general resource on the various roles/responsibilities of health care stakeholders in terms of safeguarding children, see [Safeguarding Children and Young people: Roles and competences for health care staff](#), published by the Royal College of Pediatrics and Child Health 2014.
- Information booklets for children/families/caregivers to understand impact of sexual assault

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**Psycho-Social Support Services**

Making sure children and families are aware of and appropriately referred to psychological support services is as much a part of their healing as the other aspects of their medical management. Evidence suggests those who receive immediate mental health support have improved mental health outcomes in cases of sexual violence (Brooker and Durmax 2015). For someone who has been sexually violated, the first interactions with the health care provider will have a significant impact on his/her ability to manage the crisis. Meeting a considerate and caring person in the health system when one has been assaulted can have a profound impact on the client, and goes a long way in managing and coping with the event. Yet psychological recovery is not necessarily an immediate process. It can occur in the months and sometimes years following sexual violence and exploitation. However, a number of studies on post-sexual assault care in Africa has indicated that mental health care is not prioritized in either the acute or long-term service phases.

The importance of interventions for non-offending caregivers following the disclosure of child sexual abuse is increasingly recognized in the literature (Toledo and Seymour 2013). Caregivers
have indicated that they were better able to support their children when provided with information on the dynamics of abuse and disclosure, how to be more supportive to their children, the investigation process, long-term consequences on their child, and implications of disclosure on wider family processes.

*Psychological risk assessment*

This refers to an assessment of the child/adolescent for trauma, especially to identify and provide interventions for those at risk of self-inflicted harm, including suicidal thoughts and impulses. This should be done by a trained trauma counselor (social worker, case worker, or nurse). Asking child and adolescent clients about suicidal thoughts and/or plans can be challenging for providers, but it is necessary. Crisis response for suicide, if needed, is one component in the overall assessment and treatment plan for a child survivor (Erickson 2013). Any site working with child/adolescent clients should have specific suicide protocols and training for all staff working with children/adolescents in recognizing the danger signs. Questions that may help assess suicidal thoughts, depending on culture and context are:

- Do you ever wish you were dead?
- Have you tried to hurt yourself?
- Do you want to kill yourself?
- Do you have a plan to kill yourself?
- Have you started to think about ending your life but changed your mind? What happened?

The provider should gently probe for clues to determine if the child/adolescent has a plan and assess past suicide attempts. The provider should assure the child/adolescent that having feelings of sadness or wanting to die is okay and normal. Overall, children/adolescents should not be made to feel that they are being judged (IRC 2012).

For more resources on suicide assessment, support, and action planning, see resources below.

*Immediate psychosocial support*

The goal of the immediate psychosocial assessment/support is assess the child’s functioning, including any immediate/acute risk, and to help determine the longer-term plan of action. This should be done by a trained trauma counselor with knowledge of child/adolescent sexual abuse (social worker, case worker, or nurse).

People who have experienced sexual violence and exploitation need to feel they are in a safe environment and have control over what is happening to them. They should not be made to feel coerced into answering any questions (Day and Weeks 2013). To begin the psychosocial assessment, the provider should clearly explain to children and/or caregivers what will happen so they know what to expect, the purpose of asking these questions, and that they do not have
to answer anything they do not want to. From there, the provider should ask a series of simple questions to determine if the child and/or caregiver perceive significant changes following the abuse experience. The assessment should include an initial safety screening, and determine the strengths of the child and family including the protective capacity of the family. The psychological assessment should consider the developmental stage of the child vis a vis the signs of distress the child may be experiencing as a result of the sexual violence and exploitation. In brief, children and adolescents who have experienced sexual violence and exploitation should be assessed for (WHO 2003):

- Depression
- Anxiety
- Symptoms associated with post-traumatic stress disorder such as avoidance, numbing, and hyper-arousal
- Inappropriate sexual behavior
- Loss of social competence
- Cognitive impairment
- Substance abuse
- Alterations in body image
- Suicide ideation

The information gathered during the psychosocial needs assessment helps the provider understand the extent of the abuse currently affecting the child and what strengths the child and family can call upon during the case management process. Based on the information gathered and the discussion between the caseworker and child client, the provider should document the psychosocial assessment summary in a available form, and work directly with the child/caregiver on a follow-up plan for longer-term support.

There are multiple tools that can be adapted to help professionals assist children and adolescents gain access the needed services. For example, based on answers a provider could determine whether a child needs a general mental health referral, a referral to a specialized program such as a hospital, or a trauma-specific mental health referral.
In cases where the client receives a referral for psychosocial services, it is important that the referral be based on specific mental health needs (i.e., not just geographic proximity). It is also important to help clients, who may be scared and overwhelmed, understand and retain information about possible follow-up services (i.e., providing not only the NGO contact information, but also a pamphlet detailing what services they can provide). One suggestion is to document this general information in a pamphlet that is given to clients (with room to write-in specific follow-up details). This pamphlet could also contain space to write details of any medication requirements as well as dates, times and purpose of any follow-up visits.

**Health providers and the courts: Providing written evidence and court attendance**

Generally speaking, the health worker would be expected to:

- be readily available;
- be familiar with the basic principles and practice of the legal system and obligations of those within the system, especially their own and those of the police, as it applies to their jurisdiction;
- make sound clinical observations (these will form the basis of reasonable assessment and measured expert opinion);
- collect samples from victims of crime (the proper analysis of forensic samples will provide results which may be used as evidence in an investigation and prosecution).

Health workers may be called upon to give evidence, either in the form of a written report or as an expert witness in a court of law. When charged with this task, health care practitioners should be aware of the following pitfalls and potential problem areas and avoid providing opinions:

- that are at the edge of or beyond the expertise of the witness;
- that are based on false assumptions or incomplete facts;
- based on incomplete or inadequate scientific or medical analysis
- that are consciously or unconsciously in favor of one side or the other in proceedings.

Above all, health workers should aim to convey the truth of what they saw and concluded in an impartial way to ensure a balanced interpretation of the findings.

From WHO, Documentation and Reporting Guidelines for Medico-legal Care for Victims of Sexual Violence
The psychological impact of childhood sexual trauma and abuse does not depend solely on the type of trauma experienced. The extent and nature of the impact varies from person to person. For example, research shows that the family's reaction following identification of the abuse and the general family environment can influence the long-term impact of abuse (Futa et al., 2003); and that social support, both inside and outside the nuclear family, can facilitate recovery from trauma (Lauterbach, Koch, & Porter, 2007). Accordingly, the longer-term needs of a child/adolescent will depend on the situation of that particular individual.

Caregiver and family support

The importance of interventions for non-offending caregivers following the disclosure of a child’s sexual abuse is increasingly recognized in the literature, and the great value of caregiver support in the child’s recovery process (Walters 2002, Toledo and Seymour 2013). Parenting skills are critical in cases of child maltreatment, and a number of programs in the Program Highlights section offer parenting classes to help non-offending caregivers enhance their ability to prevent abuse.

Legal/Justice Services

In many countries, real and perceived dysfunctions in the legal/justice system affect reporting—both delayed reporting and failure to report sexual violence incidents at all—and violate the rights and health needs of those who have experienced sexual violence and exploitation. Barriers to reporting incidents of sexual assault include lack of confidence that the legal process will result in a conviction, poor treatment by personnel in the criminal justice system, and having to relive the trauma in court (Christofides et al. 2003; Levy et al 2012; Vetten 2014; key informant interviews). Investigation and prosecution of these crimes remains highly compromised in many settings. Despite provisions of laws to the contrary, crimes such as sexual violence are often treated as a civil matter between families and resolved locally. Witnesses are often reluctant to testify in court due to the stigma, fear of the perpetrator and/or other retribution, transportation

RESOURCES: IMMEDIATE PSYCHOLOGICAL SUPPORT TOOLS AND FORMS

- CCS Guidelines
- Sample Suicide Screening Tool/Questions
- Sample Psychosocial Assessment Form
- The National Child Traumatic Stress Network
- Risk Identification Tools

Trauma-informed long-term psychosocial support services

Longer-term Response

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constraints, frequent adjournments and delays, and/or an overall feeling that their efforts are futile.

A number of assessments have noted that the integration of medico-legal and police services enhances legal outcomes for those who have experienced sexual violence and exploitation, and that the justice and legal components of an integrated service provision are key to ensuring that legal action is taken if desired (Keesbery et al 2012). In particular, linking medical services with legal/police services in one physical entity increases the likelihood that people who have experienced sexual violence and exploitation will get the care and services they need (Keesbery et al 2012, key informant interviews).

**Legally empowered medical practitioner to sign police forms**

One of the major barriers for cases entering the criminal justice system begins when individuals present at the health facility and there is no legally empowered medical practitioner available to sign the examination forms (which subsequently become evidence in a trial). To address this, all facility providing sexual violence services to children should have staff on-site or on-call to conduct the examination and sign the forms. In some situations (as in South Africa), a legally empowered medical practitioner is required to sign both the police forms as well as the hospital/clinic forms for the forensic exam (in SA called the J88). While in many cases only doctors have the legal mandate to complete examinations and sign forensics forms, a number of countries, including Kenya, are introducing guidelines to allow nurses to sign these forms. Given the dearth of doctors in many places, giving nurses the power to conduct these exams and sign these forms should be a major area of advocacy.

**Police report process**

Many children/adolescents and families have major challenges with the reporting process. In some police stations, there is limited confidentiality and sense of safety for children and their caregivers because there is no place for private discussion, they are asked the same questions by different officers, and overall are treated with insensitivity. In one assessment in Lesotho, several respondents noted that the overall emphasis of the police is on the perpetrator, with insufficient attention to the victim’s well-being (Levy et al 2012). While there have been a number of promising initiatives working with police departments, children and adolescents often still need assistance navigating the police reporting process.

**Legal assistance services for immediate justice system engagement**

There are few resources to help children, adolescents, and families who hope to pursue criminal charges navigate this unfamiliar and daunting process. Offering information on how to access legal services, and providing a victim’s advocate to accompany a child/family, can help people access this support (see section below, legal assistance services for justice system involvement).
A focus of such efforts, however, should help clients come to an informed decision appropriate for their healing (Keesbury et al 2105).

**Legal assistance services for justice system involvement**

Even for those children/adolescents/families who are able to prosecute their cases, it is a daunting and difficult process due to many factors, including the absence of witness shelters before trial, unskilled and ill-trained prosecutors (with perceived lack of will to bring perpetrators to justice), frequent release of perpetrators on small amounts of bail, excessively lengthy processing and resolution of cases, and stigma and discrimination against the plaintiffs during the court procedures, including public stigma as a result of indiscriminate media use of journalistic license and access to cases. In some countries, civil society organizations provide support for children and caregivers faced with a legal case, but at times these organizations are not recognized by the courts or allowed to play an official role.

Support for court preparation for the child/adolescent and family can familiarize the client with all aspects of the court and the proceedings, and what to expect when s/he goes to court. This preparation helps the client be an effective witness and minimizes client stress and fear. *TVEP in South Africa* instructs victim advocates to start this process at the first home visit, so that the client does not withdraw because of fear. Useful pre-trial activities include explaining courtroom/legal language and terminology used, a visit to the courtroom, and arranging for the client and witnesses to meet the prosecutor (to reassure that the prosecutor is on their side) (*TVEP, Victim’s Advocates manual draft*). In some places, children’s courts have been set up for youth cases and may offer ways to make the process easier on children and their families.

Child witness preparation will vary, but may include:

- Encourage the child to give testimony in the order that things occurred (chronological).
- Tell the child to listen carefully to all of the questions and to ask for the question to be repeated if s/he does not hear or understand.
- Advise the child to answer questions honestly, clearly, and as completely as possible.
- Inform the child that the court officials will need time to discuss or debate an issue and write down aspects of the testimony. Therefore the child will have to be prepared for possible silences between questions.
- Tell the child that the same question may be asked more than once in order to clarify what the child has said.

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• Reassure the child that it is okay if s/he is unable to remember aspects of anything asked and to tell the court that this is the case.
• Encourage the child to use the toilet before giving testimony in court but that a short break can be taken if s/he needs to go to the toilet while giving testimony.
• Reassure the child that it is okay to cry.
• Inform the parent/s or guardian/s that the child should dress in comfortable clothing that s/he likes on the day of the trial.
• Advise the parent/s or guardian/s to bring food, tissues, and quiet games to the court on the day of the trial because they will likely be required to wait for an extended period of time.
• Explain the purpose of the trial and the concepts of guilty and not guilty and the different types of sentences.

![RESOURCES: LEGAL/JUSTICE SERVICES](image)

- Victim’s Advocate’s Manual (TVEP)
- Court Preparation Process Program / Court Training Manual (Teddy Bear Clinic)

Other/Social Support

**Immediate basics**

A number of organizations, such as TVEP and GRIP, offer clients a care package, including soap, body lotion, a facecloth, a toothbrush, toothpaste, sanitary pads, and underwear; as well as clothes for when theirs are taken for forensic exams. Additionally, children/adolescents who receive PEP should receive food supplements along with the medication.

**Education support and livelihood support**

Over the longer term, children and adolescents may require support to return to/be retained in school and for making an income. Some programs have responded by linking their clients to income-generating activities, or forging partnerships with school programs, teachers and principals.

We understand that the above minimum standards may not be possible in all settings. **Figure 5** is a summary of suggested starting-point goals and aspirational standards to provide comprehensive services to children and adolescents who have experienced sexual violence and exploitation.
**Figure 5: Starting Points/Aspirational Standards**

<table>
<thead>
<tr>
<th>Starting point goals</th>
<th>Yes</th>
<th>Not yet</th>
<th>Steps to reach next level</th>
<th>Aspirational standards</th>
</tr>
</thead>
<tbody>
<tr>
<td>At a minimum, a counselor and an on-call nurse and doctor available for sexual</td>
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<td></td>
<td>At least one medical doctor, nurse, social worker/counselor, paralegal, and police officer available on site.</td>
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<tr>
<td>violence cases. Where not feasible to have dedicated staff, consider a roster of</td>
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<td>trained providers who are available on an on-call basis.</td>
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<tr>
<td>Ensure that job descriptions contain specific roles and responsibilities in</td>
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<td></td>
<td>Clinical and service referral protocols.</td>
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<td>dealing with GBV response.</td>
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<tr>
<td>Protocols in place for addressing cases of sexual violence and exploitation of</td>
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<td></td>
<td>Regular refresher training is offered; staffing supervision and mentoring plans are in place and operational.</td>
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<tr>
<td>children and adolescents, regardless of <code>entry point</code> so that if a child/adolescent</td>
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<td>presents first at a police station or legal service NGO, staff there know how to</td>
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<td>refer him/her.</td>
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<td>All staff have been trained in the protocols and procedures.</td>
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<td>All staff trained and sensitized in guiding principles for working with children and adolescents.</td>
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<tr>
<td>The first point of contact will offer compassion and consideration to child/adolescent.</td>
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<td></td>
<td>Integration of all medico-legal, psychosocial support, and police services, in one physical location.</td>
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<tr>
<td>Integration of as many services as possible at one site.</td>
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<tr>
<td>Signing of the police medical report forms takes place at the medical site.</td>
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<tr>
<td>Allow the client to make the choice about whether s/he wants services and at his/her own pace.</td>
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<td>Reporting to the police is not a prerequisite for obtaining medical care.</td>
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</tr>
<tr>
<td>Starting point goals</td>
<td>Yes</td>
<td>Not yet</td>
<td>Steps to reach next level</td>
<td>Aspirational standards</td>
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<td>------------------------------------------------------------------------------------</td>
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<tr>
<td>The child/adolescent is offered all available services, including PEP, even if there is no physician available to sign the medico-legal forms or if the child or caregiver chooses not to report to the police.</td>
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<tr>
<td>Dedicated staff/services available for extra hours as well as daytime (beyond typical office hours).</td>
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<td>Dedicated staff/services are available 24 hours/7 days a week/365 days a year.</td>
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<tr>
<td>Any medico-legal form or certification is free of charge.</td>
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<tr>
<td>All services are clearly explained to clients; clients receive appointment cards for follow-up visits. If PEP is prescribed, written instructions are provided explain its purpose, the regimen, the importance of following the full course, information on side-effects, and specific follow-up testing appointments.</td>
<td></td>
<td></td>
<td></td>
<td>Clients get written information outlining services s/he received during an initial visit; information about the health consequences of sexual violence and exploitation and treatment prescribed; follow up services; and where/how they will access the services.</td>
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<tr>
<td>Transport subsidies are offered for return visits.</td>
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<td>Free bus or taxi vouchers are provided.</td>
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<tr>
<td>Clients are offered a support person for the duration of the case (includes home visits, PEP monitoring, liaison between police and client, referrals and support for psychological visits, court preparation, etc.</td>
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<td></td>
<td>A specialized caseworker with training in trauma, sexual abuse, and child development is assigned and follows the case.</td>
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</tbody>
</table>
SECTION 4: ROLES AND COORDINATION OF VARIOUS STAKEHOLDERS

This section provides a general overview of the roles and responsibilities of the key stakeholders who need to be engaged to ensure a multi-sectoral response to children and adolescents who experience sexual violence and exploitation. The exact nature of these roles and responsibilities will vary from setting to setting, depending on local laws and protocols. It is suggested that programs develop locally relevant job descriptions with roles and responsibilities for each cadre of the response system.

This section is also intended to guide ministries on the various cadres needed to support children, adolescents, and families who have experienced sexual violence and exploitation.

Effective multi-sectoral response mechanisms require a multi-disciplinary team of professionals from the medical, social, psychological, criminal, legal, and educational fields. While all team members may not be involved in every case, it is important that this team work collaboratively and in the best interest of the child or adolescent. Figure 6 illustrates this relationship with duty bearers in the overall system indicated in red, and community resources to support and reinforce duty bearers indicated in blue.

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Figure 6: Duty Bearers and Community Resources

- **Police**: Raise awareness of children’s issues, respond to and aid in preventing violence; act as single point of contact between all services and advocate on behalf of survivor to receive necessary PRC services.
- **Social Workers/Care Managers/Case Workers**: Statement taking, investigation, collection of forensic evidence, prosecution, ensure survivor safety.
- **Mental Health Professionals**: Provide PRC information and education, specialized short-term and/or long-term mental health counseling.
- **Civil Society Organizations**: Identify and report cases of sexual violence to police and carry out community sensitization on child protection issues.
- **Physicians, nurses, and other medical personnel providing PRC services for children and adolescents**: Impose customary laws and practices in place of the formal legal system.
- **Victims/Survivors Advocates**: Link clients between clinical and legal services and ensure PEP adherence in household.
- **Traditional Leadership**: Child-focused Community Groups: Provide an array of psychosocial services in the community including mental health, housing, economic and food support, etc.
Police are often the first point of contact for a child or adolescent who has experienced sexual violence. In sub-Saharan Africa, police stations are often the only point of contact for rape survivors (Population Council, 2014). In some settings, reporting sexual violence to the police is thought to be a requirement for accessing health services. In Lesotho, for example, the forms required to file a criminal complaint are located at the police station, and interview anecdotes included many instances of caregivers bringing children to a health facility and being told to report to the police because the facility would only conduct the examination if the caregivers had the form in hand (Levy et al, 2012). This is an example of why it is crucial to ensure linkages between the legal and clinical sectors to ensure that timely PEP and other clinical services are offered. In Zambia, one program equipped police with emergency contraception and training to link survivors to clinical services. Pilot results demonstrated an increase in reporting cases of sexual violence. Clinicians reported that police were safely providing emergency contraception and linking clients to health services in a cost-efficient and sustainable manner (Keesbury and Askew, 2010).

Police who help children and adolescents who have been sexually exploited and abused should:

- Be readily available.
- Be familiar with the basic principles and practice of the legal system and obligations of those within the system, especially their own and those of the health sector (WHO).
- Have training in how to communicate with GBV survivors (including not victim-blaming).
- Communicate reassurance.
- Provide a secure and private environment for speaking with the child/family.
- Reliably document the case.
- Follow leads and be willing to press charges in a professional and appropriate manner.
- Provide expert statements, reports, and testimony for the courts.
- Set up decentralized units of officers who are trained to handle GBV cases (e.g., Tanzania’s Police Gender and Children Officers and Lesotho’s GPGU).

Physicians, nurses, and other medical personnel have a major role in cases of sexual violence and exploitation against children and adolescents. Generally, physicians are responsible for working with nurses to treat injuries, conduct a thorough medical screening and forensic exam, and provide appropriate referrals and follow-up. In many settings, physicians are the only clinicians licensed to conduct the forensic exam and sign the formal legally valid police report. Medical personnel should never determine whether sexual assault occurred. They should focus on providing clinical care, psychological support, and active referrals.

Nurses play a fundamental role as they are often the first point of contact when a child or adolescent enters the health system, offering injury treatment, clinical management, basic immediate psychological support, and referrals to case management services. Ideally, nurses (especially at higher level facilities) have been trained to provide specialized services.
including a forensic examination and (at least initial) trauma counseling in a developmentally appropriate manner. They often provide counseling on HIV and PEP if within the 72 hour time frame. Some research of sexual violence programs suggests that nurse-led interventions have the potential to cut down on waiting time for clients and are particularly critical in rural areas where there are physician shortages (Keesbury and Thompson 2010; key informant interviews). However, a major challenge in many settings is that nurses do not have a legal mandate to sign the formal report to the police.

Health personnel who help children and adolescents who have been sexually exploited and abused should:

• Be readily available.
• Be familiar with the basic principles and practice of the legal system and obligations of those within the system, especially their own and those of the police, as it applies to their jurisdiction (WHO).
• Communicate care and reassurance.
• Provide a secure and private environment for the examination and management of the child/adolescent.
• Conduct medical screening, treat injuries, and offer treatment/prophylaxis.
• Conduct or assist forensic examination; make sound clinical observations.
• Collect samples from victims.
• Provide basic, immediate psychological support, including identifying risk of self-harm.
• Make client-specific referrals to case management and ensure the child/adolescent receives these services.
• Follow up.
• Provide expert statements, reports, and testimony for the courts.

Mental health professionals are a prerequisite for any community system designed to address child abuse and neglect (U.S. Department of Health and Human Services 2003). Whether a psychiatrist, psychologist, social worker, nurse, or case manager, mental health professionals who support children and adolescent should be trained to provide child protection information and social services, including short- and long-term mental health interventions based on the specific needs and developmental stage of the child/adolescent (see Section 3: Psychosocial Support Services, for immediate and long-term mental health needs).

Key functions of mental health professionals who treat children and adolescents who have been sexual exploited and abused include:

• Identifying and reporting suspected cases of child abuse and neglect.
• Providing diagnostic and treatment services (medical and psychiatric) for children, adolescents, and their families.
• Providing consultation to legal services on medical aspects of child abuse and neglect.
• Providing expert statements, reports, and testimony for the courts.
• Providing information to caregivers about the needs, care, and treatment of children.
• Identifying and providing support for families at risk of child mistreatment.
• Developing and conducting primary prevention programs.
• Training medical and nonmedical professionals on the medical aspects of child abuse and neglect.
• Participating in community multidisciplinary teams.
• Facilitating self-help groups for parents who have mistreated or are at risk of mistreating their children.

Social worker/case manager/case worker describes individuals who work within a service providing agency and are responsible ensuring that health, social welfare, protection, and other services are provided to clients. Depending on the setting and roles/responsibilities, these cadres may also be referred to as counselors, GBV workers, child protection workers, case holders, and other titles. This provider should be trained in client-centered case management; supervised by senior staff; and adhere to a specific set of systems and guiding principles designed to promote health, hope, and healing for their clients.

Key functions of a social worker/case manager who helps children and adolescents who have been sexual exploited and abused include:

• Educating and supporting children, adolescents, and families throughout the case management process.
• Following informed consent procedures according to local laws and age/developmental stage of the child.
• Assessing the child’s immediate health, safety, psychosocial, and legal/justice needs.
• Mobilizing services, providing referrals, and helping the child/family access those services.
• Conducting ongoing safety assessments, taking decisive action when needed.
• Assessing PEP adherence and side effect management, referring to medical personnel as needed.
• Identifying strengths and needs to engage the child and family in a strength-based care and treatment process.
• Including non-offending caregivers in the process.
• Supporting the child and family throughout the court process, including preparing them for what to expect.
• Leading case coordination, including communication, information sharing, and collaboration with case management and other staff serving the child client within and between agencies.

Victim/survivor advocates often have a role similar to social workers/case managers/case workers. Typically, a social worker/case manager/case worker receives more formal training than a victim/survivor advocate, but the essential objectives of these roles are similar: to help
meet the immediate and ongoing needs of the child/adolescent’s health, safety, psychological, and legal needs following the disclosure of sexual violence. In some cases, a victim/survivor advocate has received less training than a case worker and has more of a supportive, rather than professional, role in their care, treatment, and follow-up. A good example of victim/survivor advocate functions is in TVEP in South Africa (see resource list for a training manual for victim/survivor advocates with more detail about their roles and responsibilities). Key functions of Victim/Survivors Advocates include:

- Educate and support children, adolescents and families throughout the follow-up process, including ongoing home visits
- Follow informed consent procedures according to local laws and age/developmental stage of the child
- Assess the child’s immediate health, safety, psychosocial and legal/justice needs
- Mobilize services and provide referrals appropriately, supporting the child/family to access those services
- Assess PEP adherence and problem solve side effect management issues/refer to medical personnel as needed
- Identifying strengths and needs to engage the child and family in a strength-based care and treatment process
- Support the child and family throughout the court process, including preparing them for what to expect

**Child-focused community groups.** There is great diversity in the mandate, scope, and efforts of various child-focused bodies at the community level. Wessel et al. highlight the differences between two common child-focused community groups, specifically Child Rights Committees and Child Protection Committees (or Child Welfare Committees). Generally speaking, the mandate of Child Rights Committees are to raise awareness about children’s survival, development, and participation rights, monitor and report violations of children’s rights, and advocate for improved policy and legislation to support children’s rights. Child Protection Committees, on the other hand, generally emphasize children’s protection rights and complement awareness-raising, monitoring, and reporting with direct responses such as mediation, problem-solving, referral, support for survivors, and development of local solutions to the child protection threats (Wessels 2009). In some settings, these groups network with elements in the formal protection system such as police, magistrates, district- and national-level committees, and social services and education officials; as well as with elements in non-formal systems such as traditional justice mechanisms (Wessels 2009).

Traditional leaders (including community leaders, chiefs, religious leaders, traditional healers) are often the first point of contact for children and adolescents (and families) who experience sexual violence, even when the formal legal system is present in the community. In some settings, traditional leadership involves extended family and chiefs to impose customary laws and practices to settle cases of child and adolescent sexual violence in place
of the formal legal system (The Columbia Group for Children in Advocacy 2011); in other places, families first approach their traditional leaders before seeking medical care and/or reporting a case to police.

As with civil society organizations, traditional leaders are able to establish strong linkages with service providers from whom they can negotiate and leverage social, economic, and psychological resources. Traditional leadership can also play an important role in negotiating disclosure; for example, if a family refuses to report a case to the police, traditional leaders can reassure the family that the community supports them. Traditional leaders can also support the survivor of abuse and the family throughout their contact with the justice system and, where necessary, during the post-trial period. Traditional leaders can lobby for systemic changes that, for example, require health staff to prioritize child sexual abuse, expand provision of the medico-legal exam to include trained nurses, and allow nurses to sign sexual offense forms.

Working with traditional leaders must be a deliberate approach and one that makes efforts to build relationships. One should not assume (with any of these cadres) that people will approach GBV from a human rights perspective, and a program may need to develop strategies to help sensitize them about harmful cultural practices that perpetuate and even in some cases promote GBV.

Civil society organizations can play a critical role in the early identification of abuse: supporting children and adolescents to access statutory services; helping them and their families cope with the effects of the abuse; facilitating safe reintegration of children back to their communities; and holding service providers accountable. In some cases, CSOs deliver services with or on behalf of government. They can act as an early warning for when service delivery quality slips, and provide a strong advocacy voice for children, adolescents, and their families in policy reform and program development and securing their rights under national laws and policies. They also have the ability to establish strong linkages with service providers, from which they can negotiate and leverage social, economic, and psychological resources that can address the root causes of violence and abuse.

Teachers and other education officials, as trusted adults in their lives, are often the first point of contact for a child/adolescent who has experienced sexual violence and abuse. Teachers and other education officials are responsible for establishing and enforcing safe school policies and reporting cases of suspected abuse. Education officials can build in reporting of abuse requirements into job descriptions of teachers and school administrators and provide pre- and in-service trainings on recognizing and reporting signs of abuse.
SECTION 5: REFERRALS PATHWAYS AND COORDINATION

Figure 7 presents a referral pathway that can be used as a template for the development of national flowcharts that clearly guide the response to cases of violence.

There are a number of ways that survivors typically enter the formal ‘system,’ usually via reporting a violation directly to a community chief or leader (who then facilitates a medical visit or police report), reporting to the authorities (the police), presenting at a health facility (either with immediate trauma or, in many cases, pregnancy), or through specialist service centers if they or a contact are aware of these services (Gevers and Abrahams 2014).
Figure 7: Illustrative Referral Pathway

A child or adolescent presents OR A case is discovered
Children and adolescents should aim to seek medical attention within 72 hours of assault. However, frequently children and adolescents present as part of a different process, not within 72 hours.

Most common referral pathways:
- Health facility (especially if pregnant)
- Police
- Traditional leadership/community group

Support child’s or adolescent’s access to immediate medical/forensic and psychological care

The child’s health and injury treatment should be prioritized over police questioning

Medical/forensic management includes:
- Medical stabilization/treatment of acute injury or pain
- Prevention of HIV (HIV/PEP)
- Hepatitis B treatment
- Prevention of pregnancy (emergency contraception where available)
- Evidence collection

Legally empowered medical practitioner to sign forms

Immediate psychological support should be prioritized alongside medical/forensic treatment and care

Acute trauma assessment

Immediate psychosocial support

Immediate safety assessment and action planning

Temporary care arrangements, including transportation

If a child’s guardian wants to pursue legal action

Police report process

Legal assistance services for immediate justice system engagement

After immediate response, follow-up

Ongoing treatment and medication for STIs, HIV (HIV/PEP), side effect management

Other services over time are based on client’s needs and choices

<table>
<thead>
<tr>
<th>PLHIV and/or sexual and gender-based violence support groups</th>
<th>Legal assistance services for justice system involvement</th>
<th>Trauma-informed psychosocial support services</th>
<th>Caregiver and family support</th>
</tr>
</thead>
</table>
Setting Up a Referral Pathway

Even for one-stop center models, providing integrated care to children, adolescents, and their families requires referrals to one or more service providers, such as government offices or NGOs, and/or those providing direct services (medical providers, police, prosecutors, social services, community shelters and safe havens, legal advice centers, local clinics, youth and women’s organizations, and/or psychosocial support organizations).

The responsibility for setting up a strong referral network lies with all involved in care and support for children and adolescents who have experienced sexual violence and exploitation, so there is no reason to wait for a health facility to initiate these services. Children and adolescents with signs of sexual violence and exploitation may also present (or be identified) at a police station, educational institution (e.g., school or university), religious organization, community shelter, or children, adolescent, or women’s organizations. Any of these groups can initiate a network to provide more comprehensive services.

One of the most critical aspects of setting up a referral network is building on existing practices and infrastructure and aligning services with local laws, policies, and protocols. The following checklist provides guidance. ³

Determine what a minimum service package might contain (even if much is aspirational at the moment) and what resources might be available

- **Review minimum standards package** to get general idea of what an integrated package entails (see: Minimum Standard Package)
- **Consider what services and resources** are needed for this network to comprehensively serve children and adolescents who have experienced sexual violence and exploitation (initial brainstorming of organizations and services you will need to link with).
- **Conduct assessment** of internal service offerings and available resources (what do you already offer internally, and what can be built upon?)
- **Review the basic principles and practice** of the legal system and obligations of those in it to children and adolescents who have experienced sexual violence and exploitation, and implications in terms of service delivery.
- **Conduct community mapping** of potential referral points that provide relevant services, including government and nongovernmental resources. Determine which resources have stable, long-term funding, and which may be more precarious (this activity could be conducted with other stakeholders). Remember there are traditional and informal community structures that can play an important role in supporting children, adolescents and their families (Resource: UNFPA Partner Mapping)
- **Conduct community-based assessments and/or focus group discussions** to get community input, identify social, economic, and physical barriers to services and ways to mitigate them, and to identify opportunities for accessing services. If you are unsure of where services are offered, this is an opportunity to find out (Keesbury and Thompson 2010).

*At this initial stage, it may be useful to contact other organizations/programs offering similar models to get informal advice (and support) about developing/strengthening the referral process. See Section 9 for contact information for various other program models and the Resources section.*

Invite/encourage the multi-disciplinary stakeholder team to participate

- **Ask stakeholders** to consider joining network of referral providers, including traditional and informal stakeholders. Hold introductory stakeholders meeting.
- **Agree upon general, network-wide principles for working with children and adolescents.** This includes principles for all service providers/agencies to communicate standardized, positive messages to the child/adolescent. All members of the network should commit to putting these principles into action and add them to their memorandum of understanding (see Guiding Principles).
- **Adapt or develop** a context-specific Minimum Standard Services Package, based on national/local protocols, laws and norms, and available resources. It may be helpful to develop an aspirational Minimum Standard Services Package for the future that includes steps needed to achieve the next level, such as advocacy to government or soliciting of funds.
Workshop, review, and develop agreed-upon network service offerings and coordination (standards /protocols)

- **Develop agreed-upon standards/protocols for network service offerings and coordination.** These standards should be based on national guidelines and/or protocols that have already been developed. If not, global guidance provides various examples. This includes:
  - Agreement on minimum standard services package, see [Minimum Standard of Care](#).
  - Documented roles and responsibilities for all staff and volunteers available to all network members, see [Roles and Responsibilities](#).
  - Standardized algorithms for care, including safeguards to ensure children/adolescents are not interviewed multiple times about their experience/history with sexual violence and exploitation.
  - Guidelines for informed consent and confidentiality procedures for children under the legal age of consent.
  - Standards for data collection and information-sharing protocols, including how information about cases will be shared with network members.
  - Standard operating procedures and expectations for network agencies (frequency of meetings, lead agency, etc.).

Workshop, review, and develop agreed-upon referral mechanisms, including case coordination/case management (standards /protocols)

See [Case Management](#)

- **Develop agreed-upon standards/protocols for referrals, case management coordination, and case coordination.** These standards should be based on already developed national guidelines and/or protocols. This includes:
  - Identifying the lead case management agency’s:
    - Specific responsibility for actions made in case response (case managers, victim’s advocates, etc.).
    - Protocols for case managers and supervisors.
    - Protocols to support case managers and for difficult cases and case coordination meetings.
    - Determining when a case is considered closed.
  - Determining when and how referrals should be made and documented (use of a form, verbal, etc.).
  - Determining what type of referrals can be accepted and under what circumstances (e.g., if a referee service only works with youth under a certain age).
  - Establishing a process for case conferencing using a multi-disciplinary team approach to care review and case planning.
  - Type of information that can be shared between agencies, professionals, and family members. See [Sample Informed Consent Form](#)

Formalize relationship between referral institutions/sign Memorandum of understanding

*This step can happen earlier; however, there are many discussions to be had re: the details of the protocols, etc. so it may be useful to go through that process and then finalize the MOU.*
Document the MOU details including:

- Expectations and client-centered norms for all agencies, professionals, and volunteers in the network.
- Service provider agreements that outline referral and information-sharing protocols.
- Agreement on case management protocols.
- Agreement on guidelines for interacting with clinical, legal, and other reporting systems.
- Guidelines on monitoring, information-sharing, and quality assurance protocols.
- Expectations/guidelines on regular referral network meetings. See Sample MOUs.

Develop short- and long-term staff development plan

- Even if all the managers/heads of services agree on the protocols/steps outlined above, their staff still need regular training. Work as a network to develop a practical curriculum and determine how staff can get this training in a cost-effective manner. Call upon resources already operating in your area, such as other donor-funded programs and professional associations already offering training.
- Develop a plan for ongoing and refresher trainings so service providers have the knowledge, skills, attitudes, and tools to use referral pathways, reporting agreements, and information-sharing protocols.
- Develop a curriculum and plan for self-care as professionals and volunteers working in this field are at risk for secondary trauma.

Ensure monitoring and evaluation plans, including accountability mechanisms, are in place

These may include:

- Referral pathways and reporting agreements are utilized properly.
- Info-sharing protocols utilized properly.
- Processes for client feedback.
- General quality assurance processes to maintain quality.
- Mechanisms to hold all stakeholders accountable to their mandates and ensure efficient services.

Develop/finalize forms and materials

This may include:

- A clear referral directory for all members of the network. See Sample Referral Directory.
- Develop/print/have available standardized referral forms.
- Pamphlet with information available for clients, pocket-size lists of useful phone numbers any other forms/tools/items to give to clients. See Survivors Manual.
- Making sure copies of police forms and forensic reporting forms are readily available.
SECTION 6: CASE MANAGEMENT

Case management and referral mechanisms are the ‘glue’ that binds populations affected by HIV with services.⁴

Follow-up care and support is one–if not the–most challenging aspects of providing appropriate care and support for children and adolescents who have experienced sexual violence and exploitation. Case management can improve coordination and integration between and among sectors, facilitating the delivery of multiple services and helping survivors navigate complex and disparate service delivery systems. Case management is an essential component for helping children, adolescents, and families manage the myriad of services/appointments they need in the immediate and long-term to heal.

Case management, also referred to as care management or care coordination, are practices that involve survivors (and their families, if applicable) in a collaborative process of identifying, planning, accessing, advocating, coordinating, monitoring, and evaluating resources, supports, and services–and helping clients to navigate complex service delivery systems (National Association of Social Workers 2013). There are many different models of case management, and this document does not provide details about them. Yet given the importance of case management and its role in helping survivors navigate resources and support, this section provides the basics of what a system might entail and resources for learning more.

As the International Rescue Committee Guidelines for Caring for Child Survivors of Sexual Abuse highlights, the primary role of the caseworker is to:

| Support and advocate on behalf of the child and family | Be the child and family's main point of contact for assessment of needs | Support care and treatment goals; plan interventions to meet needs | Provide, coordinate, and follow-up on the provision of services |

In some settings, certain agencies are designated as case management lead, which requires caseworkers to take additional responsibilities of handling mandatory reporting requirements and organizing case conferencing meetings, among other tasks.

⁴ From Protection and resilience: A simple checklist for why, where and how to coordinate HIV and child protection policy and programming.
While in some settings social workers take the lead on the case management, in many places no social workers are available. When they are, they are often overworked, under-trained, and ill prepared to handle the caseload of child and adolescent sexual violence and exploitation. Some programs have adapted to the dearth of social workers by training and incorporating other cadres into their programs ranging from counselors, GBV caseworkers, victim’s/survivor advocates, to ‘buddies’ to serve as the essential and consistent link between a survivor and services and provide primary case management services to survivors. There are six basic components to case management illustrated in Figure 8 that form the basis of case management systems.
Figure 8: Case Management Flow

CHILD/adolescent IS IDENTIFIED FOR SERVICE
(Referral, direct disclosure)

STEP 1
INTRODUCTION AND ENGAGEMENT
Greet and develop rapport. Introduce services and attain permission.

STEP 2
INTAKE & ASSESSMENT
Assess child/adolescent’s situation and needs.*

STEP 3
CASE ACTION PLANNING
Identify child/adolescent’s needs and plan for care and treatment.

STEP 4
SUPPORT CHILD/adolescent
AND THEIR FAMILIES TO IMPLEMENT THE CASE PLAN
Connect the child/adolescent to resources and services.
Provide direct interventions as appropriate (e.g. psychosocial interventions).

STEP 5
CASE FOLLOW-UP
Have the goals been achieved?

YES

NO

Reassess the child/adolescent and family’s needs and identify barriers to achieving care and treatment goals.

STEP 6
CASE CLOSURE
Child/adolescent ‘exits’ the service.

STEP 7
EVALUATE SERVICE PROVISION
Client Satisfaction Questionnaire
Case Supervisor feedback

* Medical/forensic care and treatment; safety and protection; psychological support; legal/justice; other/social support

Adapted from Clinical Care for Child Survivors of Sexual Abuse. International Rescue Committee, ©@. 
Regardless of the level of training, education, or certification, the following are important considerations for supporting this cadre.

- The case worker should be the person who, from the first point of contact until a case is closed, is the child/adolescents’ main contact (to minimize ongoing re-traumatization by having to see multiple service providers). The TVEP Victim’s Advocate is an excellent model. The Victim’s Advocate on duty becomes the survivor’s ‘buddy’ for the duration of the case and is responsible for the holistic management of all aspects the case until its conclusion (i.e., trial is over, counseling sessions completed). This includes home visits, PEP monitoring, liaison between the police, referrals and support for psychological care, and court preparation.

- Explain case worker role and service(s) available to the child/adolescent and family, including explaining meaning of confidentiality, when information will not be confidential, and how information will be stored. This should be handled with great compassion and consideration, as meeting with a kind, considerate and caring person in the (health) system when one has been assaulted can have a profound positive impact on the survivor, and goes a long way to managing and coping with the event.

- Assess the child’s health, safety, psychosocial and legal/justice needs. Case managers must identify the risks to the child/adolescent and the family’s attributes and challenges using developmentally and culturally appropriate tools (Davis 2014). Ideally, the caseworker has simple assessment tools to help with these).

- Identify a child/adolescent and family’s strengths, needs and resources, as well as the available community supports, is an ongoing process. Since needs evolve over time and community resources may change, case managers should have access to updated resource maps and seek ongoing feedback on whether interventions have helped the child/adolescent heal and the family’s needs or strengths (Davis 2014)

- Accompany the child/adolescent (and family, if appropriate) to the police, health, psychosocial, and other services.

- Lead meetings with service providers and share information (as appropriate and per informed consent and confidentiality protocols) so the child/adolescent does not have to repeat his/her story again and again.

- Depending on the mandate of the case worker, other interventions may include:
  - As appropriate, meeting with the family to discuss issues and helping them access support
  - Sharing with the child / adolescents tools and techniques for reducing stress and anxiety
  - Advocating for the child (with police to take protective measures, for safe housing, etc.)
RESOURCES: CASE MANAGEMENT

• The **International Rescue Committee Guidelines for Caring for Child Survivors of Sexual Abuse** is an excellent resource for case management. It is a step-by-step guide to the case management of child survivors of sexual abuse and explains how to adapt case management for children of different ages. It also provides sample forms for responding to child sexual abuse and the following supervision tools for assessing case management competencies and evaluating applied practice:
  - Sample script for informed consent and client rights statement (page 118)
  - Child needs assessment and case action plan (page 170)
  - Child case follow-up form (page 172)
  - Supervision for case management checklist (page 183)

• The **National Association of Social Workers Standards for Social Work Case Management**

• **Case Management Toolkit: A User’s Guide For Strengthening Case Management Services In Child Welfare**
SECTION 7: GUIDING PRINCIPLES FOR WORKING WITH CHILDREN AND ADOLESCENTS WHO HAVE EXPERIENCED SEXUAL VIOLENCE AND EXPLOITATION

When caring for children who have experienced sexual violence and exploitation, common principles should inform decision-making. It is critical that care and support are provided in a child-friendly manner and that the child is not re-victimized in the process. Following these principles ensures that actions taken on behalf of the child are supported by standards of care that aim to benefit the child's health and well-being.

The table below lists these guiding principles and corresponding actions as described in the UNHCR Guidelines on Sexual Violence Response and Prevention and the United Nations Convention for the Rights of the Child (UNHCR 1995).\(^6\) **These guiding principles should be applied by all members of the referral network and can be adapted as part of the process overview.**

<table>
<thead>
<tr>
<th>Principle</th>
<th>Actions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Promote the child and adolescent’s best interest</td>
<td>• Secure physical and emotional safety (well-being) throughout care and treatment&lt;br&gt;• Evaluate positive and negative consequences of actions with participation of the child/adolescent and caregiver (as appropriate)&lt;br&gt;• The least harmful course of action is always preferred&lt;br&gt;• All actions should ensure that the child/adolescent’s rights to safety and ongoing development are not compromised</td>
</tr>
<tr>
<td>Ensure safety of the child/adolescent</td>
<td>• Ensure physical and emotional safety&lt;br&gt;• All actions should safeguard the child/adolescent’s physical and emotional well-being in the short and long term</td>
</tr>
</tbody>
</table>

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\(^6\) Adapted slightly to include adolescents and focus more broadly beyond the medical provider.
<table>
<thead>
<tr>
<th>Principle</th>
<th>Actions</th>
</tr>
</thead>
</table>
| Comfort the child/adolescent    | • Offer comfort, encouragement, and support  
• Assure that service providers are prepared to handle the disclosure of sexual violence and exploitation appropriately  
• Believe the child/adolescent when s/he discloses sexual violence and exploitation  
• Never blame the child/adolescent for the sexual violence and exploitation  
• Make the child/adolescent feel safe and cared for |
| Ensure appropriate confidentiality | • Information about the child/adolescent’s experience of sexual violence and exploitation should be collected, used, and stored in a confidential manner  
• Ensure the confidential collection of information during all aspects of care including interviews and history taking  
• Share information only according to local laws and policies and on a need-to-know basis, after obtaining permission from the child/adolescent and/or caregiver  
• Store all case information securely  
• If mandatory reporting is required under local law, inform the child/adolescent and caregiver at the time s/he is seen  
• If the child/adolescent’s health or safety is at risk, there may be limits to confidentiality to protect the child/adolescent |
| Involve the child/adolescent in decision making | • Children/adolescents have a right to participate in decisions that have affect their lives  
• The level of a child/adolescent’s participation in decision making should be appropriate to the level of maturity and age, and local laws  
• Although service providers may not always be able to follow the child/adolescents’ wishes (based on best-interest considerations), they should always empower and support children/adolescents and deal with them in a transparent, respectful, and open manner  
• If a child/adolescent’s wishes are not able to be followed, explain why |
| Treat every child/adolescent fairly and equally | • Utilize the principle of non-discrimination and inclusiveness for all children/adolescents  
• All should be offered the same high-quality care and treatment, regardless of ethnicity, religion, sex, disability, family situation, status of their parents or caregivers, cultural background, or financial situation, affording them the opportunity to reach their full potential  
• No child/adolescent should be treated unfairly for any reason |
<table>
<thead>
<tr>
<th>Principle</th>
<th>Actions</th>
</tr>
</thead>
</table>
| Strengthen children/adolescents’ resiliencies | • Each child/adolescent has unique capacities and strengths, and the capacity to heal  
• Identify and build upon the child, adolescent, and family’s natural strengths as a part of the recovery and healing process  
• Factors that promote the child/adolescent’s resilience should be identified and built upon during the episode of care  
• Children/adolescents who have caring relationships and opportunities for meaningful participation in family and community and who see themselves as strong are more likely to recover and heal from sexual violence and exploitation (Perry 2007) |
| Providers should be trained to manage children/adolescents who have experienced sexual violence and exploitation | • All providers who care for children who have experienced sexual violence and exploitation should:  
• Undergo training and orientation to the sexual violence/post-rape care clinic and referral protocols  
• Health care centers should:  
• Identify and train dedicated practitioners (doctors, forensic nurses, or clinic officers) to provide post-rape care and services for children; including those tasked with case management and follow-up (case managers, social workers, etc.) |
| The health and welfare of the child takes precedence over the collection of evidence | • Crisis intervention; treatment of serious injuries; and assessment, treatment, and prevention of HIV, pregnancy, and Sexually transmitted infections are of primary importance  
• The welfare of the child/adolescent ensures that s/he is able to maintain dignity after sexual violence and exploitation, and do not feel coerced, humiliated, or further traumatized by the process of seeking services  
• Children/adolescents should NEVER be forced to undergo the medical forensic examination against their will unless the examination is necessary for medical treatment (WHO 2003) |
<table>
<thead>
<tr>
<th>Principle</th>
<th>Actions</th>
</tr>
</thead>
</table>
| Reporting to police should not be a prerequisite for obtaining medical care | • The child/adolescent’s decision regarding police involvement should be respected at all times  
• The child/adolescent should not be pressured, coerced, or forced to report the sexual violence and exploitation as a condition of receiving medical care  
• If reporting is tied to payment of fees, the hospital might provide free services only if the patient has reported the violence to the police and is in possession of the official documentation. In most cases, these are procedural not legal requirements and should be changed at the facility level  
• Facilities should have a clear policy on reporting that is consistent with national policy and that is patient-centered  
• Police forms should be kept at the facility for children who present to the facility first and should be free of charge  
• The child should be offered all available services including emergency contraception (EC) where legal, HIV and PEP, and other needed health services even if there is no physician available to sign medico-legal forms or the child chooses not to report to the police |
| Use person-first approaches to care          | • Professionals must have a strong understanding of current approaches to inclusive care of all patients regardless of ability  
• Recognize that children with disabilities (physical as well as mental/emotional) are at increased risk for sexual violence and exploitation, and have equal right to care and access treatment  
• Ensure that someone trained is available when necessary for communication alternatives (e.g., sign language) for patients who require this approach |
SECTION 8: ESSENTIAL STEPS FOR LONG-TERM SUCCESS

The following are essential ‘big-picture’ steps for the response to and reduction of sexual violence and exploitation against children and adolescents.

**Mobilize political will and resources to end sexual violence and exploitation against children and adolescents.**
While NGOs and the private sector play a critical role, ultimately full government commitment to achieving child protection is essential to a protective environment and an effective response. This requires multi-sectoral coordination among the health, education, legal, judicial, and social development sectors. The Ministry of Finance and donors should also be included to ensure follow-up and resources to:

- **Establish accountability.** Governments must formally and publically identify who “owns” violence against children in general, and in sexual exploitation and violence in particular.
- **Link the issue of sexual violence and exploitation against children to health.** Support activities to help stakeholders understand that sexual violence and exploitation against children is not only a child protection issue but a critical health issue, and link the highly active HIV response with GBV and the sexual abuse of children in national responses (focusing on GBV and child sexual abuse as structural drivers of HIV).
- **Coordinate roles and responsibilities.** Support the creation of a task force that focuses on sexual abuse of children, with the goal of harmonizing and clarifying the roles and responsibilities of the different government sectors. The task force should develop clear terms of reference and a set of actionable milestones. Responsibilities and activities should be consistent with national laws and policies on child rights.

**Support the drafting and implementation of policies and guidelines to prevent and respond to sexual violence and exploitation against children.**

Many governments have child protection documents, yet challenges remain to make them operational and linked to the service environment. For example, developing subsidiary regulations, a costed implementation plan, and clear guidance on the child protection system requires disseminating and enforcing child protection laws and policies; and educating communities, families, and children about the laws, in particular those that address sexual violence and exploitation. Standard operating procedures are needed to help communities, providers, civil society, and governments understand national- and district-level responses and reporting procedures for ensuring child protection, including protection from sexual abuse. For each audience, guidelines should detail how to report, refer, and
follow up cases and articulate best practices for maximizing benefits to the child. At a minimum, these guidelines should include:

- **Definitions**: Roles and responsibilities of formal and informal systems (e.g., various ministries and agencies, caregivers, chiefs, facilities, village councils, and other stakeholders), including the various institutional arrangements and linkages.

- **Reporting procedures**: Specify reporting options for families and children and make it clear that reporting to the police is not a prerequisite for obtaining medical care, and that a child who has experienced sexual exploitation and violence should never be forced or pressured to report the sexual assault or undergo the medico-legal examination as a condition of receiving other essential care.

- **Services**: The core or minimum package of services for all settings and references to any supporting guidelines such as clinical protocols for the facility level.

- **Required competencies**: These guidelines should also articulate the supporting capacities and competencies that need to be in place for these services to function sustainably, including the legal and normative framework (laws, policies, regulations, and standards); human and financial resources; management, coordination, and referral mechanisms; and monitoring and oversight. Guidelines must be developed in consultation with civil society stakeholders, so that all parties who support care for children and adolescents who have experienced sexual violence and exploitation support the process. The guideline development process will also enable governments and stakeholders to communicate more effectively about the child protection system, support advocacy for strengthening the system, and identify obstacles and opportunities in implementation, especially in reaching vulnerable or excluded groups.

**Have clear and agreed upon national definition of referral mechanisms and a case management system for children, and a common understanding of how they will function.**

This includes definitions of what referral mechanisms and case management mean and how they function, so there is a common understanding among all service providers and clients and policy standards to hold systems accountable.

**Programs must link the informal and formal sectors.**

As one service provider in Lesotho noted, “we cannot continue to pretend they [traditional leaders and the informal sector] are not there.” Traditional leaders play a major role in cases of child and adolescent sexual abuse, but are often excluded from formal “models.” Programs must include members of the informal sector—including traditional healers—in discussions from the beginning to determine their roles in reporting, accessing care, and long-term follow-up. This is especially critical in rural communities, where resources are scarce and underfunded and any support will need to be supplemented by the community.
This is also related to the services and support provided by traditional healers—“we cannot continue to pretend they are not there.”

Re-orient health managers and providers to their responsibilities to clients to go beyond the medical/forensic realm.

Pre-service and refresher training should cover attitudes, knowledge, and skills, information on child/adolescent development, sexual violence and exploitation, and legal considerations (mandatory reporting requirements, consent, justice process, and the expected role of health providers). The training must also teach providers to identify and overcome their own biases, fears, and prejudice.

Programs must acknowledge and support the reality of health manager and provider lives.

Many providers/managers live and work in the same communities as perpetrators. Fear and reluctance to call attention to cases is a significant security issue for them and for programs. For this reason, it can be a major challenge for health providers to go through the court process.
SECTION 9: PROGRAM HIGHLIGHTS

This section provides summaries of select programs that provide services to children and adolescents who have experienced sexual violence and exploitation. It includes Program Highlights from:

- Livingstone Child Sexual Abuse One Stop Centre, Zambia
- Women And Child Protection Units, The Philippines
- The Mirabel Centre, Nigeria
- Swaziland Action Group Against Abuse (SWAGAA), Swaziland
- The Teddy Bear Clinic, South Africa
- The Thohoyandou Victim Empowerment Program (TVEP), South Africa
- Thuthuzela Care Centres (TCC), South Africa
LIVINGSTONE CHILD SEXUAL ABUSE ONE STOP CENTRE, ZAMBIA

Child sexual abuse is a deeply entrenched phenomenon in Livingstone and in Zambia as a whole. Up to 20 percent of children under 16 years of age have experienced some form of sexual violence in Livingstone. Despite a growing public recognition of the consequences of child sexual abuse and its consequences, fewer than 50 percent of survivors ever seek care at a health facility. Of those, only a small fraction seek comprehensive care, including physical and mental health care, forensic evidence collection, and legal support after the violence or assault. Those who seek medical care services often delay seeking care for many reasons, including knowing the perpetrator; believing that their assault was not serious enough to report; and fear—of the family or community learning about the assault, knowing their own HIV status, and being stigmatized or discriminated against by health care workers.

History
High HIV prevalence in the Livingstone area, coupled with the frequency of sexual violence against children, pointed to the need for a comprehensive multidisciplinary center to increase public awareness of child sexual abuse and improve management of cases, with an emphasis on HIV prevention. The Livingstone Child Sexual Abuse One Stop Centre was established in March 2008 within the Livingstone Paediatric Centre of Excellence. The facility’s mandate is to improve integration of services for preventing sexual abuse and providing care and treatment for physically, psychologically, and sexually abused children in Livingstone city and the surrounding areas. In its first eight months of operation, the center handled 1,433 cases of child sexual abuse. The center also serves as the entry point for HIV prevention, treatment (including antiretroviral treatment), and care for both adults and children.

There are three entry points for clients seeking care. Some come to the center directly. Others are referred via the medical department (where patients with conditions such as malaria, tuberculosis, pneumonia, and diarrhea receive care; while others come via the casualty department where surgical (wounds, burns, fractures) and obstetrics/gynecological (maternity, cervical cancer) cases are attended to. Both entry points are part of Livingstone Central Hospital with a referral linkage to the center for cases of sexual abuse and exploitation.

The center is staffed by a committed multidisciplinary team of health care workers, a police officer, a paralegal officer, and psychosocial counselors. The program’s services to survivors include preventing and treating sexually transmitted infections including HIV; providing reproductive health services including prevention of unwanted pregnancies; ensuring linkages to such services as legal aid and temporary shelter; and organizing programs for community sensitization and campaigns against child sexual abuse and violence against children.
The center operates from 8 a.m. to 4 p.m. During off-hours, survivors of sexual violence are attended to at the Casualty Department and referred to the Child Sexual Abuse One Stop Centre the following morning for continuous management.

**Services**
The center is designed to be a child-friendly, safe place where child survivors of sexual, physical, and psychological abuse and exploitation can receive all necessary services in one place. The center takes survivors’ diversity into account, acknowledging each child’s sex, ethnicity, culture, and religion. The center has a mechanism for case review and tracking through appointment dates (visits after 1 week, 1 month, 3 months, 6 months, 9 months, and 12 months, after which the file is closed). Children lost to follow-up are tracked by phone calls or physical follow-up using a physical residential address.

In addition to treating survivors of abuse, the center conducts education and campaigns to increase awareness of child abuse. Advocates for the survivors speak on their behalf and draw the attention of community, civic, and political leaders through community meetings and radio programs. The Livingstone Child Sexual Abuse One Stop Centre provides:

- Child-friendly, multidisciplinary services
- Cultural competency and diversity
- Forensic interviews
- Medical evaluation
- Therapeutic intervention
- Survivor advocacy
- Case review and tracking
- Medical and forensic management on-site: counseling, specimen collection/forensic evidence for court
- HIV testing
- Post-exposure prophylaxis
- Emergency contraception
- Treatment of sexually transmitted infections
- Police medical forms

**Case Management**
The typical pathway for a client or survivor of sexual violence is as follows:

1. Registry clerk records survivor’s details in the register and issue a file/card, then refers to the Triage Nurse.
2. Triage Nurse conducts initial assessment, takes vital statistics, and refers to the Child Sexual Abuse Coordinator.
3. Child Sexual Abuse Coordinator conducts further assessment, obtains initial history, assists the Medical Officer in client examination, and refers client to appropriate service provider.
4. Psychosocial counselor conducts counseling, assesses for psychosocial needs, and refers as appropriate: criminal cases to police victim support unit, civil cases to social worker, medical cases to medical personnel.

5. Doctor and other medical personnel provide appropriate medical services (e.g., testing for HIV, syphilis, hepatitis B, and pregnancy with appropriate treatment including post-exposure prophylaxis and emergency contraceptive pills), collect forensic evidence for court, and refer survivor to social worker.

6. Social worker provides social support according to need, and also provides court preparation and court updates to survivors where necessary.

7. Police officer conducts necessary investigations and arrests, prepares cases for prosecution, and provides court case feedback to survivor.

The client receives mental health services on-site, and consultations are sent to the psychiatric department.
LIVINGSTONE CHILD SEXUAL ABUSE ONE STOP CENTRE CLIENT FLOW CHART

SEXUALLY ABUSED CHILD

CENTRAL HOSPITAL

Medical Department (diabetes, hypertension, TB, pneumonia, diarrhea, etc.)

LCH CSA One Stop Centre

Currently offering:
- Pre- and post-HIV-test counseling
- Psychosocial counseling
- Provide PEP & ECP
- Collect evidence for court

Assessed by medical officer

Casualty Department

Assessed by medical officer

Life threatening

No life-threatening investigations. Virginal Swab for microscopy and spermatozoa. Urine for pregnancy, Blood for RPR, HBV & FBC.

HIV -

Within 72 hours urgent PEP, Emergency Oral Contraception treating medical conditions

HIV +

After 72 hours treat medical conditions

Follow up for 12 months (one week, one month, three months, six months, nine months and twelve months)

HIV Clinic

Ob/Gyn and Surgical unit
- Assessment
- Surgery
- Management

Life threatening

No life-threatening investigations. Virginal Swab for microscopy and spermatozoa. Urine for pregnancy, Blood for RPR, HBV & FBC.

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WOMEN AND CHILD PROTECTION UNITS, THE PHILIPPINES

In 2013, 7 out of 10 patients brought in for child protection service were victims of sexual abuse – a consistent trend for the past 16 years (3,650 cases of sexual abuse). 76% of sexually abused children seen at the women and child protection units were young girls, although cases of sexual abuse against boys are often underreported. Sexual abuse cases remained more common among teens in their middle adolescence (13 to 15 years old).

In response to the need to provide abused children and their family comprehensive, coordinated, and continuing care by trained professionals, the first child protection unit was established in 1997 at the Philippine General Hospital, a state university training hospital. It was a partnership between the academy, the government, and private philanthropy. It cut the red tape of agencies and brought physicians, mental health professionals, social workers, police, and lawyers together in one unit to provide immediate and long-term care to abused children and their families. The investigation and legal protection are done with rehabilitation and reintegration of the child back to her/his family and community. Team members work with the community to provide support for families. With scarce resources and minimal political support, initiative, creativity, and perseverance are necessary for success. In areas where child protection unit are present, partnerships among health, social welfare, law enforcement, local officials, NGOs, and private philanthropy are crucial.

It became clear in the first few years of establishment that one child protection unit would be overloaded with referrals and unsustainable.

Equity of access was a challenge because referrals were not limited to the city of Manila and came from different parts of the country. This led to the establishment of the Child Protection Network, whose goal was to facilitate the development of child protection unit across the country.

It also became apparent that because of scarce resources, it would be more efficient for the child protection unit to be combined with the women’s desks, which led to the establishment of women and child protection units. The budget came from the local government unit, which facilitated forming a team from different departments. To ensure sustainability of the women and child protection units and its personnel and operational budget, the program had to be approved by the local legislative assembly.

The child protection units at the Philippine General Hospital has grown from a direct-service unit for abused children to a training center for frontline child protection professionals,
residents, and students and is a resource center for research, public policies, and laws affecting children. Competencies of all WCPU personnel were defined and training was mandatory.

The establishment of women and child protection units was supported by the Department of Health’s Administrative Order No. 2013-0011: Revised Policy on the Establishment of Women and Children Protection Units in all Government Hospitals (see attached). The revised policy set a “ladderized” scheme in the establishment of women and child protection units in recognition of the wide range of resource available in the different areas of the country. The smallest women and child protection units (level 1) is comprised of a trained physician and a trained social worker who collaborate to provide acute medical treatment, medico-legal examination, with safety and risk assessment, peer review, documentation and record keeping, and expert testimony in court cases. Level 2 add a police officer and/or a mental health professional. Level 3 is a training center. Mental health is the most difficult resource to access, and the program is now piloting the provision of adapted trauma-focused cognitive behavior therapy to be delivered by non-mental health professionals, including social workers.

This model is most appropriate in countries with a relatively well-developed health care delivery system. The members of the team and the services offered depend on the resources available in the area, but the “ladderized” system allows the model to be adapted to resource-poor areas.

A major challenge of the model is monitoring and evaluation. A shared database, the Child Protection Management Information System was built to facilitate case management, patient tracking, and surveillance. The system was piloted at the Philippine General Hospital child protection units to facilitate child protection case management research in the unit and at other child protection units across the country. Twenty-five child protection units now use the Child Protection Management Information System. The goal is to have a national surveillance system that will provide ongoing, systematic collection, analysis, and interpretation of child mistreatment data for planning, implementing, and evaluating child abuse and neglect services in the care continuum. This would gauge the magnitude and impact of child abuse and neglect in the general population; identify those at highest risk and emerging health concerns; monitor trends; inform allocation of resources, and detect changes in professional practice. Presently, collected data informs country reports to bodies such as the UN Committee on the Rights of the Child.

The adoption of the Child Protection Management Information System continues to be a challenge and is a work in progress. The pilot indicated the importance of a lead government agency and dedicated personnel to input the data.

**Contact Information**
THE MIRABEL CENTRE, NIGERIA

“A 10-month-old baby girl and a 70-year-old woman were among a total of 737 survivors (17 male, 720 female) of rape and other forms of sexual assault treated and offered psychosocial support free of charge, in the 2 years since the Mirabel Centre, the first sexual assault referral center in Nigeria, opened its doors to victims of sexual assault. The baby was sexually molested by the father, while the 70-year-old woman was raped by a boy that ran errands for her in the neighborhood.” (Obinna, 2015)\(^7\)

History
The Mirabel Centre was established in 2013 in Lagos State to provide services to rape and sexual assault survivors in a caring and compassionate manner. The Mirabel Centre is a safe and friendly place where people who have been raped or sexually assaulted can get free medical and counseling services. Many of clients are referred to the center by police, staff at the hospital in which Mirabel is housed, civil society organizations, or government agencies, while others walk in unreferred.

Within the first six months of opening, the center treated an average of 25 clients a month. In the first five months of operation, a total of 86 people came for care, support, and counseling. Eleven were cases of statutory rape; 29 were assault; four battery; and one defilement. Forty of the victims were ten years of age or younger; 17 were under the age of six; and 44 were between 11 and 15 years old. Seventy-eight of the 84 victims who were younger than 15 were assaulted by people they knew. All victims were brought to the center by the police, and 81 were referred to social welfare or nongovernmental organizations for additional support (Ogundipe, 2013).\(^8\)

The center is located in the Lagos State University Teaching Hospital, which reduces the stigma associated with walking into a building designated for sexual-related services, because everyone who comes into a hospital is presumed in need of medical attention.

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Another important advantage of this location is that reports from private hospitals are not accepted in court. Although Mirabel is not a government initiative, its location in the government hospital lends it the authority for its evidence to be used in court and in police investigations.

**Services**

With funding from the Justice for All Programme of the Department of International Development (DFID) and in cooperation with the Lagos State Ministry of Health, the Mirabel Centre, an initiative of Partnership for Justice, is a place where women and men who have experienced rape and sexual assault can access free forensic medical and counseling services. Modeled after the St Mary’s Sexual Assault Referral Centre in Manchester, U.K. and adapted to the Nigerian context, the Mirabel Centre is run by doctors and nurses who are trained forensic medical examiners and counselors who are trained in sexual assault trauma.

The center provides the following services:

- Counseling (in-person and telephone) to help people cope with emotional and psychological effects of rape.
- Head-to-toe medical examination and treatment for illness and injuries caused by the assault.
- Information on services and support such as the legal system, and help with filing police reports.
- Referral to other agencies for help not provided at the center.

The center also provides outside services to or on behalf of its clients:

- Submitting medical reports to the police.
- Referring clients to the hospital lab for further tests that the center cannot conduct (the center covers the cost of these tests).
- Center doctors and nurses serve as experts/witnesses in court proceedings involving the clients.
- Reporting every minor who comes to the center to the Social Welfare Department for follow up.
Case Management
When a client arrives at the center, the security officer notifies the counselor on duty. The counselor takes the client to the counseling room and explains to her (or if a child, her caretaker) the services provided at the center. Before she reports the incident to the counselor, the client is asked to sign a consent form. After the session, the counselor refers the client to the medical doctor on duty, who tells the client what to expect, gets her consent for the forensic medical examination, and assures her she can halt or postpone the examination at any time.
Client confidentiality is a key principle at the center. The counselor only provides enough information to enable the medical team to conduct the examination. The doctor on duty may ask the client for additional information needed for full medical treatment. Ultimately, however, the counselor is the case manager and is the only one who has complete knowledge of the incident. The counselor also serves as the client's contact for follow up services and other issues.
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REGIONAL GBV REFERRAL NETWORKS, SWAZILAND

Since its establishment in 1990 as a nongovernmental organization, the Swaziland Action Group Against Abuse (SWAGAA) has been the leading organization in the prevention and response to sexual and gender-based violence and child sexual abuse in Swaziland where such cases are drastically high. On a weekly basis, SWAGAA receives no less than eight clients, mostly women and children, who have been raped, beaten, displaced, and dehumanized.

SWAGAA is modelling an internationally recognized school-based girls’ empowerment program that aims to empower adolescent girls (ages 9-19) enrolled in primary and secondary school with knowledge about women’s rights, GBV, sexual reproductive health and HIV/AIDS, and the support services available. Much of the clubs’ successes can be attributed to the creation of a ‘safe space’ for girls to share their experiences, learn about their rights, develop a sense of solidarity, build confidence, and acquire leadership skills to promote their rights.

As much as adolescent girls within the empowerment clubs are becoming more confident to share experiences in school, many cases of abuse in the community remain unreported and in instances where reporting happens, access to services is uncoordinated and not comprehensive, resulting in further victimization. In response to this gap, SWAGAA has piloted and established a regional GBV referral network in the Shiselweni Region since 2010. The network creates a platform where issues relating to violence prevention, response, and multi-sectoral collaboration are dissected at a decentralized level by adopting a survivor-centered approach. Through this mechanism, SWAGAA has worked with government partners and nonprofit organizations to mobilize community leaders, community police, men, women, and young people on issues related to GBV. The network holds quarterly meetings to strengthen relationships between stakeholders, deliberate on issues, and discuss challenges to reporting cases of violence. The increased awareness of GBV in the region has led to a rise in the number of reported cases. To strengthen community linkages, coordination, and response to GBV, SWAGAA is currently piloting a community-based referral network that would form the basis for conversations within the regional referral networks.

9 Through support from UNFPA and Crossroads International.
10 Including the Swaziland National Youth Council, the Royal Swaziland Police, the Department of Social Welfare, the Ministry of Education and the Ministry of Health.
11 Such as the National Emergency Council on HIV/AIDS, World Vision, Save the Children, Judiciary, One Stop Centre, Nhlangano Aids Training Information and Counseling Centre.
The community-based referral network is being piloted in five constituencies (tinkhundla centres)\textsuperscript{12} in three of the four regions of Swaziland.\textsuperscript{13} Community service providers, community-based organizations and local government officials are sensitized on issues affecting children and adolescent girls to increase knowledge and skills about identifying cases of violence and encourage referral to relevant response agencies in a timely manner.

Communities with schools that have the girls’ empowerment clubs will link with community leadership, which will support initiatives for non-tolerance of violence and responding to cases of violence against adolescent girls and children at the chiefdom level. The goal is to develop referral networks at the local level in all constituencies where girls’ empowerment clubs exist.

The network commences with community engagement meetings that are attended by service providers\textsuperscript{14} and traditional leadership inner council members.\textsuperscript{15} During these sessions, SWAGAA conducts trainings on gender, GBV, how to identify cases of violence, and how to refer cases to SWAGAA, the police, and other agencies. Two people from each community are selected by the community to work with local government representatives and serve as members of a 12-person referral committee at the constituency level, who then work as local GBV prevention ambassadors.

Committee members are also trained on survivor support provision and follow-up at the local level. This prepares committee members to sensitize communities and schools to GBV. The committee members also direct survivors to other critical services such as health facilities and social service agencies. Capacity building on legal responses to GBV and support, counselling, court preparation, intermediary services, and court case monitoring services by organization like SWAGAAA is also conducted.

\textsuperscript{12} Tinkhudla are local government administrative centers. Swaziland is made up of four regions, with 55 tinkhundla centres distributed across all four regions of the country. Each Constituency/tinkhundla is made up of a cluster 5-7 chiefdoms/communities.

\textsuperscript{13} The constituencies are Manzini North, Manzini South, and Kwaluseni in Manzini region; Mhlume in Lubombo region; Shiselweni Two in Shiselweni region.

\textsuperscript{14} Among the service providers that attend the meetings include community health motivators (umgcugcuteli), community police, school committee members, and girls’empowerment club mentors and facilitators, community headmen (indvuna), Domestic Violence, Child Protection and Sexual Offences (DCS) office of the Royal Swaziland Police, Department of Social Welfare, Diabetes Swaziland, Men Engagement Network Swaziland, Family Health Initiative (FHI 360), Health Communication Collaborative (HC3), Council on Smoking, Alcohol and Abuse (COSAD), Members of Parliament, and community child protectors (previously trained by SWAGAA).

\textsuperscript{15} Community gatekeepers at the chiefdom level.
Committee members conduct house visits, particularly in areas where cases of violence may have been reported anonymously as well as child-headed households. At present, the system uses existing structures and service provider tools to guide service provision and referral. There is a need to develop standardized protocols and standard operating procedures to guide the referral processes at the community level.

The regional referral network informs other regional and national coordination structures. Information from the referral network is presented at quarterly Report on Regional Multi-sectoral HIV and AIDS Coordinating Committee meetings, coordinated by the Coordinated Assembly of Nongovernmental Organizations, and attended by partners working under the National HIV/AIDS implementation program in partnership with National Emergency Council on HIV/AIDS. Reports from the Regional Referral Networks will also be shared with the newly launched National Multi-sectoral Technical Task Team on Violence, coordinated by the Deputy Prime Minister’s Office.

The main challenge faced by the networks is limited funding. In a number of cases, committee members incur financial costs when assisting survivors at the community level, for example when accompanying or referring them to the police or other services. In addition, constituency-level meetings require funding for transportation of committee members to central meeting places, which is neither possible nor sustainable. An interim referral tool has been developed; however, proper use by community committee members is not systematic, as they tend to make verbal referrals, which makes it difficult to track the number of cases and assess the impact of the referral network to date. In addition, while many community partners and organizations are participating in the referral system, many other stakeholders are not part of the initiative. The challenge lies in determining how extensive the network should be. It is anticipated that clear guidelines and terms of reference can assist to address this.

The mechanism has contributed to an increase in community awareness on GBV and collaboration and learning between organizations working on violence against children. SWAGAA comprehensive case management has also informed approaches and content for community education on violence against women, adolescents, and children. The model has been developed to influence work with traditional governance structures such as the chiefs and inner council members, legislators, and policy makers. While SWAGAA has led the process of establishing and coordinating the networks, community members have been running them, thus ensuring that the mechanism is owned by the community, responds to local needs, and is not fully dependent on external support for leadership.

Contact Information
ANNEX 1: GLOSSARY OF TERMS

**CHILDREN AND ADOLESCENTS WHO HAVE EXPERIENCED SEXUAL VIOLENCE AND EXPLOITATION:** Persons under the age of 18 years who have experienced an act of sexual abuse. Exploitation is the use of children or adolescents for someone else’s economic or sexual advantage, gratification, or profit, often resulting in unjust, cruel, and harmful treatment of the child (Weeks and Day 2012).

**CHILD SEXUAL ABUSE:** The World Health Organization defines child sexual abuse as the involvement of a child in sexual activity that he or she does not fully comprehend, is unable to give informed consent to, or for which the child is not developmentally prepared and cannot give consent, or that violates the laws or social taboos of society. Child sexual abuse is evidenced by this activity between a child and an adult or another child who by age or development is in a relationship of responsibility, trust, or power, the activity being intended to gratify or satisfy the needs of the other person. This may include but is not limited to:

- inducement or coercion of a child to engage in any unlawful sexual activity,
- use of a child in prostitution or other unlawful sexual practices,
ANNEX 2: LIST OF RESOURCES/TOOLS

CLINICAL MANAGEMENT GUIDELINES


GUIDELINES/TRAINING MODULES FOR PRACTITIONERS (GENERAL)

Guidelines for Caring for Child Survivors of Sexual Abuse (IRC and UNICEF)
The IRC, in partnership with UNICEF, developed field-tested guidelines and tools for health and psychosocial staff working with child survivors of sexual abuse in humanitarian settings. They include new care guidelines for child survivors and tools to build the capacity of service providers working with children affected by sexual abuse and their families.

Caring for Child Survivors Training Materials (IRC and UNICEF)
In addition to the Caring for Child Survivor Guidelines, training materials have been developed to support staff in carrying out training on the content of the guidelines. The training materials are broken down by topical modules that follow the outline of the CCS guidelines. Each module includes a PowerPoint presentation and a facilitators’ guide outlining the training content, methodology, and materials required to deliver the module. Supplementary handouts are provided in modules when relevant. The training package also includes a sample agenda, evaluation tools (e.g., pre/post tests and a workshop evaluation), and a users’ guide that summarizes how the training materials should be used. Full materials available online at: http://gbvresponders.org/response/caring-child-survivors/#CCSTrainingMaterials.

Counselling Manual Sept 2013 – This is a training manual for basic training skills for counselors who work with children and adolescents who have experienced sexual abuse and exploitation.

Court Prep Manual Sept 2013 – This training manual is for workers supporting children through the children’s court process.

Diversion Handbook - SPARC is a diversion program that aims to empower low- to medium-risk child sexual offenders to understand the consequences of their behavior and equip them with the skills and psychosocial resources to change it. By intervening with youth who exhibit sexually offensive or inappropriate behavior in childhood, the program works to break the cycle of abuse by preventing these children from becoming career sexual offenders.
**Forensic Manual Sept 2013** – This manual serves to outline the processes and procedures to follow in order to prepare a professional in the child protection field to conduct a forensic assessment.

**Victim’s Advocate Training Manual (TVEP/South Africa)**

This manual from the Thohoyandou Victim Empowerment Program (TVEP)/ South Africa is given to all newly appointed victim advocates to familiarize themselves with the duties that they will be expected to perform while working with victims of GBV.

**SAMPLE CLIENT INTAKE FORMS**

**Sexual Abuse Client Intake Form (TVEP/South Africa)**
This sample client intake form from the Thohoyandou Victim Empowerment Program (TVEP)/ South Africa is for intake of clients who have experienced sexual abuse and exploitation.

**SAMPLE RISK IDENTIFICATION TOOLS**

**Risk Identification Tool (Initial Contact) and Risk Identification Tool (at Follow-up) (Zimbabwe National Management Guidelines Assessment and Follow Up Documents)**
These tools are to be used by health providers to assess the survivor’s emotional and mental state and to assist in making determinations for referrals for counseling or additional support as needed.

**Child Sexual Exploitation (CSE) Risk Identification Tool (Zimbabwe National Management Guidelines Assessment and Follow Up Documents)**
This ‘Traffic Light Tool’ forms part of a resource designed to help professionals who work with children and young people to identify, assess, and respond to sexual behaviors. By identifying sexual behaviors as GREEN, AMBER or RED, professionals across different agencies can use the same criteria when making decisions and protect children and young people. The normative list aims to increase understanding of healthy sexual development and distinguish it from harmful behavior.

**CASE MANAGEMENT FORMS**

**Child Needs Assessment and Case Action Planning Form (IRC and UNICEF/part of full toolkit)**
This form documents the assessment summary outlining the child’s main needs and the required actions. This form includes a section to document care and treatment needed and planned action (e.g., referral and/or safety plan).

**Child Case Follow-up Form (IRC and UNICEF/part of full toolkit)**
This form is used during follow-up visits with the child/caregiver to assess progress in care and treatment goals. It is also used re-assess the child’s safety and other actions required to help the child.
Child Case Closure Form (IRC and UNICEF/part of full toolkit)
This form is used to formerly document the reasons why the case has been closed, and has a checklist of actions to take prior to closing the case. Case closure should always be discussed with the case supervisor, and the case supervisor’s signature should be documented on the case closure form.

Child and Family Psychosocial Assessment Form (IRC and UNICEF/part of full toolkit)
The Child and Family Psychosocial Assessment Tool helps caseworkers follow a systematic process for a more comprehensive psychosocial needs assessment for children and families. Structured psychosocial assessments provide caseworkers with a more complete picture of a child’s family, home, community, school, and individual context to better direct psychosocial support. This tool is meant to be used in more stable settings where caseworkers see their clients more than once. It is also meant to be used once the crisis period has ended and the child has received urgent safety and medical care.

MANUALS/GUIDES FOR CLIENTS

Rape Survivors Manual (TVEP/South Africa)
This brochure is for clients and their families to read once they have left the TVEP Trauma Centre. It documents what happened at the Trauma Centre, and has information on the medical and legal procedures that they will go through. It also outlines free services that may be of use.

A guide for survivors of rape and sexual assault (Department of Health/South Africa)
This booklet was developed by the Medical Research Council (MRC) for the National Department of Health. The project was funded by the UK Government’s Department for International Development (DFID). It provides survivors with information on what happens after rape, including medical care, examination, emotional reactions, the role of family support, and legal processes.

ADVOCACY MANUALS (for CIVIL SOCIETY)

This guide from the Thohoyandou Victim Empowerment Program (TVEP)/ South Africa is a resource to assist members of civil society who advocate on behalf of others where essential services are not delivered, where survivors’ rights are not upheld and service providers’ responsibilities are not met. This manual gives survivor advocates information to hold service providers accountable to those services and standards of care as mandated by law, and to advocate for changes and improvements in the system where necessary.

CAREGIVER RESOURCES

What Parents Need to Know About Sexual Abuse
The National Child Network Traumatic Stress Network offers Caring for Kids: What Parents Need to Know about Sexual Abuse, a consumer-focused resource kit that contains information and fact sheets for parents, caregivers, and adolescents. The kit provides parents and caregivers with tools to help them support children who have been sexually abused, information on the importance of talking to children and youth about body safety, and guidance on how to respond when children disclose sexual abuse. Also included is advice on how to cope with the shock of interfamilial abuse and the emotional impact of legal involvement in sexual abuse cases.

**CHILD SAFETY RESOURCES**

**A Framework for Safety in Child Welfare or Safety**

The National Association of Public Child Welfare Administrators (NAPCWA) has developed this document to promote a comprehensive, child welfare system-wide response to child safety by clearly articulating how to define and apply safety concepts; provide an in-depth discussion of the key concepts related to the safety of children and their protection from serious harm; provide a context for how safety fits into all aspects of child welfare work, emphasizing the need to engage, support, and strengthen families to care for their own children; provide a clear set of criteria, fundamental patterns of thinking, and steps to keep children safe; and ensure there is a continuing and primary focus on safety in all public child welfare policies, procedures, practice guidelines, and administrative processes, including quality assurance, systems design, training, and performance appraisals.
REFERENCES


Chomba et al. 2010. Integration of Services for Victims of Child Sexual Abuse at the University Teaching Hospital One-Stop Centre. Journal of Tropical Medicine.


Machtinger, Wilson, Haberer, & Weiss, 2012; Silverman JG et al. 2008). Even if a child or adolescent is not infected with HIV immediately after an act of sexual violence and exploitation, research indicates that s/he becomes more likely to contract infectious and chronic diseases later in life (Jewkes, Sen, and Garcia-Moreno 2002; Jewkes 2010).