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AIDS Free
Strengthening High Impact Interventions
for an AIDS-free Generation

**STRENGTHENING LINKAGES
BETWEEN CLINICAL AND
SOCIAL/COMMUNITY
SERVICES FOR CHILDREN AND
ADOLESCENTS WHO HAVE
EXPERIENCED SEXUAL
VIOLENCE
A COMPANION GUIDE**



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This publication is made possible by the generous support of the American people through the U.S. President's Emergency Plan for AIDS Relief (PEPFAR) with the U.S. Agency for International Development (USAID) under the terms of Cooperative Agreement Strengthening High Impact Interventions for an AIDS-free Generation (AIDSFree), number AID-OAA-A-14-00046. The contents are the responsibility of AIDSFree and do not necessarily reflect the views of USAID, PEPFAR, or the U.S. Government.

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

Levy, Marcy, Lyn Messner, Malia Duffy, and Jennifer Casto. 2016. *Strengthening Linkages Between Clinical and Social/Community Services for Children and Adolescents who Have Experienced Sexual Violence: A Companion Guide*. Arlington, VA: Strengthening High Impact Interventions for an AIDS-free Generation (AIDSFree) Project.



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ACRONYMS

ACE(s)	adverse childhood experience(s)
AIDSFree	Strengthening High Impact Interventions for an AIDS-free Generation
CAVE	Vigilance Committees to Alert, Watch and Listen (French acronym)
CPSP	Court Preparation and Support Programme
CPU	Child Protection Unit
GBV	gender-based violence
IRC	International Rescue Committee
NAPCWA	National Association of Public Child Welfare Association
NGO	nongovernmental organization
PEP	post-exposure prophylaxis
PEPFAR	U.S. President's Emergency Plan for AIDS Relief
PTSD	post-traumatic stress disorder
SWAGAA	Swaziland Action Group Against Abuse
TCC	Thuthuzela Care Centre
TVEP	Tohoyandou Victim Empowerment Program
USAID	U.S. Agency for International Development
WCPU	Woman and Child Protection Unit
WHO	World Health Organization
VA	victim advocate
ZTVA	Zero Tolerance Village Alliance

ACKNOWLEDGMENTS

Thank you to the PEPFAR Gender and Orphans and Vulnerable Children Technical Working Groups for their vision and guidance in the development of this guide.

We are deeply grateful to the many individuals who contributed to this resource by participating in interviews, serving as part of the Technical Advisory Group (TAG), answering questions, sharing resources, and reviewing specific sections. This resource would not be possible without their support. In particular, we extend our gratitude to the following individuals:

Shaheda Omar (Teddy Bear Clinic, South Africa); Bernadette Madrid (Child Protection Unit, University of the Philippines Manila); Rudo Masanzu (Faculty of Forensic and Legal Medicine, UK and consultant, Zimbabwe); Rebecca Davis (Center for International Social Work, Rutgers University); Cebile Manzini-Henwood (Swaziland Action Group Against Abuse, Swaziland); Fiona Nicholson (Thohoyandou Victim Empowerment Programme, South Africa); Chi Chi Undie (Population Council, Kenya); Itoro Eze-Anaba (Mirabel Center, Nigeria); Derrick Sialondwe (Livingstone Child Sexual Abuse One Stop Centre, Zambia); Abigail Erickson (International Rescue Committee, U.S.); Neckvillius Kamwesigye (John Snow, Inc., Uganda); Sanni Bundgaard (International Rescue Committee, Kenya); Lalick Banda (One Stop Shop for Child Sexual Abuse, University Teaching Hospital, Pediatrics and Child Health, Zambia); Janel Smith (Nursing Education Partnership Initiative, U.S.); Nozipho Motsa-Nzuza (Sexual Reproductive Health Program, Ministry of Health, Swaziland); Virginia Francis, (USAID/South Africa); Laura Berger (USAID/South Africa); Ria Schoeman (Foundation for Professional Development, South Africa); Renee Wentzel (Foundation for Professional Development, South Africa); Futhi Gamedze (One Stop Center, Swaziland); Naomi Reich (Bantwana Initiative, World Education, U.S.); Joan Van Niekerk (Childline, South Africa); Edith Morch-Binnema (FHI 360, Mozambique); Ana Gatuguta (Kenya); Nataly Woollett (Wits Reproductive Health and HIV Institute, University of the Witwatersrand, South Africa); Rebecca Gordon (Together for Girls, U.S.); Edward Pettitt (Baylor International Pediatric AIDS Initiative, Botswana); Charles Clemmons (CDC, U.S.); Tiago Jamie (Associação Nacional para o Desenvolvimento Auto-sustentado, Mozambique); Albertino Atanasio (Associação Nacional para o Desenvolvimento Auto-sustentado, Mozambique); and Netsai Mudziwapasi-Shambira (World Education, Zimbabwe).

A special thank you to the reviewers of specific sections for their helpful feedback on initial drafts: Rudo Masanzu (the Minimum Package); Nataly Woollett (mental health); the American Public Human Services Association (safety assessment and planning); Naomi Reich (roles and responsibilities); and Rebecca Davis (referrals); and to the organizations which provided summaries for the Program Highlights section.

Responsibility for any errors or misperceptions in the document lies fully with the authors. Please note that the tools included/cited here are not necessarily recommended as best practice. Rather, they are provided to give the reader ideas and inspiration about resources used in other settings.

INTRODUCTION AND OVERVIEW

This document 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. The 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.

Why this Guide?

Strengthening Linkages Between Clinical and Social/Community Services for Children and Adolescents who Have Experienced Sexual Violence: 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 of 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 their needs
- Contribute to changes in sociocultural norms that perpetuate a culture of violence and silence that can also increase HIV risk and vulnerability.

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 multisectoral support and funding in environments that have few resources?

It is our hope this guide will provide inspiration for even the small "next steps" that a program can take to better serve the needs of children, adolescents, and their families. The guide is intended as a general resource; we envision that the information provided here will be adapted to country-specific contexts, resources, needs, laws, and policies. This guide borrowed heavily from nongovernmental organizations (NGOs) and other programs that have developed *promising guidelines and resources* on various aspects of these integrated care needs.

Target Audience/s

The primary audiences of this guide are health providers and managers. However, children and adolescents who experience and seek services for care, treatment, and support for sexual violence and exploitation may enter the system at any number of points: a lower-level health facility, a hospital, a nongovernmental organization office, a police station, a school, a church or mosque; by reporting a violation to a community leader or traditional court mechanisms; or another community point.

To ensure that children and adolescents receive the services they need, all stakeholders in this system must coordinate their service provision, and be aware of what resources are available in their communities more broadly. Therefore, information contained within this guide can also serve as a useful resource for community actors within the health, child welfare and protection, education, legal/justice, and other social service sectors, as well as government stakeholders.

How to Use this Guide

This guide can be read from beginning to end, or the reader can jump to the relevant section. External links to online resources are indicated by *blue italics* and internal hyperlinks to navigate within the document are indicated by *red italics*. Details on contact persons are included when available.

Icon Key

	Supplemental resources are included throughout the guide and are indicated by a magnifying glass icon.
	Selected program highlights are indicated throughout the guide by a ribbon icon.
	Key tips are provided periodically throughout the guide and are indicated by an exclamation point icon.

Quick access to each section of the guide is provided by the tabs located in the right margin of each page. Click on a section tab to jump directly to that section of the guide. If at any point you wish to return to the previously viewed page, click on the “Back to previous” button located at the bottom of each page. The sections in the guide are organized as follows:

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: Approaches for Integrated, Multisectoral Response summarizes the various integrated, comprehensive models.

Section 3: The Minimum Package gives an overview of the minimum services needed by children and adolescents who have experienced sexual violence and exploitation, 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 starting points and aspirational standards.

Section 4: Roles and Coordination of Various Stakeholders and Essential Elements for Bridging Community-Facility 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 forms a part of the overall response system.

Section 5: Mandatory Reporting overviews some key issues regarding mandatory reporting laws and policies, and how to reconcile these with what is in the best interest of the child/adolescent.

Section 6: Referral Pathways and Community/Facility Coordination suggests a generic pathway that programs can adapt to their contexts, and provides a checklist for setting up a network.

Section 7: Case Management offers a brief overview of the important case management processes, outlines case manager roles/responsibilities, and presents a basic flowchart that programs can adapt to their particular settings.

Section 8: Guiding Principles is an overview of principles and suggestions to help ensure that the actions that service providers take on behalf of children and adolescents are supported by standards of care designed to benefit the child/adolescent’s health and wellbeing.

Section 9: Program Highlights presents brief overviews of seven 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.

Annex 1 comprises a glossary; **Annex 2** offers lists and tools for various programmatic functions.

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 against children and adolescents is universally condemned but occurs much more frequently 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 eight countries) show that approximately **one in four girls and one in seven boys** (see Figure 1) experience sexual violence as children, in their homes, lower and upper schools, care and justice institutions, workplaces, religious centers, and communities at large (Together for Girls 2015). Certain children and adolescents are more at risk

Figure 1. Incidence of Sexual Violence among Children



than others: a 2012 Lancet review indicated that children with disabilities are 3.7 times more likely than those without disabilities to experience any sort of violence, and 2.9 times more likely to experience sexual violence and exploitation (Hughes et al. 2012; also see Box 1). Such instances happen in developed and developing countries, in emergency settings, and during peacetime.

Sexual violence against children and adolescents differs from that of adults, and thus cannot be handled in the same way. Such sexual violence 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 the severe consequences of the HIV epidemic on family and community structures. Similar to sexual violence against adults, sexual violence against children and adolescents is surrounded by a culture of secrecy, stigma, and silence. Too often, it is viewed as a private matter, especially when the perpetrator is a family member.

There is also evidence that various forms of adverse childhood experiences (ACEs), including sexual abuse, physical abuse, and physical neglect, overlap rather than occurring independently; and that the occurrence of multiple types of child maltreatment may be common. Dong et al. looked at the interrelationship between different forms of ACEs including physical abuse, emotional neglect, physical neglect, and household substance abuse, and found significant associations between these ACEs and childhood sexual abuse. The presence of childhood sexual abuse significantly increased the odds of an ACE, most notably for physical abuse and physical neglect (Dong et al. 2003a; Dong et al. 2003b; Higgins and McCabe 2001). Providers who work with children and adolescents must be aware of these co-occurrences and trained to identify, treat, and refer clients for multiple forms of ACEs.

A growing body of evidence has firmly 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 does not contract HIV immediately after an act of sexual violence, 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 against them is frequently associated with multiple episodes of violence, and might result in mucosal trauma (Weeks and Day 2013). Various studies have further established linkages between experiences of sexual violence during childhood and future engagement in sexual risk-taking behaviors, such as having multiple partners, using condoms inconsistently, drug and alcohol abuse, and engagement in intergenerational and transactional sex (Lalor and McElvaney 2010; Roemmele and Messman-Moore 2011; Richter et al. 2014).

There are also major psychological consequences of sexual trauma during childhood, although no single response is experienced by all. The diversity of emotional outcomes is evident in the

Box 1. Among the Most Vulnerable Young People: Children and Adolescents with Disabilities

For children and adolescents with disabilities who have experienced sexual violence, dynamics related to their disabilities and access to disability-specific services exacerbate and heighten their risk (Vera Institute of Justice 2013). The challenges are many. Those with disabilities are systematically denied basic information about sexual health and relationships, including sexual violence. They may be in isolated settings away from neighbors, extended family, or local community members who could play a role in identifying abuse. Staff at disability-specific organizations may lack training in recognizing ACEs, including sexual violence, and thus miss signs of abuse of their clients. Those services that do exist are likely not able to provide disability-specific services, due to physical barriers to access or lack of providers who are trained to work with children/adolescents with disabilities. Access to justice is routinely denied to children and adolescents with disabilities who have been victims of a crime (for multiple reasons: they are not considered credible witnesses, and/or their cases are not taken seriously, and/or the court system lacks appropriate services). Overall, many children and adolescents with disabilities and their families are unaware of their rights and unable to speak out about violations.

variability in existing protective capacities, severity, timing (immediate to delayed impact), duration (short- to long-term), and types of consequences (e.g., psychological symptoms, maladaptive behaviors) (Yuan, Koss, and Stone 2006). Research in adults strongly indicates an increased risk of a wide range of psychological morbidities 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). Girls who experience sexual violence are three times more likely to have an unintended pregnancy, and those girls under 15 are five times more likely to die in childbirth (Together for Girls 2015).

It is widely accepted that few child/adolescent sexual violence cases are reported to authorities. When children and adolescents 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 has important implications for medical management and the collection of forensic evidence, and poses different and important psychological, safety, and legal needs over the short and long term, as compared to those who present immediately after a single violation. Most typically, child/adolescent cases enter the system via reporting a violation directly to a community leader in the “informal” sector, described in Box 2, (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 (Levy 2012 et al.; Gevers and Abrahams 2015; key informant interviews). In settings where the police and/or health systems may be weak, NGOs are often the first point of contact (key informant interviews).

Box 2. Formal and Informal Sectors/Systems

While it varies from setting to setting, the “formal” sector/system typically refers to national or government-led elements (e.g., structures/bodies, laws, policies, workforce, etc.).

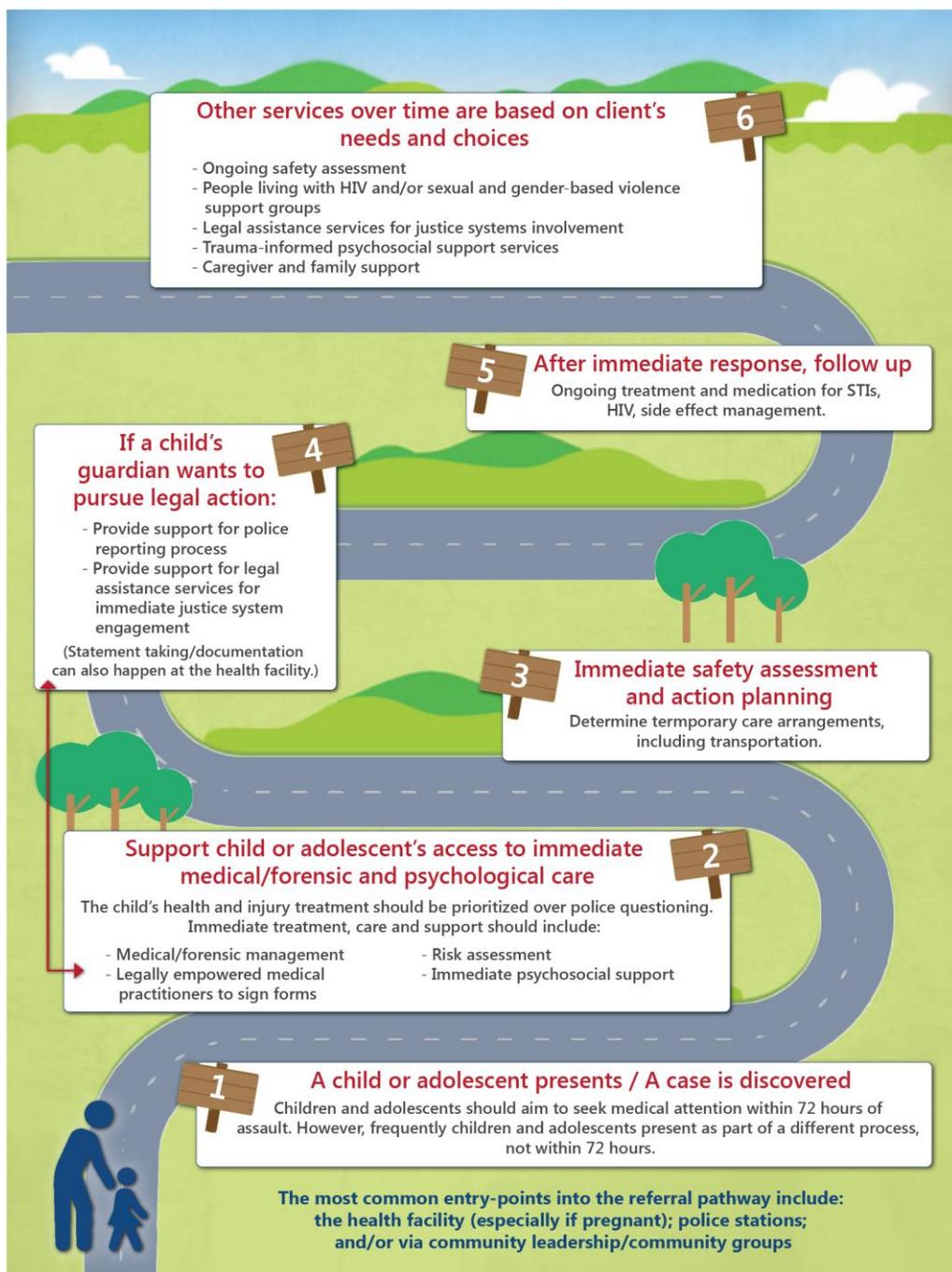
“Informal” elements typically refer to community-based initiatives undertaken by families, communities, and/or children/adolescents themselves. Formal and informal can be considered as two ends of a continuum, and there are often elements of crossover between the two.

Despite the overwhelming evidence on the prevalence of sexual violence and exploitation against children and adolescents, and growing consensus on the need for integrated services and clear referral pathways, there is limited to no global guidance for health facilities on how a referral system for children and adolescents who have experienced sexual violence and exploitation should function, or what follow-up such a system should include (and much of the guidance and tools that exist focus on humanitarian settings). Many countries still lack national protocols for the delivery of services for children and

adolescents who have experienced sexual violence and exploitation, including protocols for establishing services tailored to children and adolescent needs and for ensuring linkages to the critical short and long-term medical, psychosocial, safety/protection, legal/justice, and other social services.

Figure 2 provides an illustrative referral pathway based on best practices in responding to the needs of children and adolescents who have experienced sexual violence and exploitation.

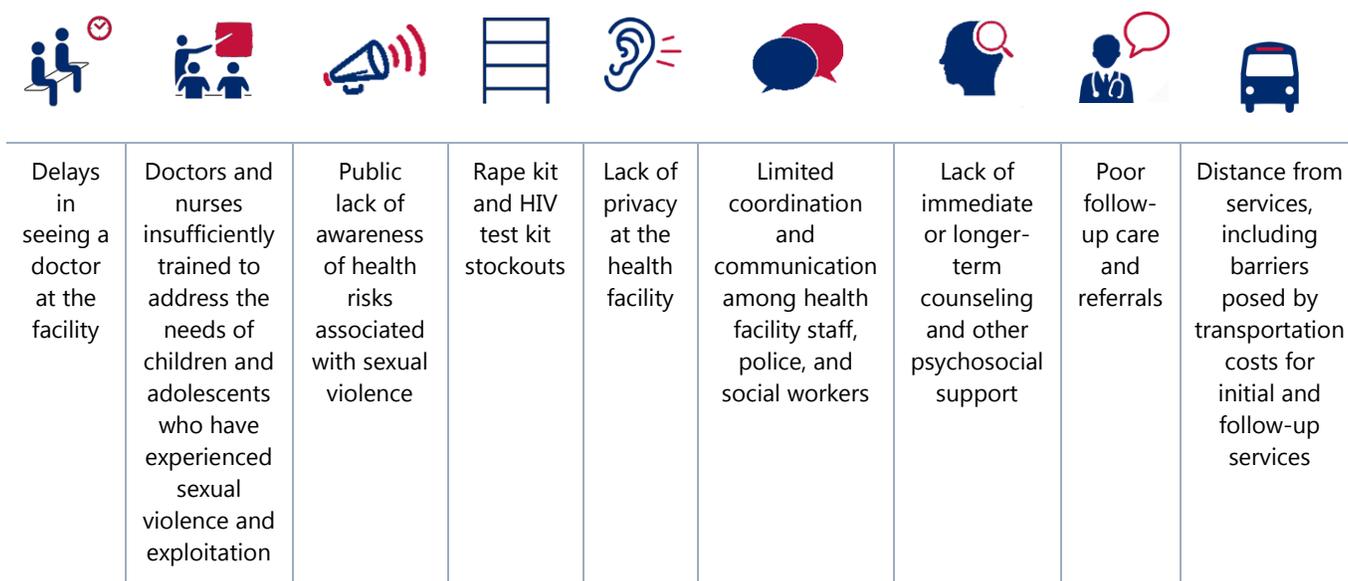
Figure 2. Illustrative Referral Pathway (Adapted from Roelen, Long, and Edström 2012)



Gaps in Providing an Adequate Response

Children, adolescents, and their caregivers face well-documented challenges to accessing and receiving quality clinical treatment, care and supportive, and follow-up services, including those overviewed in Figure 3.

Figure 3. Common Challenges Facing Children, Adolescents, and Caregivers in Accessing and Receiving Services



The process of reporting sexual violence can be extremely complicated and is often prohibitive. Some systems require that a person who has experienced sexual violence and exploitation visit a health facility (often at the hospital level), police station, police doctor, and the local magistrate, in order for the claim to be brought to court—with additional steps for children under the legal age of consent (Freccero et al. 2011). Multiple forms and documents may be required; repeated statements may be requested; and evidence transported back and forth between institutions. In service sites such as health facilities and police stations, there may be limited confidentiality and sense of safety for children/adolescents and their caregivers, because there is no place for private discussion; they are asked the same questions by different personnel; and overall they are treated with insensitivity.

In some settings, police reports are legally required before a child or adolescent who has experienced sexual assault can receive services such as a forensic exam; in other settings, reporting sexual violence to the police is perceived as a requirement for accessing health services, even if this is not required by law. Navigating each step of the process can be a daunting effort. In high HIV prevalence settings, delays and/or non-disclosure can prevent

children and adolescents who have experienced sexual violence and exploitation from receiving necessary HIV post-exposure prophylaxis (PEP) treatment.

Traditional/community leadership (including faith-based/religious leadership, chiefs, traditional healers, and other community leaders) are often the first point of contact for children and adolescents (and families) who experience sexual violence. Families may first approach these leaders before seeking medical care and/or reporting a case to police, to obtain their guidance and permission to seek care and/or report. These leaders are often able to establish strong linkages with service providers, with whom they can negotiate and leverage social, economic, and psychological resources; support children and adolescents who have experienced sexual abuse and exploitation throughout their contact with the justice system and, where necessary, during the post-trial period; and shape community attitudes toward sexual violence. While there are many programs working with traditional leadership on prevention and awareness of GBV generally, there are few programs that actively and formally involve traditional leaders in the response network (through formalized protocols, memorandums of understanding or regular meetings with health facilities and others in the network). Globally, this is a tremendous gap.

In sub-Saharan Africa it is commonly reported that doctors themselves may avoid identifying cases of sexual violence against children and adolescents 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; and/or concern about the length of time that cases take in court. The reality is that many health providers and managers live and work in the same communities as perpetrators. Fear and reluctance to call attention to cases, and potential perpetrator and/or community backlash comprise significant security issues for providers and for programs.

In some countries, it is mandated to assign a social worker to each case of a child who has experienced sexual violence and exploitation. In reality, severe human resource limitations affect nearly all sub-Saharan African countries. When social workers are available, they are often unclear about their role, unequipped for short- or long-term case management, and unfamiliar with the development and unique needs of children and adolescents.

Multiple assessments and key informant interviews in various countries also reveal serious concerns about police services, including lack of sensitivity or professionalism on the part of police handlers, and corruption that inhibits the delivery of services. There are reports of 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 communicating appropriately with traumatized clients, and there are currently

few dedicated cadres at police academies specializing in sexual violence and exploitation against children and adolescents.

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, and efficient processing and resolution of cases. Plaintiffs face stigma and discrimination during the court procedures, including public intimidation resulting from indiscriminate use of journalistic license and access to cases by the media.

For additional information on violence against children and adolescents, including prevalence, gaps, challenges and opportunities, and approaches to address and prevent violence, see the resources listed below.



Resources

- *Together for Girls*
- *THRIVES: A Global Technical Package to Prevent Violence Against Children*
- *Hidden in Plain Sight: A Statistical Analysis of Violence Against Children*
- *Sexual Violence Research Initiative*
- *Virtual Knowledge Center to End Violence Against Women and Girls*

SECTION 2: APPROACHES FOR INTEGRATED, MULTISECTORAL RESPONSE

This section highlights various approaches for providing integrated, multisectoral services (medical/forensic care, psychosocial care, legal advice, and other support services, either on-site or via referrals) for children and adolescents who have experienced sexual violence and exploitation; and provides a brief discussion of what the literature suggests about the best outcomes for these vulnerable groups.

It is important to note that all these approaches have major potential shortcomings, including but not limited to expense, limited reach into the community, range of services offered in both the short and long term, and human resource constraints. Any decisions about the appropriateness of various models must apply to the particular setting and be informed by local needs and financial and human resource capacities. In all cases, even in well-resourced settings, managers/implementers are encouraged to clearly and honestly identify existing or potential shortcomings/challenges (in an ongoing manner), and to work with their networks and supporters to best identify locally-feasible and long-term solutions to those challenges.

Generally speaking, the most common models for providing services/support for children and adolescents who have experienced sexual violence and exploitation are:

Service Model	"Owned" by:	Located in:	Clinical services provided by:	Supportive services provided by:
1	Health facility/hospital with government and/or donor assistance	Health facility/hospital	Health facility/hospital	Health facility/hospital
2	Health facility/hospital	Health facility/hospital	Health facility/hospital	Local nongovernmental organizations
3	Nongovernmental organization	Health facility/hospital	Health facility/hospital	Referrals to nongovernmental organization—services outside the facility
4	Nongovernmental organization	Health facility/hospital	Health facility/hospital	Nongovernmental organizations (and possibly police) on-site
5	Nongovernmental organization	Stand-alone center	Nongovernmental organization	Nongovernmental organization
6	Nongovernmental organization	Stand-alone center	Referrals to health facility/hospital	Nongovernmental organization

Integrated Care Approach

The term “one-stop center” is often used to describe an integrated approach, although the various models that self-identify as one-stop centers vary greatly from setting to setting in terms of actual services provided. What many of these models do have in common is standard medical-forensic care offerings, some immediate counseling services and linkages to police, with large variation in how the short- and long-term after care is provided, including how much support is provided for ongoing psychosocial, legal, and other social services.

How services are delivered largely depends on the setting and resources available. In some integrated programs, all immediate and some follow-up services are physically co-located in one setting. Other programs have a referral network to ensure access to other essential services, with one or more individual staff or volunteer members assigned to a particular client.

Medical Outcomes

For medical outcomes (not including psychosocial outcomes), hospital-based and/or -owned integrated centers are often better suited for achieving the broadest range of health outcomes for children and adolescents experiencing sexual violence or exploitation than are NGO-based centers, because they have adequate infrastructure, supplies, equipment, and staff to offer clinical management of rape (or other kinds of violence). 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 and Thompson 2010).

Yet there are also important roles for smaller health centers/facilities to play in ensuring the broadest range of medical outcomes. Critically, these are frequently located close to the community and/or outside of urban areas where accessing hospitals may be difficult. Such facilities may not have the capacity to treat serious injuries, offer specialized care, or have antiretroviral therapy facilities available, and may not be staffed with qualified health personnel (usually doctors). However, when appropriately trained and equipped in areas such as conducting risk assessments, crisis counseling, emergency contraception, and PEP, these staff and facilities can offer important services to children and adolescents who have experienced sexual violence and exploitation. This is an important consideration for rural communities, where hospitals may be too far away to access quickly. These centers can also provide follow-up care for clients who visit a larger facility for initial care but cannot travel similar distances for follow-up (Keesbury and Thompson 2010).

Psychosocial Outcomes

Evidence suggests those who receive immediate mental health support have improved mental health outcomes in cases of sexual violence (Brooker and Durmaz 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 following an assault 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 have indicated that mental health care is not prioritized in either the acute or long-term service phases, and that services are severely lacking.



In South Africa, many cases of child/adolescent abuse are committed by other youth. To disrupt the cycle of abuse and prevent the development of adult offenders, the Teddy Bear Clinic's *Support Programme for Abuse Reactive Children (SPARC)* provides rehabilitation to young sex offenders. Clients are referred to SPARC through the court system (involuntary clients), or by parents, schools, or children's homes (voluntary clients).

Legal/Justice Outcomes

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 (Keesbury 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 (Keesbury et al. 2012, key informant interviews).

Linkages between Health and Social Services

For those programs highlighted in the literature and discussed via key informant interviews, few to no detailed comparisons can be made about the particular types of models and quality of aftercare offered, given the limited available information, different research or study designs, and paucity of rigorous reviews.

Typically, psychosocial care was better integrated than other critical social support services, such as legal/justice services and essential safety/protection services, regardless of the model. It is also not clear from the literature whether hospital-owned facilities—which may offer the best medical/forensic outcomes—are better placed to offer the range of social/support services in addition to the necessarily medical/forensic services. Some research on 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, but this generally refers to medical outcomes (Keesbury and Thompson 2010; key informant interviews).

Overall, the limited evidence suggests that integrated care models, in whatever form, should be established within a health institution where many who have experienced sexual violence and exploitation may present or be 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 and systems (Keesbury and Thompson 2010; key informant interviews). Key elements for facilitating use in any integrated approach following sexual violence and exploitation include confidentiality, no or small fees for services, easily accessible (in terms of distance or available transportation), and extended or around-the-clock operating hours (Munalula and Kanyengo 2011; Undie et al. 2012; key informant interviews).



In South Africa, *Thohoyandou Victim Empowerment Program (TVEP)* supports the Zero Tolerance Village Alliance (ZTVA) approach, a holistic, community-based approach that relies on positive behavior change to eradicate gender-based violence and crimes against children and engages traditional leaders in reporting mechanisms as well as prevention. In Swaziland, *Swaziland Action Group Against Abuse (SWAGAA)* has established a regional GBV referral network, working with community leaders, police and others, to increase awareness and improve referrals for services.

The models that seem to function best have strong ties to community groups that can provide essential social services and ensure follow-up. Many of the most promising models employ case managers and/or victim’s advocates to serve as an ongoing resource to and advocate for their clients beyond the initial visit.

To be successful—given the tremendous role the informal sector plays in the lives of children, adolescents, and families in many settings—programs must include initiatives to effectively 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” (Levy et al. 2012). Local community resources as well as local leaders, including chiefs, traditional healers, and religious leaders, can all play a vital role in ensuring that children and adolescents are linked to the appropriate services following sexual violence and exploitation.

For examples of various integrated care models, see *Section 9: Program Highlights*, especially *The Mirabel Center*, *The Teddy Bear Clinic*, and the *Thohoyandou Victim Empowerment Program (TVEP)*.

Standardized Nationwide Centers

Some countries have sought to optimize an integrated approach and ensure consistency by implementing standardized, nationwide integrated models. These (usually) government-supported models are often enshrined in local laws and policies, with some NGO involvement, and may be offered at lower levels of the health system (see the *Thuthuzela Care Centres*). 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; ongoing 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).

Ultimately, in resource-limited settings, it may not be possible to promote a single integrated model for all levels of care. The expectation that a national or even regional standard is possible is likely unrealistic and impractical. Rather, a more practical approach would be for each level to have an adapted version of an integrated approach.

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 4:

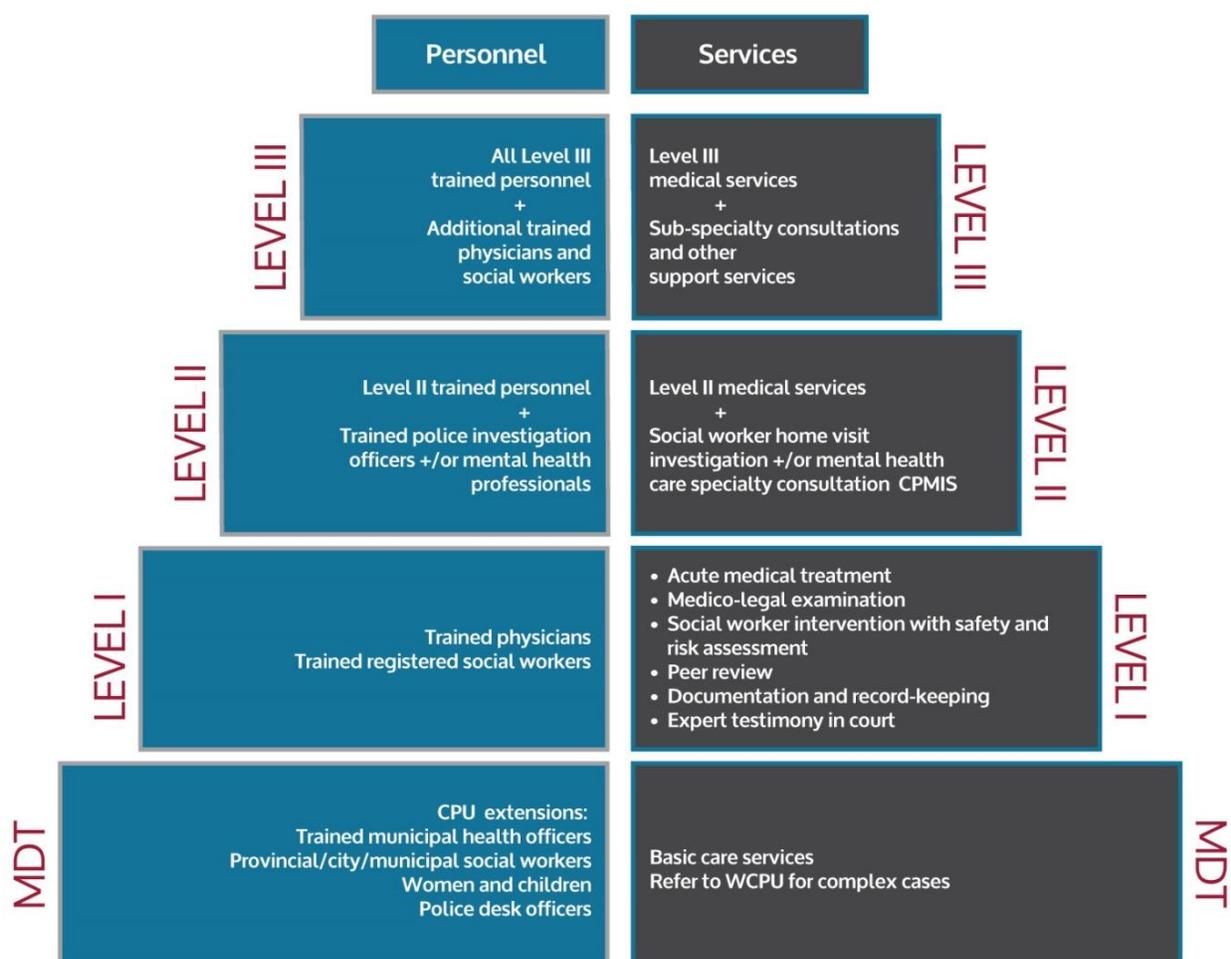
- Level I Women and Child Protection Units provide minimum medical services in the form of medico-legal examination, acute medical treatment, minor surgical treatment, monitoring and follow-up, social work interventions (such as safety and risk assessment), coordination with other disciplines (i.e., local social welfare and development office, police, legal, NGOs), peer review of cases, proper documentation and record-keeping, and expert testimony in court.
- Level II facilities offer 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-hour, 7 days a week 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.

- Level III Women and Child Protection Units include 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).

Not all areas are ready to establish a Woman and Child Protection Unit. Therefore, multidisciplinary training is also provided for frontline physicians, social workers, and police working in the community. This enables these agents to provide basic services wherever they work, and to coordinate with each other in the absence of a WCPU.

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 4. Levels of Women and Children Protection Units, the Philippines



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 in no way represents a comprehensive package.

Figure 5 presents an overview of the minimum package of a multisectoral response to children and adolescents who have experienced sexual violence: medical/forensic, safety/protection, psychological, legal/justice, and other support that will vary by the context. Those who have experienced sexual violence 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 5. Framework of Needs

WELLBEING	IMMEDIATE RESPONSE	LONGER-TERM
 <p>Medical and Forensic Care and Treatment*</p> <p><i>*psychological support should always be considered part of overall medical care and treatment. See Psychosocial Support for more information.</i></p>	<ul style="list-style-type: none"> • Medical stabilization/treatment of acute injury or pain • Prevention of HIV transmission (HIV-PEP) • Prevention of hepatitis B virus transmission (HBV-PEP) • Prevention of pregnancy (emergency contraception where available) • Sexually transmitted infection prophylaxis • For those who become pregnant, referrals (in countries where abortion is legal) to services for those who desire to terminate the pregnancy, as well as support for prenatal pregnancy services • Evidence collection <p>See <i>The Clinical Management of Children and Adolescents Who Have Experienced Sexual Violence: Technical Considerations for PEPFAR Programs</i> for clinical management guidelines (medical/forensic management)</p>	<ul style="list-style-type: none"> • 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)
 <p>Safety and Protection</p>	<ul style="list-style-type: none"> • Immediate safety assessment and action planning • Temporary care arrangements, including transportation 	<ul style="list-style-type: none"> • Ongoing safety assessment (as needed) • Long-term care arrangements • Services for reintegration into family/household
 <p>Psychosocial Support</p>	<ul style="list-style-type: none"> • Psychological risk assessment (suicidal/homicidal ideation) • Immediate psychosocial support (in tandem with medical/forensic management) • Immediate caregiver/family support 	<ul style="list-style-type: none"> • 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
 <p>Legal/Justice</p>	<ul style="list-style-type: none"> • 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) 	<ul style="list-style-type: none"> • Legal assistance services for justice system involvement (pre-court training/preparation, care and support during trial for child/adolescent and family)
 <p>Other/Social Support</p>	<ul style="list-style-type: none"> • Basics such as clothing, hygiene, and sanitary items 	<ul style="list-style-type: none"> • Economic security support • Education support (trauma-informed services that provide age-appropriate educational and development activities)

Case Management (through case managers, social workers, victim advocates, etc.)

Medical and Forensic Care and Treatment

This document does not cover medical/forensic care and treatment. For details on these topics, please see *The Clinical Management of Children and Adolescents Who Have Experienced Sexual Violence: Technical Considerations for PEPFAR*, as well as the clinical management resources below.



Resources

- *Kenya Clinical Guidelines for Sexual Exploitation and Violence* (including module on children and adolescents)
- *Service Specification for the Clinical Examination of Children and Young People Who May Have Been Sexually Abused*
- *The Care Continuum for Child Abuse and Neglect: A Physician’s Guide, Manila*
- *RCGP Safeguarding Children Toolkit for General Practice*
- *Health Care for Women Subjected to Intimate Partner Violence or Sexual Violence A Clinical Handbook* (field test version)

Safety and Protection Services

Immediate Safety Assessment and Action Planning

Immediate Response

Safety interventions are actions taken to secure the **immediate protection** of a child/adolescent who is being or has recently experienced sexual violence and exploitation. The question that should guide the providers is: *Is the child/adolescent 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 adolescent (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/adolescent?
- Is there an immediate threat of serious harm?
- Are protective capacities within the family 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 planning is an *ongoing process*. Safety assessments should be conducted throughout the case management process, not solely as a one-off action taken when a case is first reported. Over time, new concerns may arise that require adjusting the safety plan.

Whenever possible, the full safety assessment should be done by a trained social worker, although it can also be initiated by a medical/health provider.

Service providers should also be aware that there are instances when the perpetrator his/herself may bring the child/adolescent in for services. This can be a very complicated situation. A provider should not assume that an individual accompanying a child/adolescent is a non-offender.

Safety Decisions/Action Plan

The above questions and subsequent discussions are critically important to the health and welfare of a child/adolescent, and should inform an **immediate safety decision** and **safety plan**. By making a safety decision, the provider is determining whether safety interventions are

¹ From NAPCWA 2009. Additional acknowledgements for the information in this section to International Rescue Committee (IRC) and United Nations Children's Fund (UNICEF) 2012.

needed to protect a child/adolescent. 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 National Association of Public Child Welfare Association (NAPCWA) states in its document, *A Framework for Safety in Child Welfare*, “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 future maltreatment. Safety interventions are actions to immediately control and mitigate the threat of serious harm to keep the child [and adolescent] 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/adolescent being in danger of immediate or ongoing harm. Common features of a safety plan include:

- Actively seeking and considering the child/adolescent's opinions and ideas
- Whenever possible, involving the caregivers and family 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)
- Describing the child/adolescent’s vulnerability and the caregiver’s protective capacities
- Providing details of how the intervention will work (i.e., how it will protect the child/adolescent and any appropriate timeframes)
- Providing 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; some prioritize the family’s control over implementing safety plans, while others promote more direct interventions to ensure child/adolescent 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
- Authorizing emergency food/cash/goods



While the safety assessment and action plan are generally focused on the child/adolescent who presented with signs of sexual violence, *it is also important to consider the safety of other children/adolescents* in the home and/or neighborhood, and work with the (non-offending) caregiver—and/or community—to address any threats. The presence of other children/adolescents in an offending home or environment is essential information to provide in an urgent manner to social workers and the police.

- 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, and other resources).

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 (see Box 3).

After a sexual assault, a child/adolescent may develop harmful coping mechanisms (such as substance abuse, cutting/self-mutilation, eating disorders, and increased risk-taking). Some may experience trauma-induced mental health conditions, isolate themselves from friends and/or family, or feel unsafe (Victim Rights Law Center 2013).

Providers must be especially alert for children/adolescents who implicitly or explicitly mention that they are thinking of hurting themselves or taking their life. If a provider believes this may be a possibility, they should 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* for more detail on assessing and addressing suicide risks with clients).

Box 3. Child/Adolescent Traumatic Stress

The term "traumatic stress" refers to the child/adolescents' responses, both physical and emotional, to situations that threaten the life or physical integrity of the youth or someone critically important to them (e.g., a parent or sibling) (Chadwick Trauma-Informed Systems Project 2013). The National Child Traumatic Stress Network has adopted the following definition of a trauma-informed system:

"A trauma-informed child- and family-service system is one in which all parties involved recognize and respond to the impact of traumatic stress on those who have contact with the system, including children, caregivers, and service providers. Programs and agencies within such a system infuse and sustain trauma awareness, knowledge, and skills into their organizational cultures, practices, and policies. They act in collaboration with all those who are involved with the child, using the best available science, to facilitate and support the recovery and resiliency of the child and family."

A trauma-informed approach to child-serving systems can provide multiple benefits. It can help equip staff with the skills, knowledge and tools to assist the children and families in their care. It also provides a framework for educating stakeholders on the impact of trauma, and furnishes strategies for managing a child's difficult behaviors and overwhelming emotions, and ensuring that the child receives the services he/she needs.

*Adapted from the Chadwick Trauma-Informed Systems Project. For more resources, see **Resources: Trauma-Informed Child Welfare Systems.***

Temporary Care Arrangements, Including Transportation

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

Ongoing Safety Assessment

Longer-term
 Response

An ongoing safety assessment refers to ongoing monitoring and evaluation of the child/adolescent's safety by the caseworker and other collaborating partners (family members, case supervisor, child protection staff, community-based security) if needed (Erickson 2011). The purpose is to make sure that the plan is actually keeping a child/adolescent safer, and to monitor whether modifications or adjustments are needed. A safety review is a formal process for monitoring the effectiveness of interventions applied in cases and then evaluating 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 an option of last resort.

Services for Reintegration into Family/Household

Communities have a responsibility not only to identify and report cases of abuse but also to help reintegrate children and adolescents back into their communities following an incident of abuse. Reintegration can be challenging due to the stigma and discrimination associated with abuse. Children and adolescents who have experienced sexual violence and exploitation may also feel isolated and may struggle to connect with others because of the trauma they have experienced. Communities can support the reintegration of these children/adolescents by developing and maintaining strong referral networks through which they can continually access services. In Lesotho, the Maseru Children's Village operates a reunification program to help children who have experienced sexual abuse to reintegrate into their communities, offering children a safe place to stay, schooling, counseling, and referrals to other community services as needed. In Sierra Leone and Cambodia, *World Hope International* offers safe residential care, ongoing care through partner organizations and/or reintegration services for girls who have experienced sexual violence and exploitation.



Resources

- *Caring for Child Survivors of Sexual Abuse*
- *A Framework for Safety in Child Welfare*
- *Child Welfare Information Gateway (U.S. Department of Health & Human Services Resources for Safety and Assessment Planning)*
- *Safety Assessment/Safety Plan*
- *Safety Planning with Adult Sexual Assault Survivors: A Guide for Advocates and Attorneys*
- *Safeguarding Children and Young People: Roles and Competences for Health Care Staff*

Psychosocial Support Services

Making sure children, adolescents 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.

Psychological Risk Assessment

An immediate **risk assessment** 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. 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.

Asking child and adolescent clients about suicidal thoughts and/or plans can be challenging for providers, but it is extremely important. However, and despite the best of intentions, probing questions about a child/adolescent's suicide risk could inadvertently cause more emotional trauma for the child/adolescent. Such an assessment should always be conducted by a provider trained and experienced in trauma counseling (most often, a social worker, case worker, or nurse).

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 can 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 (IRC 2012).

Immediate Psychosocial Support and Caregiver/Family Support

The goal of an immediate **psychosocial assessment** (which can be combined with the above risk assessment) is to assess the child/adolescent's functioning, including any immediate/acute risk, and to help determine the longer-term plan of action. As with the above suicide probing questions about a child/adolescent's psychosocial functioning could inadvertently cause more emotional trauma for the child/adolescent. Such an assessment should always be conducted by a provider trained and experienced in trauma assessments and counseling (most often, a 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 Pierce-Weeks 2013). To begin the psychosocial assessment, the trained provider should clearly explain to children/adolescents 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 answer.

Subsequently, the trained provider can ask a series of simple questions to determine if the child, adolescent and/or caregiver perceive significant changes following the abuse experience. The assessment should include an immediate safety assessment, and determine the strengths of the child/adolescent and family, including the family's protective capacity. The psychological assessment should consider the developmental stage of the child/adolescent by means of the signs of distress the client 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 ideally be assessed for:²

- 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

² Source: WHO 2003.

- Substance abuse
- Alterations in body image
- *Suicidal ideation*

The information gathered during the psychosocial needs assessment helps the provider understand the extent of the abuse currently affecting the child/adolescent, and what strengths the child/adolescent and family can call upon during the case management process. Based on the information gathered and the discussion between the caseworker and client, the provider should document the psychosocial assessment summary in an available form, and work directly with the child/adolescent and caregiver (as appropriate) on a follow-up plan for longer-term support. Based on the assessment, a provider could determine whether a child/adolescent needs a general mental health referral, a referral to a specialized program or facility such as a hospital, or a trauma-specific mental health referral.

Box 4. Supportive Interventions for Non-offending Caregivers

Caregivers have indicated that they were better able to support their children/adolescents 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 to their child/adolescent, and implications of disclosure for wider family concerns. A number of programs offer parenting support for non-offending caregivers. Parent support groups can be a particularly helpful resource for supporting a family's recovery from the trauma of sexual abuse. For more resources, see:

- *A Guide to Psychoeducational Support Groups for Nonoffending Parents and Caregivers of Children who have been Sexually Abused*
- *Nonoffending Caregivers of Abused Children: A Bibliography*

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 simply geographic proximity). It is also important to help clients, who may be scared and overwhelmed, to 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 on any medication requirements as well as dates, times, and purpose of any follow-up visits.



Resources

- *Sample Risk Identification Tools*

Trauma-informed Long-term Psychosocial Support Services

Longer-term Response

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, and Porter 2007). Accordingly, it is important to recognize that 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/adolescent's sexual abuse is increasingly recognized in the literature, as well as the great value of caregiver support in the child/adolescent's recovery process (Walters 2002; Toledo and Seymour 2013). A number of the programs in the *Program Highlights* section offer parenting classes to help non-offending caregivers enhance their ability to prevent and/or respond to abuse. Also see Box 4.

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 stigma, fear of the perpetrator and/or other retribution, transportation constraints, frequent adjournments and delays, and/or an overall feeling that their efforts are futile.

Legally Empowered Medical Practitioner to Sign Police Forms

Immediate Response

One of the major barriers keeping cases from 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 facilities providing services to children and adolescents

following sexual violence should have staff on-site or on-call to conduct the examination and sign the required forms.

In some countries (as in South Africa), a legally empowered medical practitioner is required to sign both the police forms and the hospital/clinic forms for the forensic exam. 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. Considering the scarcity of doctors in many settings, mandating that nurses have the authority to conduct these exams and sign these forms should be a major focus of advocacy.

Police Report Process

Many children/adolescents and families experience significant challenges during the reporting process, including in their interactions with police. In some police stations, there is limited confidentiality and sense of safety for children/adolescents and their caregivers, because there is no place for private discussion; they are asked the same questions by different officers; and overall they 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 wellbeing of the person reporting the assault (Levy et al. 2012). While there have been a number of promising initiatives working with police departments, children and adolescents often still need help navigating the police reporting process. See the *Section 4 police overview* for some examples of promising initiatives with police.

Legal Assistance Services for Immediate Justice System Engagement

Children, adolescents, and families who hope to pursue criminal charges often find that there are few resources to help them navigate this unfamiliar and daunting process. In the immediate period after presenting with sexual violence, children/adolescents and their families may need support for making a police report. Some integrated programs enable police themselves to visit a center/facility where the clients first present; and others offer immediate staff/volunteer support to accompany the child/adolescent and their family to the police station. Programs should focus on helping the client navigate their options and make an informed decision appropriate for their own healing.

Legal Assistance Services for Justice System Involvement

Even for those children/adolescents/families who are able to prosecute their cases, the prosecution process itself can be overwhelming. The difficulties stem from 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;

**Longer-term
 Response**

and stigma and discrimination against the plaintiffs during the court procedures, including public stigma resulting from journalistic access to case information and, sometimes, inappropriate reporting. In some countries, civil society organizations provide support for children/adolescents and caregivers who face 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 stress and fear. See *Program Highlights: Teddy Bear Clinic* for more detail on their Court Preparation and Support Programme. *TVEP in South Africa* offers Victim Advocates to clients who start the sensitization process at the first home visit, so that the client does not withdraw from a potential prosecution because of fear. In Zimbabwe, Family Support Trust supports Field Case Workers, who provide ongoing support to clients by helping to follow up case investigations with the police, advise those who have experienced sexual violence and exploitation on the court processes, and help to follow up court outcomes. Useful pre-trial activities include explaining courtroom/legal language and terminology used, visiting the courtroom, and arranging for the client and witnesses to meet the prosecutor (for reassurance that the prosecutor is on their side).

Child witness preparation will vary, but may include:³

- Encouraging the child/adolescent to give testimony in the order in which events occurred
- Telling the child/adolescent 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
- Advising the child/adolescent to answer questions honestly, clearly, and as completely as possible
- Informing the child/adolescent 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
- Telling the child/adolescent that the same question may be asked more than once in order to clarify what s/he has said
- Reassuring the child/adolescent 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
- Encouraging the child/adolescent 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
- Reassuring the child/adolescent that it is okay to cry

³ From *TVEP Victim's Manual and Child Law Manual for Prosecutors*, pp. C3-29-30.

- Informing the parent/s or guardian/s that the child/adolescent should dress in comfortable clothing that s/he likes on the day of the trial
- Advising 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
- Explaining the purpose of the trial and the concepts of *guilty* and *not guilty* and the different types of sentences.



Resources

- *Strengthening the Medico-legal Response to Sexual Violence*
- *Victim's Advocate's Manual (TVEP)*
- *Court Preparation Process Program / Court Training Manual (Teddy Bear Clinic)*

Other/Social Support

Immediate Basics

Immediate Response

Because reporting sexual abuse or exploitation is complex and time-consuming, children/adolescents who present for care and legal action need provisions for their comfort. A number of organizations, such as *TVEP* and the *Greater Rape Intervention Project*, 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

Longer-term Response

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. Table 1 suggests starting point goals and aspirational standards for providing comprehensive services to children and adolescents who have experienced sexual violence and exploitation.

Table 1. Starting Points/Aspirational Standards

Starting point goals	Yes	Not yet	Steps to reach next level	Aspirational standards
At a minimum, a counselor and a trained on-call nurse and doctor available for sexual violence cases. Where not feasible to have dedicated staff, consider a roster of trained providers who are available on an on-call basis.				At least one trained medical doctor, nurse, social worker/counselor, paralegal, and police officer available on-site.
Ensure that job descriptions include specific roles and responsibilities in dealing with GBV response.				
Protocols in place for addressing cases of sexual violence of children and adolescents, including referral pathways.				Clinical and service referral protocols.
All staff have been trained in the protocols and procedures.				Regular refresher training is offered; staffing supervision and mentoring plans are in place and operational.
The first point of contact will offer compassion and consideration to child/adolescent.				All staff trained and sensitized in guiding principles for working with children and adolescents.
Integration of as many services as possible at one site.				Integration of all medico-legal, psychosocial support, and police services, in one physical location.
Signing of the police medical report forms takes place at the medical site.				
Allow the client to make the choice about whether s/he wants services and at his/her own pace.				
Reporting to the police is not a prerequisite for obtaining medical care.				

Starting point goals	Yes	Not yet	Steps to reach next level	Aspirational standards
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.				
Dedicated staff/services available for extra hours as well as daytime (beyond typical office hours).				Dedicated staff/services are available 24 hours/7 days a week/365 days a year.
Any medico-legal form or certification is free of charge.				
All services are clearly explained to clients; clients receive appointment cards for follow-up visits. If PEP is prescribed, written instructions are provided, with explanations of its purpose, the regimen, the importance of following the full course, information on side effects, and specific follow-up testing appointments.				Clients receive 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.
Transport subsidies are offered for return visits.				Free bus or taxi vouchers are provided.
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.)				A specialized caseworker with training in trauma, sexual abuse, and child/adolescent development is assigned and follows the case.

SECTION 4: ROLES AND COORDINATION OF VARIOUS STAKEHOLDERS AND ESSENTIAL ELEMENTS FOR BRIDGING COMMUNITY-FACILITY STAKEHOLDERS

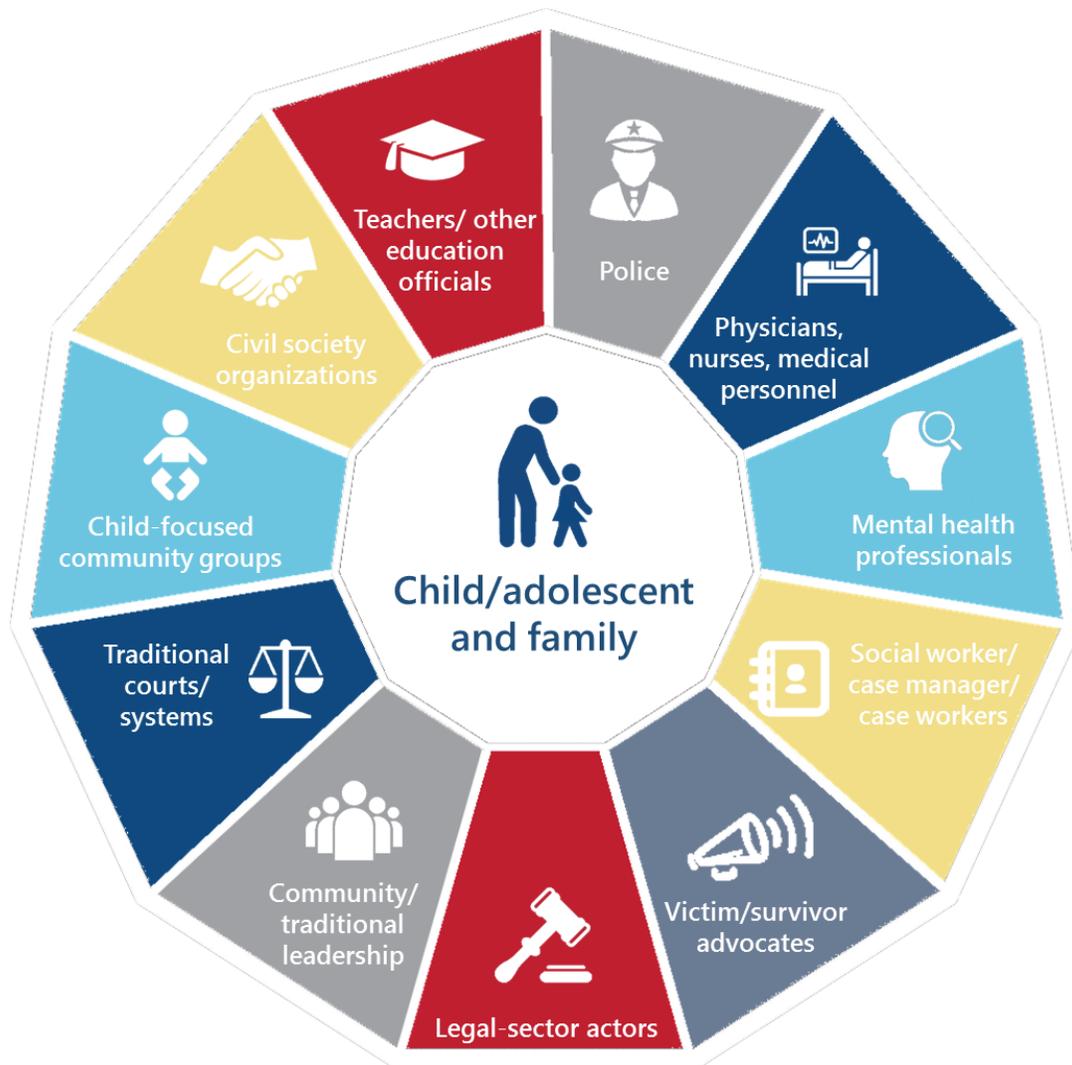
This section provides a general overview of the roles and responsibilities of the **key stakeholders** who need to be engaged to ensure a multisectoral response for children and adolescents who experience sexual violence and exploitation. The exact nature of these roles and responsibilities will vary 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 or been affected by sexual violence and exploitation.

Effective multisectoral 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 the various duty bearers in the overall system and the community resources to support and reinforce duty bearers.

This section also includes a brief summary of the essential elements for linking community and facility stakeholders. *Section 6: Referral Pathways and Community/Facility Coordination* offers more detail on the step-by-step process by which facility and community stakeholders can work together).

Figure 6. Duty Bearers and Community Resources

(Click on each actor to learn more about their role.)



Police These stakeholders are often the first point of contact for a child or adolescent who has experienced sexual violence and exploitation. In many societies, police play a “gate-keeping role” when deciding whether or not a criminal act took place and, if a crime was committed, how to investigate the charge (Frazier et al. 2006). Overall, their role is tremendously important, and all programs must work closely with the police.

In Zambia, one program equipped police with emergency contraception and training to link those who experience sexual violence and exploitation to clinical services. Pilot results demonstrated an increase in reporting cases of sexual violence, and clinicians reported that police were safely providing emergency contraception and linking clients to health services in a cost-efficient and sustainable manner. (For the program feasibility study document on integrating emergency contraception into police care in Zambia, see [here](#). See [here](#) for a feasibility report on a follow-on project in Malawi which looked to adapt the Zambia model.) In Zimbabwe, all police stations have a "Victim Friendly Unit" which is mandated to handle cases of violence against women and children, and staffed by personnel specifically trained to handle vulnerable individuals. Timor-Leste has established special female-operated police stations/police desks dedicated to women’s issues and sexual violence. Tanzania and Lesotho have also set up decentralized units of officers who are trained to handle GBV cases, although the functioning and scope of these teams vary.

Police who assist children and adolescents assists children and adolescents who have experienced sexual violence and exploitation should:

- Be readily available
- Know the signs of sexual abuse in children and adolescents
- Follow informed consent procedures according to local laws and age/developmental stage of the child
- 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 2003)
- Uphold the client's privacy and confidentiality
- Have training in how to communicate with GBV survivors (including not blaming the survivor)
- Express caring and reassurance
- Provide a secure and private environment for speaking with the child/adolescent/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.

Physicians, nurses, and other medical personnel Medical personnel play a major role in cases of sexual violence and exploitation against children and adolescents, and they are often first

responders. Medical personnel should never determine whether sexual assault occurred. They should focus on providing clinical care and a forensic exam, offering psychological support, and offering appropriate referrals.

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.

Nurses are fundamental in cases of sexual violence, because 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 timeframe. 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 assist children and adolescents who have experienced sexual violence and exploitation should:

- Be readily available
- Know the signs of sexual abuse in children and adolescents
- Follow informed consent procedures according to local laws and age/developmental stage of the child/adolescent
- 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 2003)
- Uphold the client's privacy and confidentiality
- Express caring 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 the child or adolescent
- Provide basic, immediate psychological support, including identifying risk of self-harm
- Make client-specific referrals to case management and ensure that the child/adolescent receives these services
- Provide expert statements, reports, and testimony for the courts.

Mental health professionals These 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 youth-oriented

information on protection as well as 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).

Mental health professionals who assist children and adolescents who have experienced sexual violence and exploitation should:

- Know the signs of sexual abuse in children and adolescents
- Report suspected cases of child abuse and neglect
- Follow informed consent procedures according to local laws and age/developmental stage of the child/adolescent
- Uphold the client's privacy and confidentiality
- Express caring and reassurance
- Provide diagnostic and treatment services (medical and psychiatric) for children, adolescents, and their families
- Provide consultation to legal services on medical aspects of child abuse and neglect
- Provide expert statements, reports, and testimony for the courts
- Provide information to caregivers about the needs, care, and treatment of children/adolescents
- Identify and provide support for families at risk of child mistreatment
- Develop and conduct primary prevention programs
- Participate in community multidisciplinary teams
- Facilitate groups for parents who have mistreated or are at risk of mistreating their children/adolescents.

Social worker/case manager/case workers These cadres typically work within a service-providing agency and are responsible for ensuring that health, social welfare, protection, and other services are provided to clients. This provider should be trained in client-centered case management; be 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.

A social worker/case manager who assists children and adolescents who have experienced sexual violence and exploitation should:

- Know the signs of sexual abuse in children and adolescents
- Educate and support children, adolescents, and families throughout the case management process
- Follow informed consent procedures according to local laws and age/developmental stage of the child/adolescent
- Uphold the client's privacy and confidentiality
- Express caring and reassurance

- Assess the child’s immediate health, safety, psychosocial, and legal/justice needs
- Mobilize services, provide referrals, and help the child/adolescent/family access those services
- Conduct ongoing safety assessments, taking decisive action when needed
- Assess PEP adherence and side effect management, referring to medical personnel as needed
- Identify strengths and needs to engage the child/adolescent and family in a strength-based care and treatment process
- Include non-offending caregivers in the process
- Support the child and family throughout the court process, including preparing them for what to expect
- Lead case coordination, including communication, information sharing, and collaboration with case management and other staff serving the child/adolescent client within and between agencies.

Victim/survivor advocates These workers often have a role similar to that of social workers/case managers/case workers (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). Typically, a social worker/case manager/case worker receives more formal training than a victim/survivor advocate and may hold a professional degree. However, the essential objective of these roles is 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 and exploitation. In some cases, a victim/survivor advocate 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 noted in the *Program Highlights: TVEP*.

Victim/survivors advocates should:

- Know the signs of sexual abuse in children and adolescents
- 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/adolescent
- Uphold the client's privacy and confidentiality
- Express caring and reassurance.
- Asses the child/adolescent’s immediate health, safety, psychosocial and legal/justice needs
- Mobilize services and provide referrals appropriately, supporting the child/adolescent/family to access those services
- Assess PEP adherence and problem-solve side effect management issues, and refer to medical personnel as needed

- Identify strengths and needs to engage the child and family in a strength-based care and treatment process
- Support the child/adolescent and family throughout the court process, including preparing them for what to expect.

Legal-sector actors, including paralegals, magistrates, family courts, and other legal role players (other than police) These groups are part of a range of legal-sector actors who, if trained and supported, can play a very important role in supporting children/adolescents (and their families) who have experienced sexual violence and exploitation. Paralegals are not lawyers, but are trained in legal issues. Some programs offer paralegals on-site and/or free paralegal services that can offer child/adolescents and their families legal advice and support, and guide them through the legal process in the event of a criminal case (although they are not a substitute for a lawyer, since they cannot legally represent a child/adolescent in a court proceedings). In many of these cases, programs have partnered with legal/justice community-based organizations and/or lawyer associations to be able to offer these services. A number of programs around the world have also worked with magistrates/judges (and lawyers) to train them on GBV prevention and response, including sexual violence against children and adolescents, to enable them to deal sensitively and effectively with cases of sexual violence.

Family courts, or Children’s Courts, are typically child-focused, auxiliary courts that deal with issues affecting children under a certain age. They are often tasked with the power to make decisions about issues such as guardianship and custody, and to intervene in cases of children who may be abandoned, neglected, or abused (although note that a number of children’s courts, such as that in South Africa, are not legally able to deal with criminal cases).

Community/traditional leadership Community/traditional leadership (including faith-based/religious leadership, chiefs, traditional healers, and other community leaders) are often the first point of contact for children and adolescents (and families) who experience sexual violence and exploitation. As mentioned earlier, families may approach these leaders before entering the broader system to seek care. Even in cases where the formal legal system has reached, extended family, religious leaders and/or chiefs may work with traditional justice mechanisms to determine 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 Adversity 2011).

Community leadership can play an important role in negotiating disclosure. For example, if a family refuses to report a case to the police, these leaders may have a high status in the community, which allows them to effectively reassure the family that the community supports them. An important role for community leaders can be to help identify and offer support to households, caregivers, and children/adolescents who may have cases of child/adolescent maltreatment. In particular, community leaders can support children, adolescents, and the family

throughout their contact with the justice system and, where necessary, during the post-trial period. Overall, and as with civil society organizations, community leaders are able to establish strong linkages with service providers from whom they can negotiate and leverage social, economic, and psychological resources.

Community leaders also have an enormous role to play in shaping community attitudes toward sexual violence and exploitation. They can lobby for systemic changes, such as requiring health staff to prioritize child/adolescent sexual violence and exploitation, expand provision of the medico-legal exam to include trained nurses, and allow nurses to sign sexual offense forms. Female traditional/community leaders in particular can help prevention of sexual and gender-based violence and provide support for girls.

Work with community leadership should take a deliberate approach that seeks to build and maintain relationships between the community and facility- or system-based services offered. One should not assume (with any of these cadres) that people will approach GBV from a human rights perspective. Therefore, a program may need to develop strategies to identify community leaders who can serve as "champions"; help sensitize leaders about harmful cultural practices that perpetuate or even promote GBV; develop strategies with them; and work with them on an ongoing basis to ensure effective and positive messaging.

See *Program Highlights: TVEP* for information on their Zero Tolerance Village Alliance (ZTVA) approach, a holistic, community-based approach that relies on positive behavior change to eradicate GBV and crimes against children, and engages traditional leaders in reporting as well as prevention. In Kolda, Senegal, World Vision's *Vélingara Child Protection* project sets up local and accessible community-based child protection structures called 'CAVEs' (an acronym in French that translates as 'Vigilance Committees to Alert, Watch and Listen'). The CAVEs became referral points for cases of child abuse, where children, parents and community members would bring abuse-related concerns. In total, 114 CAVEs formed, as did an inter-village network that joined local groups together and connected them to district-level monitoring and action. Complementing this work were school-based committees that trained teachers and children to recognize, report and prevent child abuse. Also see *Regional GBV Referral Networks, Program Highlights* for more information on one program's efforts to pilot a community-based referral network, and *Resources: Traditional Leadership* for more resources on working with community/traditional groups.

Traditional courts/systems In many countries there are customary (and at times, religious) accountability systems with an established set of processes and traditions, governed by a group of individuals who resolve disputes based on local concepts of justice or customary ideas of what constitutes an appropriate outcome (Ferraro 2014). These informal systems may be the only available form of justice for some members of the population, particularly in rural areas.

Since many who have experienced sexual violence and exploitation may turn to these informal judicial systems (either because they are the only accessible option or due to of cultural and communal pressure), these systems must be considered and engaged to develop effective responses to sexual violence (Wojkowska 2006). These traditional courts/systems are often closely tied to community leaders (see above).

Child-focused community groups There is great diversity in the mandate, scope, and activities of community-level organizations focused on children and adolescents. Wessel et al. highlight the differences between two common community groups: Child Rights Committees and Child Protection Committees (or Child Welfare Committees). Generally speaking, the mandate of Child Rights Committees is to raise awareness about children’s development and rights; monitor and report violations of these rights; and advocate for improved community efforts 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 protection threats (Wessels 2009). In some settings, these groups network with entities in the formal protection system such as police, magistrates, district- and national-level committees, and social services and education officials; and with those in non-formal systems such as traditional justice mechanisms (*Ibid.*) Many of these groups also work closely with community-based volunteers, who may be tasked with providing household-level, regular support to vulnerable families, and who play an invaluable role in identifying violence in the household and providing referrals for services and support. While there appear to be few programs where health providers directly work with child-focused community groups, there are many opportunities for these groups to come together as part of one referral network. For more detail, see *Section 6: Referral Pathways and Community/Facility Coordination* and *Checklist: Essential Elements for Bridging Community-Facility Stakeholders*.

Civil society organizations These groups can play a critical role in the early identification of violence; supporting children and adolescents to access statutory services; helping them and their families to cope with the effects of the abuse; facilitating safe reintegration of children/adolescents back to their communities; and holding service providers accountable. In some cases, civil society organizations deliver services with or on behalf of government. They can act as an early warning when service delivery quality slips, and provide a strong advocacy voice for children, adolescents, and their families in policy reform and program development, helping to secure their rights under national laws and policies. They also have the ability to establish strong linkages with service providers, with whom they can negotiate to leverage social, economic, and psychological resources to address the root causes of violence and abuse. For more detail, see *Section 6: Referral Pathways and Community/Facility Coordination* and *Checklist: Essential Elements for Bridging Community-Facility Stakeholders*.

Teachers and other education officials Education officials function as another key point of contact for children/adolescents. Teachers may be among the only adults with whom a child/adolescent interacts on a regular basis outside the home environment; and in rural communities in particular, educators are held in high esteem and often called in for advice, guidance and support. Educational settings, such as primary and secondary schools and universities, can be safe places where children/adolescents can report cases of sexual assault.

Those in the education system should receive training on recognizing, addressing, and reporting cases of sexual violence, as well as options available for shelter and protection (Freccero et al. 2011). Education officials can build requirements on reporting abuse requirements into teachers' and administrators' job descriptions and provide pre- and in-service trainings on recognizing and reporting signs of abuse. Teachers and education officials are also responsible for helping children and adolescents reintegrate into the classroom following incidents of abuse. This uniquely positions them to provide holistic support for abused children/adolescents throughout the cycle of violence.

However, it is important to note that schools can also be locations where children and adolescents experience violence and exploitation. This violence and exploitation may be perpetrated by teachers, education officials, and/or other students, and can occur at and on the journey to and from school. For more information about GBV in the education sector, please see *Beyond Access: Toolkit for Integrating Gender-based Violence Prevention and Response into Education Projects*. This toolkit, produced by the U.S. Agency for International Development (USAID), provides an overview of GBV in the education sector and offers strategies for integrating prevention and response into education projects. The toolkit also provides guidance on building the capacity and skills of teachers and education officials to identify and respond to GBV, establish and use GBV referral networks, increase parent and community involvement, and ensure a safe school environment for students and educators, including those who may have experienced trauma.

Checklist: Essential Elements for Bridging Community-Facility Stakeholders

Below is a summary of the essential elements that health providers/managers can use to work with community services to ensure children/adolescents are receiving the full range of support and care. Also see *Section 6: Referral Pathways and Community/Facility Coordination*, which provides step-by-step guidance on setting up a multisectoral referral pathway.



1 Start with Community Mapping

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 that traditional and informal community structures play a tremendous important role in supporting children, adolescents, and their families; too often these groups are excluded from formal systems. If you are unsure of where services are offered, this is an opportunity to find out (Keesbury and Thompson 2010).



2 Hold Consultations with Children and Adolescents

Hold consultations with children and adolescents themselves to learn about their priorities, needs and gaps. These consultations can give programs insight in how to better serve these groups while fostering informal "word of mouth" about the upcoming available services. Like community mapping, consultations offer an important opportunity to solicit community input; identify social, economic, and physical barriers to services and ways to mitigate against them; and identify opportunities for accessing services. As importantly, consultations create opportunities to learn more about how to support and serve the most vulnerable, such as children and adolescents living with disabilities or HIV.



3 Invite/Engage Community Advocates

Invite/engage community advocates conducting prevention/awareness activities/campaigns to regular meetings to discuss ways to better coordinate (i.e., to identify opportunities for advocates to include information about available services in their campaigns; to invite advocates to leave literature regarding violence prevention/awareness-raising literature in the waiting room at your center; to hold monthly meetings with advocates regarding pressing community issues, etc.). *This engagement should include both formal leadership (i.e., Community Protection Committees) and informal structures (traditional leaders, those involved in informal justice systems) that engage with children and adolescents.*



4 Incorporate Combined Training

Incorporate combined training of those in the system, including health care personnel, formal and informal community groups, service site workers, police, and criminal justice system/legal teams. This will help foster a culture of working together, build trust and understanding, and broadly increase capacity in caring for and managing victims/survivors. Mixed training can also help different cadres understand how other sectors function, and encourage dialogue and networking to improve standards of care for children and adolescents.



5 Conduct Specific Outreach

Conduct specific outreach with persons who regularly interact with children/adolescents (teachers, pastors, community leaders, sports coaches, etc.), invite them to visit the center/facility and ensure that they know how to handle cases of suspected child/adolescent sexual violence; are familiar with the services offered at your center; and are aware of opportunities to refer children/adolescents. *This engagement should include both formal and informal leadership/structures who might engage with children and adolescents.*

SECTION 5: MANDATORY REPORTING⁴

One of the main differences in working with children and adolescents, as opposed to adults, is that providers working with children and adolescents must comply with laws and policies regulating response to suspected or actual abuse. These laws and policies are often referred to as “mandatory reporting laws,” and they vary in scope and practice across countries.

To appropriately comply with mandatory reporting laws, service providers must thoroughly understand the mandatory reporting laws in their setting; and procedures for reporting suspected or actual abuse must be in place before providers can offer services directly to children/adolescents.

If a mandatory reporting law or policy exists in a particular setting, stakeholders should establish procedures based on the following questions:

- Who is required to report cases of child/adolescent abuse?
- Who are the officials designated to receive such reports?
- When is the obligation to report triggered (i.e., with suspicion of abuse?)
- What information needs to be shared?
- What are the reporting regulations regarding timing and other procedures?
- How is confidentiality protected?
- What are the legal implications of not reporting?

Box 5: Cultural Considerations and the Best Interest of the Child/Adolescent

The best interest of the child/adolescent should be the primary consideration, even in the context of mandatory reporting laws. However, there is no single definition of what the “best interest” of the child/adolescent refers to. In some settings, local customs and cultures could, for example, place harmony above justice and therefore lead people to minimize the reporting of cases that may cause family or community discord. This is a very complicated issue to navigate. Program managers/implementers should be aware of this potential tension and engage with other members of their referral network to address this issue openly, and look for solutions to encourage reporting of cases. Community sensitization is needed to ensure that cases of sexual violence and exploitation against children and adolescents are not neglected due to larger community notions of harmony. See the list of questions in this section to help guide decisions about reporting.

⁴ This section comprises a condensed and slightly revised version of original text developed by the International Rescue Committee (IRC). The full text is available [here](#).

Mandatory reporting in cases of abuse is not the same thing as referring a child/adolescent for immediate protection if they are in imminent danger. If a child/adolescent is in imminent danger, then caseworkers should first take actions to secure his/her safety (through referral to local police, protection agencies, etc.)—*before* reporting to the designated mandatory reporting agencies. Once the child/adolescent is safe, caseworkers should proceed with mandatory reporting procedures.

Remember *the best interest of the child/adolescent should always be the primary consideration* when taking actions on behalf of children/adolescents, even in the context of mandatory reporting laws.

Key actors should discuss and agree on strategies for reporting abuse while maintaining *discretion and confidentiality* in cases of children/adolescents and families who have experienced sexual violence and exploitation. Approaches for preserving discretion and confidentiality in mandatory reporting circumstances should include: agreeing with other actors on the least amount of information necessary for sharing; reporting to only one mandatory reporting entity/person; and establishing guidelines regulating how third parties store information.

Mandatory reporting requirements can raise *ethical and safety concerns* in some settings, where laws may exist in theory but not in practice. In some settings, mandatory reporting can set off a chain of events that potentially exposes the child/adolescent to further risk of harm, and as such it may not be in the child’s best interest to initiate a mandatory report.

Even if a mandatory law exists in theory, service providers are advised to use the central guiding principle—*the best interests of the child/adolescent*—to guide decision-making. Service providers are advised to follow these steps to determine the best course of action:

1. Use these questions to guide decision-making:
 - a) Will reporting increase risk of harm for the child/adolescent?
 - b) What are the positive and negative impacts of reporting?
 - c) What are the legal implications of not reporting?
2. Consult with the program case management supervisor and/or manager to make a decision and develop an action plan.
3. Document with a supervisor or manager the reasons for reporting the case; otherwise, document the safety and protection concerns that rule out making a report.

If mandatory reporting policies and laws are in place, service providers are required to explain their reporting responsibilities to the child/adolescent and caregiver at the beginning of services. This can be done in conjunction with the initial informed consent procedure for the services being offered. Children/adolescents, particularly older children (adolescents), and caregivers should take part in decisions made on addressing mandatory reporting in the safest

and most confidential way. This means that service providers should seek and consider their opinions and ideas on how to draft the report. It does *not* mean the caregiver and child/adolescent can decide whether or not a report is made; rather, they can help decide how and when the report is made.

SECTION 6: REFERRAL PATHWAYS AND COMMUNITY/FACILITY COORDINATION

Children/adolescents who have experienced sexual violence may enter the system at any number of points: reporting a violation to a community leader, or reporting to the police, a medical facility, or a specialist center, with or without their families (Levy 2012 et al.; Gevers and Abrahams 2015; key informant interviews). In settings where the police and/or health systems may be weak, NGOs are often the first point of contact (key informant interviews).

Figure 2 presents a referral pathway that can be used as a template for developing local flowcharts to guide the response to cases of violence; and the subsequent section presents a comprehensive checklist for programs looking to initiate or improve a coordinated referral network.

Checklist: Setting Up a Referral Pathway/Coordination Network

Providing integrated care to children, adolescents, and their families almost always 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).

All actors involved in care and support for children and adolescents who have experienced sexual violence and exploitation are responsible for setting up a strong referral network. Children and adolescents with signs of sexual violence and exploitation may first 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.

The following checklist provides more detailed guidance to help with setting up a referral pathway/coordination network.⁵



Among the most critical aspects of setting up a referral network are:

- Identifying the service-delivery needs of children, adolescents, and their families
- Building on existing practices and infrastructure
- Ensuring that all services are in the best interest of the child/adolescent
- Creating institutional buy-in of key stakeholders (from national level policymakers to institutional administrators and service providers)
- Engaging both the formal and informal sectors in the process
- Aligning services with local laws, policies, and protocols
- Having standardized tools, protocols and norms throughout the entire network
- Defining roles and responsibilities of service providers throughout the network
- Having trained providers at each referral point who are well-versed in the protocols and norms of the referral network
- Ensuring ongoing capacity development of providers
- Building and maintaining safe and ethical data collection and monitoring systems, including case review processes

⁵ Basic steps adapted from Keesbury and Thompson 2010.



Determine what a minimum service package might contain (even if much of the package 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 legal staff 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 that there are traditional and informal community structures that can play an important role in supporting children, adolescents, and their families.
- **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 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).
- **Hold consultations with children and adolescents themselves** to learn about their priorities, needs, and gaps. These consultations can give programs insight in how to better serve these groups as well as foster informal word of mouth about the upcoming available services.

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

 Resource: [UNFPA Partner Mapping](#)



Invite/encourage the multidisciplinary stakeholder team to participate

- **Ask stakeholders** to consider joining network of referral providers, including traditional and informal stakeholders. Hold an introductory stakeholders meeting.
- **Agree upon general, network-wide principles for working with children and adolescents.** This includes principles for all service providers/agencies for communicating 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 also 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 (see *Minimum Standard Package*).



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 of all network members (including mandatory consent responsibilities) (see *Roles and Responsibilities*).
 - Standardized algorithms for care, including safeguards to ensure that children/adolescents are not interviewed multiple times about their experience/history with sexual violence and exploitation; with clear follow-up and after care procedures.
 - Guidelines for informed consent and confidentiality procedures for children/adolescents under the legal age of consent (See *Mandatory Reporting*).
 - 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, and other procedural details).



Resource: *Sample Consent Forms*

4

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, other actors)
 - Protocols for case managers and supervisors
 - Protocols to support case managers, also covering difficult cases and case coordination meetings
 - Determination of when a case is considered closed.
 - Determining when and how referrals should be made and documented (use of a form, verbal, other means).
 - 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 multidisciplinary team approach to care review and case planning.
 - Specifying the type of information that can be shared between agencies, professionals, and family members.



Resources: *Child Needs Assessment and Case Action Planning Form*, *Child Case Follow-up Form*, *Child Case Closure Form*, *Risk Identification Tools*, *Child Sexual Exploitation Risk Identification Tool*, *A Framework for Safety in Child Welfare*

5

Formalize relationship between referral institutions/sign Memorandum of Understanding

**This step can happen earlier; however, the details require many discussions, so it may be useful to go through that process and then finalize the memorandum of understanding.*

Document the memorandum of understanding 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.



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 be trained 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 that service providers have and retain the knowledge, skills, attitudes, and tools to use referral pathways, reporting agreements, and information-sharing protocols.
- Develop a curriculum and plan for self-care, since professionals and volunteers working in this field are at risk for secondary trauma.

Note that there are many country examples of training programs that incorporate combined training of health care personnel, community groups, service site workers, police, and criminal justice system/legal teams to foster a culture of collaboration while also educating people on caring for and managing young people who have experienced sexual violence.

 Resources: *Caring for Child Survivors Training Materials*; *NACOSA Guidelines and Standards for the Provision of Support to Rape Survivors in the Acute Stages of Trauma*; *The Teddy Bear Clinic Training Manuals for Management of Child Abuse*



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

These may include:

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

Note the importance of having a process for peer review and clinical case review in place.

 Resource: *Illustrative Referral Pathway*



8 Develop and finalize forms and materials

This may include:

- Client posters and other information for display
- A clear referral directory for all members of the network
- Standardized referral forms
- Pamphlet with information available for clients (i.e., client manuals, pocket-size lists of useful phone numbers, checklist of services so clients can see if they have received all the services they need for proper care and support, and any other forms/tools/items to give to clients to take home)
- Making sure that copies of police forms and forensic reporting forms are readily available.



Resources: *Rape Survivors Manual*; *A Guide for Survivors of Rape and Sexual Assault*; *Advocacy Manual: A Guide for Survivor Advocates*; *What Parents Need to Know About Sexual Abuse*

SECTION 7: CASE MANAGEMENT

Case management and referral mechanisms are the "glue" that binds populations affected by HIV with services.⁶

Follow-up care and support is perhaps the most challenging aspect 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 clients navigate complex and disparate service delivery systems. Strong case management is critical to enabling children, adolescents, and families to manage the myriad of services and appointments they need, in the immediate and long term, to facilitate their own healing.

Case management, also referred to as care management or care coordination, involves those who have experienced sexual violence and exploitation (and their families, if applicable) in a collaborative process of identifying, planning, accessing, advocating, coordinating, monitoring, and evaluating resources, supports, and services; and subsequently helps these clients to obtain the constellation of services that meet their needs (National Association of Social Workers 2013). While this document does not provide details about the many different models of case management, this section provides the basics of what a system might entail, and offers resources for learning more.

While social workers take the lead on the case management in some settings, in many places no social workers are available. When social workers are present, 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

 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 and 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 for handling mandatory reporting requirements and organizing case conferencing meetings, among other tasks.*

⁶ From 4Children. n.d. *Protection and Resilience: A Simple Checklist for Why, Where and How to Coordinate HIV and Child Protection Policy and Programming*. Available online [here](#).

incorporating other cadres into their programs ranging from counselors, GBV caseworkers, victim's/survivor advocates, to "buddies" to serve as the essential, consistent link between a young client (and family) and services, and to provide primary case management services. In other instances, countries have chosen to train more social workers and/or provide additional training to lower-level social workers.

Regardless of the cadre tasked with case management, there are six essential components to case management. These are illustrated in Figure 7.

Figure 7. Case Management Flow⁷



⁷ Adapted from International Rescue Committee (IRC). 2012. *Caring for Child Survivors of Sexual Abuse*. Available at: http://www.unicef.org/protection/files/IRC_CCSGuide_FullGuide_lowres.pdf.

Regardless of the level of training, education, or certification, the following are important considerations for supporting this cadre.

- **Ensure that the case worker is the person who, from the first point of contact until a case is closed, is the child/adolescent's main contact (to minimize ongoing re-traumatization by having to see multiple service providers).** The *TVEP Victim's Empowerment Programme* offers a promising model. The Victim Advocate on duty becomes the client'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 with the police, referrals and support for psychological care, and court preparation.
- **Explain the case worker's role and service(s) available to the child/adolescent and family, including the meaning of confidentiality, instances when information will not be confidential, and how information will be stored.** This should be handled with great compassion and consideration, because for a person who has been assaulted, meeting with a kind, considerate, and caring person in the (health) system can have a profound positive impact and goes a long way to helping the client manage and cope with the event.
- **Assess the client'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 processes.
- **Understand that identifying a child/adolescent and family's strengths, needs and resources, and available community support mechanisms, 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 to heal and supported 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 multiple times.**
- **Conduct other interventions (depending on the case worker's mandate), including:**
 - As appropriate, meeting with the family to discuss issues and helping them access support
 - Sharing tools and techniques for reducing stress and anxiety with the child or adolescent
 - Advocating for the child/adolescent (with police to take protective measures, for safe housing, and for addressing other needs)

- Convene ongoing case conferences and case reviews so that all professionals working on the case can share their findings; and then involve the non-offending caregivers and child/adolescent in the decision-making for their next steps.



- 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)
- *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 8: GUIDING PRINCIPLES FOR WORKING WITH CHILDREN AND ADOLESCENTS WHO HAVE EXPERIENCED SEXUAL VIOLENCE AND EXPLOITATION

When caring for children and adolescents who have experienced sexual violence and exploitation, common principles should inform decision-making. It is critical that care and support be provided in a youth-friendly manner, and that the child/adolescent is not re-traumatized in the process. Following these principles ensures that actions taken on behalf of the child or adolescent are supported by standards of care that aim to benefit their health and wellbeing.

Table 2 below lists these guiding principles and corresponding actions as described in the *United Nations Refugee Agency Guidelines on Sexual Violence Response and Prevention and the United Nations Convention for the Rights of the Child*.⁸ The table has been adapted slightly to include adolescents and focus more broadly, beyond the medical provider. **These guiding principles should be applied by all members of the referral network and can be adapted to the particular setting.**

Table 2. Guiding Principles for Working with Children or Adolescents Who Have Experienced Sexual Abuse and Exploitation

Principle	Actions
Promote the child and adolescent’s best interest	<ul style="list-style-type: none"> • Secure physical and emotional safety (wellbeing) throughout care and treatment • Evaluate positive and negative consequences of actions with participation of the child/adolescent and caregiver (as appropriate) • The least harmful course of action is always preferred • All actions should ensure that the child/adolescent’s rights to safety and ongoing development are not compromised
Ensure safety of the child/adolescent	<ul style="list-style-type: none"> • Ensure physical and emotional safety • All actions should safeguard the child/adolescent’s physical and emotional wellbeing in the short and long term

⁸ Adapted from United Nations High Commissioner for Refugees (UNHCR). 1995. *Sexual Violence Against Refugees: Guidelines on Prevention and Response*. Geneva, Switzerland: UNHCR.

Principle	Actions
Comfort the child/ adolescent	<ul style="list-style-type: none"> • 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	<ul style="list-style-type: none"> • Information about the child/adolescent’s experience of sexual violence and exploitation should be collected, used, and stored in a manner that ensures confidentiality • 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 client
Involve the child/ adolescent in decision-making	<ul style="list-style-type: none"> • Children/adolescents have a right to participate in decisions that 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 cannot be followed, explain why
Treat every child/adolescent fairly and equally	<ul style="list-style-type: none"> • Use 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 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

Principle	Actions
Strengthen children/adolescents' resiliencies	<ul style="list-style-type: none"> • Each child/adolescent has unique capacities and strengths, and the capacity to heal • Identify and build upon the child/adolescent's and family's natural strengths as a part of the recovery and healing process • Identify and build upon factors that promote the child/adolescent's resilience during the episode of care
Providers should be trained to manage children/adolescents who have experienced sexual violence and exploitation	<ul style="list-style-type: none"> • All providers who care for children/adolescents who have experienced sexual violence and exploitation should undergo training and orientation in child/adolescent-friendly services (case managers, social workers, and others performing that role)
The health and welfare of the child/adolescent takes precedence over the collection of evidence	<ul style="list-style-type: none"> • The welfare of the child/adolescent ensures that s/he is able to maintain dignity after sexual violence and exploitation, and does 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)
Reporting to police should not be a prerequisite for obtaining medical care	<ul style="list-style-type: none"> • 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 • 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 client should be offered all available services even if there is no physician available to sign medico-legal forms or the client chooses not to report to the police
Use person-first approaches to care	<ul style="list-style-type: none"> • Professionals must have a strong understanding of current approaches to inclusive care for all patients regardless of ability, and must be gender- and age-appropriate in their approach • Service providers should recognize that children/adolescents 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 • Providers and facilities should ensure that a trained person is available when necessary for communication alternatives (e.g., sign language) for patients who require this approach

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:

- *Thohoyandou Victim Empowerment Program (TVEP), South Africa*
- *Women And Child Protection Units, the Philippines*
- *Livingstone Child Sexual Abuse One Stop Centre, Zambia*
- *The Mirabel Centre, Nigeria*
- *Swaziland Action Group Against Abuse (SWAGAA), Swaziland*
- *The Teddy Bear Clinic, South Africa*
- *Thuthuzela Care Centres (TCC), South Africa*

1. Thohoyandou Victim Empowerment Programme, South Africa



History

The Thohoyandou Victim Empowerment Programme (TVEP), in Limpopo, South Africa, operates a number of integrated prevention, empowerment, and support interventions, including two one-stop trauma centers that provide support and advocacy for survivors of sexual and gender-based violence. In 1997, after the National Crime Prevention Strategy identified victim empowerment as a key element, the Thohoyandou Community Policing Forum joined with the South African Police Service (SAPS) to initiate a Victim Empowerment Committee, which eventually became the TVEP. In 2001, with seed funding from the Department of Health, the South African police, and local business, TVEP opened its first one-stop trauma center at the Tshilidzini Regional Hospital in Thohoyandou, Thulamela Municipality, Vhembe District. This is now a “partnership” with Thuthuzela. The second center opened in 2003 at the Donald Fraser District Hospital, also situated in the Thulamela Municipality.

TVEP’s prevention and empowerment work is centered on rights-based community dialogues covering five thematic areas: sexual assault, domestic violence, child abuse, HIV and AIDS stigma mitigation, and rights for minority communities—specifically, foreign nationals, sex workers, and lesbian, gay, bisexual, transgender and intersex (LGBTI) individuals. Cross cutting these dialogues is accountability monitoring, which, by holding service providers accountable to their delivery mandates, empowers participants not just to know their rights, but also to exercise them. Accountability monitoring has served to improve stakeholder response, particularly in cases of sexual and gender-based violence.

Services

Support

TVEP’s Access to Justice initiative provides multisectoral support services to survivors of sexual assault, child abuse, and/or domestic violence. Access to these services is generally through one of TVEP’s trauma centers, which are located at state hospitals and which are open 24/7. Since 2001, TVEP has assisted an average of 45 survivors of rape and 80 survivors of domestic violence each month. Nearly 60 percent of those reporting rape are minors and nearly 30 percent are preteens. At these centers, survivors can make a statement to SAPS and receive counseling, a medical examination, and treatment in the same location, with support from holistically trained victim advocates (VAs). When reporting a sexual assault at a TVEP trauma center, victims make their first disclosure to a VA, and the VA remains that victim’s “buddy” for the duration of the case—longer, if needed. VAs are trained as first responders and lay counselors as well as in

trauma center procedures and protocols, medications, basic forensic evidence collection, and related paralegal matters. The VA coordinates the services of all providers, in accordance with protocol. Victims are examined within an hour of their arrival at the hospital and prescribed post-exposure prophylaxis (PEP) if the incident occurred during the preceding 72 hours.

After the survivor leaves the trauma center, the VA follows up and, on the third day after reporting, conducts a home visit to victims who have received PEP, to help ensure adherence; TVEP clients achieve a PEP-completion rate averaging 85 percent. However, most survivors do not return to the trauma center for the post-PEP HIV testing required at six weeks, three months, and six months (and resources for following up with these survivors are limited), so it is difficult to ascertain PEP’s efficacy. To close this gap, TVEP plans to provide training on the finger-prick rapid test to VAs, who are ideally placed for testing during home visits.

With supervision and support from TVEP’s Access to Justice team, the VA also monitors the progress of a survivor’s case through the criminal justice system. Together, the VA and the Access to Justice team ensure that correct procedures are followed and try to minimize the number of case withdrawals; these have diminished radically in number since the introduction of this intervention. When required, TVEP’s legal officers oppose bail or challenge excessive remanding of cases. Court monitors provide support to prepare child and adolescent survivors and their families for court, to familiarize them with all aspects of their upcoming legal proceedings, to minimize trauma and so that they will be effective as a witness. When funding permits, TVEP subsidizes transport for survivors, increasing their access to services, court appearances, and follow-up counseling (provided free by TVEP’s trauma counselors). The Access to Justice team also works closely with the Department of Justice and Correctional Services, facilitating victim offender dialogues (VODs), which form part of the government’s Restorative Justice program. The VODs are a methodology for restorative justice; before a perpetrator is released from prison, meetings are convened between the perpetrator and those hurt—the rape victim, his/her family, people from the community, etc. VODs have proved so successful that the government has asked TVEP to share its methodology so that similar programs can be rolled out nationwide.

- **Other Activities:** In addition to the trauma centers, TVEP manages help desks at 10 rural clinics in Limpopo, effectively expanding its reach to remote areas of Vhembe, Limpopo’s northernmost district. TVEP’s Positive Support Services cluster delivers HIV-related activities with a focus on stigma mitigation, antiretroviral therapy adherence, facilitation of community support groups, and prevention strategies, including social marketing of female condoms. Finally, having determined from its database that 9 percent of known perpetrators of sexual and gender-based violence are children, TVEP also operates a diversion program for young sex offenders as an alternative to prison. Its objective is to prevent recidivism.

Prevention & Empowerment

TVEP prevention and empowerment programming sensitizes and educates all sectors of the community on individual rights and responsibilities with regard to sexual assault, domestic violence, child abuse, HIV and AIDS, and minorities.

TVEP’s flagship empowerment intervention is the Zero Tolerance Village Alliance (ZTVA), a holistic, community-based approach that relies on positive behavior change to eradicate gender-based violence and crimes against children. The ZTVA targets high-crime communities by inviting them to become ZTVA members. Membership requires a community to democratically elect a stakeholder forum that will take full ownership of the project on behalf of the community; TVEP provides technical assistance to guide the process. The stakeholder forum will be trained and assisted to ensure that all state service providers are fulfilling their mandates—that, for example, clinics offer HIV counseling and testing, and that police stations comply with the Victim’s Charter (the Victim’s Charter, developed by the Department of Justice, combines current legal frameworks on the rights of victims of crime with the commensurate services to be provided to them by government and civil society, and outlines seven key rights). As part of ZTVA enterprises, community activists are trained to conduct dialogues on TVEP thematic areas and to encourage individual accountability.

After ZTVA membership criteria have been met, the village is awarded ZTVA status, and community members are invited to publicly pledge zero tolerance for sexual and gender-based violence, child abuse, and HIV-based stigma. This pledge is made in the presence of a magistrate and led by a chief. Witnessing hundreds of men committing themselves in this manner encourages women and children to “break the silence.” Thus, immediately after the intervention, reporting typically increases, and the reduction of sexual and gender-based violence, child abuse, and HIV stigma is sustained as the community takes ownership of both its challenges and the solutions. To expand the ZTVA model to other communities, TVEP has also developed an *e-Toolkit Repository*, which walks organizations through the steps required to effectively adapt and implement the ZTVA model. The Zero Tolerance School Alliance, which follows ZTVA methodology, is being tested in four schools as of December 2015.

TVEP’s unique Initiation School intervention is in its fourth year of testing. For it, local chiefs and traditional surgeons have granted TVEP access to the highly secretive Initiation Schools, where boys are circumcised according to local traditions. Initiates and their mentors participate in four days of rights-based TVEP thematic workshops, with a goal of ensuring that youngsters—while learning to be men—are also made aware of the laws of South Africa, particularly those pertaining to equality and the rights of women and children.

Challenges

Despite TVEP’s success in supporting survivors of sexual and gender-based violence, a number of service-provision gaps remain in the province—principal among them the failure of state stakeholders to deliver services in accordance with their mandates. Despite the fact that South Africa’s constitution and legislation are among the most progressive in the world, implementation remains poor. Services for children are particularly lacking; there are no interventions for children who witness violence in their homes, police often interview child witnesses without a social worker present, and the long-term psychological needs of abused children are not addressed. Limited resources restrict the number of children the organization can reach. TVEP advocates with the government and with community stakeholders for improvement in all these service areas. Additionally, although TVEP operates two short-term shelters for women and children at risk, there is an urgent need for a fully-fledged shelter in the district.

Sustainability

TVEP has resisted pressure to expand into other areas, in the belief that it would be more sustainable to capacitate and mentor other community-based organizations to offer a similar range and quality of services in their own districts. The TVEP sustainability plan further provides for:

- **Downsizing:** Over the long term, the emphasis on holding state service providers accountable should enable TVEP to downsize, with the state increasingly taking over its own responsibilities. As required by the constitution, these responsibilities extend to provision of essential services to victims—or the funding of such services. As of December 2015, less than 1 percent of TVEP’s annual budget was provided by government, despite its acknowledged appreciation of the range and quality of services provided. TVEP has also joined the *Shukumisa Campaign* to lobby for realistic funding for service providers.
- **Accreditation by SETA for Victim Empowerment Programme Training:** TVEP is in the process of acquiring accreditation from the Sector Education and Training Authority. Once achieved, TVEP will be the only training provider in South Africa that can provide both theory and practicums on site.
- **Search for a Long-Term Research Partner:** TVEP’s database holds a cohort of 20,000 cases, more than 7,000 of them pertaining directly to sexual assault. Recognizing the value of this resource, TVEP is actively seeking a long-term research partner that is prepared to subsidize database operational costs in return for access to both current and historical data.

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2. Women and Child Protection Units, the Philippines



In 2013, seven out of ten 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 percent 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 (or PGH), 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 unit 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 Women and Child Protection Unit personnel were defined and training was mandatory (see Box 6).

Box 6. Certificate in Child Protection

This is specifically designed for physicians, social workers and police who are committed to become experts in the field of child abuse. The onsite training at PGH CPU is a total of 6 weeks for physicians and 4 weeks for social workers and police. For those whose duties in their institutions prevent them from taking up courses that would require them to leave work for several weeks, a 15-module program was created which is conducted through a combination of online learning, computer-aided, interactive instruction. The trainee completes the training through a two-week practicum with actual encounter with clients at PGH CPU.

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*. 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 (see Figure 4). 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 adds 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 (see Box 7). 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 are 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.

Box 7. Child Protection Management Information System Database

The Child Protection Management Information System Database is a database system piloted at the PGH CPU to facilitate child protection case management research in the unit as well as in other CPU's across the country. The vision is to create a national surveillance system that will provide ongoing, systematic collection, analysis and interpretation of child maltreatment data for the use in the planning, implementation and evaluation of the serves in the care continuum for child abuse and neglect. This will gauge the magnitude and impact of child abuse and neglect in the general population; identify those how are at highest risk and emerging health concerns; monitor trends; inform the allocation of resources and detect changes in professional practice. Presently, the data collated serves as a resource for country reports to UN bodies such as the UN Committee on the Rights of the Child.

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

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3. 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 seven years of operation from March 2008 to March 2015, 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 treatment and 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:

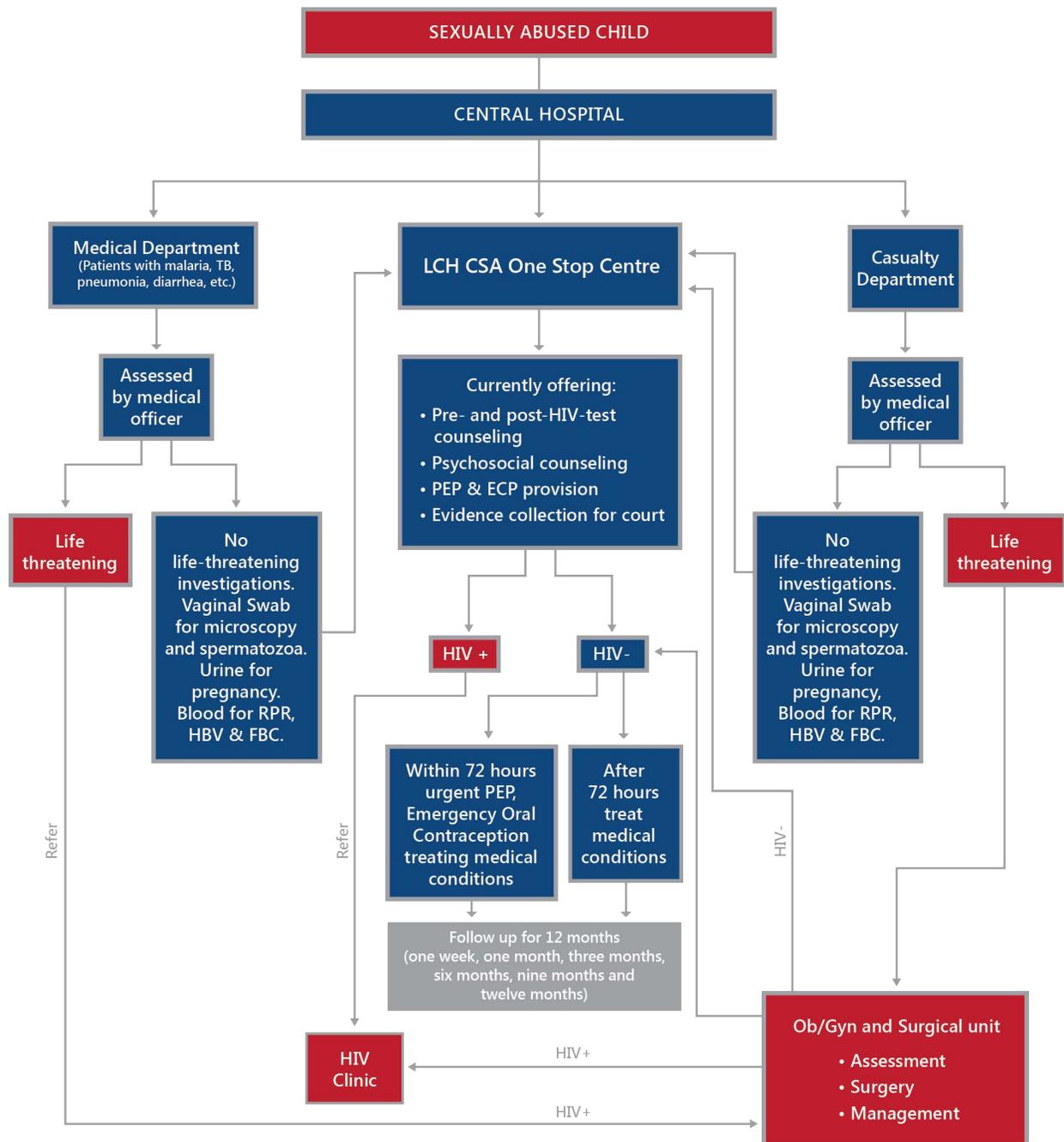
- Child-friendly, multidisciplinary services
- Cultural competency and diversity
- Forensic interviews
- Medical evaluation
- Therapeutic intervention
- Survivor advocacy
- Case review and tracking
- Medical and forensic management on-site: counseling, specimen collection/forensic evidence for court
- 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.
8. 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



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4. 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)⁹



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 unrefereed.

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).¹⁰

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. Another important advantage of this location is that reports from private hospitals are not accepted in court.

⁹ Obinna, Chioma. 2015. *70 Year Old and Baby Among Rape Survivors Treated in Lagos*. Vanguard. Available online at: <http://www.vanguardngr.com/2015/07/70-yr-old-baby-among-rape-survivors-treated-in-lagos-mirabel/>.

¹⁰ Ogundipe, Sola. 2013. *Mirabel Centre confronts sexual assault in Lagos*. Vanguard. Available online at: <http://www.vanguardngr.com/2013/12/mirabel-centre-confronts-sexual-assault-lagos/>

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.

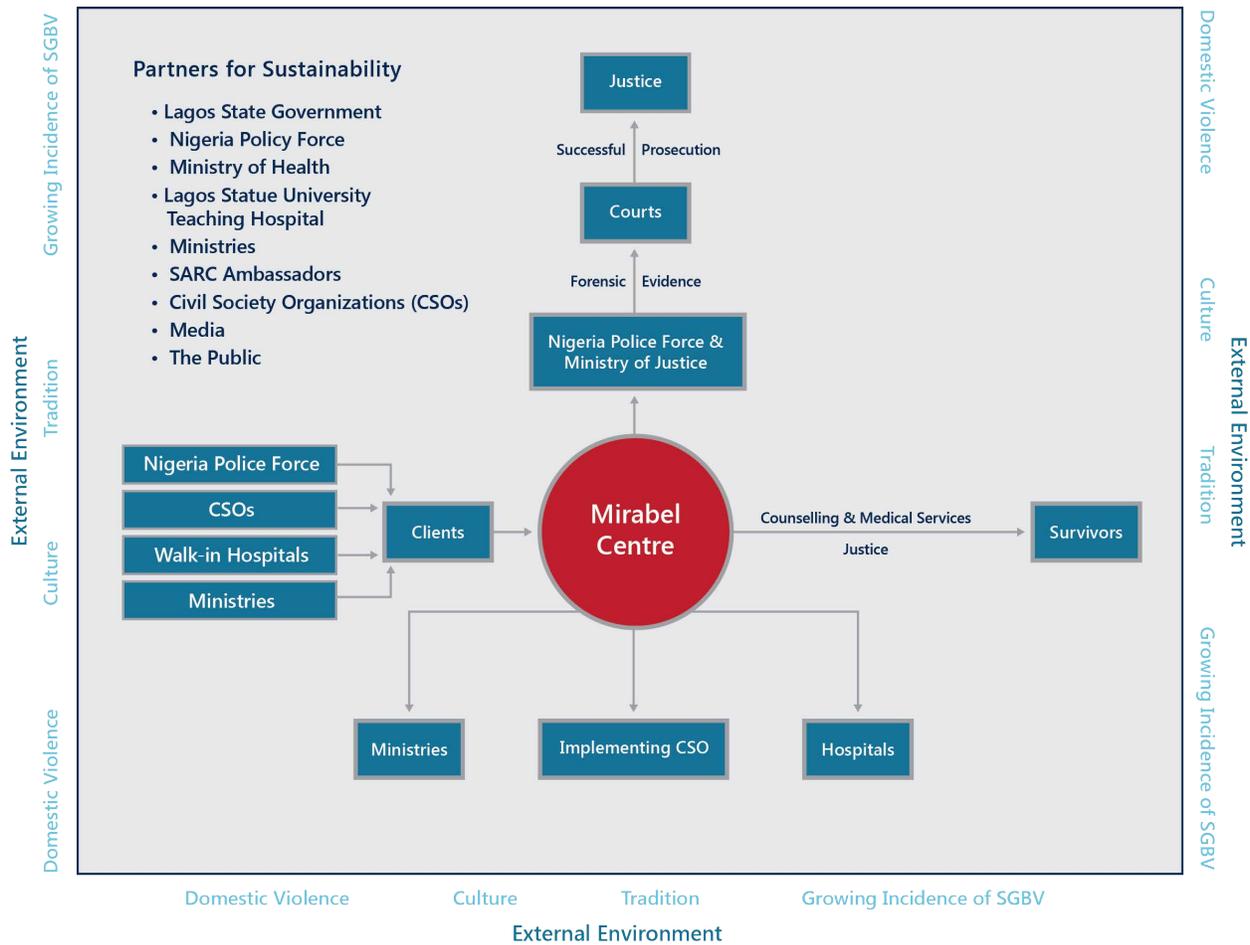
The center provides the following services:

- 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.

COORDINATED APPROACH TO SGBV



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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5. 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 modeling 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 and 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, SWAGAA¹¹ 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 multisectoral collaboration are dissected at a decentralized level by adopting a survivor-centered approach. **Through this mechanism, SWAGAA has worked with government partners¹² and nonprofit organizations¹³ 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

¹¹ Through support from UNFPA and Crossroads International.

¹² Including the Swaziland National Youth Council, the Royal Swaziland Police, the Department of Social Welfare, the Ministry of Education, and the Ministry of Health.

¹³ Such as the National Emergency Council on HIV/AIDS, World Vision, Save the Children, Judiciary, One Stop Centre, Nhlanguano Aids Training Information and Counseling Centre.

piloting a community-based referral network that would form the basis for conversations within the regional referral networks.

The community-based referral network is being piloted in five constituencies (*tinkhundla* centres)¹⁴ in three of the four regions of Swaziland.¹⁵ 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 providers¹⁶ and traditional leadership inner council members.¹⁷ 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, counseling,

¹⁴ Tinkhundla 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 of 5–7 chiefdoms/communities.

¹⁵ The constituencies are Manzini North, Manzini South, and Kwaluseni in Manzini region; Mhlume in Lubombo region; Shiselweni Two in Shiselweni region.

¹⁶ Among the service providers that attend the meetings include community health motivators (*umgcugcuteli*); community police; school committee members; girls' empowerment club mentors and facilitators; community headmen (*indvuna*); representatives from the Domestic Violence, Child Protection and Sexual Offences (DCS) office of the Royal Swaziland Police, the Department of Social Welfare, Diabetes Swaziland, Men Engagement Network Swaziland, Family Health Initiative (FHI 360), Health Communication Collaborative (HC3), and the Council on Smoking, Alcohol and Abuse (COSAD); Members of Parliament; and community child protectors (previously trained by SWAGAA).

¹⁷ Community gatekeepers at the chiefdom level.

court preparation, intermediary services, and court case monitoring services by organization like SWAGAAA is also conducted.

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 Multisectoral 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 Multisectoral 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.

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6. The Teddy Bear Clinic for Abused Children, South Africa



History

The Teddy Bear Clinic for Abused Children works to mitigate and break the cycle of child abuse in South Africa by providing services to both child victims and perpetrators of abuse. It was established in Johannesburg in 1989 in response to an urgent need for medical examinations for sexually abused children. It has since provided services to more than 50,000 children and expanded to eight locations across South Africa. The Teddy Bear Clinic is a rights-based organization that provides essential services to children who have experienced abuse, with the ultimate goal of creating a society free of child abuse. The clinic engages the local community through outreach programs and free-service provision to ensure that all children, including those from families with limited or no income, have access to its programs.

Historically, the Teddy Bear Clinic has supported abused children through a multidisciplinary approach to meet the medical, legal, and psychosocial needs of abused children. This approach comprises forensic examinations, psychological counseling, play therapy, court preparation, diversion, and outreach services. The clinic also develops resources and trainings for other organizations that provide services to abused children in South Africa.

Services

Medico-legal Examinations

The Teddy Bear Clinic's Medico-legal Clinic is a specialized medical facility for children who have been abused or neglected and a training service for medical professionals working in the child protection field. It is based within the Charlotte Maxeke Academic Hospital, and is run by a multi-disciplinary team of pediatricians, doctors, forensic nurses, social workers, and volunteers.

Forensic Assessments

Forensic assessments form the basis of court proceedings in convicting perpetrators of violence against children. They take the form of a structured process where the child is engaged through various techniques, by qualified Social Workers. The aim is to elicit information from the child victim regarding the details of an alleged crime, and then to verify these through collateral sources, such as witnesses and other people known to the victim.

Psychological Assessments

This service was established specifically for children with cognitive disabilities for the purpose of providing them with fair access to the criminal justice system. In the context of sexual abuse

cases, the psychological assessment that has to be conducted depends on the psychological questions posed by the court. In most cases, the psychological assessments are aimed at determining the victims’ mental age as opposed to their chronological age, their capacity to testify with regard to an alleged crime and the impact of the trauma on the victims.

Therapeutic Counseling and Support

Child abuse causes trauma and emotional scars that can have a negative impact on a child’s development and result in long-term consequences. Every child who is a victim of abuse is provided with the opportunity to receive therapeutic counseling and support, which focuses on reducing tension and alleviating any fear and anxiety that the child may have, increasing self-acceptance and releasing the internal resources that will help the child to cope with the trauma. Supportive counseling is also provided to the caregivers of children who have been abused, as our experience has been that the better equipped the caregivers are to cope with the trauma, the better able they are to support the child through the process.

Court Preparation and Support Programme

The Court Preparation and Support Programme (CPSP) supports abused children (3–18 years old) during preparation for and appearance in court. Entering the court system is often a traumatic experience and support throughout the process is critical to an abused child’s healing. Trauma deeply impacts children and may lead them to become unreliable witnesses in court, which may result in low conviction rates of child sexual offenders. CPSP works with children and partners with prosecutors, police, and community volunteers to ensure that perpetrators of child abuse are convicted.

Children who have witnessed sex crimes also experience anxiety about facing the accused. CPSP sees clients for a minimum of three sessions but younger children may have additional sessions depending on their age and level of understanding. The CPSP helps children manage the anxiety of having to recall traumatic events and helps key players in the justice system make clear and informed decisions about each child’s safety and wellbeing.

The support component of the CPSP involves accompanying the child to court, following up with the criminal justice team, giving information to parents, providing snacks, covering transport costs, and a teddy bear for each child. Parents and guardians are involved in the process so they can understand the situation and support to their children. Group therapy gives parents an opportunity to raise concerns and discuss their experiences. Prosecutors and police officers assist by answering the group’s questions. Some parents remain involved so that they can help other parents who are struggling with the same challenges and emotions. Some parents also invited to become involved in media advocacy and serve on local management committees.

A special debriefing session is conducted with the child after s/he has testified to congratulate her/him for his/her courage and to ascertain if the child requires further therapeutic support. The CPSP has proved to be vital and most magistrates who are familiar with the program will not proceed with children’s cases unless the child has first attended the CPSP. Despite low conviction rates in South Africa, CPSP has contributed to increasing the rate of conviction for crimes against children.

CPSP Benefits	CPSP Challenges
<ul style="list-style-type: none"> • Increased conviction rate. • Helps child and family obtain closure after an incident of abuse. • Child has opportunity to tell his/her story. • Parents/caregivers gain skills to manage their child’s trauma and/or behavior. • Children and parents/caregivers feel validated and supported. • Prosecutors and magistrates are sensitized to children’s trauma and development. 	<ul style="list-style-type: none"> • The child protection system is largely under-resourced, which can result in service delays for abuse victims. • Lengthy waiting periods for court hearings and regular postponements means that children must wait to testify. • Exposure to the justice system may have negative impacts on children’s resilience and healing. • Children with disabilities are often unable to testify. • Lack of availability of intermediaries and court interpreters.

Support Programme for Abuse Reactive Children

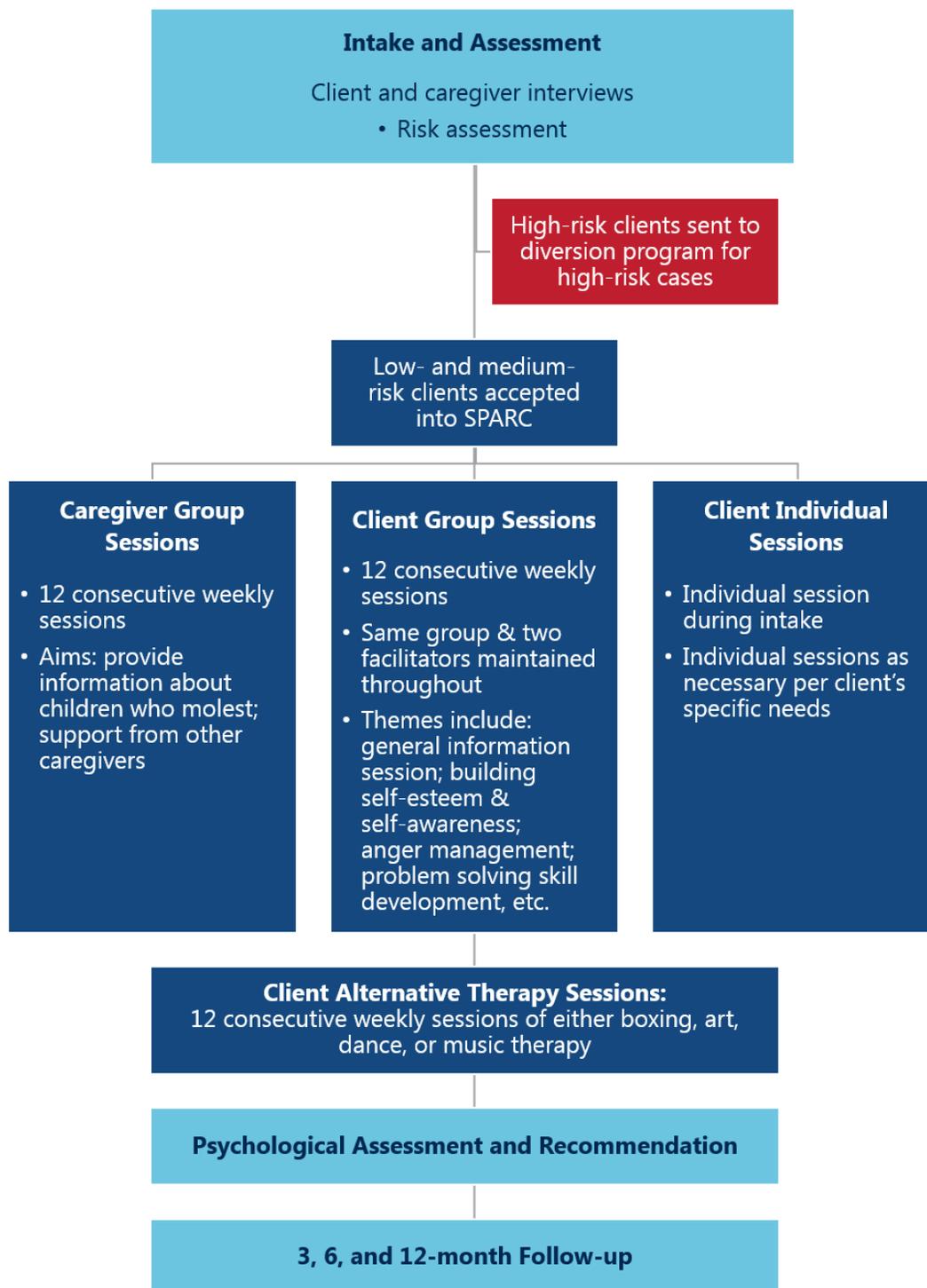
Many cases of child abuse in South Africa are committed by other children. To disrupt the cycle of abuse and prevent the development of adult offenders, the Support Programme for Abuse Reactive Children (SPARC) provides rehabilitation to young sex offenders and complements the CPSP. Clients are referred to SPARC through the court system (involuntary clients), or by parents, schools, or children’s homes (voluntary clients).

SPARC provides a safe and rehabilitative environment for children who have committed sexual offenses or displayed sexually inappropriate behavior. The children are supported to acknowledge and take responsibility for their actions, either before or during program enrollment. By participating in SPARC, the child is protected from the stigmatizing and brutalizing effects of the criminal justice system and does not obtain a criminal record.

SPARC takes place after school and comprises three concurrent 12-week sessions that include caregiver therapy, group therapy, and individual therapy. The children also participate in alternative therapies such as dance, boxing, art, and music. A psychological examination is conducted at the end of the program and SPARC conducts quarterly check-ups for one year.

SPARC Benefits	SPARC Challenges
<ul style="list-style-type: none"> • Provides a court-mandated diversion program and after-school activity for the rehabilitation of child offenders. • Integrating group sessions and creative activities into therapy engages children more effectively than traditional therapy. • The holistic approach offers families and caregivers a support system. • The early intervention model is effective at rehabilitating child offenders. • The highly-trained responsive facilitators, including positive male role models, support and understand participants. 	<ul style="list-style-type: none"> • Referral system faces challenges due to age and risk-level restrictions, as well as low awareness about SPARC’s services. • South Africa does not track child sexual offenders. This limits SPARC’s ability to track program participants and measure long-term effectiveness. • Because of work commitments and stigma associated with child sexual abuse, only 30–50 percent of caregivers attend sessions. • Children may feel isolated after completing the program because they no longer fit in with their negative peer group. In many cases, this isolation leads to eventual regression.

Teddy Bear Clinic Support Program for Abusive Reactive Children (SPARC) Flowchart



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7. Thuthuzela Care Centres, South Africa



History

The Thuthuzela Care Centres (TCCs) were introduced in 1999, after the South African government created an interdepartmental management team (IDMT) to develop a strategy to mitigate rape. Under the leadership of the Sexual Offenses and Community Affairs (SOCA) unit of the National Prosecuting Authority (NPA), the IDMT established sexual offense courts, trained prosecutors and magistrates, conducted outreach campaigns, and introduced the TCCs at major public hospitals.

Services

The TCCs provide emergency medical care, post-exposure prophylaxis (PEP), counseling, and court preparation to people who have been sexually assaulted. Clients may report directly to TCCs or be referred by police, schools, and/or health care workers.

Upon arrival at the care center, the client is welcomed by the site coordinator (SC) who is responsible for liaising with medical and legal service providers and other community stakeholders to ensure effective service provision. The client is assigned a victim assistance officer (VAO), who explains the TCC process and the client's rights during the reporting stage. Once the client understands and agrees to the procedures, a doctor conducts a medical examination. If the client agrees to the medical examination, forensic evidence is gathered according to protocol, and the client is offered a shower and change of clothes. If the exam takes place within 72 hours of the assault, PEP is initiated for those who qualify. The investigating police officer takes a statement and a social worker or nurse offers counselling. The client is given medication and a follow-up date or referral for further medical and/or counselling treatment. If appropriate, s/he is transported home; if not, arrangements for a safe location are made and the person is brought there.

Each client is assigned a case manager (CM), who is responsible for securing the attendance of witnesses, investigating officers, and the accused at court. The CM works to improve relationships in the criminal justice system to expedite case outcomes (within nine months at most), and follows up with the forensic laboratory, psychologists, forensic practitioners, expert witnesses, prosecutors, and the police. The VAO works with community stakeholders to manage the client's case, and informs the client of case status and any change in the perpetrator's status. The SC coordinates meetings between TCC stakeholders to mitigate service delivery problems, maintains a database of people who access services, and submits monthly reports on TCC

activities to the NPA/SOCA provincial coordinator. This coordinated community approach gives the client consistent support and access and referral to essential services.

Challenges

Though the TCC model is widely heralded as a best practice, the centers still face a number of implementation challenges. They are designed for survivors of sexual assault, leaving people who suffer other forms of gender-based violence without services. Some TCCs are only staffed during regular office hours because of limited resources. This is a problem for people seeking services after-hours or on weekends. A core network of nongovernmental organizations is helping these TCCs provide 24-hour services.

The success of the referral system depends upon the ability and willingness of stakeholders to work together. Follow-up appointments and referrals are provided, but clients must get to appointments on their own, which some cannot do. The sheer number of cases and survivors makes it difficult for TCC staff to follow up with all clients.

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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; or 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
- Use of children in pornographic performance and materials (WHO 1999; Weeks and Day 2012).

ANNEX 2: LIST OF RESOURCES/TOOLS

CLINICAL MANAGEMENT GUIDELINES

Clinical Management of Children and Adolescents Who Have Experienced Sexual Violence: Technical Considerations for PEPFAR Programs (U.S. President's Emergency Plan for AIDS Relief)

This document provides step-by-step guidance on the appropriate clinical/forensic care for children and adolescents who have experienced sexual violence and exploitation.

GUIDELINES/TRAINING MODULES FOR PRACTICITONERS (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 (CSS) Guidelines, IRC and UNICEF developed training materials 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 facilitator's 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 user's guide that summarizes how the training materials should be used.

NACOSA Guidelines and Standards for the Provision of Support to Rape Survivors in the Acute Stages of Trauma (NACOSA—Networking HIV/AIDS Community of South Africa)

This booklet introduces a set of norms and standards guiding the provision of post-rape care to survivors in the acute stage of trauma. The guidelines apply to the group of support workers employed by nonprofit organizations in South Africa to help survivors immediately after an incident of sexual violence at health facilities, including the Thuthuzela Care Centres, or victim friendly rooms at police stations. The guidance will also be helpful to health workers, police officers, and any other frontline worker who engages with rape survivors immediately, or soon after, an experience of sexual violence.

Training Manuals for Management of Child Abuse (The Teddy Bear Clinic)

- **Counselling Manual** (September 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** (September 2013): This training manual is for workers supporting children through the children’s court process.
- **Diversion Handbook:** SPARC (Support Programme for Abuse Reactive Children) 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** (September 2013): This manual outlines 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) (Draft form)

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

Curriculum for Provision of Services for Physical and Sexual Violence at One Stop Centres (BRANCH—Building Regional Alliances to Nurture Child Health)

This curriculum is designed with several aims: 1) improving the identification and medical treatment of children and adults who have been physically, sexually, and emotionally abused; 2) increasing communication, information exchange, and networking among multidisciplinary professionals in local private and public agencies and organizations; 3) building and strengthening multidisciplinary teams; and 4) strengthening and expanding existing services through more qualified professionals. The curriculum was tailored for Malawi, but can serve as a foundation for work in other settings.

SAMPLE CLIENT INTAKE FORMS

Sexual Abuse Client Intake Form (TVEP, South Africa)

This sample client intake for from the TVEP)/ South Africa is for intake of clients who have experienced sexual abuse and exploitation.

Intake Form for Statement (The Teddy Bear Clinic)

Intake Form, General (The Teddy Bear Clinic)

SAMPLE CONSENT FORMS

Sample Consent Form for Children and Other Vulnerable Survivors (Zimbabwe Government - Ministry of Health and Child Care)

Sample Consent Form for Therapy (The Teddy Bear Clinic)

Sample Consent Form (not child/adolescent-specific) (WHO), United Nations Population Fund, and United Nations High Commissioner for Refugees. 2004 (revised edition).

Sample Consent Form for Forensic Examination (The Teddy Bear Clinic)

This clinic acts as a consultant of the court and works as a neutral party in assessing children. The evaluators employed by the clinic are not aligned to any single party but work in the capacity of expert witnesses, thus remaining objective about the process.

SAMPLE RISK IDENTIFICATION TOOLS

Risk Identification Tool (Initial Contact) and Risk Identification Tool (at Follow-up) (Zimbabwe Government - Ministry of Health and Child Care/adapted from The Havens London Risk Assessment tool)

These tools are to be used by health providers to assess the survivor’s emotional and mental state and to help make determinations for referrals for counseling or additional support as needed.

Child Sexual Exploitation (CSE) Risk Identification Tool (Zimbabwe Government - Ministry of Health and Child Care)

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 actions required to meet them. 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 includes 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)

This 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 contexts 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)

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.

Coping with Sexual Assault: A Guide for Young People (The Haven Paddington)

This booklet has been written for young people aged 13 to 16 who have been raped or sexually assaulted. The Haven Paddington, at St Mary’s Hospital, is one of three Havens in London providing specialist forensic, medical, and aftercare services for women, men, and children who have been sexually assaulted or raped.

ADVOCACY MANUALS (FOR CIVIL SOCIETY)

Advocacy Manual: A Guide for Survivor Advocates (TVEP)

This guide is a resource for members of civil society who advocate on behalf of others where essential services are not delivered, survivors’ rights are not upheld, and service providers’ responsibilities are not met. It provides 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 (National Child Traumatic Stress Network)

This consumer-focused resource kit 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 (NAPCWA)

This document promotes a comprehensive, child welfare system-wide response to child safety. The document articulates how to define and apply safety concepts; provides an in-depth discussion of the key concepts related to the safety and protection of children; offers a context for how safety fits into all aspects of child welfare work; outlines a clear set of criteria, fundamental patterns of thinking, and steps for keeping children safe; and emphasized the need for continuing and primary focus on safety in all public child welfare policies, procedures, practice guidelines, and administrative processes.

ENGAGING TRADITIONAL LEADERSHIP

The Role of Traditional Leaders in Preventing and Addressing Sexual and Gender-Based Violence: Findings from KwaZulu-Natal, Northwest and Limpopo Provinces in South Africa (Population Council)

The Population Council, in partnership with the Ubuntu Institute, embarked on a program to engage traditional leaders in three South African provinces (North West, KwaZulu-Natal and Limpopo) to address sexual and gender-based violence in rural communities. This report is a summary of their findings.

REFERRAL MAPPING

Template for identifying and mapping potential referral partners (UNFPA, WAVE Network, and European Info Centre Against Violence)

This template provides the basic information that should be collected from potential collaborators.

TRAUMA-INFORMED CHILD WELFARE SYSTEMS

Creating Trauma-Informed Child Welfare Systems: A Guide for Administrators and Trauma-Informed Child Welfare Practice Toolkit (Chadwick Trauma-Informed Systems Project)

This guide was designed as a tool for administrators across child welfare and other child-serving systems who are interested in having their systems become more trauma-informed and responsive to the needs of children and families within the child welfare system who have experienced traumatic events. The guide is part of the larger Trauma-Informed Child Welfare

Practice Toolkit that contains multiple resources designed to assist the child welfare and mental health workforce in creating a more trauma-informed child welfare system. These additional resources include:

- *The Trauma System Readiness Tool (TSRT)*: A community assessment tool that can be completed by individuals within the child welfare workforce to determine the trauma-informed nature of their system.
- *Desk Guide on Trauma-Informed Child Welfare for Child Mental Health Practitioners*: This guide is designed to help child mental health professionals expand their knowledge of the policies, practices, and culture of the child welfare system. *Guidelines for Applying a Trauma Lens to a Child Welfare Practice Model*: These guidelines are designed as a resource for child welfare agencies as they strive to update or articulate their current practice model. The guidelines will provide concrete strategies *on how to update the common aspects of a practice model so that it may become more trauma-informed.*

Developing a Trauma-Informed Child Welfare System (Child Welfare Information Gateway)

This issue brief discusses the steps that may be necessary to create a child welfare system that is more sensitive and responsive to trauma. After providing a brief overview of trauma and its effects, the document covers some of the primary areas of consideration in that process, including workforce development, screening and assessment, data systems, evidence-based and evidence-informed treatments, and funding.

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