CARING FOR CHILD SURVIVORS OF SEXUAL ABUSE TRAINING

FACILITATOR'S GUIDE

SECOND EDITION

INTERNATIONAL RESCUE COMMITTEE

unicef for every child

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

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

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

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

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Federal Ministry for Economic Cooperation and Development

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GUIDANCE NOTE

1. Background

The Caring for Child Survivors of Sexual Abuse Training (Second Edition) is the product of learning and feedback from ten years of implementation of the previous training package, field testing of revised modules and inter-agency technical reviews.

It is recommended that at least two facilitators deliver the training. Due to the sensitive nature of the subject of CCS, not only do the trainers need special knowledge and experience, it is very important they have an appropriate attitude.

The training is intended to be delivered to a group of 25 participants at the most, to allow full interaction and participation of all those attending. Participants should already have knowledge of either GBV case management practice or Child protection case management practice.

2. Objectives of the training.

The overall objectives of the training are as follows:

2.1. Gain a solid foundation of technical knowledge in child sexual abuse using an intersectional framework.
2.2. Strengthen safe and helpful attitudes towards young and adolescent girl and boy survivors of sexual abuse.
2.3. Demonstrate application of CCS guiding principles when navigating key issues in case management to child survivors.
2.4. Increase communication skills in building a healing relationship with child survivors and their non-offending caregivers and providing psycho-social support.
2.5. Foster collaboration between CP and GBV case management actors and strengthen coordination with other multi-sectoral actors.
2.6. Understand the criticality of prioritizing staff care well-being when caring for child survivors of sexual abuse.

3. Modules. The modules of the training include:

Module 0: Opening Session	1.5 hours
Module 1: The Caring for Child Survivors Approach	2.5 hours
Module 2: Core Knowledge Areas	3.5 hours
Module 3: Caseworker Attitudes and Beliefs	2 hours
Module 4: Communication Skills	5 hours
Module 5: Key Issues in Case Management	3.5 hours
Module 6A: Steps of Case Management	5.5 hours
Module 6B: MHPSS Assessment and Interventions	5 hours
Module 7: Coordinating Care for Child Survivors	2 hours
Module 8A: Staff Well-being	1.25 hours
Module 8B: Supervision and Staff-Care (for Supervisors)	1.25 hours
Module 9: Closing	0.5 hours

4. Suggested agendas for implementing the training

The CCS training consists of approximately 35 hours of training content. There are two suggested approaches to implement the CCS training as an in-person, consecutive day training:

7 day in-person option

This option includes 4.5 – 5.5 hours of training content each day spread over 7 days. This option would be best for less experienced caseworkers or contexts in which simultaneous translation will be required to deliver the training. It also allows for more time for self-care practice – either by planning shorter training days or incorporating longer or more frequent breaks. The breakdown is as follows:

Day 1	Module 0	1.5 hours
	Module 1	3.5 hours
Day 2	Module 2	3.5 hours
	Module 3	2 hours
Day 3	Module 4	5 hours
Day 4	Module 5	3.5 hours
	Module 6A (Opening and Step 1)	1.25 hours
Day 5	Module 6A (Steps 2-6)	4.25 hours
Day 6	Module 6B	5 hours
Day 7	Module 7	2 hours
	Module 8A	1.25 hours
	Module 8B (supervisors only)	1.25 hours
	Module 9	.5 hours

5-day hybrid option

This option is best suited for contexts in which participants are experienced caseworkers and will have the capacity to carry out self-learning over the course of the in-person training. It also assumes a longer training day between 6-7 hours inclusive of self-study.

Day 1	Module 0	1.5 hours
	Module 1	3.5 hours
	Module 2 (first half)	1.5 hours
Day 2	Module 2 (second half)	2 hours
	Module 3	2 hours
	Module 4 (first half)	2.5 hours
Day 3	Module 4 (second half)	2.5 hours
	Module 5	3.5 hours
Day 4	Module 6A	5.5 hours
	Module 7 (self-study)	.5 hour
	Module 8 (self-study)	1 hour
Day 5	Module 6B	5 hours
	Module 7 & 8 discussion	0.5 hour
	Module 9	0.5 hour

5. How Facilitator Guidance is Structured

Each module has a PPT presentation with the slides that the facilitator will need for the training. Each module also has a Facilitator's Guide which includes the following information:

» **Overview**
  - Length of the module
  - Key objectives of the module
  - Key messages of the module
  - Materials required (including flip chart, handouts, etc.)
  - Pre-reading (if being assigned)

» **Module Outline** outlines how many minutes each session will take.

» **Contextualization** highlights which PPT slides and other materials will require contextualization for session where relevant.

» **Sessions** is the content the facilitators will need to deliver for the module. Session content is broken down into DO, EXPLAIN and SAY instructions. Slides that accompany the content are always referenced.

Facilitators will need to decide when to place breaks in the agenda.

6. Approach to participant well-being and care

Learning about and discussing child sexual abuse can be emotionally draining and hard, particularly over the course of a five-seven day intensive training. The facilitators should emphasise that while participants are expected to be present to learn and participate, it is also recommended that they priorities their well-being and that facilitators will also be attentive to how participants are doing over the course of the training. Here are some strategies facilitators can incorporate into the training:

» **Set the stage for self-care** in the opening session – when reviewing the objectives of the training, when discussing group agreements – emphasise how important it is that participants check-in with themselves and with each other to see how they are doing throughout the day and with each other. Give them permission to take breaks when they need to.

» **Allot and protect time for structured breaks** – at least two 15-20 minutes breaks in the morning and the afternoon and 1 hour for lunch. Do not compromise this time.

» **Include intentional energizers** that help participants connect with how they are doing and feeling, energizers that allow the participants to move, laugh and connect with each other. Participants often have great ideas for this because they are experienced trainers. Facilitators can ask for ideas or ask for support in carrying these out.

- **Identify** two participants per day who can be **"well-being representatives"** – they will act as listeners, observers and people who check in with the other participants to see how they are doing and can provide facilitators with anonymous feedback at the end of each training day.
- **Assign participants to a self-care buddy** for the training. They commit to checking in with each other throughout the day and the training.
- **Organize activities** that participants can do after the training days – this can be organizing a group dinner one or two nights, a walk outside if the environment allows for it, yoga, dancing, a movie night. Be sure to emphasise that these are not mandatory to attend as some people will prefer to have downtime alone than to be in groups as part of their self-care.

Module 0

OPENING SESSION

1. OVERVIEW

Duration	1.5 hours
Module Aim	To establish a safe training environment where participants feel comfortable and motivated to engage, participate, and learn.
Module Learning Objectives	For participants to: » Get to know the facilitator and one another. » Understand the training objectives and approach. » Agree upon ways of working together during the training.
Key Messages	» The training builds off your existing case management training and experience and prepares you to safely care for young and adolescent girl and boy survivors of sexual abuse. » It is critical to learn the content of the training in context and adapt accordingly while upholding the CCS guiding principles. » You will benefit from the training to the extent that you engage in and contribute to the training. » This training asks a lot of you, so take care of yourselves and do what you need to stay engaged and get the most out of the training.
Materials	» Facilitator's drawing of the fruit/vegetable/food that represents them (to be used as an example). » 1 pre-training assessment per participant (if not completed in advance of the training). » Blank sheets of paper (at least 1 sheet per participant). » Crayons.
Pre-reading	N/A

2. MODULE OUTLINE

Minutes	Activity
40	Welcome and introductions
20	Pre-training assessment
15	Training objectives, approach, and agenda
10	Group agreements
5	Closing

3. CONTEXTUALIZATION

Activity	Slides	Contextualization
Welcome and introductions	1-3	» Invite a prominent child protection and/or gender-based violence colleague to welcome participants, express hope for and commitment to their learning, and officially start the training. » Modify "getting to know each other" activity to one more fitting with the local context as needed.
Pre-training assessment	4	» Review the pre-training assessment in advance and change language for relevancy to local context to ensure participants' understanding of the questions.
Training objectives, approach, and agenda	8-9	» Include training agenda for your training » Review the training logistics and adapt as needed.

4. SECTIONS

Welcome and introductions (40 minutes, slides 1-3)

DO: Show slide 1, welcome participants to the training, and introduce yourself. Have the guest speaker provide opening remarks. Then show slide 2.

4. SECTIONS

Welcome and introductions (40 minutes, slides 1-3)

DO: Show slide 1, welcome participants to the training, and introduce yourself. Have the guest speaker provide opening remarks. Then show slide 2.

SAY: Now we are going to spend some time getting to know one another. We will be doing a lot of group work, role plays, and other activities that require collaboration, so it is important we are comfortable with one another. This training will be most effective if we are able to honestly exchange on challenges and sensitive topics and learn from one another through this process.

DO: Give each participant a sheet of blank paper and some crayons.

EXPLAIN: On the sheet of paper they will draw a fruit, vegetable, or any other food that represents who they are. Provide your own personal example (see below) to help participants understand the request. After participants finish their drawings, they will each go to the front of the room, introduce themselves (name, organization, location they work in), show their drawing, have other participants guess what food/fruit/vegetable it is, and then explain why that particular food/fruit/vegetable represents them. They will also name one expectation they have from this training. Do this until all participants have introduced themselves. Emphasize that participants will have about 1 minute so that you can get to everyone equally.

» Example: Draw a chili pepper on a piece of paper, show it to the participants, and ask them to guess what it is. After a few guesses say, "*My food is a chili pepper because it is small and looks unassuming, but it actually has a lot of spice and heat inside. Similarly, I look quiet and calm on the outside, but inside I have a big passion for child protection and women's protection and empowerment. In addition, we use a lot of chilis to cook in the country I come from.*"

DO: Note down expectations as participants say them – starring those that are repeated.

SAY: Thank you for participating in this activity. Hopefully you got to know one another a little better and will continue to do so throughout this training. We will review your expectations in the next session.

Pre-training assessment (20 minutes, slide 4)

DO: Show slide 4 and hand out copies of the pre-training assessment to each participant.

SAY: Before we dive into the training content, we first need to complete the pre-training assessment.

EXPLAIN: The pre-training assessment is not a test, but a way to understand participants' current competency on caring for child survivors to adapt the training accordingly. Participants should answer as best they can and not worry about their scores.

DO: Give each participant a pre-training assessment and give them 20 minutes to complete it. After all pre-training assessments have been submitted, give each participant a pre-training confidence survey.

Training objectives, approach, and agenda (15 minutes, slide 5-9)

DO: Show slide 5.

EXPLAIN: The CCS guidelines and training were developed over 10 years ago in response to a request from child protection and gender-based violence caseworkers for guidance on how to care for young and adolescent girl and boy survivors who have been sexually abused. The CCS guidelines and training build off the inter-agency Child Protection Case Management Guidelines and Training and inter-agency Gender-Based Violence Case Management guidelines and training. That is why it is a prerequisite that everyone in this training has training and experience in child protection and/or gender-based violence case management.

DO: Show slide 6 and ask for volunteers to read the training objectives aloud. Go back to the expectations that participants identified and clarify any misalignment with training objectives to ensure everyone has the same understanding.

DO: Show slide 7 and review the training approach, explaining the following points:

» Interactive and participatory
    - How much participants get out of the training will be equivalent to how much participants put into the training.
    - Ask for volunteers to keep time, facilitate energizers, do re-cap activities, obtain feedback, etc.

» Feedback and communication methods
    - Facilitators will ask participants for feedback at the end of each training day to adjust the following day as needed.

    - Participants can place outstanding questions in the "parking lot". Facilitators will address these during the training.
    - There will be an overall training evaluation on the last day.
    - Participants can provide feedback to facilitators during breaks, lunch, and/or before or after the training.
- Balance of evidence-based and context
    - CCS was developed from research and best practice from mostly global minority countries. So it is important to balance the training content with the local context, particularly given the sensitivity of child sexual abuse.
    - Participants should continuously consider whether the training content will work in their context and raise concerns so that facilitator(s) and participants can brainstorm together more effective approaches.
- Continuous learning and reflection
    - Participants must learn from a place of humility and curiosity. Participants will be asked to reflect on their own beliefs and ways of doing things, and to learn, unlearn, and relearn.
- The CCS training asks a lot of participants, so participants should do what they need to take care of themselves and stay engaged throughout the duration of the training.

DO: Show slide 8 and go through the training agenda.

DO: Show slide 9 and review the training logistics. Ask if there are any questions before moving on to the next section.

Group agreements (10 minutes, slide 10)

DO: Show slide 10.

EXPLAIN: Now that participants have a better understanding of what will be covered in the training and how it will be facilitated, we need to agree on how we are going to work together during the training.

DO: Write "GROUP AGREEMENTS" at the top of a blank piece of flipchart paper. Ask participants to share ideas on how they would like themselves and everyone else to participate during the training (i.e., "ground rules"). Write down the suggestions on the flip chart paper. Some examples include:

- Take care of yourself.
    - *Consider your own psychological wellbeing – if a story would be distressing to share, consider before you start talking about it.*
- Take care of others.
    - *Respect, listen, and be attentive to others.*

» Take care of yourself.
    - *Consider your own psychological wellbeing – if a story would be distressing to share, consider before you start talking about it.*
» Uphold confidentiality.
    - *Do not mention names or other identifying information when sharing examples or case studies. Also protect the confidentiality of experiences that participants may share.*
» Be curious and listen to understand.
    - *Be open-minded, consider different opinions, backgrounds, and cultural contexts.*
» Be on time and engage.
    - *Do not be on laptops or phones, active participation, etc.*
» Actively create a safe space.
    - *Remember that we are learning together and allowed to make mistakes in this space.*
    - *Be aware of verbal and non-verbal language (facial expressions, tone, etc.).*
» Commit to checking our own biases.
    - *Use discomfort and tension as moments for learning and growth.*
» Give constructive feedback.
    - *Give and receive feedback with grace (oops/ouch) and include positive feedback when providing constructive feedback.*

DO: After there is a comprehensive list of group agreements, ask participants to commit to abiding by the group agreement and post the group agreements somewhere visible in the training room.

Closing (5 minutes, slides 11-12)

DO: Show slide 11 and explain each of the key messages and ensure understanding of participants.

» The training builds off your existing case management training and experience.
    - *And prepares you to safely care for young and adolescent girl and boy survivors of sexual abuse.*
» Contextualization and adaptation of the training content while upholding the CCS guiding principles is critical.
    - *It is critical to learn the content of the training in context and adapt accordingly while upholding the CCS guiding principles.*
» You will benefit from the training to the extent that you engage in and contribute to the training.
» This training asks a lot of you, so take care of yourselves to optimize learning.
    - *Do what you need to stay engaged and get the most out of the training.*

DO: Show slide 12 and ask if participants have any outstanding questions.

PRE/POST TRAINING ASSESSMENT

Name	
Date	
Consent	All responses will be kept confidential. This means that your responses will only be shared with the CCS training facilitator(s). We will ensure that any information we include in our report does not identify any of the respondents. If you have any questions you would like to ask prior to signing the informed consent to complete the pre-training assessment, please do not hesitate to ask your facilitator(s). You can also ask questions for clarification at any time as you complete the assessment. If you have any concerns or complaints to report about the process, you may contact [insert general contact information] and you will be referred to the appropriate person for follow-up. If you are willing to complete the pre-training assessment, please include your signature below. Thank you!
Signature	

A. Foundations and Guiding Principles in Caring for Child Survivors

1. What is child sexual abuse?

A. Foundations and Guiding Principles in Caring for Child Survivors

2. Which types of abuse are considered child sexual abuse? Select all that apply.
   a. Sexually exploiting a child.
   b. Forcing a child to witness sexual violence.
   c. Sexually assaulting a child.
   d. Making a child touch another person's genitals or private parts.
   e. Coercing a child to create or share sexual images or videos.

B. Foundations and Guiding Principles in Caring for Child Survivors

3. Match the signs and symptoms of child sexual abuse to the appropriate age/developmental stage.

Signs/Symptoms of Child Sexual Abuse	Age/Developmental Stage
Unusually attaching themselves to caregivers	Adolescents (ages 10-17)
Difficult to soothe or unresponsive	Toddlers (ages 3-5)
Refusal to go to school or activities	Young children (ages 6-9)
Pregnancy for girls who have begun ovulation	Infants (ages 0-3)

4. What are 4 areas of need that caseworkers must assess for children who have been sexually abused?

C. Beliefs and Attitudes Critical to Helping Child Survivors

5. True or False: If a girl is sexually abused while out on her own and wearing clothes that show too much of her body parts, she is partially to blame for her sexual abuse.

6. True or False: A child may purposefully make up stories about being sexually abused.

7. Why is it critical for caseworkers to have child survivor-friendly beliefs and attitudes when working with child survivors?

D. Engaging and Communicating with Child Survivors

8. What are 3 healing statements you can say to a child who has been sexually abused?

9. What should a caseworker do if a child survivor does not want to talk about their experience of sexual abuse? Select all that apply.
   a. Use non-verbal communication techniques to help the child feel comfortable and safe enough to talk.
   b. Tell the child they must tell you what happened so you can move forward with service delivery.
   c. Ask the child if they would like to have another safe/trusted adult in the room with them.
   d. Reflect on whether you are creating a safe, comfortable, and trusting environment.
   e. Understand that the child does not want to work with you and transfer the case to another caseworker.

E. Key Issues in Case Management with Child Survivors

10. What is the role of the caseworker when it comes to mandatory reporting of child sexual abuse cases? Select all that apply.
    a. Know the mandatory reporting laws or policies in the context.
    b. Explain the mandatory reporting laws or policies to child survivors and their non-offending caregivers.
    c. Understand the risks and benefits of mandatory reporting for child survivors with different identities.
    d. Develop organizational policies on mandatory reporting of child sexual abuse cases.
    e. Work with their supervisor if concerns with mandatory reporting exist.

11. What are areas a caseworker needs to assess to effectively safety plan with a child survivor? Select all that apply.
    a. The child's knowledge of the perpetrator.
    b. The child's support systems.
    c. The child's skills in self-defense.
    d. The child's sense of safety at home.
    e. The child's sense of safety in the community.

12. What are the critical factors a caseworker must understand and explain to child survivors about health services including clinical care of sexual assault? Select all that apply.
    a. The details of the sexual abuse so that the caseworker can determine the health services that are needed.
    b. The time-sensitive nature of clinical management of rape services.
    c. The range of health services depending on the type of sexual abuse, whether the child is experiencing physical pain or injuries, and the child's age, gender, and reproductive stage.
    d. The life-saving nature of clinical management of rape services.
    e. That health services are not available if more than 3 or 5 days have passed since the sexual abuse.

F. Psychosocial Support for Child Survivors

13. Please share 2 relaxation strategies that can be taught to and practiced with child survivors of sexual abuse.

14. What are critical pieces of information a caseworker must include when providing healing education/psycho-education to child survivors and their non-offending caregivers? Select all that apply.
    a. The caregiver's role in the child's healing process.
    b. Common reactions of children after being sexually abused.
    c. Mental health interventions for child survivors and their effectiveness.
    d. Explanation of what child sexual abuse is.
    e. Body safety and safety planning.

G. Case Coordination for Child Survivors

15. Share 3 ways a caseworker can coordinate effectively with other service providers.

H. Supervision and Support When Caring for Child Survivors

16. Effective supervision for caseworkers supporting child survivors includes which of the following characteristics? Select all that apply.
    a. Promotes the well-being of caseworkers, including self- and collective-care.
    b. Provides a safe space for caseworkers to reflect, think, and learn in order to better meet child survivors' needs.
    c. Focuses on disciplinary action for caseworkers who are not able to keep-up with the demands of their cases.
    d. Supports the caseworker to uphold the best interests of child survivors.
    e. Prioritizes quality documentation and reporting for donor accountability.

PRE/POST TRAINING ASSESSMENT

ANSWER KEY

Directions for Scoring:

» Each question is worth 1 point. Since there are 16 questions, respondents can score a maximum of 16 points. 16 points is equivalent to 100%.

» Respondents must get the entirety of each question correct according to the answer key to receive the point for the question.

» The respondent's final score will be the number of questions answered correctly divided by the total number of questions and then multiplied by 100. For example, if a respondent answered 12 questions correctly, then this is how you calculate their score:

- 12/16 = 0.75 x 100 = 75%

A. Foundations and Guiding Principles in Caring for Child Survivors

1. What is child sexual abuse ?
   Child sexual abuse definition: Any form of sexual activity, physical or not, with a child, perpetrated by an adult or by another child who has power over the child. Child sexual abuse often involves body contact, but not always.

   Answer must include all the following elements:
   » Any form of sexual activity with a child.
   » Often involved body contact but not always.
   » Perpetrated by an adult or by another child who has more power.

2. Which types of abuse are considered child sexual abuse? Select all that apply. (highlighted answers are correct)
   a. Sexually exploiting a child.
   b. Forcing a child to witness sexual violence.
   c. Sexually assaulting a child.
   d. Making a child touch another person's genitals or private parts.
   e. Coercing a child to create or share sexual images or videos.

B. Child Sexual Abuse Core Knowledge Areas

3. Match the signs and symptoms of child sexual abuse to the appropriate age/developmental stage.

Signs/Symptoms of Child Sexual Abuse	Age/Developmental Stage
Unusually attaching themselves to caregivers	Adolescents (ages 10-17)
Difficult to soothe or unresponsive	Toddlers (ages 3-5)
Refusal to go to school or activities	Young children (ages 6-9)
Pregnancy for girls who have begun ovulation	Infants (ages 0-3)

4. What are 4 areas of need that caseworkers must assess for children who have been sexually abused? (only need to name 4 out of the 5 below)
   - » Physical and emotional/psychological safety.
   - » Health services.
   - » Psychosocial support.
   - » Safe care arrangements.
   - » Legal/justice support.

C. Beliefs and Attitudes Critical to Helping Child Survivors

C. True or False: If a girl is sexually abused while out on her own and wearing clothes that show too much of her body parts, she is partially to blame for her sexual abuse. **False**

C. True or False: A child may purposefully make up stories about being sexually abused. **False**

7. Why is it critical for caseworkers to have child survivor-friendly beliefs and attitudes when working with child survivors ?
   Answer must include all the following elements:
   - » Caseworkers' beliefs and attitudes impact their behaviors.
   - » Caseworkers with harmful beliefs and attitudes may cause further harm to child survivors.
   - » Caseworkers with helpful beliefs and attitudes will help child survivors recover and heal.

D. Engaging and Communicating with Child Survivors

8. What are 3 healing statements you can say to a child who has been sexually abused? (only need to write 3 of the statements below)
   - » I believe you.
   - » It is not your fault.
   - » I am sorry this happened to you.
   - » You are not alone – I am here to support you.
   - » You are very brave for sharing about what happened to you.

9. What should a caseworker do if a child survivor does not want to talk about their experience of sexual abuse? Select all that apply. (highlighted answers are correct)
   a. Use non-verbal communication techniques to help the child feel comfortable and safe enough to talk.
   b. Tell the child they must tell you what happened so you can move forward with service delivery.
   c. Ask the child if they would like to have another safe/trusted adult in the room with them.
   d. Reflect on whether you are are creating a safe, comfortable, and trusting environment.
   e. Understand that the child does not want to work with you and transfer the case to another caseworker.

E. Key Issues in Case Management with Child Survivors

10. What is the role of the caseworker when it comes to mandatory reporting of child sexual abuse cases? Select all that apply. (highlighted answers are correct)
    a. Know the mandatory reporting laws or policies in the context.
    b. Explain the mandatory reporting laws or policies to child survivors and their non-offending caregivers.
    c. Understand the risks and benefits of mandatory reporting for child survivors with different identities.
    d. Develop organizational policies on mandatory reporting of child sexual abuse cases.
    e. Work with their supervisor if concerns with mandatory reporting exist.

11. What are areas a caseworker needs to assess to effectively safety plan with a child survivor? Select all that apply. (highlighted answers are correct)
    a. The child's knowledge of the perpetrator.
    b. The child's support systems.
    c. The child's skills in self-defense.
    d. The child's sense of safety at home.
    e. The child's sense of safety in the community.

12. What are the critical factors a caseworker must understand and explain to child survivors about health services including clinical management of rape? Select all that apply. (highlighted answers are correct)
    a. The details of the sexual abuse so that the caseworker can determine the health services that are needed.
    b. The time-sensitive nature of clinical management of rape services.
    c. The range of health services depending on the type of sexual abuse, whether the child is experiencing physical pain or injuries, and the child's age, gender, and reproductive stage.
    d. The life-saving nature of clinical management of rape services.
    e. That health services are not available if more than 3 or 5 days have passed since the sexual abuse.

F. Psychosocial Support for Child Survivors

13. Please share 2 relaxation strategies that can be taught to and practiced with child survivors of sexual abuse.
    » Controlled belly breathing.
    » Body relaxation.

14. What are critical pieces of information a caseworker must include when providing healing education/psycho-education to child survivors and their non-offending caregivers? Select all that apply. (highlighted answers are correct)
    a. The caregiver's role in the child's healing process.
    b. Common reactions of children after being sexually abused.
    c. Mental health interventions for child survivors and their effectiveness.
    d. Explanation of what child sexual abuse is.
    e. Body safety and safety planning.

G. Case Coordination for Child Survivors

15. Share 3 ways a caseworker can coordinate effectively with other service providers. (only need to name 3 out of the 4 below)
    » Accompaniment.
    » Follow-up.
    » Case conferencing.
    » Client advocacy.

H. Supervision and Support When Caring for Child Survivors

16. Effective supervision for caseworkers supporting child survivors includes which of the following characteristics? Select all that apply. (highlighted answers are correct)
    a. Promotes the well-being of caseworkers, including self- and collective-care.
    b. Provides a safe space for caseworkers to reflect, think, and learn in order to better meet child survivors' needs.
    c. Focuses on disciplinary action for caseworkers who are not able to keep-up with the demands of their cases.
    d. Supports the caseworker to uphold the best interests of child survivors.
    e. Prioritizes quality documentation and reporting for donor accountability.

Module 1

THE CARING FOR CHILD SURVIVORS APPROACH

1. OVERVIEW

Duration	3.5 hours
Module learning objectives	For participants to: » Begin thinking about child sexual abuse within their context. » Understand foundations of social work case management that inform CP and GBV case management and make up the CCS approach. » Become familiar with the CCS guiding principles in practice. » Reflect on power and identity and how that impacts the healing relationship.
Key messages	» Child survivors must be kept at the center of case management and overall service delivery. » The CCS approach to and guiding principles for case management integrate GBV and CP case management principles and approaches. » The caseworker's ability to establish and maintain trusting relationships with child survivors and their non-offending caregivers is critical to their healing. » Caseworkers must continually reflect on how their power, identities, beliefs, attitudes, and actions may impact the child survivor and non-offending caregiver.
Materials	» Candy or other contextually relevant sweets or small prizes. » Handout 1.1. Guiding Principles of the CCS Approach – 1 per participant » Handout 1.2. Definitions of Case Management – 1 per participant » Handout 1.3. Power Walk Characters – 1 per facilitator » Handout 1.4. My Power – 1 per participant » GBV and CP Case Management Guiding Principles "Jeopardy" • For this activity you can either use the game board on Mural or create the game board with flipchart paper.

<table>
<tr><td></td><td colspan="3">

If using the Mural for the game board, it can be found here.
If creating your own game board on flipchart paper, create a replica of the table below.

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<tr><td></td><td colspan="3">
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<tr><th>CP CM Guiding Principles</th><th>GBV CM Guiding Principles</th><th>Wild Card</th></tr>
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<tr><td>Pre-reading</td><td colspan="3">

» CCS Guidelines Chapter 1
» GBV caseworkers should review the following modules of the Inter-Agency CP Case Management Training – Level 1, Module 1: Foundations of Child Protection, inclusive of the following sections:

What is child protection?
How does the child's environment impact their safety and well-being?
How to adapt to the child's age, developmental stage, and abilities?
What is a child protection risk?

» CP caseworkers should review the following modules of the Inter-Agency GBV Case Management Training:

Module 1 – GBV Basic Concepts
Module 2 – Power and GBV
Module 3 – Consequences of GBV
Module 4 – Causes & Context of GBV
Module 5 – GBV Basics Review

» GBV Case Management Guiding Principles
» CP Case Management Guiding Principles

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2. MODULE OUTLINE

Minutes	Session
5	Opening
35	What is child sexual abuse?
75	CCS approach: Theoretical foundations
60	CCS approach: Guiding principles
30	Reflecting on our own identities
5	Closing

3. CONTEXTUALIZATION

Session	Slides	Contextualization
What is child sexual abuse?	3	» Have a good understanding in the local context of the types of child sexual abuse that are prevalent, social identities of children who are predominantly at risk for sexual abuse, humanitarian and other actors who respond to cases of child sexual abuse, and the quality of the response.
What are the theoretical foundations of the CCS approach?	6-18	» Have a good understanding of the humanitarian case management system as well as other actors in the context who may get involved with or interact with the humanitarian case management system (e.g., government social workers and/or social services agencies, non-humanitarian case management actors, etc.). » Slide 10 (person-in-environment): Think through risk and protective factors at each level relevant to the local context and provide examples if participants cannot think of any. » Include "power walk statements" that are relevant to context. » Adapt "power walk characters" to include those with more or less power in the local context.

CCS guiding principles	22-23	» Review the CCS guiding principles and think through how each might be applied in the local context and the difficulties CP and GBV caseworkers might face in adhering to each principle due laws, policies, social/ cultural norms, religion, available services, etc.

4. SECTIONS

Opening (5 minutes, slides 1-2)

DO: Show slide 1. Explain this module will set the foundation for caring for young and adolescent girl and boy survivors of sexual abuse.

DO: Show slide 2 and read each objective aloud. Ask if participants have any questions.

What is child sexual abuse? (35 minutes, slides 3-5)

DO: Show slide 3.

SAY: In the communities where you live and work, what is child sexual abuse? How would you define or describe it?

EXPLAIN: The term "child survivor" describes young and adolescent girl and boy survivors of sexual abuse. "Child survivor" will be used throughout the training, but participants should be thinking about young and adolescent girl and boy survivors and how sexual abuse impacts them differently.

DO: Discuss the remainder of the questions on the slide with participants for around 15-20 minutes. Additional questions that may help participants to think about child sexual abuse in context are:

» How is sexual abuse understood in your context?
» What is considered sexual abuse?
» What is considered child sexual abuse?
» Which children are considered survivors of sexual abuse in your context?
» Are there any children in your context that are more likely to be blamed if they are sexually abused?
» Are there practices in your context that meet the CCS definition of child sexual abuse but are not considered child sexual abuse?

SAY: Thank you everyone for helping me to get a better understanding of child sexual abuse and the response to it in the communities where you live and work.

DO: Show slide 4 and read the CCS definition of child sexual abuse. Ask participants if they have any questions or need any clarification, and how this resonates based on how child sexual abuse is viewed in the local context.

DO: Show slide 5 and ask participants for examples of each type of child sexual abuse. It may be useful to explain the following:

» Physical contact
  - Rape, penetration of the vagina, anus, or mouth with a penis, another body part, or an object

» Facilitated by technology
  - While these are forms of child sexual abuse listed under physical and non-physical contact, we felt it was important to mention the use of technology to facilitate child sexual abuse.
  - These forms of child sexual abuse are constantly evolving and expanding.
  - The non-physical contact forms of child sexual abuse facilitated by technology can lead to violence consequences for young and adolescent girl and boy survivors.

DO: Ask if there are other forms of child sexual abuse that participants would add to the list that are common in the local context.

SAY: We will dive deeper into what child sexual abuse is and how to respond in the upcoming modules. For now, we are going to focus on some important foundations and principles for caring for child survivors of sexual abuse.

CCS Approach: Theoretical Foundations (75 minutes, slides 6-18)

SAY: As many of you stated in our previous discussion on child sexual abuse, case management is one of the approaches we use to care for child survivors of sexual abuse. What is case management?

DO: Give participants time to respond and thank them for the responses.

SAY: Does anyone know where case management has its roots?

EXPLAIN: The case management approach that GBV and CP actors use today in humanitarian settings is rooted in social work, one of the first professions to use the case management approach for vulnerable populations requiring a range of services across sectors in a coordinated manner. Distribute the Handout 1.2. Definitions of Case Management. Ask a different participant to read each definition.

SAY: Key aspects of social work case management are that it is client-centered, strengths-based, and uses a person-in-environment perspective and a power analysis.

DO: Show slide 6. Ask participants what they think each means.

DO: Review the content on slide 7. If participants are not familiar with the term "client" being used to describe beneficiaries, explain that "client-centered" is used to give power back to those who seek, access, and receive services (versus a charity or benefactor approach where power sits with the person/organization providing the services, funding, or other resources).

EXPLAIN: In the context of CCS, being client-centred also means being child-centred (show slide 8) and surivor centered (show slide 9).

DO: Show slide 10.

EXPLAIN: Person-in environment (also called the socio-ecologcial model) recognizes that:

» The client (child survivor in this case) cannot be separated from their environment nor understood outside of it;
» Services cannot adequately meet clients' needs without considering the context in which they live their daily lives;
» Systemic injustice and oppression underlie many challenges faced by clients.

In addition, at every level there are factors that put clients at risk and factors that exist to protect clients. Ask participants for examples. There are a few examples noted below in case participants are stuck.

» Individual level:
  - Risk factor = client is a separated child
  - Protective factor = child is aware of the safe people in her community and how to reach them for support
» Relationship level:
  - Risk factor = child is being neglected by their non-offending caregiver
  - Protective factor = child has an older sibling, relative, or mentor who safely cares for them
» Community level:
  - Risk factor = the lack of secondary education for adolescent girls
  - Protective factor = women and girls safe spaces where adolescent girls can access livelihood opportunities
» Society level:
  - Risk factor = customary laws/cultural norms that allow the early and forced marriage of girls
  - Protective factor = national and international laws and policies that protect the rights of all children including girls

Caseworkers must be aware of risk and protective factors in the communities where they work and work with clients to identify individual and relationship level risk and protective factors as these will impact the client's ability to recover and heal.

DO: Show slide 11 Power Analysis.

SAY: A power analysis recognizes that child sexual abuse is by definition an abuse of power (power over). It is inherently tied to the power imbalances associated with being a child as well as the dynamics of sexual violence which are rooted in the power differential between the survivor and perpetrator. In CCS case management, this means that caseworkers consistently examine how a child survivor is being influenced by, navigating and accessing power dynamics, including in the helping relationship.

DO: Show slide 12 and ask what is power. Show the points explaining that these are a few definitions.

DO: Show slide 13 and ask about the four types of power that we commonly talk about in GBV work.

EXPLAIN: Understanding the different types of power are critical to GBV work including work with child survivors.

» Power over = The power one person or group uses to control another person or group or to impose decisions on others.
» Power within = The strength that arises inside ourselves when we recognize the equal ability within all of us to positively influence our own lives and the community.
» Power with = The power felt when two or more people come together to do something they could not do alone.
» Power to = The belief and actions that individuals and groups use to create positive change.

DO: Distribute the Handout 1.4. My Power to participants and ask them to reflect on their own examples of the four types of power for a few minutes. For "power over", ask them to think about a time someone had power over them and how it felt.

EXPLAIN: Understanding power and particularly "power over" is critical to working with child survivors because they have experienced someone (the perpetrator) having power over them and taking power from them. We want to make sure that we are not another person in their lives who has power over them and takes power from them by making decisions for them. Instead, we want to facilitate case management in a way that gives power back to child survivors and their caregivers.

DO: Show slide 14 and explain that we are going to do a group activity to better understand how the different parts our identities intersect to give us more or less power. Ask for volunteers, hand-out the power walk characters to them, and ask them to read their characters to themselves. Direct all the volunteers to stand in a row on an imaginary horizontal line in the middle of the room and read the directions. Then show slide 15 and read each statement aloud, giving volunteers time to take steps forward or back. After all statements have been read, have the volunteers reveal their characters and then show slide 16 and go through the debrief questions.

DO: Show slide 17 on strengths-based approach and review the content. Additional points that may clarify how we care for child survivors through case management are that we:

» Integrate the child- and survivor-centered approaches of CP and GBV case management.
» Make every effort to enter a child survivor's world and to view things from their perspective.
» Hold the reality that child survivors may not have the capacity to understand the entirety of their situation and the information being shared with them depending on their age, developmental stage, and other factors.
» Are always guided by the best interests principle, which necessitates consulting with and taking into serious consideration the perspective of the child and non-offending caregiver when making decisions.

EXPLAIN: That in addition to the key aspects already discussed, there is one additional key aspect that is critical to the case management approach: the client-caseworker relationship as a therapeutic intervention.

DO: Show slide 18.

EXPLAIN: Quality case management is inherently a form of psychosocial support for child survivors and their non-offending caregiver(s) because the client-caseworker relationship services as a vehicle for alleviating distress and enabling change in the child. This is why the client-caseworker relationship is often called a "healing relationship". How a caseworker responds to and relates to a child survivor can have a helpful or harmful impact on the child's ability to recover and heal from sexual abuse.

CCS approach: Guiding principles (60 minutes, slides 19-22)

DO: Show slide 19.

SAY: Since casework is impacted by who we are as individuals and how we relate to others, principled approaches are critical to safely and effectively care for child survivors. What do you think "principled approaches" means?

SAY: Case management is the overall approach we are using to respond to child survivors of sexual abuse. The case management approach, however, should be adapted to your target client population. For example:

» Child protection case management must be adapted to the needs of children, taking into consideration their rights, developmental capacity to make informed decisions, parental rights, child protection laws and policies, etc.
» GBV case management must be adapted to the needs of women and girls, taking into consideration the gender discrimination and abuse of power they faced in their experience of violence and that they continue to face in their daily lives.

Both GBV and CP case management have their own guiding principles that establish a framework for expected values, behavior, and decision-making.

EXPLAIN: Everyone should be familiar with GBV and CP case management guiding principles as this is something that the CCS toolkit recommends before engaging in the CCS training. In order to see how well-versed everyone is in both CP and GBV case management guiding principles, we are going to play a game.

DO: Show the participants either the Mural or paper version of the "Jeopardy" game.

EXPLAIN: Each team will choose a category ("CP CM Guiding Principles", "GBV CM Guiding Principles", "Wild Card") and the number of points they want to answer a question for. *For example, the team can say: "I'd like to CP CM for 20 points"*. The facilitator will then read the sentence relevant to that category and points and ask the team to share the guiding principle or approach the sentence describes. *For example, if the facilitator says "This principle ensure that actions and interventions designed to support the child do not expose them to further harm", the correct answer the team needs to response with is: "Do No Harm"*. If the team does not answer correctly, they lose the number of points associated with the question and another team can answer the question and score the points. The question statements, answers, and points can be found in the table below. (30 minutes)

CP CM Guiding Principles	GBV CM Guiding Principles	Wild Card
Question Statement: This principle demands that children and their non-offending caregivers fully understand the services and options available, potential risks and benefits, how information will be used, and confidentiality and its limits. Answer: Seek Informed Consent and/or Informed Assent Points: 10	Question Statement: Which principle guides caseworkers to consider and strengthen clients' physical and psychological security, as well as the security of the people they care about? Answer: Right to Safety Points: 10	Question Statement: Which approach entails providing services in ways that are appropriate and accessible for children? Answer: Child-Friendly Approach Points: 10
Question Statement: We often use the phrase "on a need-to-know" basis for this guiding principle. Answer: Respect Confidentiality Points: 20	Question Statement: This principle reflects the belief that people have the right to choose to whom they will or will not tell their story. Answer: Right to Confidentiality Points: 20	Question Statement: CP case management and GBV case management share this guiding principle. Answer: Non-Discrimination Points: 20
Question Statement: This principle highlights that children and families possess resources and skills to help themselves contribute positively towards finding solutions to their own problems.	Question Statement: Respecting a client's right to decline case management services or choose whether or not to access legal or other support services upholds which guiding principle?	Question Statement: Which approach upholds the right for clients, appropriate to their age and circumstances, to decide who should know about what has happened to them and what should happen next in the case management process?

Answer: Empower Children and Families to Build Upon Their Strengths Points: 30	Answer: Right to Dignity and Self-Determination Points: 30	Answer: Survivor-Centered Approach Points: 30
Question Statement: Care should be taken to avoid creating conflict between individuals, families, and communities. What principle does this reflect? Answer: Do No Harm Points: 40	Question Statement: Caseworkers can uphold this guiding principles by using a validating, non-blaming, and non-judgmental approach, and providing clients with unconditional care, support, and respect. Answer: Right to Dignity and Self-Determination Points: 40	Question Statement: This principle must guide all decisions made during the case management process for child survivors of sexual abuse. Answer: Best Interests of the Child Points: 40
Question Statement: This principle guides caseworkers to uphold the right of children to not answer questions that make them uncomfortable. Answer: Facilitate Meaningful Participation of Children Points: 50	Question Statement: The GBV approach, training, and skills have been developed with women and girls as the primary intended clients. Does this violate the principle of non-discrimination? Answer: No, because GBV caseworkers will never deny services to men and boys. Points: 50	Question Statement: True or False: The guiding principles are interrelated and mutually reinforcing. There is no one guiding principle that is prioritised over any other guiding principle. Answer: True Points: 50

DO: Congratulate all teams for a job well done and then show slide 20.

EXPLAIN: The CCS Guiding Principles were derived from the CP and GBV guiding principles.

DO: Show slide 21 and explain that all guiding principles aim to ensure that caseworkers do no further harm to child survivors. Talk through each CCS guiding principle, showing how the principles integrate the CP and GBV case management guiding principles. Ask if participants have any questions. Then show slide 22.

EXPLAIN: That participants will do a group activity to familiarize themselves with the CCS guiding principles and think about how to put them into practice – ask them to reflect on what they may find challenging about putting that principle into practice. Each group will be given two guiding principles and will have 20 minutes to identify concrete examples of how they have/or can put that guiding principle into practice. Each group will then give a few minutes to present their work.

DO: Break participants up into 4 groups and give each group two principles (one group will need to be assigned three). Give groups 20 minutes to do the group work. After 20 minutes, bring the groups back together in plenary and give each group 5 minutes to present their case and how they would uphold the CCS guiding principles. Give other groups the opportunity to ask questions and provide suggestions after each presentation. Once all groups have presented, thank the groups and remind them that the guiding principles are interrelated and mutually reinforcing.

Reflecting on our own identities (30 minutes, slides 23-25)

SAY: Before we end our first day, we want to take a few minutes to reflect on ourselves and how we are showing up to this work. This can help us establish healing relationships with child survivors.

DO: Show slide 23 and ask what the word "identity" means. Show the definition and highlight key terms in the definition (characteristics, roles, groups, society, etc.). Then show slide 24.

EXPLAIN: The different components that make up someone's identity.

» Characteristics – socio-cultural and biological characteristics (e.g., sex, age, gender identity, religion, disability, etc.); not personality traits (e.g., nice, kind, generous, etc.).
» Environmental factors – parts of a person impacted by the greater ecosystem in which they exist (e.g., language, accent, nationality, nomadic, pastoral, etc.).
» Roles – who we are in relation to other people; often based on our daily activities (e.g., parent, teacher, community leader, sibling, etc.)

EXPLAIN: We are now going to do an activity to help us reflect on our own identities.

DO: Show slide 25 and hand out blank sheets of paper, explain the directions, and give participants a few minutes to complete the activity. Ask if anyone would like to share any reflections from the activity.

EXPLAIN: Identity is a large part of what makes us who we are. Some parts of our identity provide us with opportunities and power, while others restrict our power and opportunities. It is important to understand this as we think about how to create healing relationships with child survivors.

Closing (5 minutes, slides 26-27)

DO: Show slide 26 and read the key messages. Let the participants know that the guiding principles will continue to be a theme that we discuss throughout the training as we get deeper into the case management process.

DO: Show slide 27 and ask if there are questions about anything covered in the module.

HANDOUT 1.1. GUIDING PRINCIPLES OF THE CARING FOR CHILD SURVIVORS APPROACH

The CCS approach is also made up of specific guiding principles that represent best practice from both the CP and GBV sectors which should guide how caseworkers work with child survivors of sexual abuse:5

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

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

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

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

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

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

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

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

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

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

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

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

HANDOUT 1.2. DEFINITIONS OF CASE MANAGEMENT

Social work-based case management is a systematic process in which a trained and supervised caseworker assesses the needs of the client and, when appropriate, assesses the client's family. The caseworker will then arrange, sometimes provide, coordinate, monitor, evaluate, and advocate for a package of multiple services to meet the specific client's complex needs (NASW Standards for Social Work Case Management, 2013). Social work caseworkers work with diverse and often vulnerable clients in a broad range of specializations and settings, including CP and GBV in humanitarian settings. Depending on the specialization, the approach to case management may shift to ensure the best possible care for the particular client population.

GBV case management is a structured method for providing help to a survivor. It involves one organization, usually a psychosocial support or social services actor, taking responsibility for making sure that survivors are informed of all the options available to them and that issues and problems facing a survivor and her/his family are identified and followed up in a coordinated way, and providing the survivor with emotional support throughout the process. Because GBV results in harmful physical, emotional, and social consequences that often require information and care from multiple service providers, social work case management has become an integral part of the response to GBV in humanitarian settings. Case management has also become the primary entry point for survivors to receive crisis and longer-term psychosocial support, given the lack of more established health and social support service providers in humanitarian settings. (Inter-Agency GBV Case Management Guidelines, 2017)

CP case management is a way of organizing and carrying out work to address and individual child's (and their family's) needs in an appropriate, systematic and timely manner, through direct support and/or referrals, and in accordance with a project or project or program's objectives. CP case management should focus on the needs of an individual child and their family, ensuring that concerns are addressed systematically in consideration of the best interests of the child and building upon the child and family's natural resilience. CP case management should be provided in accordance with the established case management process, with each case through a series of steps involving children's meaningful participation and family empowerment throughout. (Inter Agency Guidelines for Case Management and Child Protection, 2014)

HANDOUT 1.3. POWER WALK CHARACTERS

Directions

1. Review the characters in the table below and make changes to ensure characters relevant to your context are included.
2. Print the table.
3. Cut out each individual character so that you can hand one character to each volunteer for the activity.

A 12 year old deaf girl left in a care home every day.	A 17 year old boy living with his biological parents.	A 15 year old girl who is soon to sit her school exams.	A 35 year old male teacher.	A 45 year old female school head teacher.
An 8 year old boy in an orphanage.	An 11 year old girl living on the streets of the capital city.	A 40 year old man who lives in a conflict affected area.	A boy who has lost his parents when fleeing an earthquake.	An NGO worker.
A 15 year old boy fleeing from conflict.	A policeman.	A 60 year old woman in a conflict affected area.	A taxi driver.	The President.
A 9 year old boy living with his two biological parents.	A 14 year old girl in a wheelchair left at home alone most of the day.	A 35 year old woman who works as a waitress in a bar at night.	A 15 year old autistic girl living in a residential care home.	A social worker.
A doctor.	A 14 year old boy who goes to school every day.	A 14 year old girl working in a bar at night.	A member of the national army.	A man who owns a bar.

A two year old girl living with her step father and step siblings.	A 28 year old woman who lives with her husband, two children & her parents.	A 14 year old boy who works in a nightclub dancing for customers.	A 13 year old girl living in an internally displaced people's (IDP) camp.	An 8 year old girl who sells tissues to restaurant customers at night.

HANDOUT 1.4. MY POWER

Power Over

Power With

Power To

Power Within

Module 2

CORE KNOWLEDGE AREAS

1. OVERVIEW

Duration	3.25 hours
Module Learning Objectives	For participants to: » Know the core child sexual abuse knowledge areas. » Understand the importance of the core child sexual abuse knowledge areas. » Consider the core child sexual abuse knowledge areas in their context.
Key Messages	» Caseworkers must have a strong understanding of the core knowledge areas to provide services that are in the best interests of child survivors. » Understanding power dynamics is critical to understanding risks child survivors face. » Age, development, and gender impact children's experiences of abuse, access to services, and prioritization of needs. » Signs and symptoms are indicators that a child may have been sexually abused. » Disclosing sexual abuse is very difficult for children and is a process. » Caregivers are also impacted by child sexual abuse and need support.
Materials	» Exploring Handout 2.1. Exploring Barriers to Disclosure – 1 per participant » Exploring Handout 2.2. Exploring Barriers to Disclosure – 1 per facilitator » Handout 2.3. Disability and Impairment – 1 per participant

	» The following supplemental materials have also been provided if facilitators would like more information and examples to include in the training on the following areas: • Typical child development. • Teaching children about sexual development. • Video of a role play on caring for non-offending caregivers of child survivors.

2. MODULE OUTLINE

Minutes	Session
10	Opening
5	Knowledge Area 1: Definition of child sexual abuse
10	Knowledge Area 2: Scope of the problem
10	Knowledge Area 3: Perpetrators of child sexual abuse
30	Knowledge Area 4: Children and sexual abuse disclosure
5	Knowledge Area 5: Needs of child survivors
40	Knowledge Area 6: Gender and child sexual abuse
60	Knowledge Area 7: Age, development, and child sexual abuse
15	Knowledge Area 8: Intersectionality and child sexual abuse
15	Knowledge Area 9: Risk and protective factors related to the impact of child sexual abuse
5	Knowledge Area 10: Impact of child sexual abuse on non-offending caregivers
5	Closing

3. CONTEXTUALIZATION

Activity	Slides	Contextualization
Knowledge Area 1: Definition of child sexual abuse	6-7	» Highlight where and how cultural and contextual understandings of child sexual abuse do and do not align with the CCS definition. For example: • The acts or scenarios that may be acceptable to the culture/not viewed as child sexual abuse that are considered abuse under the CCS definition. • How views of child sexual abuse may change if the child is a girl or a boy, or if the child is younger or older (in adolescence). • What laws/policies of the country say and whether local beliefs align with these AND whether these laws/policies align with the CCS definition.
Knowledge Area 2: Scope of the problem	10	» Populate with non-identifiable, locally-available data on child sexual abuse from sources such as GBVIMS, CPIMS, etc.
Knowledge Area 3: Perpetrators	12-13	» Be aware of any sensitivity in the local context regarding perpetrators – particularly with government or armed groups – and adapt slides and discussion accordingly.
Knowledge Area 4: Children and disclosure	19	» Read and adjust the case studies for "exploring barriers to disclosure" to be relevant to the local context. If you adjust the case studies, adjust the answer key for facilitators as well.

Knowledge area 5: Gender	24-26	» Ensure gendered norms and stereotypes and gender-specific risk factors that impact disclosure, reporting, and access to services are highlighted. » If gender-expansive identities (e.g., genderfluid, genderqueer, non-binary, agender) are recognized in the local context and it is not an issue that will put the facilitator(s) and participants at risk, in the groupwork add two additional groups – "young gender-expansive children" and "older gender-expansive children" – and modify slides.
Knowledge area 6: Age/ developmental stage	29-34	» Be aware of evolving capacities and that in the local context, children may behave and have responsibilities outside of "typical" child development which will impact signs/symptoms of abuse – e.g., girls married in early adolescence, girls and boys work and may not attend school, girls and boys may be heads of their households, etc. » Adapt Handout 2.3. Disability and Impairment to be appropriate for local context in terms of language, examples of disabilities more prevalent locally, etc. » If needed/helpful and appropriate to context, slides on "typical" child development and teaching children about sexual development are in the supplemental materials folder.
Knowledge area 9: Impact on non-offending caregivers	44-46	» Have an understanding of parenting culture and practices in the local context, as well as common reactions to child sexual abuse and whether this differs based on the child's gender, age/ developmental stage, disability, marital status, etc.

4. SESSIONS

Opening (10 minutes, slides 1-4)

DO: Show slide 2 and review the objectives of Module 2.

SAY: Today we are going to learn about and discuss core knowledge areas that are an essential part of caring for child survivors of sexual abuse.

DO: Show slide 3. Read the themes of the core knowledge areas.

DO: Show slide 4. Using the points on the slide go over why the core knowledge areas are important.

Knowledge area 1: Review of Child Sexual Abuse Definition and Types (5 minutes, slides 5-7)

DO: Show slide 5.

EXPLAIN: We already covered this in our session yesterday so we will very briefly review this content (covered in Module 1).

DO: Show slide 6 and review the definition, ensuring comprehension.

DO: Show slide 7 and ask for examples of each type of sexual abuse (physical, non-physical, technology-facilitated) as you move through each type.

Knowledge area 2: Scope of Child Sexual Abuse (10 minutes, slides 8-10)

DO: Show slide 8.

EXPLAIN: The second core knowledge area is to understand the prevalence of child sexual abuse globally and locally.

DO: Show slide 9 and ask for volunteers to read each of the bullet points aloud.

SAY: Is anything surprising. If yes, what? Do the statistics differ from what they believed/thought? How do the statistics resonate with what is happening locally?

SAY: Although the figures for child sexual abuse are high, the reality is that the number of children who have been sexually abused is much higher because many incidents go unreported.

Underreporting for girl survivors is common in most contexts.

DO: Show slide 10 and go through the data points. Ask participants to reflect on the local data by asking if the data aligns with what they discussed yesterday or if they find anything surprising about the data, etc.

DO: Ask participants why the global and local prevalence of child sexual abuse is important for them to know.

SAY: Understanding the scale of the issue of child sexual abuse is important to raise awareness that child sexual abuse happens everywhere and at alarming rates, recognize that it is a problem that needs to be addressed, and reduce stigma, shame, and blame that child survivors and families may face.

Knowledge area 3: Perpetrators of child sexual abuse (10 minutes, slides 11-13)

DO: Show slide 11. Explain that now we will talk about who most commonly perpetrates child sexual abuse.

SAY: Think back to the exercise we did on power yesterday. Power is directly related to perpetrators of child sexual abuse. Perpetrators often hold identities that have more power.

DO: Show slide 12 and ask:
» Who amongst the characters in the power walk was a potential perpetrator?
» Who are perpetrators in this context?

DO: Show slide 13.

SAY: These are common characteristics of perpetrators. Perpetrators of child sexual abuse always hold more power than child survivors. They are most often within or close to the family or someone else the child trusts. In conflict-related sexual violence, perpetrators may also be non-state armed groups such as police, security entities, local militias, traffickers, etc.

Knowledge area 4: Children and disclosure of sexual abuse (30 minutes, slides 14-22)

DO: Show slide 14 and say the next core knowledge area is disclosure of child sexual abuse. Show slide 15 and ask participants to share what disclosure means and the difference between direct and indirect disclosure and to provide examples.

SAY: Some examples of indirect/third party disclosure are someone witnessing a child being sexually abused, a doctor observing that a girl is pregnant or that a girl or boy has a sexually transmitted infection, or a community member hearing about the sexual abuse and reporting it.

DO: Show slide 16.

SAY: Different from child protection case management, we do not identify girls and boys who have been sexually abused because of the sensitivity of the issue and could put the child, family, and caseworker or community member at risk of harm. Instead, we stay aware of signs and symptoms of sexual abuse. If we suspect sexual abuse due to the signs and symptoms, we discuss with our supervisors the safest way to move forward.

DO: Show slide 17 and ask participants to share what voluntary and involuntary disclosure are and to provide examples. Then show slide 18 and ask participants why it is important for caseworkers to know how the sexual abuse was disclosed.

SAY: It is important for caseworkers to know how the sexual abuse was disclosed because it may give an indication of how willing a young or adolescent girl or boy survivor will be to engage with the caseworker and receive services. For example, if the child voluntarily and directly disclosed the sexual abuse, they will likely be more willing to engage in services. If the disclosure was an involuntary, third-party disclosure (e.g., doctor observes a girl is pregnant and tells a caseworker), the child may be angry, scared, etc. and less willing to speak with the caseworker and engage in services. In addition, if the child receives a non-judgmental and caring reaction to their disclosure, is asked about their needs, and provided with information about relevant services, they will likely feel safe to continue engaging in services. If the reaction to the disclosure is one of judgement, shock, anger, fear, etc., and the child is scolded, punished, or the incident is shared with others without the child's assent/consent, then the child may retract their disclosure or be hesitant or refuse to continue with services.

DO: Show slide 19 and explain that we will explore barriers that child survivors have in disclosing sexual abuse. Read the directions for the group work, hand out the case studies (participant version), and give a few minutes for the groups to work on the activity. Have the groups share key points in plenary and include any points not covered from the answer key.

DO: Show slides 20 and 21, covering any points not already mentioned in the plenary discussion on the group activity. Then show slide 22 and emphasize the difficulty in disclosing sexual abuse and that it is a process.

Knowledge area 5: Needs of child survivors (5 minutes, slides 23-24)

DO: Show slide 23 and say that the next core child sexual abuse knowledge area is the needs of the child survivors. Show slide 24.

EXPLAIN: The child's recovery requires both immediate response to critical needs and longer-term responses and support.

SAY: List and explain each need – what will be the role of the service provider?

Knowledge area 6: Gender and child sexual abuse (40 minutes, slides 25-28)

DO: Show slide 25 and say that the next core child sexual abuse knowledge area is gender.

SAY: In Module 1 we talked about the impact of the different identities we hold. Today we are going to dive deeper into one particular characteristic: gender.

DO: Show slide 26. Divide the participants into four groups and assign each group a category and give them 20 minutes to discuss and write down answers to the questions on the slide on flipchart paper. After groups are done, do a gallery walk with participants and ask them to note highlights.

DO: After the gallery walk show slide 27 and go through key points. Ask participants if they would like to add anything.

SAY: Child sexual abuse is gendered and sexual abuse of girls is rooted in gender inequality. Patriarchal social norms normalize sexual violence against girls.

DO: Show slide 28 and go through the points. Ask participants if they would like to add anything.

Knowledge area 7: Age, developmental stage, and child sexual abuse (60 minutes, slides 29-36)

DO: Show slide 29 and say the next core child sexual abuse knowledge area is age and developmental stage. Show slide 30.

EXPLAIN: Participants will be broken up into 5 groups. Each group will be assigned a developmental stage. On flip chart paper, they should create a table like the one on the slide and populate it with behavioral, emotional, physical, and sexual signs and symptoms of abuse for girls and boys in the developmental stage they've been assigned. The group assigned with "children with disabilities" should think about the different types of disabilities girls and boys may have and will be provided a Handout 2.3. Disability and Impairment of the different types of disabilities.

DO: Give the groups 20 minutes to complete the activity. Ask for two representatives from each group to explain their chart in plenary beginning with Infants (0-3) and going chronologically by developmental stage, ending with children with disabilities. After each group's presentation show the relevant slide (from slides 31-35) covering any points not covered and correcting any information (you will have about 5 minutes in total for each developmental stage). As you progress through the exercise, pointing out signs and symptoms that remain the same and highlight key signs and symptoms that are different for each developmental stage.

DO: Show slide 36 and highlight the key points to remember for this knowledge area.

Knowledge area 8: Intersectionality in Child Sexual Abuse (15 minutes, slides 37-39)

DO: Show slide 37. Ask if anyone has heard of the term "intersectionality" and can share what they know about it. Allow a few participants to respond.

DO: Show slide 38. Read the definition of intersectionality.

SAY: Let's reflect back on the Power Walk from yesterday and the reflection on our own identities. Intersectionality requires that we understand the relationship between power and identity.

DO: Show slide 39. Ask participants why understanding the relationship between power and identity is important for providing quality care to child survivors of sexual abuse. Go through the points on the slide.

SAY: We will continue to come back to the concept of intersectionality throughout this training as we consider how holding different identities and their relationship to power impacts child survivor's needs, their access to services and the way in which we as service providers need to provide services.

Knowledge area 9: Risk and Protective Factors related to the impact of child sexual abuse (15 minutes, slides 40-45)

DO: Show slide 40 and say the next core knowledge area is understanding risk and protective factors related to the impact of child sexual abuse.

DO: Show slide 41 and ask participants what categories of services children generally need if they have been sexually abused. Review the points on the slide.

SAY: Not all child survivors will have the same needs. If you think about our discussion on intersectionality, what factors affect the needs a child survivor may have? What are some examples?

SAY: The needs of a child survivor will likely be different depending on their gender, age, disability status, etc. There are also other factors that can influence the impact of child sexual abuse on a child, which in turn impacts their needs. What might be some other factors?

DO: Give participants some time to name other factors and write them on flipchart paper.

EXPLAIN: There are several factors related to the circumstances of the abuse and the circumstances of disclosure that mediate the impact of sexual abuse on a child and their needs following the sexual abuse. Review the points on slides 42-43. Provide examples as needed (e.g., a child who was shown pornography likely won't need health services; if the perpetrator is in the home, the child may need alternative care services; if the abuse was perpetrated over a long period of time by a family member, the child may need longer-term MHPSS services, etc.), if a non-offending caregiver does not believe or support the child, the child may begin to question him/herself and recovery takes longer.

SAY: We have talked about how individual identities as well as the circumstances of abuse and disclosure influence the impact of the abuse on a child and thus their needs. You also named some other factors (refer to the flip chart work).

DO: Show slide 44.

SAY: One way for us to think about this is to frame them as risk and protective factors that either worsen (risk) or lessen (protective) the impact child sexual abuse has a child.

» Risk factors: Characteristics at the biological, psychological, family, community, and cultural level that are associated with a higher likelihood of negative outcomes.
» Protective factors: Characteristics at the biological, psychological, family, community, and cultural level associated with a lower likelihood of negative outcomes. Reduces the impact of risk factors.

DO: Show slide 45.

EXPLAIN: Children will have both protective and risk factors across these different levels, pointing to the examples provided on the slides. If we look at what we have already discussed – factors related to identity, factors related to circumstances of the abuse and the disclosure, and the other factors you named (refer to the flip chart), we can see that they exist across these different levels.

DO: Ask participants why it is important to understand the risk and protective factors related to the impact of the abuse.

SAY: Risk and protective factors related to the impact of the abuse will also influence a child survivor's healing and recovery—what they need and how long it takes. Some risk and protective factors are not malleable – meaning they cannot be changed. However, in the process of case management we as caseworkers can support children and their families to mitigate the consequences of risk factors and strengthen protective factors to better facilitate their healing and recovery.

Knowledge Area 10: Impact of child sexual abuse on non-offending caregivers (5 minutes, slides 46-48)

DO: Show slide 46 and say the next child sexual abuse core knowledge area is the impact of child sexual abuse on non-offending caregivers. Then show slide 47 and ask the following questions before reviewing the points on the slide.

» What are common feelings or reactions a caregiver would have if they found out their child was been sexually abused?
» Would the reaction change depending on the child's gender, age, or other characteristics?

DO: Show slide 48 and ask why it is critical to work with non-offending caregivers when caring for child survivors.

SAY: Caregivers are usually those closest to the child and have the largest impact on their lives, the services they access, and the child's outcomes. Research has shown that a caregiver's ability to accept and care for their child after sexual abuse is the biggest factor in a child's ability to recover and heal. If a caregiver is in distress, the child survivor will be directly impacted. We need to therefore also care for caregivers when caring for child survivors. Identifying how you can work with the child and their caregiver includes recognizing different reactions that a caregiver might be having, the factors driving those reactions, and the support the caregiver may need.

Closing (5 minutes, slides 49-51)

DO: Show slide 49 and congratulate participants for completing the child sexual abuse knowledge areas. Explain the importance of going back to these core knowledge areas as we continue through the other components of the training.

DO: Show slide 50 and review the key messages. Show slide 51 and ask participants if they have any questions before closing the module.

HANDOUT 2.1. EXPLORING BARRIERS TO DISCLOSURE – PARTICIPANT

Directions

» Read the case study below assigned to your group.
» Discuss this question: **What are the barriers to disclosure for the child survivor?**
» Select one group member to BRIEFLY (2-3 minutes) share key points in plenary.

Case Studies

Group 1: A mother came home from the market early one day and witnessed her uncle laying naked with her 5-year-old son and her son touching the uncle's genitals. The uncle ran away and the boy will not talk about what happened.

Group 2: An 11-year-old girl is in love with her 21-year-old neighbor. He is very nice to her and gives her small gifts. Recently she has allowed him to touch her private parts since he says they will be married one day. She wonders if she is pregnant.

Group 3: A 16 year-old girl with a developmental delay is pregnant and has come to the health clinic with her mother for pre-natal services. Her mother is angry and says she does not know how her daughter got into this trouble because she does not attend school and rarely goes outside the home.

Group 4: A 14 year-old unaccompanied boy living on the street was sexually exploited by an older man who offered to give him money in exchange for sexual favors. Since then, the boy has continued to provide sexual favors for the man and other men the man introduced him to in exchange for money and basic resources.

HANDOUT 2.2. EXPLORING BARRIERS TO DISCLOSURE – FACILITATOR

Directions for the Groups

» Read the case study below assigned to your group.

» Discuss the following questions:

1. What is the type of disclosure? (direct, indirect/3rd party, voluntary, involuntary)
2. What barriers may the child face in talking about the sexual abuse?

» Select one group member to BRIEFLY (2-3 minutes) share key points in plenary.

Directions for Facilitator(s)

» Give groups 10 minutes to read the case study and respond to the question.

» In plenary, give each group 2-3 minutes to share the key points. Allow other groups to add reflections and ensure key points listed beside each case study (in red) are covered.

CASE STUDIES	KEY POINTS TO COVER
Group 1: A mother came home from the market early one day and witnessed her uncle laying naked with her 5-year-old son and her son touching the uncle's genitals. She screamed and cried when she saw what was happening. The uncle ran away and the boy will not talk about what happened. The mother brings him to a caseworker for help.	» Involuntary, indirect/third party disclosure. » The boy may be too young to understand what happened and that it is wrong. » He may think it was his fault and does not want to get in trouble. » He may feel protective of his uncle. » He may not want to upset his mother more.
Group 2: An 11 year-old girl is in love with her 21-year-old neighbor. He is very nice to her and gives her small gifts. Recently she has allowed him to touch her private parts since he says they will be married one day. She wonders if she is pregnant so tells a caseworker.	» Voluntary, direct disclosure » The girl may trust her neighbor, want to protect him, and want the relationship to continue. » The girl may not know he is abusing her. » The girl may fear getting in trouble if anyone finds out.

Group 3: A 16 year-old girl with a developmental delay is brought to the health center by her mother. The doctor tells them the girl is pregnant. The mother reacts in anger, saying it is impossible because her daughter does not attend school and rarely goes outside the home. The girl asks to speak to the doctor alone about what happened to her.	» Involuntary, indirect/third party disclosure. » The boy may be too young to understand what happened and that it is wrong. » He may think it was his fault and does not want to get in trouble. » He may feel protective of his uncle. » He may not want to upset his mother more.
Group 4: A 14 year-old unaccompanied boy living on the street was sexually exploited by a man. Since then, the boy has continued to provide sexual favors for the man in exchange for money, food, and place to stay. A community member witnesses this exchange and threatens to call the police if the boy does not tell what he has been doing, so the boy discloses.	» Involuntary, direct disclosure » The boy may fear judgement and blame. » The boy may fear that he will be criminalized for his actions. » The boy may feel shame in telling others. » The boy may fear losing his livelihood. » The boy may not trust service providers to help him since they were not able to help him access resources to meet his needs.

HANDOUT 2.3. DISABILITY AND IMPAIRMENT

Disability – the interaction between an impairment and barriers which can cause delays.

Types of Impairments

» **Physical impairment:**
- Temporary or permanent limitations that inhibit the physical function of one or more limbs of a person, including complete inability to use or function.
- Examples:
  - Injuries to muscles or bones that severely limit functioning.
  - Amputations.
  - Spinal cord injuries.
  - Cerebral Palsy (group of disorders that affect a person's ability to move and maintain balance and posture)

» **Sensorial impairment:**
- Conditions that affect the ability to process information through the senses (sight, hearing, taste, touch, smell)
- Examples:
  - Blindness and low vision.
  - Deafness.
  - Sensory Processing Disorder (affects how your brain processes stimuli, often resulting in over sensitivity what is seen, heard, touched, smelt, tasted, etc.)

» **Psychosocial impairments:**
- Mental health impairments that can be chronic or episodic that make it difficult to carry out day-to-day tasks, causing significant impairments to daily life.
- Many of these conditions are well hidden while others may present more directly as abnormal behavior or functioning.
- Examples:
  - Depression (persistent feeling of sadness and loss of interest in activities).
  - Generalized Anxiety Disorder (persistent feeling of anxiety or dread).
  - Bi-polar Disorder (unusual shifts in a person's mood, energy, activity levels, and concentration)
  - Schizophrenia (abnormal interpretation of reality which may result in hallucinations, delusions, and extremely disordered thinking and behavior)
  - Catatonia (disrupts a person's awareness of the world around them, resulting in little or no reaction to surroundings or behaviors that are unusual, unexpected, or unsafe to themselves or others)

» **Intellectual and developmental impairments:**
  - Chronic conditions that impair learning, language, and behavioral development.
  - These usually occur before adulthood and limit a person's ability to learn at an expected or typical level or function in daily life.
  - Examples:
    - Autism Spectrum Disorder (caused by differences in the brain resulting in challenges with social communication/interaction, restricted or repetitive behaviors/interests, different ways of learning, moving, and paying attention).
    - Attention Deficit Hyperactivity Disorder (cause unknown but results in difficulty paying attention, controlling impulsive behaviors, overly active)

Impairments themselves are not the driver of disability. The interaction between barriers, societal norms, and maladaptive environments and the impairment of the person creates the disability.

Module 3

CASEWORKER ATTITUDES AND BIASES

1. OVERVIEW

Duration	2 hours
Module Learning Objectives	For participants to: » Explore attitudes toward young and adolescent girl and boy survivors of sexual abuse in the local context. » Understand key child-centered and survivor-centered attitudes.
Key Messages	» Caseworkers must reflect on their personal attitudes towards child survivors and non-offending caregivers. » Caseworkers' attitudes towards child survivors and non-offending caregivers will directly impact service delivery. » Caseworkers must have child survivor-centered attitudes to help child survivors recover and heal. » The core child sexual abuse knowledge areas service as a foundation for child survivor-centered attitudes. » Caseworkers must continually work towards child survivor-centered attitudes with the support of their supervisors.
Materials	» Flip chart paper » Markers » Sticky notes
Pre-reading	» CCS Guidelines Chapter 3

2. MODULE OUTLINE

Minutes	Session
15	Opening
60	Unpacking our attitudes and beliefs
40	Further developing child survivor-centered attitudes
5	Closing

3. CONTEXTUALIZATION

Session	Slides	Contextualization
Opening	3	» Have a good sense of the harmful attitudes and comments expressed to young and adolescent girl and boy survivors in the local context. » For slide 3, adapt point on children with diverse sexual orientation, gender identity/expression, and sex characteristics (SOGIESC) from slide if not safe to raise within the local context. Add any other specific characteristics of children to the list that would be important to consider for the local context.
Unpacking our attitudes and beliefs	7-19	» Review the statements on each slide and adjust or remove any that may put facilitators and participants at-risk due to sensitivity within the context. » Add statements on myths/harmful beliefs within the context that are important to debunk. » For slide 19, modify the harmful belief/attitudes to those that are common in the local context.

Further developing child survivor-centered attitudes	24	» For slide 24, modify the characteristics of child survivors to mimic the changes made in slide 3ز

4. SESSIONS

Opening (15 minutes, slide 1-3)

DO: Show slide 2. Explain that in this module we will discuss the core attitudes that caseworkers must have to safely care for young and adolescent girl and boy survivors of sexual abuse.

DO: Show slide 3.

EXPLAIN: Participants will be broken up into small groups and each group assigned one of the child survivors listed on the slide. Groups should be assigned child survivors with characteristics most relevant to the local context. Each group should draw a large figure of their assigned child survivor on the flip chart paper and give the child a name. Group members should then think of themselves as the child survivor and imagine all the things the people listed in the thought bubble would say to them. They should write these statements on sticky notes and place them all over the drawing of the child on the flipchart paper (The point is for the drawing of the child to be covered with sticky notes with statements written on them).

DO: Give participants 10 minutes to complete the exercise—asking them to identify what comes to the top of their minds. After the groups are done, ask them to tape their flipchart paper to the wall. Give them a few minutes to look at each group's flip chart paper and then bring everyone back together.

SAY: How did it feel looking at each child and the statements covering them? What do you think this means for how child survivors are treated?

EXPLAIN: The statements are literally covering the child survivors so that they become invisible. This means that these children are holding and being impacted by all these statements while also being de-centered and unseen by those who should be helping them.
These statements / what people say to a child survivor reflect their attitudes and beliefs. As caseworkers, it is our responsibility not to hold or perpetuate harmful attitudes and beliefs but to counteract them so that the child survivor is helped and not further harmed.

Unpacking our attitudes and beliefs (60 minutes slides 4-19)

DO: Show slide 4. Ask participants what is an attitude? Where do attitudes come from? Ask them to give you some examples.

SAY: An attitude is the way you think or feel about someone or something, which gets conveyed through your behavior. It is a learned evaluative reaction toward something or someone. We have attitudes about many things – people, places, beliefs, systems, etc. We may even have attitudes about one another in this room based on our characteristics and personalities.

DO: Show slide 5.

EXPLAIN: Attitudes are made up of three components, often in English called the "ABCs of attitudes":

» Cognitive (thoughts) – A person's thoughts/beliefs about the person, place thing, issue, etc. (non-evaluative)
» Affective (feelings) – A person's feelings about the person, place, thing, issue, etc. (evaluative)
» Behavioural (actions) – A person's actions toward the person, place, thing, issue, etc.

DO: Provide an example of how the 3 attitudinal components interact with one another. For example:

» Cognitive – Children with disabilities are weaker than other children; they cannot help themselves.
» Affective – I feel pity for children with disabilities.
» Behavioural – I come to the rescue of children with disabilities by helping and making decisions for them.

DO: Show slide 6 and ask participants to stand in the center of the room. Designate one side of the room to be "agree" and the opposite side of the room to be "disagree".

EXPLAIN: You will read a statement. If participants agree, they should go to the "agree" side of the room. If they disagree, they should go to the "disagree" side of the room. If they are unsure, they can stand in the middle or toward the side of the room that they think is right. After everyone has taken their place according to the statement, we will hear people's perspectives and discuss what is factual. Remind participants of the group agreement ("ground rules"), particularly those in relation to non-judgement and safety as everyone is here to learn.

DO: For slides 7-18, show the slide, read the statement aloud, give participants time to move to the place in the room that aligns with what they believe, and then ask a few participants to share why they chose "agree", "disagree", or "unsure". Then share the correct sentiment and explain the facts about the statement. Each of the statements, correct sentiments, and facts are listed below.

» Slide 7: Child sexual abuse is a common problem. – **AGREE**
  - While no definitive prevalence rate for child sexual abuse worldwide exists, meta-analyses report similar estimates of 7-12% of boys worldwide reporting experiencing sexual abuse and 18-20% of girls reporting experiencing sexual abuse.
  - It is important to remember that many children do not disclose incidents of abuse. Girls and boys have different reasons why they do not disclose. For example, boys may not disclose because of social norms about masculinity and for fear of being perceived as homosexual. Girls may not disclose for fear of being blamed for the sexual abuse and retaliated against.

» Slide 8: Children lie or make-up stories about sexual abuse. – **DISAGREE**
  - Children rarely lie about abuse and should be trusted when they disclose.
  - False allegations rarely happen.
  - Contextually, children with certain identities or combinations of identities are less likely to be believed than other children. For example, a girl with a disability may face more scrutiny or doubt because she is a girl (patriarchal values may place more trust in men/boys' accounts of events than girls' accounts) and she has a disability (ableist biases tend to discount the opinions and intelligence of people with disabilities, even when the disability has no impact at all on cognitive function).
  - If a child is not telling the truth, it is a signal something else may be wrong. It is not the job of the caseworker to investigate the child. Rather, it is the caseworker's responsibility to build trust with the child and help them feel safe enough to tell the truth about what is happening.

» Slide 9: Only a stranger would sexually abuse a child. No one known and trusted by the family would do this. – **DISAGREE**
  - Most children are sexually abused by someone they know.
  - Younger children are most likely to be abused by a family member, relative, or family friend. Oftentimes it is someone the child trusts and someone who has access to the child.
  - As children age into adolescence, the risk for abuse perpetrated by an acquaintance, peer, or stranger increases but does not surpass the existing risk of experiencing abuse from someone known to them.
  - Because of patriarchal values and the perceived worth of men/boys above women/girls in many cultures, men benefit from 'believability' over children, particularly girls. Perpetrators can and do use this to their advantage when denying abuse. Example: "She's just a jealous girl, lying to get attention."
  - This myth allows for minimizing and denial of the issue. If a caregiver believes this, they may not believe their child when the child tells them about abuse perpetrated by another trusted adult. This can result in victim blaming and further distress and harm for the child.

» Slide 10: It is appropriate and necessary to talk about sexual and reproductive health and sexual abuse with children. – **AGREE**
  - It is important for children to be able to name their body parts, understand what sexual abuse is, and understand sexual health matters in line with their evolving capacities as they age.
  - Children who know the names of their body parts, can name sexual organs, and understand "good touch" and "bad touch" are better positioned to understand that sexual abuse is wrong and to disclose.
  - Views around purity and virginity may make it more acceptable for boys to discuss sex and less acceptable for girls, resulting in the potential that girls are the least knowledgeable or informed about any aspect of sexual and reproductive health and sexual abuse despite being at the highest risk for sexual abuse.

» Slide 11: Sometimes girls are to blame for being sexually abused because of the way they dress or behave. – **DISAGREE**
  - Children are never responsible for or cause the abuse they have experienced.
  - This myth is pervasively directed at girls and shifts the blame to them rather than the perpetrators. This shift in blame helps reinforce harmful solutions like child early forced marriage to the perpetrator.
  - Contextually, girls with particular identities or combinations of identities are less likely to be trusted than others. For example, girls from African countries who are refugees in European or Middle Eastern countries have a higher chance of being perceived as hyper sexualized, viewed as more mature at earlier ages than other girls, and therefore seen as more responsible for the abuse or "asking for it" because of the intersections of sexism and racism at cultural levels that objectify and commodify Black women and girls.

» Slide 12: Adolescent boys can be sexually abused. – **AGREE**
  - Adolescent boys can and do experience child sexual abuse.
  - This myth is rooted in beliefs that adolescent boys are always seeking and enjoy sexual experiences, therefore negating their ability to be survivors of assault. This belief can be particularly entrenched if the perpetrator is a woman.
  - If caseworkers believe this myth, they may deny boys services when they do seek them, engage in victim-blaming or denial, and cause further stigmatisation, distress, and harm to boy survivors.

» Slide 13: Child survivors should not be trusted if they cannot remember the details of the sexual abuse and recall them every time they are asked. – **DISAGREE**
  - The reliability of children's memories is often called into question, especially in situations where the justice sector is involved.
  - Children do not lie about sexual abuse but the distress and trauma may impact the way children recall events.

- In contexts where mandatory reporting laws and procedures exist, this myth can result in further harm when a child (and family) is required to engage in a legal process. Constant doubt and questioning of the account by actors across the justice system, coupled with loss of agency from engaging with the justice system, can result in additional distress in the child survivor.
- Also refer back to slide 8 (children do not lie about sexual abuse).

» Slide 14: If a man sexually abuses a boy, the boy survivor will become gay/homosexual. – **DISAGREE**

- Sexuality is not and never has been created or changed by experiences of abuse.
- This myth is rooted in patriarchal beliefs that disregard and disdain feminine characteristics and traits. Homosexuality's perceived proximity to femininity means in many cultures it is seen as one of the 'worst' things a man or boy can be.
- Homosexuality is often responded to with violence, so the perception that a boy who experiences child sexual assault is gay could make him more vulnerable to other forms of violence as well.
- This myth is very pervasive with many boy survivors believing it about themselves. This, in turn, often prevents boys from seeking services.

» Slide 15: A girl's value lies in her purity; therefore if she is sexually abused, she no longer has value to the family or community. – **DISAGREE**

- This myth is rooted in beliefs that tie women and girls' worth to perceived chasteness and seek to control women and girls' actions, including their experiences of sexuality.
- Investment in girls increase the overall well-being of families and communities.
- Girls have the right to attend school regularly and attain the highest education level available.

» Slide 16: Children who are sexually abused might not show signs of physical and emotional distress. – **AGREE**

- Healing and recovery are not linear. A child may have signs and symptoms that a caregiver or caseworker does not recognize or they may not currently be exhibiting disruptive signs and symptoms of abuse.
- Stress, further experiences of abuse and violence, drastic changes to their routine or environment, and even shifting into adolescence or adulthood may bring up signs and symptoms years after abuse has occurred. If this happens, it is important that caseworkers can normalize this for the child and their caregiver.

» Slide 17: If a child is sexually abused, they will end up abusing other children or be perpetrators later in life. – **DISAGREE**

- The majority of boys who experience sexual abuse do not perpetrate abuse.
- Evidence suggests that girls are very unlikely to perpetrate child sexual abuse.

- This myth can lead to victim blaming, stigmatization, and harmful treatment of survivors. By anticipating that they will become abusers themselves, focus may shift to preventing this or viewing the survivor in a negative light rather than on their healing and recovery.
- Children who do sexually abuse other children may do so in an attempt to heal from or understand their own abuse. Child sexual abuse is an extreme violation of bodily autonomy and personal rights. In seeking to regain a sense of control, some children may perpetrate abuse seeking to take on a powerful position over others.

» Slide 18: Community or religious leaders should be involved in cases of child sexual abuse. – **DISAGREE**
  - The child survivor and non-offending caregiver provide informed assent/informed consent as to who should be informed of and involved in their case.
  - Mediation with a perpetrator through community and religious leaders should be approached with caution. Many leaders may believe some or all the myths highlighted here about child sexual abuse. This makes them less likely to engage in supportive actions for the child and more likely to cause harm.
  - Mediation may be asked for by non-offending caregivers. This makes it important for caseworkers to understand all the risks, including how those involved in mediation may engage in types of resistance, how this enables them to promote harmful solutions, and how often these harmful actions may be taken in the context.

DO: After all statements have been discussed, ask participants to go back to their seats. Show slide 19.

EXPLAIN: Harmful beliefs and attitudes lead to harmful behaviors. These harmful beliefs, attitudes, and behaviors are often called "resistance attitudes". Resistance attitudes negatively impact child survivors and remove accountability from perpetrators for the harm they have caused.

» Denial – asserting that something is not true or not a problem.
» Minimizing – making something smaller or less serious than it is.
» Remaining silent – choosing to keep quiet or not speaking up in the face of an injustice or problematic act.
» Justification – arguing acceptable reasons for doing an unjust or problematic act.
» Victim blaming – stating or implying that the survivor is at fault for the violence they experienced.
» Comparing victimhood – shifting the focus of the discussion/situation by stating that another group also experiences the same problem.
» Reinforcing norms – engaging in behaviors that support power inequality and harmful beliefs and attitudes.

DO: Participants to share additional harmful beliefs, attitudes, behaviors, myths, and resistance attitudes that are common in the local context that have not already been mentioned.

Further developing child survivor-centered attitudes (40 minutes, slides 20-26)

DO: Show slide 20.

SAY: Recognizing that we all have some measure of harmful or unhelpful beliefs and attitudes, we need to constantly work towards having safe and helpful attitudes towards child survivors.

DO: Show slide 21 and ask participants to share some child-centred attitudes. Then ask where these attitudes come from – i.e., the foundation of these attitudes (child development, child rights, child protection). If helpful, provide additional information on the child-centered approach and the best interests principle. Then show slide 22.

SAY: Similarly, what are some survivor-centred attitudes?

DO: Give participants a few minutes to answer and then show the points on the slide. Ask where these attitudes come from (trauma theory and practice, women's movements, evidence from survivors, social work case management). If helpful, provide additional explanation on the survivor-centred approach. Then show slide 23.

EXPLAIN: In order to have safe attitudes, we need to make sure that we have the correct knowledge and beliefs and self-awareness. For core knowledge areas, we covered these in module 2. It is important to gain mastery of the core knowledge areas because they should inform our beliefs. We also need to be aware of our own thoughts, feelings, and behaviours – particularly in terms of how they show up when we are working with child survivors – and continually work towards being a safe, trusted, and healing person for child survivors.

DO: Show slide 24.

EXPLAIN: Participants will do a similar activity to the one we did at the start of this module, but instead think about all of the child survivor-centred things caseworkers can say to child survivors, ways caseworkers can engage with child survivors, and all the things they can do with them. Participants should draw another figure of a child on their flip chart paper, write down all of the child survivor-centred thoughts, feelings, and behaviours on sticky notes, and place them on the picture of the child.

DO: Give participants 10-15 minutes in their groups. After the groups are done, ask them to tape their flipchart paper to the wall.
Give participants a few minutes to look at each group's flip chart paper and then bring everyone back together.

SAY: How did it feel this time looking at each child and the statements covering them? How do you think this will impact child survivors and their non-offending caregivers?

DO: Show slide 25 and ask participants to read each of the statements aloud. Ask if there are any additional child-survivor-centered beliefs and attitudes they would like to add. Then show slide 26 and review the actions caseworkers can take towards developing helpful attitudes and beliefs.

Closing (5 minutes, slides 27-28)

DO: Show slide 27 and review the key messages. Show slide 28 and ask participants if they have any questions before closing the module.

Module 4

COMMUNICATION SKILLS

1. OVERVIEW

Duration	5 hours
Module Learning Objectives	For participants to: » Understand the role of communication in building trust with a child survivor. » Know how to adapt communication to the individual child survivor. » Practice implementing the best practices for communicating with child survivors of sexual abuse. » Demonstrate child-friendly communication techniques. » Practice addressing communication challenges with child survivors.
Key Messages	» Children who have experienced abuse may have difficulty talking about it with others. » Communication must use child-friendly techniques, demonstrate empathy and belief, build trust, and create feelings of safety and support. » Child survivors have specific needs and require support in different ways based on their age, gender, development, capacity, the type and duration of abuse experienced, and other factors. Communication must be adjusted to successfully build a supportive relationship. » Communication skills (verbal and nonverbal) help build supportive relationships and facilitate the child survivor's healing. » Different techniques and resources can help facilitate conversations with child survivors.

Materials	» Stop-watch/timer. » Prepare a flip chart paper for each of the communication best practices- put the number and title of the best practice following the order they are explained in slides 14-26). Tape these around the room. » Toys, art materials, sports-related items, music, books, and other materials appropriate for young and adolescent girls and boys in the local context. » Handout 4.1. Communication Do's and Don'ts.
Pre-reading	» Inter-Agency Child Protection Case Management Training, Level 1, Module 3 – Communication with Children » CCS Guidelines Chapter 4

2. MODULE OUTLINE

Minutes	Session
20	Opening
30	How communication facilitates a helping relationship
90	Best practices for communicating with child survivors
60	Implementing the best practices for communication with child survivors
90	Addressing communication challenges
5	Closing

3. CONTEXTUALIZATION

Session	Slides	Contextualization
Opening	4	» Have a good understanding of communication within the local context, including norms around girls' and boys' communication, communication between girls, boy, and adults, etc. » Have a good understanding of common ways people in the local context comfort one another, including how adults comfort young and adolescent girls and boys.
How easy was it?	6	» Review the questions for appropriateness in the local context and remove and add questions that you think will help participants empathize with the experience of child survivors who are asked to tell what happened to them.
Best practices for communicating with child survivors	22	» Adjustments for age/developmental stage and disability. Review to ensure that guidelines fit with the local context, particularly regarding whether it is acceptable for girls and boys to communicate directly with caseworkers about sexual abuse or if this would put them at risk of harm by family or community members.
Implementing the communication best practices with child survivors	30	» Review the vignettes for the role plays and adjust them if needed to be relevant to the local context, ensuring that there is a diversity of child survivors represented across the vignettes.

Addressing common communication challenges	32-39	» If you made modifications to the vignettes in slide 30, also make them in slide 39 as the groups will use these vignettes again. Also make sure any additional communication challenges mentioned are assigned to vignettes. » Review guidance for each communication challenge and modify as needed according to practices in the local context.

4. SESSIONS

Opening (20 minutes, slides 1-4)

SAY: Now that we have covered the core child sexual abuse knowledge areas and the core beliefs and attitudes of the CCS approach, we are going to learn and practice core engagement and communication skills for working with child survivor of sexual abuse.

DO: Show slide 2 and share the objectives of the module.

SAY: Before diving into communication with child survivors, it is important to take a step back and reflect on what communication is and how it looks here in [local context] because we communicate differently based on where we are from, our culture, how we were raised, the communication styles that were modeled for us, etc.

DO: Show slide 3 and ask participants to share what they think are the components of effective communication (verbal, non-verbal, and active listening) and ask for examples of each, making room for context-specific examples.

DO: Show slide 4 and ask participants in plenary. Write their responses on flipchart paper.

SAY: Thank you for teaching me more about communication here. As we go through tips on effective communication and the guidelines for communication with child survivors, I invite you to challenge me if you think a particular communication technique will not work well in the context here so that we can brainstorm together what might be more effective.

How communication facilitates a helping relationship (30 minutes, slides 5-11)

DO: Show slide 5.

SAY: Before we get into communication with child survivors we will do an exercise that helps us reflect on how challenging it can be to talk about sensitive matters.

DO: Have participants get up and stand in the middle of the room. Designate one side of the room as "easy" and the other side of the room as "hard".

EXPLAIN: You will reach a series of questions. Depending on how easy or hard you think it is / it was for you, move towards the appropriate side of the room. The closer you are to the "easy" side of the room, the easier it was for you, and the closer you are to the "hard" side of the room, the "harder" it was for you.

DO: Read the first question and then give participants time to move to the side of the room that resonates for them. Ask a few participants to share why they chose to stand where they are standing. Then repeat this with each question. After all questions have been discussed, have the participants return to their seats (allow 10 minutes for the exercise).

DO: Ask a few participants to share a few reflections. What did they notice?

SAY: If it was that difficult for you to talk to your parents about something you felt ashamed of or about your feelings think about how challenging it would be for a child survivor to talk to a caseworker – an adult that is a stranger to them – about being sexually abused. For those of you who found this easier or less hard – what made it less hard/ easier?

DO: Write their responses on flip chart paper.

EXPLAIN: The reasons participants gave for why it felt less hard / easier will likely be things that can help child survivors feel more comfortable talking about sexual abuse with caseworkers. Keep these characteristics, behaviors, etc. in mind as you think about how you would engage and communicate with child survivors.

DO: Show slide 7 and review the content on the slide, emphasizing that all communication should aim to address these challenges.

SAY: What might happen if a caseworker doesn't use the appropriate communication skills with engaging with a child survivor?

DO: Give participants an opportunity to respond and then review the contents on the slide 8. Show slide 9 and ask a participant to read the slide aloud. Do the same for slides 10 and 11 as they are critical points.

SAY: Research shows that a child survivor's healing is impacted by the attitudes and behaviors of those who are caring for them. For example, if a child survivor feels they are being blamed for the abuse, they may experience deeper levels of shame, anxiety, and sadness, resulting in the refusal to share additional information or even denying the sexual abuse happened. If, however, the child survivor is met with belief, care, and empathy, they will be willing to engage further, enabling them to receive critical services.

SAY: The question is how do we show belief, care, and empathy to child survivors? We will cover this in the next session.

Best practices for communicating with child survivors (90 minutes, slides 12-26)

DO: Show slide 12 and explain that we are going to explain the "how" of communication by going through best practices for communicating with child survivors. Show slide 13 and name each of the 10 best practices.

DO: Divide participants into 10 groups and have each group stand in front of one of the communication best practices flip chart papers you have prepared and taped to the wall. Give each group a marker and ask them to agree on one person who will do the writing for the group.

EXPLAIN: We are going to play a game called round robin. As a group, they will have 3 minutes to write on the flip chart as many ways as you can to practically implement the best practice with child survivors. As soon as the 3 minutes are finished, you will yell "MOVE!" and they will have to move to the right to the next flip chart and do the same thing. Explain that as much as possible they should try to think of something new, however If one of their ideas is already on the flip chart they can put a check mark next to it. We will keep going until all groups have had a chance to contribute to each best practice.

DO: Ask participants if they have any questions on the game. Set the timer to 3 minutes and tell the groups to start. After 3 minutes, yell "MOVE" and give the groups another 3 minutes to do the next communication best practice. Continue doing this until all groups have contributed to each best practice (the groups should end in front of the flip chart they started with).

DO: Ask one participant from each group to remove the flip chart paper they are standing in front of and bring it to the front of the room. Layer the flipchart papers over one another starting with the last best practice (#10) until you reach the first best practice (#1). Ask the rest of the participants to sit down.

DO: Review each flip chart in plenary and ask if anyone wants to add anything. After each best practice show the relevant slide (slides 14-26) to make sure no points have been missed. Please note:

» For communication best practice #3 (Reassure the child), there is an additional slide with examples of healing statements. Ask participants if there are any other context specific healing statements that they would use to reassure or comfort a child survivor.
» For communication best practice #7 (speak so children understand), there is an additional slide that provides additional guidance by age, developmental stage, and disability.
» For communication best practice #8 (non-verbal communication techniques), there is an additional slide that provides examples of non-directive and directive non-verbal communication techniques. Emphasize that the purpose of the directive and non-directive techniques is to facilitate communication and **not** to interpret or psychoanalyze the drawings.

Implementing the communication best practices with child survivors (60 minutes, slides 27-30)

DO: Distribute Handout 4.1. Communication Do's and Don'ts. Explain to participants that this is quick tip sheet that consolidates some of the best practices and that they can review at another time.

DO: Show slide 27. Explain that we are now going to put the communication best practices into practice by using them in role plays.

DO: Show slide 28.

EXPLAIN: Participants will be broken up into 6 groups. Each group will be assigned a vignette. Group members will assign themselves roles of caseworker, child survivor, caregiver (if applicable), and observer(s). The caseworker will practice implementing the communication best practices as they engage the child survivor and caregiver (if present). The observer(s) will watch and take notes of how the caseworker implemented the communication best practices and will provide feedback to the caseworker after the role play.

At least two group members should practice being the caseworker. Emphasise that for the purposes of this role play the caseworker is not spending time gathering information about what happened to the child. Instead, the focus of the exercise is for the caseworker to demonstrate best practices as if they are in the initial stages of working with a case – to create an appropriate space, introduce themselves and begin to build rapport with the child/caregiver. Once all groups are done practicing, we will discuss observations and experiences as a group.

DO: Show slide 29 and explain what the role of the observer is in each group. Explain that observers should share their feedback with the person playing the caseworker after the role play and that you will ask for this feedback to be shared more generally again in plenary.

DO: Break the participants up into 6 groups and show slide 30 with the vignettes. Assign each group one vignette. Give the group 30 minutes to practice the role plays. After 15 minutes remind them to switch their role if they have not done so already. As the groups practice, walk around the room and observe.

DO: After 30 minutes bring the group back to plenary. Ask the observers from each group to share the feedback they gave the caseworkers. Note any common themes from the feedback. Ask the participants who played caseworkers to share their experience – what felt easy, comfortable/ what felt challenging? Ask those that played the child survivors about their experience. Note any common themes.

Common communication challenges with child survivors (90 minutes, slides 31-39)

DO: Show slide 31. Ask participants to think back to the first exercise in this module – "how easy was it?" and how challenging it must be for child survivors to be able to talk about the sexual abuse they experienced. With this in mind, what challenges they think may come up when trying to communicate with child survivors. Remind them that for now we are just focusing on challenges with communication (not cases themselves). Write their answers on flip chart paper.

DO: Show slide 32. Share that these are the most common communication challenges when working with child survivors and add any additional challenges named by participants from the flip chart paper.

DO: Go through each communication challenge (slides 33-38). For each one – before showing the content on the slide – ask the group what they think they could do in this situation that aligns with the communication best practices. Then review the content on the slides noting what participants already said and noting anything new the content on the slides adds.

EXPLAIN: We are going to go back into small groups to work with the same vignettes adding in some of these communication challenges. The group will be assigned two vignettes each with a different communication challenge. The group will take 5 minutes to discuss the vignette, the communication challenge and how they think it would be best to address it- keeping in mind the child's age, developmental stage and other circumstances. Group members who have not played the role of the caseworker should play the caseworker role for this exercise vignettes. Similar to before the focus is on initial engagement- the caseworker is not asking for details of the abuse or assessing needs. Observers should be prepared to provide feedback to the caseworker- what they appreciated about how the caseworker handled the communication challenge and what they might change or add. The groups will have 30 minutes in total – 15 minutes for each vignette.

DO: Show slide 39 with the vignettes. If there were additional communication challenges that the group raised earlier, you can assign those to the vignettes for this exercise.

DO: Break participants back up into their groups. Give each group two vignettes (some groups may have the same ones). Walk around to observe the role plays. After 15 minutes remind the group to switch vignettes and roles. After another 15 minutes, bring the groups back into plenary. Ask the observers to share their feedback in general. Ask those who played the role of the caseworker to share their experience and similarly for the child survivors. Note any common themes.

EXPLAIN: You did not assign anyone a vignette with "panic attacks" or "flashbacks" as a communication challenge because of the level of difficulty of these scenarios. Explain that you will role play how to respond to them now in plenary.

DO: Ask for two volunteers to play the role of a child survivor – one for each of these communication challenges. Use the following vignettes to demonstrate for the participants how to respond to these communication challenges.

» **Panic attack:** A 16-year-old girl with a developmental delay has come to the clinic for pre-natal services. Her mother brought her in to get services and says she does not know how the girl got pregnant because she does not attend school and rarely goes out in the community. Her mother mentions that this is her second pregnancy. The health worker suspects that someone in the compound may be abusing the girl and calls you for support.
» **Flashback:** A 14-year old boy was recruited into an armed group. He was sexually abused by his commanders and forced to sexually abuse others. He has returned home and swings between anger and depression. He refuses to talk about what happened.

DO: Ask participants for reflections on these role plays. Let them know that they will have a chance to learn and practice the belly breathing exercise on another day when you go over MHPSS interventions.

DO: Ask participants to turn to their partner. Explain that they will now have a chance to practice the grounding exercise that you role-played for the vignette with the child who was experiencing flashbacks. Ask them to each take a turn practicing being the caseworker in this situation. Tell them that they do not need to spend time role playing the scenario from the very start. The purpose of the exercise is for them to practice carrying out the grounding exercise.

DO: Give participants 15 minutes to take turns role playing. Bring them back to plenary and ask them to share reflections and experiences from the perspective of being the caseworker and being the child survivor.

Closing (5 minutes, slides 40-41)

DO: Show slide 40 and review key messages. Show slide 41 and ask participants if they have any questions and then close the module.

HANDOUT 4.1. COMMUNICATION DO'S AND DON'TS

DO this with child survivors	**DO NOT** do this with child survivors
Explain your role, why you are talking to the child, and their rights in a way they understand	Fail to introduce yourself to the child and jump into asking them questions
Start with general topics – build rapport	Start with questions about the sexual abuse
Be patient – allow the child to tell their story at their own pace	Push the child to tell you what happened to them
Let the child express themselves how they choose – e.g., talking, crying, drawing, being angry, etc.	Dictate how the child should express themselves (e.g., stop them from crying, indicate their behavior/ reaction is wrong
Validate the child's feelings and expression of their feelings	Tell them how to feel or that their thoughts, feelings, and reactions are not normal.
Focus on "What happened to you?"	Focus on "What is wrong with you?"
Ask non-leading questions such as: "Can you show me on this doll how you were touched?"	Ask leading questions such as: "Did he put his hands on your private parts?"
Show the child you are listening by nodding your head and saying: "And then what happened?", "Go on", and "Can you give me an example…"	Remain silent and make the child wonder if you are listening.
Gently explore issues and try to understand the child's perspective by saying "Can you tell me more about that?" and "Can you help me understand…"	Make assumptions about the child and what happened to them or ask "why?" questions as these may sound accusatory.

Try to understand the child's perspective by asking "What do you think the reason is…" or "Can you help me understand…"	Ask "Why?" or "How come?" as this may sound accusatory.
Believe the child and try to understand what they are telling you.	Doubt and question the child if the details are confusing or not correct.
Reassure the child that the abuse is not their fault, their feelings are normal, and they are not alone.	Blame or question the child's actions by asking questions such as, "Why did you do that?" and "Why didn't you…"
Thank the child and tell them they did the right thing – empower them.	Be dismissive or discouraging.

Module 5

KEY ISSUES

1. OVERVIEW

Duration	3.5 hours
Module Learning Objectives	For participants to: » Understand the key issues that may arise when caring for child survivors of sexual abuse through case management: decision-making; the process of informed consent/assent; confidentiality and its limits; and mandatory reporting. » Understand how to navigate key issues and identify potential solutions that uphold child survivors' best interests.
Key Messages	» Caseworkers are responsible for being aware of and prepared to handle the key issues that can arise when caring for child survivors through case management. » Supervisors play an important role in preparing caseworkers and supporting them as they work through these issues in cases. » The CCS guiding principles and in particular the best interest of the child principle should guide decision making and ways forward.
Materials	» Case Scenarios Participants – 1 per participant » Case Scenarios Facilitator – 1 per facilitator » Handouts on mandatory reporting in local context (must be prepared by facilitator) – 1 per participant; 1 per facilitator » Flipchart, tape, and pens » 4 flip charts – each one with one of the four key issues written at the top » 4 flip chart stands (or 4 dedicated spaces on the walls)
Pre-reading	» CCS Guidelines Chapter 5

2. MODULE OUTLINE

Minutes	Session
20	Opening
25	Key Issue 1: Navigating decision making
30	Key Issue 2: Gaining informed consent and assent
15	Key Issue 3: Upholding and navigating confidentiality
25	Key Issue 4: Navigating mandatory reporting
90	Key Issues Reflection and Practice
5	Closing

3. CONTEXTUALIZATION

Session	Slides	Contextualization
Key issue 4: Mandatory reporting	28	» Mandatory reporting laws. Facilitators should understand the mandatory reporting laws in the context, their application and enforcement and the goals of these laws/policies. Facilitators should understand how the goal may change the implementation of the law, the impact of the law on the child survivor, and the services available to the child survivor based on the law. For example, when the goal is to hold a perpetrator accountable, there may not be government provided support for the child survivor as they are not centered in the goal of that mandatory reporting law.
Key Issues Reflection and Practice	36-37	» Facilitators can slightly change the case scenarios to contextualize them. Be sure to do this on the handouts as well.

Session	Slides	Contextualization
Key issue 4: Mandatory reporting	28	» Mandatory reporting laws. Facilitators should understand the mandatory reporting laws in the context, their application and enforcement and the goals of these laws/policies. Facilitators should understand how the goal may change the implementation of the law, the impact of the law on the child survivor, and the services available to the child survivor based on the law. For example, when the goal is to hold a perpetrator accountable, there may not be government provided support for the child survivor as they are not centered in the goal of that mandatory reporting law.
Key Issues Reflection and Practice	36-37	» Facilitators can slightly change the case scenarios to contextualize them. Be sure to do this on the handouts as well.

4. SESSIONS

Opening (20 minutes, slides 1-6)

SAY: In this session, we are going to discuss key issues that are likely to arise in most if not all cases you will work on with child survivors of sexual abuse.

DO: Show slide 2 and review the objectives of the module.

SAY: Before we dig into key challenging issues in working with child survivors, we will quickly review the steps of case management that are part of the CCS approach. You will be familiar with these because they draw from the steps of case management that you are already using in your work as child protection and GBV caseworkers.

DO: Show slide 3 (without content). Ask for volunteers to name one step at a time sequentially and then show each step on the slide.

SAY: We are not going to go into detail in this module about what happens in each of these steps, however it is important for you to remember that the key issues that we discuss in this session can arise throughout the case management process – in multiple steps.

DO: Show slide 4 (without content). Ask participants from their existing experiences either working with children or working on the issues of child sexual abuse of sexual violence more generally – what do they think may be some of the biggest challenges that surface. Spend about 5 minutes brainstorming and record responses on flip chart paper.

SAY: All of what you have named may be challenges that arise in case management with child survivors. In this module we are going to discuss and examine the following four key issues.

DO: Show the content on slide 4 and say each issue as you bring it up on the slide.

SAY: We are focusing on these four because of the way in which each one brings up issues related to the safety and best interests of the child as well as because they are highly interrelated (in other words one impacts the other). They are all challenging issues that require care analysis, thoughtful decision making and actions. And they arise in nearly every case management process with a child survivor of sexual abuse.

DO: Show slide 5 (without content). Remind participants that the best interests of the child is one the CCS guiding principles. Ask participants what it means. After a few participants share their definitions, show the content on the slide.

SAY: In CCS case management, actions which promote children's best interests are those that:

» Protect the child from potential or further emotional, psychological and/or physical harm.
» Reflect the child's wants and needs.
» Empower children and families.
» Examine and balance benefits and potentially harmful consequences.
» Promote recovery and healing.

While all of the guiding principles should guide our decisions and actions in CCS case management, the best interests principle will, in particular, guide how we navigate these four key issues.

DO: Show slide 6.

SAY: We use the best interests principle by (1) carrying out a careful evaluation of the child's situation; (2) holding meaningful discussions with the child and caregivers about what they believe is in the child's best interest; and (3) seek the least harmful course of action. As we move through the four key issues we will discuss how the best interests principle can help us navigate each one.

<u>Key Issue 1: Navigating Decision Making (25 minutes, Slides 7-12)</u>

DO: Show slide 7.

SAY: The first key issue we will discuss is Navigating decision making. We know from our guiding principles that we facilitate the participation of the child in decision making. Indeed, child survivors can and should be involved in the decisions around their care to the extent possible. And it is your role as a caseworker to facilitate opportunities for the child survivor to state their opinions, wants, and needs regarding decisions about their care. And when possible, they should be able to make decisions.

EXPLAIN: Discuss with your partner the following – (1) Can you think of decisions that a young child might be able to make in their case management process? (2) What about a 13- or 14-year-old? (3) Does this change if the 13- or 14-year-old is a girl or a boy? How did you reach your decisions?

DO: Give participants a few minutes (not more than 5 minutes) to discuss. Ask a few participants (max 3) to share the key points from their discussion. Identify common themes among the answers.

DO: Show slide 8.

SAY: A caseworker has to consider the following when it comes to children and decision making:

» Age and developmental stages and evolving capacity of children affect their ability to contribute to decision making.
» The type of decision – some decisions must be made by the caregiver, but there will be others that do not require this (e.g. whether / who the child wants to have with them while they speak to a caseworker). To the extent possible, caseworkers should maximize opportunities to provide children with options that empower them to make decisions, even if they seem like small decisions.
» Degree of decision-making. A child can contribute to decisions being made even if they are not ultimately the decision maker. In critical care and treatment decisions, hearing the views and opinions of a child survivor can help a caseworker evaluate what decisions are in the best interest of the child.

DO: Show slide 9 (with text blocked out).

SAY: One of the ways in which we can assess what decisions a child survivor may be able to make is based on their age. Age is not the only element, but it gives us an approximate indicator and is useful for providing a loose framework for children's ability to make decisions.

DO: Review the general guidelines going through the slide by each age category.

SAY: As mentioned before, we should not rely solely on a child's age to evaluate their capacity to make decisions. Caseworkers are also responsible for understanding and assessing a child's development and capacity for understanding as well as their maturity.

DO: Show slide 10.

SAY: Children grow and develop in common ways but there is a lot of variation between individual children in the rates that they begin to understand different concepts. We can assess the evolving capacity of a child and their decision-making ability by considering the following:

» Expressing a choice – can the child communicate their preference?
» Understanding – does the child understand the information provided? Did the caseworker provide the information in appropriate ways to ensure understanding?
» Reasoning – can the child understand and compare the possible benefits and risks to the decision being made?
» Appreciation – does the child understand the various options and how those options are relevant to them personally?

It is also important for us to remember that there are many different factors that can impact capacity and the rate of development, including culture, disability, social norms around children and around gender, and intensive experiences of trauma and adversity.

DO: Ask participants if they can think of other things that can impact a child's capacity and how it develops? Get a few answers.

SAY: It is critical that, when working with child survivors, caseworkers continue to assess maturity and capacity throughout the case management process. Caseworkers will also need to consider how in each specific instance the child's contribution to decision making upholds the child's best interests. We will get into this more in the next sessions when we do the case scenarios.

DO: Show slide 11. Ask participants to think about the communication best practices we discussed in Module 4 and the CCS guiding principles. Ask them to name some ways that they can facilitate a child's participation in decision making.

DO: Show Slide 12. Review the responsibilities for caseworkers and supervisors. Ask participants if they have anything else to add.

SAY: We have talked about the importance of and how to engage a child in decision making based on different considerations – but let's think about why this is a key issue. What may be some of the challenges that arise in facilitating the decision-making of a child in their care and treatment? Does anyone have any experiences they would like to share?

DO: Write participants responses down on the pre-prepared flip chart paper for Navigating Decision Making.

EXPLAIN: In our upcoming case scenario activity we will explore how to work through some of these challenges.

Key Issue 2: Gaining Informed Consent and Assent (30 minutes, Slides 13-22)

DO: Show slide 13.

SAY: The next issue we will discuss is Gaining informed consent and assent from child survivors and their caregivers. This is also one of our CCS guiding principles.

DO: Show slide 14 without content. Ask participants how they would explain informed consent. What about informed assent? Go through the definition of each by reading the content on the slide. Explain that these are the definitions for informed consent and informed assent that we use in the CCS Guidelines.

DO: Ask participants when a caseworker has to obtain informed consent and/or assent. Take a few responses. Then show and read slide 15.

DO: Show slide 16 without content. Ask participants to name some of the elements of the informed consent process. In other words – what caseworkers must do as part of gaining informed consent. Get a few answers. Then go through the content on slide 16.

DO: Show slide 17.

SAY: There are general guidelines that we use in CCS case management to help us have a framework for obtaining informed consent and assent that are based on age.

DO: Review the guidelines shown on slide 17. Remind participants that these are general guidelines and are not meant to be absolute. Caseworkers will have to consider the child's evolving capacity to make decisions (which we just discussed under Key Issue 1) as well as the any local laws that delineate a legal age of consent for children.

SAY: Service providers often assume that children with disabilities are not able to provide consent – however this is not accurate.

DO: Show slide 18. Explain that when working with a child survivor with disabilities we should follow these general principles with respect to informed consent.

DO: Show slide 19. Ask participants to identify what the responsibilities of a caseworker are in the informed consent process? What about for a supervisor? Review the content on the slide starting with the caseworker. Ask if there is anything to add.

DO: Ask participants to form their own groups of three with the people near them. In these small groups ask them to discuss what they anticipate being or perhaps have already experienced

as major challenges with obtaining informed consent/ assent in child survivor cases? Give the groups 10 minutes to discuss.

DO: After 10 minutes, ask participants to share challenges they discussed. Record them on the pre-prepared flip chart paper for **Gaining informed consent/ assent.**

SAY: Seeking informed assent and informed consent can be challenging for all of the reasons you identified. There are some particular challenges I would like to highlight.

DO: Show slide 20-21. Go over these key challenges noting the ones that participants already identified and are on the flip chart paper. Also note new content not identified by the participants and add this to the flip chart paper.

SAY: Show slide 22. In situations in which it is challenging to obtain informed consent/assent for services from the caregiver, caseworkers should consider the following:

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

» **If the caregiver is refusing consent, what are the driving factors for doing so?** If a non-offending caregiver is reluctant or refuses to consent to services for their child initially or throughout, it is important to understand their underlying concerns. A caregiver may not want to consent because of shame, stigma, security/retaliation and/or fear. In the absence of an urgent health or safety need, the caseworker should:
  - engage with the non-offending caregiver to better understand their refusal or hesitancy
  - identify critical barriers to giving informed consent;
  - assess if those barriers can be addressed, removed, or the risk associated with them reduced;
  - create a plan to address barriers with the non-offending caregiver before seeking informed consent again.

» **What is the age of the survivor and their capacity for consent?** In situations in which children are old enough or determined to have the capacity for decision-making, they can give their own consent without the consent of the caregiver.

» **What are the legal parameters for consent within the context?** There may be contexts where there are legal determinations as to the age of consent and processes that must be followed. In other contexts, there may not be such legal frameworks in place, permitting the caseworker to make a determination or in some cases act on behalf of the child.

Key Issue 3: Upholding and Navigating Confidentiality (15 minutes, Slides 23-27)

DO: Show slide 23. Explain that we will now talk about **navigating limits to confidentiality in child sexual abuse.** Ask participants to explain what confidentiality means in case management. Take a few responses.

DO: Show slide 24. Remind participants that upholding confidentiality is also a CCS guiding principle.

DO: Ask why confidentiality is so important for child survivors. Take a few responses.

SAY: There are also important limits to confidentiality. Why do limits to confidentiality exist in case management with child survivors? Take a few responses.

DO: Show slide 25 and review the content.

SAY: Ultimately, limits to confidentiality exist to ensure the safety of child survivors and to uphold their best interests. When confidentiality needs to be broken, caseworkers should also do this in a way that upholds the CCS guiding principles and the best interests of the child, in particular.

DO: Show slide 26 and review the content. Ask if there are any questions and explain that we will further explore explaining confidentiality and its limits in another session.

DO: Show slide 27. Ask what the responsibilities are of the caseworker in navigating limits to confidentiality. Take a few responses and then review the content on the slide for caseworkers. Then do the same for the content on supervisors.

SAY: What do you anticipate or have you experienced being some of the challenges with confidentiality in child sexual abuse cases?

DO: Give the group 5 minutes to share challenges. Record challenges on the pre-prepared flip chart **navigating Confidentiality and its Limits.** Explain that as with the other key issues we will explore some of these challenges further in case scenarios.

Key Issue 4: Navigating Mandatory Reporting (25 minutes, Slides 28-34)

DO: Show slide 28. Explain that we will discuss the final key issue – **Mandatory Reporting laws and policies** and how we navigate them in case management with child survivors. Ask for a volunteer to explain what mandatory reporting is.

DO: Show slide 29. Review the content on what mandatory reporting is and its potential goals.

SAY: Does anyone know if there are / what the mandatory reporting laws are here? If mandatory reporting laws do exist, what are its goals? Take a few responses.

DO: (If mandatory reporting laws do exist in the training context) Give each participant a copy of the Handout of mandatory reporting laws in their context. Give them 5 minutes to read them. Then, ask them to turn to the person next to them and discuss – were they aware of these laws? What do they think the goals are? Give them 5 minutes to discuss. In plenary, ask a few participants to share key points of their discussions, focusing on what participants think the goals of the laws are.

SAY: It is important and helpful to understand the goal of the law or policy as a caseworker or supervisor because sometimes following mandatory reporting puts a child at further risk of harm. Understanding the goal of the law may help us meet that goal while mitigating the risk of further harm to the child survivor.

DO: Show slide 30. Ask participants if they think any of these circumstances may exist in their context. Take a few responses.

DO: Show slide 31. Remind participants that the best interests of the child should always guide decision making and actions with respect to mandatory reporting.

SAY: Similar to the need to break confidentiality, caseworkers must prepare the child survivor and caregiver for any mandatory reporting requirements they may need to follow. This should happen during the informed consent process. Caseworkers must also discuss with the child and caregiver how to mitigate safety concerns should the mandatory reporting present the possibility of further harm.

SAY: Just like with the other key issues, both supervisors and case workers have different responsibilities in understanding, applying, and adhering to mandatory reporting laws and policies while ensuring the best interest of the child.

DO: Review the content on slide 32. Ask if there are any questions or anything to add.

SAY: What are some of the common challenges, concerns, and issues around mandatory reporting?

DO: Note responses on the pre-prepared flip chart for **Navigating Mandatory Reporting.**

SAY: We will be working through all of these in more detail in the next activity so we will have more time to think through these challenging situations.

DO: Show slide 33.

SAY: Before we move on to the next activity, let's talk about the Prevention of Sexual Exploitation and Abuse policies and how they are related to these key issues. Sexual Exploitation and Abuse policies are policies that exist in organizations and are set up to ensure safeguarding and accountability for perpetrators who are humanitarian workers. They are not the same as mandatory reporting in that they are not part of a national law system. PSEA policies should have reporting methods that allow someone to make a report about an aid worker without divulging the identity of the survivor. Similar to all the key issues the best interests of the child survivor should always guide decision making and actions.

DO: Show slide 34. Ask if participants have any questions. If participants note particular challenges with PSEA reporting, add them to the flip chart for mandatory reporting – noting that it is specific to PSEA.

Key Issues Reflection and Practice (90 minutes, slides 35-36)

DO: Place the populated flip charts for each key issue on a wall or somewhere the participants can see them all at once.

EXPLAIN: We are now going to take some time to look at all of the challenges that you came up with for all of these key issues and reflect on common themes. Take 10 minutes to do a gallery walk of the challenges and note the common themes you see.

DO: Bring the group back to plenary and ask for a few participants to share their thoughts and reflections on common themes. If participants do not name these themes be sure to note them for the group: safety of the child, involvement and decision-making of the caregiver, caseworker making decisions based on the best-interests of the child. Allow 15 minutes for discussion.

EXPLAIN: Now we will use case scenarios to help us practice working through the challenges these key issues raise.

DO: Show slides 36-37 with the case scenarios. Distribute copies of Module 5 Case Scenarios for Participants.

EXPLAIN: Each case scenario will present one or more of the four key issues we have discussed – decision making; informed consent/assent; confidentiality and mandatory reporting. They will break into small groups and be assigned one of the case studies to work through. We will then discuss them in plenary.

DO: Show and review slide 38. Explain that these are the questions participants will use to discuss their assigned case scenario.
Break participants up into groups of four or five people. Assign a case scenario to each group. If you need to have more than five groups you can assign the same case scenario to two groups. Give the groups 20 minutes to discuss their case scenario and answer the questions provided. Go around the room during the group work to observe and be available for questions.

DO: After 20 minutes bring the groups back to plenary. Ask each group to present their scenario and the key points from their discussion. If time allows, you can ask "additional" questions listed in the Case Scenarios for Facilitators copy to prompt the group to think about how if/how their decisions and actions would change based on the identity of the child survivor. Allow 5-7 minutes of discussion time for each case scenario depending on the number of groups you have.

Closing (5 minutes, slides 39-40)

DO: Show slide 39 and review key messages. Show slide 40, ask participants if they have any questions and close the module.

HANDOUT 5.1. CASE SCENARIOS – PARTICIPANT

Scenario 1

[NAME] is a 12-year-old girl. She has come to you for case management services because her uncle has been sexually abusing her. While you are explaining services and getting informed assent from her, you tell her that you also need to get informed consent from one of her parents or caregivers. She says that he has not told her parents about this and is afraid what will happen if her parents find out. She is worried that they will blame her and tells you that if either of her parents finds out what happened that they will beat her for being "impure." She asks you if you can provide services to her 'in secret.'

Scenario 2

[NAME] is a 13 year old girl married to an older man who is prominent in the community. She has been married for a few months and comes to see you at the Women and Girls Safe Space because she heard that she could talk to someone. She tells you that her husband forces her to have sex with him and he is very rough and that it is very painful. She is worried that she needs medical attention. She says that she tried to go to the local health clinic but they turned her away saying that she needed to come with her mother. When she told them that she no longer lived with her mother and that she was married they told her she should ask her husband to come with her. She comes to you for help because she does not know what to do. The pain persists and her husband continues to force her to have sex even though he knows it is hurting her. She says she is not allowed to have contact with her family anymore.

Scenario 3

[NAME] is a 7-year-old boy whose older cousin abused him when the families moved into the same shelter after a storm destroyed the cousin's shelter. He was referred to you by his teacher when the teacher noticed a significant change in his behavior very suddenly. His mother brought him to the center to meet with you but as you explain your services and confidentiality, she becomes very worried and says that she did not know the center was a place for 'people like that' and that no one can know that she brought her son here. You try to explain confidentiality again and that you cannot tell anyone that they came here or why they have come. She keeps repeating herself and restating her fears about others finding out. You try to explain in a different way about confidentiality but it does not seem to help.

Scenario 4

You work in a setting where there was a law that required all survivors of sexual abuse to report to police, obtain a specific form from them and present that form to health care workers before the health workers could provide services to them. This law was recently repealed, and health teams can now provide services to survivors without the police form. However, the law stated that health workers who provided services to survivors without the form could lose their medical license and be prosecuted for breaking the law. Because of this, and because it is not widely known that this law has been overturned, many health providers still will not provide services without the form. An 8 year-old girl survivor you are working with came in with her mother and is complaining of pain in her 'private parts.' She and her mother both want health services to see her but they were turned away at the local health clinic when they tried to seek services there. They have come to you for help after being turned away there. They are now worried that if they go back to the health clinic the health staff will report the case to the police.

Scenario 5

[NAME] is an 11-year-old boy who has been in case management for the past 2 months after her mother discovered that she was being sexually abused by a neighbor. His mother is very supportive and usually attends case management sessions with [NAME]. During the most recent session, you discussed the issue of returning to school and some activities at the child friendly center that [NAME] used to attend. Right after being abused, [NAME] was unable to attend school and often became too upset and fearful to leave the house. Now, he has been doing better for a few weeks and has begun expressing interest in returning to school and being able to do some activities with his friends. [NAME]'s mother has not allowed him to return to school or any other activities. She says that [NAME] still gets very upset and needs more time to recover. [NAME] is insistent that he is ready and wants to return. You have tried talking with them both and suggesting slowly returning to one activity at a time. Both [Name] and his mother have refused this option, with each of them wanting their original suggestion and nothing else.

HANDOUT 5.2. CASE SCENARIOS – FACILITATOR

Facilitators can use these scenarios as a base to contextualize and make more relevant to your context and the issues that child survivors and case workers commonly face. They are split into scenarios that focus more on one aspect than others, however, facilitators should contextualize them as best as you are able to include at least some considerations for all the aspects covered in the previous activity. These four key issues are interlinked and challenges to them occur together and must be thought about and addressed together. Your scenarios should reflect that.

Scenario 1 – Informed consent and informed assent

[NAME] is a 12-year-old girl. She has come to you for help because her uncle has been sexually abusing her. While you are explaining services and getting informed assent from her, you tell her that you also need to get informed consent from one of her parents or caregivers. She says that he has not told her parents about this and is afraid what will happen if her parents find out. She is worried that they will blame her and tells you that if either of her parents finds out what happened that they will beat her for being "impure." She asks you if you can provide services to her 'in secret.'

Note for facilitators: The key to approaching this scenario is assessing whether it is in the best interests of the child to provide services to this girl without a caregiver being involved. Participants should be thinking about – assessing the level of maturity of the girl, discussing with her whether there is another trusted adult in her life who could be involved. There is also a significant safety issue given that the perpetrator is the uncle. Ultimately, at age 12 if the girl seems mature enough and she is unable to identify an adult to provide informed consent, her informed assent is sufficient because it is in her best interests.

Additional discussion questions for plenary (optional)

» How would your actions change if the girl was younger? What if she was older?

Scenario 2 – Informed consent and informed assent

[NAME] is a 13-year old girl married to an older man who is prominent in the community. She has been married for a few months and comes to see you at the Women and Girls Safe Space because she heard that she could talk to someone. She tells you that her husband forces her to have sex with him and he is very rough and that it is very painful. She is worried that she needs medical attention. She says that she tried to go to the local health clinic but they turned her away saying that she needed to come with her mother. When she told them that she no longer lived with her mother and that she was married they told her she should ask her husband to come with her. She comes to you for help because she does not know what to do. The pain persists and her

husband continues to force her to have sex even though he knows it is hurting her. She says she is not allowed to have contact with her family anymore.

Note for facilitators: In this scenario participants should be thinking about the immediate health needs of the girl and facilitating her access to services. At 13 years if she is deemed mature enough, she should be able to provide informed consent because it is in the best interests to do so. The caseworker should also try to understand if there is another adult in the girl's life who could accompany her to seek services and if not whether the caseworker can go with the girl. The caseworker should also be thinking about how they can advocate on behalf of the girl with health care providers such that she accesses services that are safe and confidential.

Additional discussion questions (optional):

» How would your decisions and actions change if the girl was 10 years old?

Scenario 3 – Navigating limits to confidentiality

[NAME] is a 7-year-old boy whose older cousin abused him when the families moved into the same shelter after a storm destroyed the cousin's shelter. He was referred to you by his teacher when the teacher noticed a significant change in his behavior very suddenly. His mother brought him to the center to meet with you but as you explain your services and confidentiality, she becomes very worried and says that she did not know the center was a place for 'people like that' and that no one can know that she brought her son here. You try to explain confidentiality again and that you will not tell anyone that they came here or why they have come. She keeps repeating herself and restating her fears about others finding out. You try to explain in a different way about confidentiality but it does not seem to help.

Note for facilitators: In this scenario, participants should be thinking first and foremost about communication skills – not only how they can explain confidentiality to both the mother and the child in a way that they can understand, but also exploring with the mother what her concerns about what will happen if anyone does find out – is she concerned about stigma, safety? Working with her to understand these concerns and do safety planning/ risk mitigation may make her feel more at ease. Re-iterating your ethical and professional commitment to confidentiality as a safety measure may also help reassure her.

Additional discussion questions (optional):

» What might you do differently if the boy was 14 years old?

Scenario 4 – Mandated Reporting

You work in a setting where there was a law that required all survivors of sexual abuse to report to police, obtain a specific form from them and present that form to health care workers before the health workers could provide services to them. This law was recently repealed, and health teams can now provide services to survivors without the police form. However, the law stated that health

workers who provided services to survivors without the form could lose their medical license and be prosecuted for breaking the law. Because of this, and because it is not widely known that this law has been overturned, many health providers still will not provide services without the form. An 8 year-old girl survivor you are working with came in with her mother and is complaining of pain in her 'private parts.' She and her mother both want her to access health services but they were turned away at the local health clinic. They have come to you for help after being turned away there. They are also afraid that if they go back again that the health staff will report the case to the police.

Note for facilitator: They key issue here is how to get health services for this girl given the obstacle of health providers declining to provide services without a police report. In this case, the caseworker should be thinking about accompanying the survivor and caregiver to the hospital and advocating with the health staff. Caseworkers should attempt to identify a supervisor at the hospital with whom they can speak and explain the change in the law and get reassurance that the new policy with be followed by health staff. The caseworker can bring printed copies of the new law for the health staff to read. The caseworker should accompany the survivor and the caregiver to the health clinic and be present to facilitate access to services. If the hospital still refuses, the caseworker should consider whether there are other clinics that the girl could go to. Lastly, the caseworker should discuss with the mother her concerns about going back to the clinic and the risk of the case being reported to the police. Identifying these concerns and safety planning around them may help the mother feel more reassured.

Additional discussion questions (optional):

» Would your actions change if the survivor was a 14?

Scenario 5 – Navigating Decision Making

[NAME] is an 11-year-old boy who has been in case management for the past 2 months after her mother discovered that she was being sexually abused by a neighbor. His mother is very supportive and usually attends case management sessions with [NAME]. During the most recent session, you discussed the issue of returning to school and some activities at the child friendly center that [NAME] used to attend. Right after being abused, [NAME] was unable to attend school and often became too upset and fearful to leave the house. Now, he has been doing better for a few weeks and has begun expressing interest in returning to school and being able to do some activities with his friends. [NAME]'s mother has not allowed him to return to school or any other activities. She says that [NAME] still gets very upset and needs more time to recover. [NAME] is insistent that he is ready and wants to return. You have tried talking with them both and suggesting slowly returning to one activity at a time. Both [Name] and his mother have refused this option, with each of them wanting their original suggestion and nothing else.

Note for facilitator: For this case, the caseworker should be thinking about evaluating the child's level of maturity and ability to make decisions on his own and helping the mother to see this capacity. The caseworker will want to explore with the mother what her concerns / fears are related to the boy returning and what they can do together to help allay her fears. It may be helpful for the caseworker to have a separate session with the mother as well to emphasise to her the value of having her son return to some level of normalcy and that engaging with other children may be beneficial for his healing. The caseworker should continue to reach a compromise between the two and carrying out safety planning and other strategies that help address the moms concerns.

Additional discussion questions (optional):

» Would your action change if the boy had a disability? What if he was older?

Module 6A

STEPS OF CASE MANAGEMENT

1. OVERVIEW

Duration	5.5 hours
Module Learning Objectives	For participants to: » Understand the key tasks involved in each step of CCS case management. » Learn and practice key elements of assessment. » Learn and practice key elements of case action planning.
Key Messages	» There are six main steps of the CCS case management process – these steps draw from GBV and CP case management practice. » The first step of case management – Introduction and Engagement is critical to the whole case management process and sets the stage for the case management relationship. » Key assessment areas and interventions include safety, health and mental health and psychosocial support. » Case follow-up is an important opportunity for monitoring the child's progress and re-assessing the child survivor's needs.
Materials	» Flipchart, tape, and pens » Printed copies of vignettes – 1 per participant » Handout 6.1. Sample Script for Informed Consent/Assent for a Child Survivor – 1 per participant » Handout 7.1. Safety Planning Tools – 1 per participant
Pre-reading	» CCS Guidelines Chapter 6

2. MODULE OUTLINE

Minutes	Activity
15	Opening
60	Step 1: Introduction and Engagement
30	Step 2: Assessment and Step 3: Case Action Planning Overview
120	Assessment and Action Planning: Safety
45	Assessment and Action Planning: Health
30	Step 4: Implementation
15	Step 5: Follow-up
30	Step 6: Evaluation and Case Closure
5	Closing

3. CONTEXTUALIZATION

N/A

4. SESSIONS

Opening (15 minutes, slides 1-4)

SAY: In this session, we are going to go through the steps of case management in detail, discuss the key actions of each step and have a chance to practice the steps through role plays and case scenarios.

DO: Show slide 2 to share the objectives of the module.

DO: Show slide 3. We identified in the last module that these are the steps of CCS case management.

SAY: Now let's review what the key tasks are of each step.

DO: Show slide 4. Going step by step, ask participants to identify the key tasks of each step and then review it on the slide. Go through each step like this. Ask if anyone has any questions.

Step 1: Introduction and Engagement (60 minutes, Slides 5-8)

DO: Show slide 5. Explain that we will now learn about the key tasks of Introduction and Engagement.

DO: Show slide 6. Ask participants what is involved in greeting and comforting the child. Take a few responses.

SAY: This part of Introduction and Engagement is critical because it is your first time interacting with the child and/or caregiver. You will introduce yourself, do what you can to make the child feel at ease, and observe the child and his/her caregiver if present. How we do this can make a big difference in a child's experience of our services. You practiced this part in the session we did on communication skills in Module 4.

SAY: In the previous module, we also discussed informed consent and assent, its key elements and the challenges that may arise with it. Can anyone name the elements of gaining informed consent and assent?

DO: After taking a few responses, show slide 7. Review on the slide the key elements of informed consent and assent.

SAY: When we gain informed consent / assent as part of Step 1, we are asking for permission to continue with our own case management services. Part of this is also taking the time to introduce ourselves, our agency/ organization and our role.

DO: Handout 6.1. Sample Script for Informed Consent/Assent for a Child Survivor as part of Step 1. Make sure participants understand that this is a sample script that needs to be adjusted for age, etc. Ask participants to take a few moments to read the script to themselves.

SAY: We are now going to read through the script together identifying the key elements of informed consent/ assent as we go.

DO: Ask for a volunteer to read the first paragraph in which the caseworker introduces themselves. Pause and identify that part. Ask for another volunteer to read the next section, pausing to note which element of the consent process it was. Continue in this way through the end of the script. Ask if anyone has any questions about the informed consent script.

EXPLAIN: They are now going to practice Step 1 using the same case studies that we used from the previous day when we were practicing our communication skills. In groups, each of you will take turns being the caseworker, the child survivor and the caregiver. When you are the caseworker, you will practice the key tasks of Step 1 – using the informed consent script as a reference.

DO: Show slide 8. Hand out copies of the vignettes. Break participants up into groups of three. Tell them that each member of the group will get to choose which vignette they use when they play the role of the caseworker. However, they should each choose a different one and to the extent possible it should NOT be the same one in which they played the role of the caseworker during Module 4. After 8 minutes, ask the participants to switch roles and vignettes and continue to do this until each member of the group has had a turn playing the caseworker.

DO: Once each person in the group had a chance to be the caseworker explain that they have now have 5 minutes to discuss and share feedback with each other. After 5 minutes, bring the participants back to plenary and ask them for any reflections, thoughts or questions about implementing Step 1. Ask them what adjustments they made to the script to tailor it for the age / development stage of the child survivor? Allow 10 minutes for discussion.

Step 2 and Step 3: Assessment and Case Action Planning Overview (30 minutes, Slides 9-14)

DO: Show slide 9.

SAY: We are now going to move into Step 2: Assessment and Step 3: Case Action Planning. While we talk about these usually as separate consecutive steps in the case management process, because they are so inter-connected and our case action planning flows from the information we gather during assessment we will discuss the two steps together. In this module, we will be focusing on the key assessment areas of safety and health and the tasks associated with case action planning for each of these areas. In the next module, we will focus on mental health and psychosocial assessment and support.

DO: Show slide 10.

SAY: In step 2, the caseworker is focused on (1) understanding who the child is and the circumstances of their abuse; and (2) understanding the needs the child may have.

DO: Ask participants if they can name some of the things it is useful for a caseworker to understand about the child and the nature of the abuse the child experienced. Take a few responses.

DO: Show slide 11 and name each component.

SAY: We generally want to start with the top tier – Family composition and living arrangements. We will want to know does the child have parents/caregivers? Does the child live with the caregivers? Are there other adults in the household?

Starting with these questions allows us to learn basic, yet essential, context (i.e., understanding) for the child. This also allows us to begin an assessment with questions that are not as threatening and/or scary as it may be for the child to be asked directly about the abuse he or she has experienced.

SAY: We can then move on to gathering certain information about the child's experience of abuse as this is vital to determining the urgency of the child's health and safety needs. Overall, the areas of focus for caseworkers in order to understand what happened include:

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

DO: Show Slide 12. Explain that there are general guidelines related to whether and how we can speak directly to children about the abuse they experienced. Such guidelines are based on the child's age, development stage and estimated capacity for them to recount such a distressing and violent experience. Review the content for each age category.

DO: Show Slide 13 (without content). Ask participants to think back to the session we did on core knowledge areas. Can they name what the primary needs may be for child survivors? Take a few responses and then show the content of the slide.

SAY: We will go into more detail on assessing safety, health and mental health and psychosocial needs in the upcoming sessions. Before we move into those three key assessment and intervention areas, let's review the tasks involved in case action planning.

DO: Show slide 14. Review the two tasks of case action planning.

Step 2 and Step 3: Assessment and Case Action Planning for Safety (120 minutes slide 15-28)

DO: Show slide 15.

SAY: Now we will discuss one of the most important needs that child survivors of sexual abuse are likely to have- safety. What do you think is important for us to understand when assessing the safety of a child survivor? (take a few responses)

DO: Show slide 16. Read the content on the slide.

SAY: What is safety planning? Can anyone share an experience in which they have carried out safety planning? What was the goal? What did you do?

DO: Take 2-3 responses to the extent possible call on a balance of GBV caseworkers who have the experience of safety planning likely with an adult woman and a CP caseworker who may have had the experience with a child not necessarily related to child sexual abuse.

DO: Show slide 17 and go over in more detail the areas of safety assessment.

DO: Show slide 18. Go through each of the points.

SAY: Safety planning is about reducing the likelihood of the child being harmed.

- Making a safety plan does not mean that the child can control the violence that they experience, but rather it is a way to mitigate the risk of violence. Violence is never the fault of the child
- In some situations, safety planning is a life-saving intervention.
- The caseworker works with the child and (when appropriate) their family to discuss the risks they are facing and to plan how to reduce those risks.
- Safety planning is not about removing the danger completely but is often about making a dangerous situation slightly less dangerous

DO: Show slide 19. Review the points on the slide about engaging caregivers.

SAY: Now we will review some safety planning tools that can be used with different ages of children.

DO: Show slide 20 and read the potential tools. Explain that caseworkers can choose one of the tools to use with the child based on the child's age / developmental stage and well as what tool would work best for the child given the circumstances of their case.

DO: Show slide 21. Safety planning table.

SAY: The safety planning table is an in-depth safety planning tool. It uses the categories of: patterns related to the child's safety, the child's responses to unsafe situations, supportive people in the child's life, and safe places the child is already accessing or can access. The caseworker can discuss these topics with the child / adolescent using the questions as a guide – first assessing safety and then using that information to support safety planning. The safety planning table is a good tool to use when you have a longer period of time with the child.

DO: Show slide 22. Explain that the table can also be simplified to be used with children ages 6 and above and show the adaptations.

DO: Show slide 23. Safety checklist.

SAY: The safety checklist is something you can use if the threats to a child's safety are already known. It focuses less on threats to the child's safety and more on specific actions the child can take when they feel unsafe. The child documents the plan and/or memorizes specific actions such as numbers, code words, etc. The safety checklist is appropriate to use with children that can read and write easily.

DO: Show slide 24 Community map.

SAY: The community map helps the caseworker gain a better understanding of the child's community; outline risks and protective factors in the community; and identify unsafe and safe people and places. In this exercise, the caseworkers asks the child to:

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

The caseworker then discusses the drawing with the child to understand the child's drawing and ways in which the child marked people and places. The caseworker can use this information to help the child understand and navigate with risk and protective factors, helping the child draw conclusions about safety threats and who they can seek out/where they can go to avoid unsafe situations or what they can do if they feel unsafe. It can be used with children ages 4-12 and is a good tool to use when a child is less verbally developed or less inclined to use verbal communication.

DO: Show slide 25. Safety circle.

SAY: The safety circle is a very basic tool to identity safety concerns and safe/supportive people in the child's life. It is a good tool to use with young children ages 3 and above who are non- or less verbal that have the ability to hold a crayon and draw basic lines and shapes. The caseworker can ask the child to draw a circle and then to draw inside the circle what and who makes him or her feel safe. The caseworker can then ask the child to draw the things outside of the circle that scare them (the circle being the symbolic boundary of safety). The caseworker should go one by one through the drawing asking the child to explain who that person/ thing is and why they have put them where they put them. If the child is non-verbal the caseworker can ask the child basic yes/no questions that they may be able to understand. With this tool the caseworker will have to help the child and non-offending caregiver formulate a very basic safety plan "When you feel unsafe because of X, you can find / ask for help from Y."

DO: Explain that we will have the chance to practice using the safety tools later in the session. Ask if participants have any questions in the meantime.

SAY: Can anyone think of scenarios when you, as a caseworker, might be so worried about the safety of the child's in their care arrangement that you do not feel you can leave them in that care arrangement? Prompts:

» What about scenarios where the perpetrator lives with the child? E.g. parent, grandparent, older sibling is perpetrator of violence, abuse etc.
» What about scenarios where the parent/caregiver does not feel they can protect the child? E.g. under pressure to agree child marriage, risk of imminent recruitment in to armed forces or armed group etc.
» What about scenarios where the perpetrator is likely to return to where the child is staying? E.g. revenge, abduction etc.

DO: Show slide 26.

SAY: If you have tried to make the child's care arrangement safe, but they are still at imminent risk of significant harm, you might need to consider removing the child from their current care arrangement. This can be done temporarily. Removal should be the last resort.

DO: Show slide 27 without content.

SAY: Changing a child's care arrangement, whether temporarily or permanently is an incredibly serious and potentially damaging thing to do. A child should not be permanently removed from his or her legal guardians or permanent caregivers without a comprehensive assessment of what is/ will be in the child's best interests Where a child is removed from his or her legal guardians or

permanent caregivers, priority should be given to addressing the cause of the separation and to putting in place actions that can enable the child to return safely.

DO: Review the content on slide 27.

DO: Explain that we will now practice using the safety planning tools to carry out safety assessment and planning. Distribute copies of Handout 7.1. Safety Planning Tools.

EXPLAIN: We will break into groups of three and each of you will take a turn being the caseworker, the child survivor and an observer. Each caseworker can choose the vignette they want to work with and identify an appropriate safety planning tool to use for that vignette. Please choose different vignettes and tools as a group so that you are exposed to as many tools as possible. In the role plays, we will assume that that you have already carried out Step 1. Each caseworker will have 15 minutes to be in the role of caseworker and then you will switch.

DO: Show slide 28 with the vignettes explaining that these are the same ones they worked with yesterday. Assign participants to groups of three. Walk around the room while the participants are working to observe. After 15 minutes, ask the participants to switch roles. After another 15 minutes remind participants to switch roles again.

DO: After 45 minutes, bring the groups back to plenary. Ask participants to share their experiences, reflections and questions with the safety planning assessment and tools. Allow 5-10 minutes for discussion.

Step 2 and Step 3: Assessment and Case Action Planning for Health (45 minutes, Slides 29-33)

DO: Show Slide 29

SAY: Now we will discuss key assessment points and interventions for the potential medical/ health needs child survivors may have. Let's think back to our session on core knowledge areas and what we learned about the health consequences of child survivors. Based on these health consequences, who can name some of the key concerns that child survivors may have?

DO: Show Slide 30 and go over the points.

DO: Show slide 31 (without content).

SAY: How do we assess health needs? During the initial phases of assessment, when gathering information from the survivor and/or caregiver about the circumstances of the sexual abuse, caseworkers should be listening for the following.

DO: Show the content of slide 31 as you talk through each point.

DO: Show slide 32.

SAY: Case action planning related to the health needs requires that caseworkers understand basic information about services available in their context, the parameters for those services and be able to explain this in a way that is accessible for the child and caregiver.

DO: Review the points on slide 32.

DO: Show slide 33. Explain that participants will discuss these questions with the person next to them. Give the participants 15 minutes to discuss in pairs. Then bring the group back to plenary and ask participants to share key points from their discussions.

SAY: Tomorrow we will focus on mental health and psychosocial support assessment and action planning. For now we will return to learning about the key tasks that are part of each of the steps of case management.

Step 4: Implementation of case action plan (20 minutes, Slides 34-39)

DO: Show slide 34. Explain that we will now talk about Step 4: Implementation. Show slide 35 and review the key tasks associated with implementation of the case action plan.

DO: Ask participants to name some of the actions that are involved in these tasks that are part of case coordination. Take a few responses. Show slide 36.

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

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

DO: Show slide 37.

SAY: In step 4, we also lead coordination of care for the child survivors we are providing case management services to.
This may include directly arranging access to services; reducing barriers to obtaining services; establishing linkages with other service providers and holding case consultations and case conferences.

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

DO: Show slide 38. Review the elements of case consultations and case conferences.

DO: Show slide 39 (this is a repeat of slide 35).

SAY: In step 4, we also implement direct interventions – which will be the MHPSS interventions that we will learn in the next module tomorrow. We also implement mandatory reporting if needed. As discussed in Module 5 Key Issues, decisions on mandatory reporting should be made with the child and caregiver and in line with best interests, survivor-centered and do no harm principles. Risk mitigation measures and safety planning related to mandatory reporting should already be in place with the child and caregiver before any reporting is implemented.

Step 5: Follow-up (15 minutes, Slides 40-41)

DO: Show slide 40. Explain that we will now talk about step 5 Follow-up. Ask participants what the key tasks are for step 5. Show slide 41 and review the key tasks associated with follow-up.

SAY: Case follow-up visits allow the child and the caseworker to "update each other" on actions taken since the first meeting and ensure the child has received the agreed upon needed services. It also allows us to assess any improvement in the child's situation, reassess the child's safety situation, assess any new urgent needs that may have arisen since the last meeting, and discuss longer-term needs and care.

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

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

Step 6: Closure and Evaluation (15 minutes, Slides 42-44)

DO: Show Slide 42. Ask participants what the tasks are for step 6. Show slide 43 and review the key tasks. Ask participants if they know what the criteria are for case closure. Then show the case closure content on the slide.

SAY: Case closure is an opportunity for caseworkers to revisit the case action plan with child survivors and non-offending caregivers and to discuss whether the case management goals have been met.

» The caseworker should facilitate a discussion with the child survivor and non-offending caregiver in a manner appropriate to the child survivor's age and developmental stage on whether their goals have been met and if additional services are needed.
» When cases are very complex, and especially where risks are very high, it is likely that a case will remain open for a long time. This is an issue that needs discussion and planning with the case management supervisor to ensure that services are not compromised by an organizational need to close a case before all issues have been worked through.
» In contexts where caseworkers may see the child survivor only one time, they must prioritize the assessment and case action planning steps and provide as much information as possible to the child survivors. The caseworker will need to thoroughly document the information provided to the child. The caseworker should keep the case file open for a period of 30 days, and then close the case if there is no contact with the child client after 30 days.
» In contexts where follow-up is possible, cases should not be closed until the last follow-up is satisfactory. This usually happens when the child's and family's needs are met and/or his/her (normal or new) support systems are functioning. It is important to make sure that case closure is child-centered, and that the child is ready for the case to be closed. When a case is closed, the caseworker should give the child (and caregiver, as appropriate) assurances that he/she is welcome to contact the caseworker in the future if necessary. Caseworkers should document when a case is closed and the specific reasons for doing so.

DO: Show slide 44.

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

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

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

DO: Ask participants if they have any questions.

Closing (5 minutes, slides 45-46)

DO: Show slide 45 and review key messages. Ask participants if they have any questions. Then show slide 46 and close the session.

HANDOUT 6.1. SAMPLE SCRIPT FOR INFORMED CONSENT/ASSENT FOR A CHILD SURVIVOR

Hello [*name of client*].

My name is [*name of staff*] and I am here to help you. I am a caseworker and my role is to help children who have experienced difficulties. I work for [*insert organisation*] and many children benefit from receiving our services. Today we may talk about why you are here so that we can discuss how I can help you and if there is other help that you need I can connect you to these services.
It is important for you to know that I will keep what you tell me confidential, including any notes that I write down during case management. This means that I will not tell anyone what you tell me or any other information about your case, unless you ask me to, or it is information that I need to share because you are in danger. There are sometimes I may not be able to keep all the information to myself for safety reasons.

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

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

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

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

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

Module 6B

MHPSS ASSESSMENT AND INTERVENTIONS

1. OVERVIEW

Duration	5 hours
Module Learning Objectives	» To learn key elements of carrying out an MHPSS assessment for child survivors of sexual abuse. » To learn and practice MHPSS interventions that caseworkers can implement as part of their CCS services.
Key Messages	» A MHPSS specific assessment can be an important tool in identifying and prioritizing the unique needs of child survivors and the MHPSS interventions that will be most impactful for them. » GBV and CP caseworkers, with appropriate training can implement specific MHPSS interventions as covered in this training. » Individual and group MHPSS interventions can be helpful for child survivors. These should be analyzed for best fit within the context.
Materials	» Flipchart, tape, and pens » Printed copies of vignettes for practice – 1 per participant » CCS Mental Health and Psychosocial Assessment – 1 per facilitator, 1 per participant » Healing Education, Relaxation Training, Coping Skills, Problem Solving – 1 per participant, 1 per facilitator
Pre-reading	» CCS Guidelines Chapter 6

2. MODULE OUTLINE

Minutes	Session
5	Opening
45	MHPSS Assessment
90	MHPSS Interventions for Caring for Child Survivors
130	Practicing MHPSS Interventions
25	MHPSS Follow-up
5	Closing

3. CONTEXTUALIZATION

Session	Slides	Contextualization
Practicing MHPSS Interventions	24	Case vignettes for practice can be contextualized with names and other details. If these details are changed they should also be changed on the printed copies that are distributed to the participants.

4. SESSIONS

Opening (5 minutes, slides 1-2)

SAY: In this module we are going to focus on MHPSS assessment and interventions that are part of the CCS approach.

DO: Show slide 2 and review the objectives of the module.

Assessment and Case Action Planning for MHPSS (45 minutes, Slides 3-9)

DO: Show slide 3. Tell participants that we are now going to discuss the mental health and psychosocial needs of child survivors of sexual abuse.

DO: Show slide 4. Ask participants what they think will need to be assessed as part of a mental health / psychosocial assessment. Go through the content on the slide.

SAY: As part of the CCS approach there is an assessment tool that has been developed specifically for assessing the MHPSS needs of child survivors of sexual abuse. Let's take a look at the tool together.

DO: Distribute copies of CCS Mental Health and Psychosocial Assessment tool.

EXPLAIN: This is a tool that is meant to be used with a child survivor after the urgent and immediate health and safety needs of the child have been addressed. This means that the caseworker is likely using this assessment later in the case management process. It may be something that, depending on the need of the child survivor, is used in the first meeting, but it is also possibly by the third meeting or even later. It can be used and updated multiple times after its first use.

DO: Give participants 10 minutes to look at the tool. Show slide 5 and review the points on the slide.

SAY: This tool is meant to help the caseworker and child define the child's existing needs and worries, areas where they might need support, and how to meet these needs. It also helps a caseworker build a better understanding of the sources of support, protective factors and the child's current functioning.

DO: Review the tool with the participants going section by section.

SAY: Part 1 is the coding information for the assessment. Here you will use the same coding you would on the child's case management forms.

Part 2 is where you should discuss with the child what they feel are their most pressing problems, what they're most worried about, etc. This will give you a picture of the concerns and issues of the individual child. It is important to adjust how you ask about the child's problems and worries based on their age and development as well as other identities that may impact their concerns. Depending on the age, development, maturity and other factors, it may be more effective to use drawing, dolls, or other forms of play to facilitate communication with the child.

Part 3 is where you will discuss what the child's family and living situation looks like, the support they have in their family and home. It is also where you discuss what support they have in the wider community. This might be with friends or at school, it might be through a religion/religious practice or through other factors. By the time you finish this section, you should have a fairly good understanding of the child's interpersonal and community support and protective factors. You should also have an idea of potential risk factors at these two layers as well.

Part 4 serves as a functioning assessment of the child and consists of 7 yes or no questions. This can help you to understand how the child is currently functioning. Part 4 can be repeated later, after an action plan has been implemented, to assess how the child is functioning after referrals, action steps, and other support has occurred. There is no set score to determine "functioning" vs. "non-functioning" – this is merely a tool to see where and how the child might be struggling in an effort to give the caseworker a fuller picture.

Part 5 is a caregiver assessment. It may not always be possible or safe to do the caregiver assessment. However, when it is safe and appropriate to do so, this will help you understand how the caregiver views the child's experience of abuse, how they think the child needs to be supported and where the caregiver may need support to be able to better help the child.

Part 6 is used to document both the child's strengths and protective factors as well as the caregiver and family strengths and protective factors. When filling this section out, the conversation may have already given you some idea of each. And you can also ask specific questions to the child. If asking specific questions, do not simply ask "what are your strengths" to the child. Instead, ask questions about what they like to do, what makes them feel good, feel safe, who they like and trust, etc.

Part 7 is the action planning part of the assessment. This section contains three yes or no questions with space to write what actions or MHPSS interventions will be used. It also has open ended questions about the strengths of the child that can support their healing, additional issues that may need action planning and be helped with specific MHPSS interventions.

DO: Show 6 and show the example video of using the tool. After participants watch the video ask them what questions they have about the assessment tool?

EXPLAIN: In the next session, we will learn about specific MHPSS interventions that you can implement with child survivors of sexual abuse based on what you learn from carrying out the assessment with them/ their caregiver.

SAY: We also want to highlight that in some cases the assessment may indicate that a child survivor is struggling with suicide ideation and/or self-harming behavior. If this surfaces, caseworkers (or their supervisors) should carry out a more in-depth assessment of risk.

DO: Show slides 7-8. Review the points on the slide. Emphasise that unless they have already been trained, the participants will require further training and support to carry out a suicide/self-harm risk assessment. Supervisors should make sure that they review this content with their staff, that they are given the opportunity to practice with feedback. Supervisors should make sure that they are available to support caseworkers in this and should ensure that there is always someone on staff that has been trained in how to carry out suicide / self-harm assessments.

DO: Show slide 9 and play the role play video on suicide risk assessment. Ask participants if they have any questions.

MHPSS Interventions for Caring for Child Survivors (90 minutes, slides 10-21)

DO: Show slide 12. Say the four listed interventions: Healing Education, Relaxation Training, Coping Skills Identification and Development and Problem Solving.

SAY: The goal of these MHPSS interventions is to help child survivors gain mastery over the impact of the sexual abuse – in other words give power back to children so that they can have power over the impact of the child sexual abuse. It is critical that caseworkers not only support children with these PSS interventions, but to also teach parents these MHPSS interventions as well so that they can use and reinforce these at home with their children.

» Healing education – emphasize that knowledge is power so providing healing education (aka psychoeducation) is a way of giving power back to child survivors and families.
» Controlled belly breathing helps children to calm their nervous systems so that they can bring their thinking brains back online when stressed or reminded of the incident of child sexual abuse (especially because the experiences are held in the body since the body is where the violation took place. When our minds/bodies are reminded of the child sexual abuse, the stress/trauma response is activated and our brains begin to operate from the place of memory and emotion rather than reason and logic. The long, slow outbreath calms the nervous system and brings our thinking brain back online.
» Coping skills – this helps children to have a toolbox of coping skills so that they are less likely to engage in different methods of extreme coping (e.g., self harm - substance use, cutting, suicide, risk-taking, etc.).
» Problem solving – facilitates giving agency/ power back to children.

EXPLAIN: We will briefly discuss each of the interventions and the key information we need to know about them before practicing them.

DO: Show slide 13 on Relaxation Training.

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

EXPLAIN: There two main exercises we will learn – one is controlled belly breathing and the other is progressive muscle relaxation. There are very simple steps to follow for theses exercise.

DO: Show slide 14 and go through the steps of Relaxation Training explaining each step with the content below:

» **Step 1: Explain the exercise.** Provide a simple explanation of the exercise and what it aims to do. If there is the potential for discomfort or difficult emotions to arise from the exercise, explain this from the beginning. For example, say, "We are going to do a type of special breathing today. This type of breathing is meant to help us feel calm when we get upset. Sometimes when we first start practicing this type of breathing, it might make us feel strange or nervous. When you try this, if it makes you feel uncomfortable, you can always stop breathing this way and return to the way you're breathing right now".

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

» **Step 2: Demonstrate the exercise.** Always demonstrate the exercise first so that the caregiver and child can see it before practicing. You may need to exaggerate the exercise for demonstration practices, particularly if it is a type of breath or an exercise without much movement.

» **Step 3: Have the child (and caregiver) practice the exercise.** Ask the child and caregiver to practice the exercise. This may include doing the exercise with them or giving them verbal instructions as they practice. For example, say, "We are going to breathe in through our noses for a count of three and out through our mouths for a count of three. We will do this three or four times. Then we will try to breathe in and out for a count of four. Are you ready to start?

» **Step 4: Have the child practice at home.** Relaxation exercises take practice. Ask children and caregivers to practice exercises at appropriate times. Tie practice to what the exercise is specifically trying to accomplish for that child. Ask children to start by practicing two or three times when they feel safe, when they can practice without interruption, or when they feel ready to practice. You should also ask the child to try to remember how these practice sessions feel and what they feel after they practice. Tell the child that you will check in about their homework at their next session. As children get more comfortable with the exercises and have ideas about which relaxation exercises they like and work for them, ask them to use these exercises when they are feeling upset, overwhelmed or with other difficult emotions the child has identified as being something where they are needing support.

DO: Show slide 15 and explain that we are going to pause here to practice Relaxation Training by doing these exercises together. First, we will do the belly breathing exercise together. Explain the purpose of belly breathing. Explain that this isn't a role play – participants are just going to be themselves and that you are going to carry out the belly breathing exercise with them.

DO: Allow participants to move in the room so that they can find a comfortable seat. They can sit on their chair or sit or lay on the floor. Follow the instructions for Belly Breathing and implement the exercise with the participants. After doing the exercise ask participants to share reflections of their experience.

EXPLAIN: We will now practice another relaxation technique called progressive muscle relaxation. Share the purpose of progressive muscle relaxation with them.

DO: Again allow participants to find a comfortable position – they can stay where they are or move if they need to. Follow the instructions for Progressive Muscle and implement the exercise with the participants. After doing the exercise ask participants to share reflections of their experience.

SAY: We will now learn about the other interventions.

DO: Show slide 16 and review the key points related to Healing Education.

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

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

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

DO: Show slide 17. Explain that because Topic 1 involves discussing sensitive topics with children it may be better suited to older children. However, Topic 2 can also be implemented with young children and should be adapted according to the child's age/ development stage. Explain that the instructions sheet that you will Handout 9.1. Healing Education will have all of the content that they need to share for each of these topics.

DO: Show slide 18.

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

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

DO: Show slide 19. Explain the steps of developing a coping plan using the text below.

Step 1: Identify safe people and self-comforting actions.
Ask the child, "When you are feeling this way [for example, scared, sad, etc.], who can you talk to?" Have the child list people they feel comfortable talking with.
Ask "When you are feeling this way, what makes you feel better? What do you do to feel better?" Always validate the feelings the child identifies.

Step 2: Identify the activities the child enjoys.
Building on the child's strengths, ask, "How do you feel when you do those things?" Help the child identify positive feelings (for example, happy, relaxed, etc.) they have when engaged in pleasurable individual, family and community activities.

Step 3: Develop a plan with the child.
Building off the child's answers, develop a plan with the child to engage people, activities, interests, skills, competencies and other strengths they have identified, to help them when they need support. Ask caregivers to support the child in carrying out the plan. Follow-up with the child and caregiver at the next meeting to find out if they have tried the plan and whether or not it is helping the child to feel better.

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

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

DO: Show slide 20.

EXPLAIN: Problem solving is an intervention that provides individuals with tools to identify and solve problems that arise from life stressors, both big and small, to improve overall quality of life. Problem solving is very practical, as it mainly focuses on the present, rather than delving into past experiences. Indeed, there are many types of problems that abused children will face, and it is likely that not all these problems are directly related to the sexual abuse the child experienced. During the psychosocial assessment, a child may report difficulties or problems they face in their day-to-day lives. The child may find themself struggling to feel accepted by a parent or friends, or they may have problems going back to school.

Caseworkers assess a child's main problems throughout the psychosocial needs assessment. They use this information to help a child take steps to solve the most important problems they face.

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

DO: Show slide 21. Go through the steps of problem solving using the content below to explain each step.

Step 1: Identify the problems which concern the child the most.
Ask questions such as, "What worries you the most right now?" or "What problems do you have right now?" (This information should be in the first section of the assessment). Some children may have a hard time answering such questions. Refer also to information gathered during the initial assessment. For example, say, "When we first talked, you mentioned that you are not going to school right now, but this is an activity that you enjoy. Can you tell me more about why you are not in school?"

Step 2: Priorities the problems.
If multiple problems are identified during the assessment, hopefully some of them can be addressed through the stress reduction, healing education and coping skills interventions. Work with the child to priorities problems that concern the child the most and can be addressed at some level of intervention. Keep the problems limited to three or fewer and be sure that concrete actions can be taken towards solving the problems.

A ranking exercise is an option to help the child priorities the problems they are experiencing. This starts with a free listing of all problems faced by the child and identified during the assessment. The caseworker and/or child can write/draw each of these or use a symbol for each problem (for example, a book to represent school) and place these on a table or the floor. Then ask the child to

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

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

Practicing MHPSS Interventions (130 minutes, slides 22-24)

DO: Show slide 22 and explain that we will now work in small groups to become more familiar with the interventions and to practice them using a case vignette. Show slide 23 and explain how the exercise will work.

DO: Show slide 24 and distribute copies of case vignettes. Assign participants to groups of four. Assign each group a vignette and explain they will work with this vignette for each practice session.

EXPLAIN: We will begin with Healing Education. You will begin in your groups first by reading individually the instructions and information for Healing Education. You will then discuss how to approach the intervention based on your vignette. Then one of you will be the caseworker, one the child survivor, one a caregiver (if present), and the other observers. You should approach the role play as if you have already gone through the steps of case management with the child survivor – imagine that this is your second or third session with the child.

DO: Distribute the copies of Handout 9.1. Healing Education. Give the group 10 minutes to review the key content for Topics 1-3. Ask them to identify roles for the role play and give them 15 minutes for the role play. Walk around the room to observe each of the groups and check in with them. Bring the group back and in plenary discuss reflections and questions. For 5 minutes. Ask what modifications groups made based on their vignette.

EXPLAIN: Now we go through the same process for coping skills.

DO: Distribute copies of Handout 11.1. for Coping Skills. Give the group 5 minutes to review the steps of the coping plan and discuss how it will apply to their vignette. Then ask them to identify their roles for the role play and begin role playing. Give them 15 minutes for the role play. Walk around the room to observe each of the groups and check in with them. Bring the group back and in plenary discuss reflections and questions for 5 minutes. Ask what modifications groups made based on their vignette.

EXPLAIN: Now we will go through the same process for problem solving. Please rotate through roles so that most group members either get to be the caseworker or the child survivor.

DO: Distribute copies of Handout 12.1. Problem Solving. Give the group 5 minutes to orient themselves to the steps of the Problem Solving intervention. After five minutes ask them to switch to role playing. Give them 15 minutes for the role play. Walk around the room to observe each of the groups and check in with them. Bring the group back to plenary discuss reflections and questions. Ask what modifications groups made based on their vignette.

SAY: Now we will move onto the final interventions – Relaxation Training. We will do this a little bit differently. In your groups you will choose one other person to work with so that you form pairs for this exercise. One person will play the caseworker for Controlled Belly Breathing. And then you will switch and the other person will play the caseworker role for Progressive Muscle Relaxation.

DO: Distribute copies of Handout 10.1. Relaxation Training. Explain that the participants will continue to use the vignette the have been working with. Explain that they will have 10 minutes for each activity.

DO: Bring the groups back to plenary and give them five minutes to discuss and additional reflections on Relaxation Training.

MHPSS Follow-up (25 minutes, Slides 25-29)

DO: Show slide 25.

EXPLAIN: That you will now discuss how to carry out follow-up on MHPSS with child survivors. One intervention, and even multiple MHPSS interventions will not always be enough to meet all the child's needs. Therefore, it is important to understand what additional support they may need. The actions you take in follow-up will depend on how the child responds to the case management process and the interventions you use with them, will depend on your next steps with the child.

SAY: After working with the child and implementing the actions in the MHPSS assessment action plan, what would be your next steps?

DO: Take some responses from participants. Show slide 26.

SAY: As you work with the child, the case worker should be looking to the goals the child has identified, the steps identified in the action plan and what the child, their family and support, and the case worker have done to reach these goals.

Returning to and reviewing the action plan and the child's goals will help both the case worker and the child to understand what MHPSS interventions the child has tried, which ones they may have been using more than others, which interventions they feel are helpful and "working" and which ones have not felt helpful to them.

DO: Ask participants – how they will know if the child is improving in terms of functioning? How will they know if they feel they are better able to move through their emotions? Take responses from participants.

SAY: There are several factors that will impact how you assess if the child is improving and if specific MHPSS interventions are useful for the child. These include:

» Do we know the functioning of the child prior to experiencing sexual abuse?
» Can the child tell us about that functioning?
» Has a parent or caregiver told us about the child's functioning prior to experiences of abuse?
» Can we look at how they were functioning when first starting the case management process vs. now?

We can look to Part 4 of the assessment and gauge the impact of MHPSS interventions based on their functioning at the time of the assessment. Reassessing using Part 4 can give us an idea of the impact and effectiveness of the interventions we have been using with the child.

DO: Ask participants what they think would be the next steps if the child is doing well and seems to be improving and regaining a sense of normalcy? Take responses from participants. Show slide 27.

SAY: If the child seems to be improving, this can be a time to reassess their worries and see if there are other concerns they need and want to try to address. It may also be a time when you discuss what continued support looks like – whether that is continuing case management as is, reducing case management sessions, or starting a transition process to community-based group interventions held within a child-friendly space or Women and Girls' Safe Space or other interventions.

DO: Ask what do you think would be your next steps if the child continues as they are but does not show any signs of doing better or regaining a sense of normalcy? Take answers from participants.

SAY: If the child is staying as is and not improving but also not getting worse, it is important to examine the coping strategies they're using and assess which strategies the child feels are helping and which do not feel effective. Then try adding in others or identifying additional community-based support as part of a process to reevaluate how we're meeting the child's needs.

DO: Bring up slide 28. Review the examples of how they can discuss this with the child.

DO: Ask what do you think would be your next steps if the child seems to be struggling or having additional concerns that do not seem to be helped by the interventions you're using/the case management process? Take answers from participants.

SAY: If the child seems to be struggling and you do not feel that the actions you've tried are making an impact, the next steps will depend on what other available MHPSS services are available. It is important for us as caseworkers to recognize that some child survivors need more specialized support that may or may not be available. We need to recognize that how we respond to each child in this situation is dependent on their unique needs and support as well as the MHPSS services that may or may not be available.

When specialized MHPSS services are not available, things like safety planning, assessing emotional and psychosocial safety, available and trusted family and community support, and others are important to reexamine and reassess how they're being accessed.

If specialized MHPSS services are available, they may be an option for referral. They should be assessed for their safety and competency with child survivors. Child survivors should also know that a referral to these services does not mean the end of case management support. You as the case worker can also still continue seeing them and working with them even after a referral is made.

DO: Pull up slide 29 on the screen. Here are some examples of how you could begin to do this.

Closing (5 minutes, slides 30-31)

DO: Show slide 30 and review the key messages. Show slide 31 and ask participants if they have any questions and close the module.

Module 7

COORDINATING CARE FOR CHILD SURVIVORS

1. OVERVIEW

Duration	2 hours
Module Learning Objectives	For participants to » Understand the importance of appropriate and effective coordination for child survivors of sexual abuse. » Begin to develop or expand collaborative ways of working between CP and GBV case management teams. » Key consideration for coordination with other actors.
Key Messages	» There is a need for a guide on how child protection and GBV actors coordinate with each other to provide quality and holistic care to boy and girl survivors of sexual abuse.
Materials	» Flipchart, tape, and pens. » For reference, the CCS Tool: Coordination with Government Agencies on Child Sexual Abuse – 1 per facilitator.

2. MODULE OUTLINE

Minutes	Session
10	Opening
75	GBV-CP Coordination
30	Multi-sectoral coordination
5	Closing

3. CONTEXTUALIZATION

Session	Slides	Contextualization
Multi-sectoral coordination	12	Coordination with governments. If government actors will attend the training consider either removing this session or create a space in which participants can discuss altogether how NGO actors and government actors can better work together on the care of child survivors.

4. SESSIONS

Opening (10 mins, Slides 1-3)

SAY: In this module we will discuss the importance of coordination in cases of child sexual abuse.

DO: Show slide 2. Review the objectives of the module.

SAY: Why is coordination important in cases of child sexual abuse? Take a few responses from participants.

DO: Show slide 3. Review the points on why coordination is important.

SAY: Coordination happens at multiple levels in case management. One level is coordination related to a particular case. We talked about this in Module 6 when we discussed Step 4: Implementation of the case action plan in which caseworkers must lead on the coordination of care for the child survivor.

SAY: In this session we are going to focus on coordination at an organization and sector level. In other words, how we can establish or strengthen relationships and systems of coordination around the care of child survivors of sexual abuse. This in turn can help facilitate more effective case level coordination that the caseworker is engaged in.

SAY: Let's take a moment to brainstorm the other service providers and actors that we must coordinate with in order to ensure quality care for child survivors of sexual abuse.

DO: Note responses on flip chart paper (ensure that CP/ GBV actors, health, MHPSS, government actors are listed).

Coordination between CP and GBV actors (75 mins, Slides 4-8)

DO: Show slide 4.

SAY: We are going to bring our focus now to coordination between CP and GBV actors. This is probably the most important relationship to build because both CP and GBV actors are usually the initial entry points for services for child survivors and because of the expertise that each sector brings to working on child survivor cases and the potential for collaboration on a case and systems level. There are also various compounding GBV and CP concerns that may show up in a child sexual abuse cases that require collaboration such as:

» Intimate partner violence (IPV).
» Child, early, and forced marriage.
» Child labor.
» Child associated with armed forces and.
» Children's need for alternative care, and others.

DO: Show slide 5. Explain that participants are going to work in small groups to discuss these questions. Break participants up into groups of 4-5 participants. Give participants 30 minutes for discussion in small groups.

DO: Bring the groups back to plenary. Ask one group to share their discussion on the first question. Ask the other groups if they had similar themes come up. Is there anything they would add? Anything different? Proceed in this way for each question.

SAY: You all came up with some excellent strategies to strengthen collaboration. Let's review together some of the ideas that are in the guidelines.

DO: Show slides 6-7 sharing the content below. Explain that these are strategies that can be implemented between service providers (so at the agency level). Highlight where the strategies that participants identified overlap.

Slide 6: Develop coordination agreements. Coordination agreements are formal documents which outline key principles and different roles and responsibilities of service providers when responding to cases of child sexual abuse. These can take various forms, including:

» dedicated SOPs for child survivors;
» provisions for child survivors in broader GBV and/or CP SOPs;
» context-specific case management guidelines;
» service-level agreements between two or more partners/teams;
» simple guidance notes developed collaboratively by the relevant actors.

They should include: underlying principles when supporting survivors of child sexual

» services / support that each partner can provide (including locations where each service is available)
» minimum standards for staff competencies;
» criteria / considerations for determining a primary caseworker to each case and differentiation of roles (see section 2. below for more information);
» mechanisms for referral, follow up and information sharing;
» outline of any relevant mandatory reporting laws and how these will be addressed in the specific context;
» coordination arrangements specific to cases of co-occurring violence where a non-offending caregiver is receiving support from another primary caseworker (e.g., a situation where a child's primary caseworker is part of the CP team and the caregiver's primary caseworker is part of the GBV team, or different caseworkers within the GBV team are working with a mother and her child).

Slide 7: Identify considerations for a primary caseworker. Considerations for determining who is the most appropriate primary caseworker will depend on the context, but should consider the following:

» **Preference of the survivor and/or their caregiver:** The child or adolescent's desires in terms of where or from whom to receive services should be honoured to the extent possible unless there is a risk of causing harm (for example, because of a lack of knowledge and/or skills or because their preferred location or organisation is unable to provide a safe and confidential space).
» **Organisational and caseworker's skills and knowledge on how to support child and/or adolescent survivors of sexual abuse:** The organisation should have substantial experience in providing GBV and/or CP case management services, including to children. It is strongly recommended that the individual caseworker should, at a minimum, have received training on GBV or CP case management, and comprehensive Caring for Child Survivor training.
» **Availability of quality supervision and support for the primary caseworker:** Clinical or supportive supervision for the primary caseworker is essential. In particularly complex cases, joint supervision by both a CP and a GBV supervisor might be appropriate.
» **Gender of caseworkers:** Children should always be offered a choice of male or female service provider. Most children, particularly girls, are likely feel more comfortable speaking to a female provider, and in many contexts a female provider will be essential for girl survivors. When a male provider is requested, CP programmes may be better placed to provide support as they often have a mix of female and male caseworkers, whereas most GBV caseworkers are women.

» **Availability of safe, comfortable and confidential spaces for the survivor and their caregivers to receive support:** Given the high risk of stigmatisation when one is identified as a survivor of sexual violence, and the ensuing safety risks, reducing the possibility of any survivor being identified as such must be a key criterion when establishing the confidential location/space for service delivery.
» **For refugee children involved in refugee case processing** (registration, refugee status determination, durable solutions), considering many of the decisions related to refugee case processing will require the best interest procedure (BIA/BID), it may be beneficial to the case to be handled by a CP case worker in order to avoid duplication of assessment and services.

In addition, differentiating the role of the primary caseworker related to others is essential. The primary caseworker should lead the case management process and as such be responsible for: conducting the initial intake and assessment, developing the action plan, conducting regular follow up with the survivor and their caregiver, initiating and following-up on referrals and reporting abuse to the authorities if required and appropriate.

DO: Show slide 8. And explain that these are strategies that could be used between the sectors at local and national levels.

DO: Ask participants for reflections on the strategies for coordination that you have discussed (those presented and that the participants identified). What if any do they think would work in their context? Do any participants already have experience implementing these strategies and if so, what can they share?

Multi-sectoral coordination (30 minutes, slide 9-12)

DO: Show slide 9. Go back to the flip chart from the opening session where you recorded the actors that will likely be involved in the coordination of care for child survivors. Explain that we will now talk about strategies for effective coordination with other sectors.

DO: Show slide 10. Go one by one through the points saying the below.

SAY: These are strategies that can support effective coordination with other sectors.

» **Accompaniment:** When referring a child for services, the primary caseworker can accompany them (if the child has provided consent and it is safe to do so) as they access different services or meet with a different provider. During the meeting, the caseworker can advocate for the survivor, supporting their decisions and encouraging them to ask questions or express any concerns they might have about the service.

- **Follow up:** After completing a referral, the primary caseworker can take the opportunity of following up with the other service provider to provide additional context, address any harmful attitudes or beliefs that might exist, and support the other service provider to better understand the phenomenon of child sexual abuse and how to support the survivor safely and effectively.
- **Case conferencing:** Primary caseworkers can use case conferences as an opportunity to disseminate key messages about child sexual abuse and how best to support a child and their caregiver in order to address harmful attitudes and beliefs and provide on-the-job coaching to other actors with less experience in supporting child survivors.
- **Capacity strengthening:** Formal and informal capacity-strengthening strategies for actors who might come into contact with child survivors include: trainings; focused orientation sessions, on-the-job mentoring and coaching sessions, joint supervision sessions.
- **Sector-level coordination and advocacy:** Leveraging coordination mechanisms at the sectoral level (e.g., cluster/sector or sub-cluster/sub-sector level) can be very effective in developing intersectoral agreements and shared policy positions on key issues that might affect case management of child survivors, such as mandatory reporting, referral mechanisms or consent and assent procedures. Sectoral-level coordination forums can also support individual actors in advocating for changes in sectoral or organisational policies that are harmful to child survivors and/or their caregivers.

DO: Ask participants if they have any examples of good multi-sectoral coordination and to describe the strategies used. Take a few responses.

SAY: Let's talk further about coordination with health actors. I am highlighting the health sector because of the critical services that health actors provide and the complexity and time sensitive nature of them. Close coordination with health providers enables the best chances for accessing health care in a timely manner and for ensuring the critical and unique healthcare needs of child survivors are met in child-led and survivor-centred ways.

DO: Ask participants if they can share any successful strategies they have used in coordination with health actors. Take a few responses and examples.

DO: Show slide 11 and review the strategies on the slide.

SAY: Let's also spend a little bit of time talking about strategies for working with government actors on caring for child survivors.

DO: Ask participants if they can share examples of successful collaboration and coordination with government actors related to caring for child survivors of sexual.

SAY: Collaboration and coordination with government actors is important and can also be complicated. These are some points to consider as you begin to engage government actors in CCS services and coordination.

DO: Show slide 12 and go through each point. Use Handout 14.1. Coordination with Government Actors to further elaborate on each point.

Closing (5 minutes, Slides 13-14)

DO: Show slide 13 and go through the key messages. Show slide 14 and ask participants if they have any questions and close the module.

Module 8A

STAFF WELL-BEING

1. OVERVIEW

Duration	1 hour and 15 minutes
Module Learning Objectives	» Research shows us that staff working with child survivors of sexual abuse experience heightened risk of different types of stress. » Understanding the difference between functional stress and negative forms of stress can help caseworkers recognise when they might be experiencing stress that can impact their own well-being. » Good supervision can mitigate caseworker burn-out or over/ under involving themselves which may cause harm to children and adolescents. » An organizational culture and team culture of feedback, openness and care can facilitate a space in which the risks of higher levels of stress can be mitigated.
Materials	A small, light ball
Pre-reading	CCS Guidelines Chapter 8

2. MODULE OUTLINE

Minutes	Session
15	Opening
20	Understanding types of stress
35	Strategies for staff-care and well-being
5	Closing

3. CONTEXTUALISATION

N/A

4. SESSIONS

Opening (15 minutes)

DO: Show Slide 2. Review the objectives of the module.

DO: Ask participants to stand up and form a circle at the back of the room/where there is space for all of them to stand. Take the small ball with you to do a popcorn round of questions and answers to discuss their teams' current culture and practices of staff support.

SAY: We are going to do a series of questions and answers about staff well-being on your current teams. I will ask a question and then throw this ball (hold up the ball) to someone. If you have the ball, answer the question in a few words and then throw to someone else for their response. We will throw the ball a few times with each question to get responses from the group. After you answer immediately throw the ball to someone else. Any questions?

SAY: In a few words describe what burn-out means.

DO: Throw the ball to a participant. Wait for them to answer and throw the ball to someone else. Let 3-4 participants answer this question. Then ask for the ball to be returned to you.

DO: Summarize their answers and pull out any themes in their answers. Explain that burn-out is a type of stress we experience in the workplace. It is stress that affects our own well-being and often our ability to do our jobs well.

SAY: How can you tell when you or a colleague are experiencing burn-out? What are the signs?

DO: Throw the ball to a different participant. Wait for them to answer and throw the ball to someone else. Let 3-4 participants answer this question. Then ask for the ball to be returned to you. Summarize their answers and articulate any themes.

SAY: What are the current practices or strategies you and/or your team use to support each other with burn-out?

DO: Throw the ball to a participant. Wait for them to answer and throw the ball to someone else. Let 3-4 participants answer this question. Then ask for the ball to be returned to you.

DO: Summarize their answers and draw out themes.

SAY: What other types of support would you like to see from your colleagues? From your supervisor? From your organization? Ask participants to return to their seats and explain that we will continue speaking about burn-out and stress more broadly as well as strategies that can facilitate staff well-being.

Understanding types of stress (20 minutes, slide 3)

SAY: Research shows us that staff working with child survivors of sexual abuse experience heightened risk of different types of stress.
Understanding the difference between functional stress and negative forms of stress can help caseworkers recognise when they might be experiencing stress that can impact their own well-being.

DO: Show slide 3. Go through the different types of stress.

- **Functional stress:** Stress associated with everyday decision making and typical problem solving. Everyone experiences functional stress, which motivates productivity. It is a normal response that can be managed routinely.
- **Cumulative stress:** Stress resulting from prolonged and unrelieved exposure to stressors. Cumulative stress is a common form of stress for humanitarian workers and when not recognised and proactively managed, it can lead to burn-out and compassion fatigue.
- **Critical incident stress:** Stress that is caused by extraordinary events – almost everyone involved in the event will experience this stress. Because this stress is the result of an extraordinary event (for example, a tsunami, earthquake or other natural disaster) it is sudden, disruptive and creates a sense of vulnerability that did not exist before.
- **Secondary traumatic stress:** Sudden adverse reactions that may occur when working with those who have experienced adverse experiences or traumatic events. This form of stress mirrors a survivor's and is generated from the survivor's experience, rather than the worker's direct experiences.
- **Vicarious trauma:** Stress resulting from witnessing or learning about others' experiences, which leads to changes to the worker's beliefs, frame of reference and world view. Vicarious trauma is a continuation of secondary traumatic stress and can lead to longer-term impacts for the worker and the need for their own supportive services as a client to work through these experiences.

EXPLAIN: You and/or your teammates may have experienced all or some of these types of stress beyond "functional stress." The first step in addressing these types of stress is to be able to recognize the signs in both yourself and your colleagues.

DO: Show slide 4. Explain that we are now going to break into groups and discuss specific strategies that can promote staff well-being. Review the questions that you want them to discuss in their groups. Ask them to be as concrete and specific as possible. Break the group up into 4-5 people per group. If there are enough supervisors in the room put them in groups together to the extent possible.

DO: Let the groups have 20 minutes for discussion. Bring them back to plenary and ask for groups to share what they identified, asking each group to share only things that have not been previously mentioned.

EXPLAIN: Ask participants to commit to bringing their reflections on this discussion back to their teammates and supervisor when they return to their jobs. They can also let their supervisors know that is important guidance in Chapter 8 of the guidelines that supervisors can draw from to help foster a climate that promotes staff well-being and collective care.

Closing (5 minutes, slides 5-6)

DO: Show slide 5 and review the key messages. Show slide 6, ask if there are any questions and close the module.

Module 8B

SUPERVISION AND STAFF-CARE

1. OVERVIEW

Duration	1 hour and 15 minutes
Module Learning Objectives	» Participants understand the importance and functions of supervision and be able to adjust to support staff working with child survivors of sexual abuse » Participants become familiar with the supervision tools that are part of the CCS approach. » Participants understand the importance of self-care and collective care for their team, and ways to support caseworkers.
Key Messages	» Caseworkers will always need supervision regardless of skill level. » Continued learning as part of the supervision process is an important part of professional growth and promoting staff well-being, not just providing safe and effective services. » Supervision facilitates quality care to children and adolescent survivors by ensuring caseworkers have the experience, care, and professional boundaries necessary to provide appropriate care. » Supervision helps to address, learn from, and rectify mistakes when they happen. » Supervision for CCS does not have to be an additional burden – integrate into existing practice.
Materials	Copies for each participant and each facilitator of the following CCS Tools: » CCS Knowledge Assessment » CCS Attitude Assessment » CCS Communication Skills Assessment » CCS Case Management Assessment » CCS Case Review
Pre-reading	CCS Guidelines Chapter 8

2. MODULE OUTLINE

Minutes	Session
5	Opening
30	CCS Supervision Practices and Requirements
35	CCS Supervision Tools
5	Closing

3. CONTEXTUALISATION

N/A

4. SESSIONS

Opening (5 minutes, Slides 1-2)

DO: Show slide 2. Review the objectives of the module.

CCS Supervision Practices and Requirements (30 minutes, Slide 3-5):

SAY: Let's talk a bit about what good supervision looks like for supporting caseworkers who are working on child survivor of sexual abuse cases. What may be unique to supervision of caseworkers working on child sexual abuse?

DO: Take a few responses from participants. Show slide 3.

SAY: First, good supervision acknowledges that caseworkers will always need supervision, no matter their experience or length of time that they have been working. In addition to what you have mentioned, the following strategies are part of good supervision for CCS work:

» Encourages and explores what boundaries are important for individual case workers and for the case management team. For example:
    - Create healthy boundaries around work hours, expectations and the limits of what is possible in the environment.
    - Recognise and acknowledge limitations to services, referrals, and operating environments. that make addressing the survivor's concerns harder, and sometimes impossible.
    - Demonstrate healthy boundaries as much as possible for the team.

» Creates learning opportunities through case management meetings and group supervision to learn from mutual experiences of providing case management to child survivors
» Maintains the child's best interests as the centre of the supervision process. Working with child survivors is complex work and caseworkers will continue to develop competencies throughout their work. They need time and space to reflect, think, and learn in order to better meet children's needs.
» Normalizes and expresses empathy for the feelings caseworkers may experience doing this work. Recognition that the complexity of child abuse cases makes can lead to burn out and vicarious trauma for case workers.
» Promotes self and collective care for the caseworkers as individuals and the case management team as a whole.

SAY: In addition to these strategies, we want to emphasise that supervision for CCS work is not intended to add many additional requirements and steps into the supervision process. Rather we encourage you to think about and address critical gaps that your team may have regarding working with child survivors. What do you think they will need support on?

DO: Ask participants to turn to the person next to them to discuss this. Give them 10 minutes and then ask for a few volunteers to share key points of their discussion.

DO: Show slide 4 and explain the supervision recommendations for newly trained caseworkers and more experienced caseworkers.

EXPLAIN: Newly CCS trained case workers must have a smaller case load when beginning to work with child survivors to account for their additional learning, supervision and support needs. Highlight both individual and group supervision processes that should be taking place. Group supervision can be in the format of group support sessions or group education and learning sessions. It can also alternate from time to time. For example, you could have 3 group support sessions per month and 1 group learning session per month.

EXPLAIN: Capacity strengthening assessments on skills, knowledge and attitudes should take place directly after caseworkers are trained in CCS. The results for these should be used to create or adjust each individual case worker's capacity strengthening/learning plan.

EXPLAIN: That capacity strengthening, and supervision never goes away. More experienced caseworkers have different needs, but they still need supervision. More experienced case workers should still have periodic assessments on knowledge, skills, and attitudes. Their capacity strengthening/learning plans should focus more on their personal learning goals around child survivors as they shouldn't need as much around the core knowledge, skills, and attitudes. They can also receive less individual supervision but should still have it. Ask If there are questions before moving to the next session.

DO: Show slide 5. Refer back to the conversations the participants had in pairs a few minutes ago and the ideas they came up with regarding what additional support caseworkers may need. Go over any points on the slide that did not already come up.

» **Addressing multiple forms of violence:** Many times, child survivors are at risk of other forms of violence. This could result in the need for multiple services and sometimes more than one caseworker across different agencies. In such situations, case coordination is integral to maintaining effective services.
» **Working with family systems:** Case workers who work with child survivors need to work with both a child and their family. While this is familiar to child protection caseworkers, it is not as common for GBV caseworkers and should be recognised within supervision processes.
» **Identifying others who need services:** Caseworkers may also identify situations where a non-offending caregiver needs case management services or a child who has perpetrated sexual abuse needs case management services. Particularly when non-offending caregivers need services as well, the need for case consultations and case coordination increases.
» **Recognising risk to other children in the home:** Other children in the home may be at risk of sexual abuse when a caseworker starts seeing a child survivor, as the perpetrator may no longer have access to that child.
» **Suicidal ideation and self-harm:** Further training on how to carry out risk assessment and safety planning.
» **Maintaining boundaries:** With child sexual abuse cases, many boundary issues may arise from multiple sources. For example, a caseworker may be pressured to provide case-identifying information and details.
» **Staff well-being:** Working with child survivors can have an emotional impact on caseworkers. For some, this may be more significant than for other cases. Because of this, boundaries are integral to both self-care and collective care for the team.
» **Caseload:** There may be workload requests that are not sustainable within the team or the larger agency. The caseworker themself may overwork or have poor boundaries with a client because of the urgency and seriousness of the situation.

CCS Supervisions Tools (35 minutes, slide 6-7):

DO: Hand out copies of all of the five supervision tools (Handouts 2.1. CCS Knowledge Assessment, 3.1. CCS Attitude Assessment, 4.1. CCS Communication Skills Assessment, 15.1. CCS Case Management Assessment, 16.1. CCS Case Review). Show slide 6. Briefly go over the main purpose of each tool. Emphasise that there isn't an expectation that supervisors use all of these tools or that they use all of the content from any of them. The idea is for supervisors to think about that they need / want to integrate into existing supervision tools or assessments. Explain that if supervisors do not have existing tools or assessment these ones could start as a foundation that they build from.

DO: Show slide 7.

EXPLAIN: Tell participants that they are going to have the opportunity to review the tools. You will give them time to review the tools individually and reflect on the questions on Slide 7. They will have 25-30 minutes for the individual review and then we will spend another 5 minutes in plenary discussing.

DO: After 25-30 minutes bring the group back to plenary and ask participants for their reflections and questions on the tools.

EXPLAIN: Handout 17.1. Guidance for Integrating CCS Assessments of the Guidelines also recommends key questions from these tools that you can use to integrate into your existing supervision practice.

Closing (5 minutes, slides 8-9)

DO: Show slide 8 and review the key messages. Show slide 9 and ask if there are any questions and close the session.

Module 9

CLOSING

1. OVERVIEW

Duration	30 minutes
Materials	Training certificates Post-assessment (if using hard copy, 1 per participant) Final Evaluation (if using hard copy, 1 per participant) If using electronic versions of these tools – ensure that the link has been sent to participants to complete these documents. Ask them to complete them online before they leave the training.
Pre-reading	CCS Guidelines Chapter 8

2. MODULE OUTLINE

Minutes	Session
30	Closing activities

3. CONTEXTUALIZATION

N/A

4. SESSIONS

Opening (15 minutes, slides 1-4)

SAY: It is now time for us to close our training. Let's take a moment to review the original objectives that we set out for the training.

DO: Show Slide 2. Ask for a participant to read aloud each objective of the training. After each objective is read, remind participants which modules we covered that helped us reach these objectives.

EXPLAIN: Before we close the training, we would like to do one final activity together. Please stand up and let's form a circle together. We will go around the circle and share one thing that we are taking away from this training – what feels most important to us about what we learned or experienced. As the facilitator you can begin and then hand it to one of the participants next to you.

DO: Once you have gone around the circle take the time to thank the participants for their time, energy and commitment. If you are using paper copies of the post-assessment and evaluation ask participants to return to their seats and distribute them so that participants can complete them before they leave the training.

FINAL EVALUATION

1. **In one word, the training was…**

2. **Please rate the degree to which you think each training objective was attained or not:** (in each case circle one choice)

» You have accurate and demonstrable technical knowledge of child sexual abuse

Very well Well Poorly Not at all

» You have a suitable approach and appropriate attitudes towards child survivors

Very well Well Poorly Not at all

» You have improved skills in engaging and communicating with child survivors of sexual abuse

Very well Well Poorly Not at all

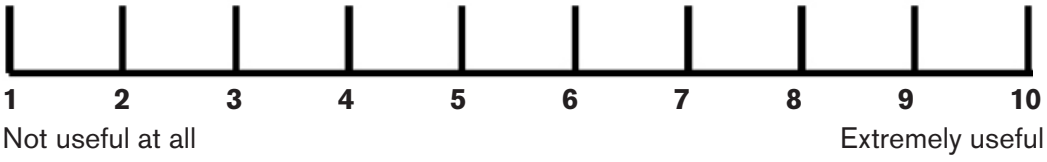
» You have increased knowledge of principles, procedures and improved skills in delivering case management for child survivors

Very well Well Poorly Not at all

» You have learned at least three key MHPSS interventions for child survivors

Very well Well Poorly Not at all

3. **How useful was this training to your work:**



4. **How was the pace of the training?** (Circle one choice)

   Much too fast Fast OK Too slow

5. **How was the level of interaction both in-between participants and between participants and the facilitators during the training?**

6. **How was the quality of logistics and administration?**

7. **What three things did you learn from this training that you did not know previously?**

   »

   »

   »

8. **What aspect of the training was most valuable to you? Why?**

9. **What is the one thing you would like to have seen included in the training, which did not get covered?**

10. **Any other comments:**

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December 2023