Child and Adolescent Survivors of Sexual Violence and COVID-19
Key Considerations and Practical Guidance

Purpose

This document provides key considerations and practical guidance for case management actors and coordination groups supporting child and adolescent survivors of sexual violence (child and adolescent survivors) in the context of the COVID-19 pandemic. It builds on existing guidance developed by the interagency Child Protection (CP) and Gender-Based Violence (GBV) communities, namely the global CP Area of Responsibility (AoR), global GBV AoR, Alliance for CP in Humanitarian Action (CP Alliance), and the GBVIMS Steering Committee. Specific guidance is provided on:

Impact on Girls and Boys

Learning from prior infectious disease outbreaks and reports of increased GBV and child abuse within the current COVID-19 crisis[1] show clear linkages between pandemics and violence perpetrated against women, children, and adolescents[2]. Through the lens of sexual violence, children and adolescents – girls[3] and boys, including those with disabilities – impacted by the COVID-19 pandemic are therefore at heightened risk of:

- Sexual abuse and intimate partner violence (IPV). Child sexual abuse is typically perpetrated within the home by someone known to the child or adolescent[4]. Movement restrictions such shelter-in-place policies increase girls' and boys' exposure to potential perpetrators and isolate girl and boy survivors at home with their perpetrators, increasing risk of continued perpetration of sexual abuse and violence. Girls who are married and experiencing sexual abuse and other forms of IPV will also be trapped at home with their abuser(s) and likely face increased frequency and severity of the abuse and violence, additional caregiving responsibilities (for children, older adults, and/or in-laws in the household), and limited or no access to support services. Being out of school and with an increase in unpaid care work may also put girls at increased risk of sexual harassment and violence outside of their homes. Perpetrators may also use the pandemic to further threaten, scare, or control child and adolescent survivors, further restricting survivors from seeking and accessing the support they need.

- Child, early, and forced marriage and female genital mutilation. Economic and food insecurity and the breakdown of informal and formal support structures due to COVID-19 may lead families – and in particular marginalized groups such as those living in isolated, remote areas and in internally displaced and refugee settings which tend to be cramped and insecure – to use child, early, and forced marriage (CEFM) of their girl children (and to a much lesser extent for their boys) as a coping mechanism. An estimated additional 13 million child marriages will take place in the next decade due to the disruption to programs and economic impacts of

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[1] https://www.nytimes.com/2020/04/07/opinion/coronavirus-child-abuse.html
[2] https://www.cgdev.org/sites/default/files/pandemics-and-vawg-april2.pdf
[3] For more information on the impact of COVID-19 on adolescent girls, please see UNICEF and IRC's *COVID-19 – GBV Risks to Adolescent Girls and Interventions to Protection and Empower Them*.
[4] http://www.d2l.org/wp-content/uploads/2017/01/all_statistics_20150619.pdf

COVID-19.[5] It is also estimated that 2 million female genital mutilation cases may occur over the next decade due to COVID-19-related disruptions to prevention programs such as community empowerment programs and abandonment proclamations which are typically implemented in group settings[6].

- Sexual exploitation and trafficking. The economic fallout of COVID-19 and restricted and reduced access to services increases the risk of children, in particular girls, to be coerced into sexually exploitative relationships to obtain basic items such as food, clothing, and menstrual hygiene products. Families may also exploit their children – sexually or in terms of child labor (e.g., domestic work) which increases risk of sexual violence – as a coping mechanism or be groomed by traffickers to so. COVID-19 quarantine measures and deaths may leave children and adolescents without their caregivers, and unaccompanied or separated or orphaned children and adolescents are particularly vulnerable to sexual exploitation, including commercial sexual exploitation. In contexts with internet accessibility, children and adolescents (girls and boys) may be groomed directly by perpetrators and traffickers. Trends from Southeast Asia have shown an increase in online, on-demand child sexual exploitation and abuse during the pandemic[7].

Important to note is that in addition to increased risk of sexual violence, the usual channels for early detection of and entry points for disclosure of sexual violence – e.g., schools, women and girls safe spaces, adolescent sexual and reproductive health services, safe healing and learning spaces, child- and adolescent-friendly spaces, etc. – may become inaccessible due to movement and gathering restrictions. In addition, health centers will likely be overwhelmed with the COVID-19 response and GBV referral pathways disrupted, leaving little capacity for safe referral of survivors.

Response [Case Management Actors and Other Relevant Direct Service Providers]

The response guidance below builds upon the case management guidance provided by the inter-agency CP and GBV communities[8] to provide guidance on the provision of case management services to child and adolescent survivors of sexual violence. The inter-agency GBV and CP case management resources for COVID-19 should be reviewed prior to reviewing the guidance below to ensure proper grounding and to determine the most appropriate modality of service delivery: continuation of face-to-face case management with integration of infection prevention and control measures, remote case management, engagement of trained community volunteers, or a combination of these. Regardless of the service modality, all direct service providers must adhere to the guiding principles for working with child and adolescent survivors[9]: 1) promote the child/adolescent's best interest; 2) ensure the safety of the child/adolescent; 3) comfort the child/adolescent; 4) ensure appropriate confidentiality; 5) involve the child/adolescent in decision-making; 6) treat every child/adolescent fairly and equally; 7) strengthen children/adolescents' resiliencies.

Entry Points for Disclosure/Early Detection

UNICEF's *Not just hotlines and mobile phones: GBV service provision during COVID-19* offers useful guidance and ideas to address inaccessibility of services and for teams facing severe access restrictions who may be considering a system that leverages trained community volunteers in highly inaccessible areas. Additional ideas to help child and adolescent survivors (and/or their safe caregivers/trusted adults as appropriate) safely request help or access support include:

➢ Adapting programming at child-friendly spaces, safe healing and learning spaces, women and girls safe spaces, and youth-friendly spaces to comply with COVID-19 risk mitigation measures. For example: having personal protective equipment and hand washing stations available, ensuring appropriate spacing of staff and participants, meeting in smaller groups for shorter periods of time throughout the day, facilitating programming outside, etc.). Recreational activities rather than curriculum-based activities should be facilitated given the volatility of the situation.
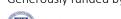
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[5] UNFPA Interim Technical Note: Impact of COVID-19 Pandemic on Family Planning and Ending Gender-based Violence, Female Genital Mutilation and Child Marriage (27 April 2020)
[6] UNFPA Interim Technical Note: Impact of COVID-19 Pandemic on Family Planning and Ending Gender-based Violence, Female Genital Mutilation and Child Marriage (27 April 2020)
[7] https://www.ecpat.org/news/covid-19-sexual-abuse/
[8] More specifically, the: GBVIMS Steering Committee, Case Management Task Force of the CP Alliance, global CP AoR (via guidance developed by country coordination mechanisms), and global GBV AoR.
[9] For more information, please see page 88-90 of *Caring for Child Survivors: Guidelines for Health and Psychosocial Service Providers in Humanitarian Settings.*

➤ Developing activity packages, tailored by gender and age/developmental stage, and distributing these household by household (in compliance with COVID-19 risk mitigation measures) on a weekly or bi-weekly basis. The activity packages can include materials adapted from programs/curriculum such as *Girl Shine* or *Supporting Adolescents and their Families in Emergencies (SAFE)*,[10] as well as information (packaged/messaged in a safe way) on how to send an alert for help (for example: having the child or adolescent draw a smiley face by their name on the "assignments" they will hand in when the next activity package is distributed the following week). Distributing and providing information/directions on the activity package each week to the household can also be an opportunity to try and observe how the child/adolescent is doing and the dynamics in the home, even if it is at a distance.

➤ Collaborating and coordinating with Education actors to integrate alert systems into classes or assignments they must submit to/have collected by teachers/education actors on a weekly basis. If children and adolescents are attending school online, then CP and GBV actors can train education actors on signs and symptoms of abuse and safe referrals, advocate with teachers to design classes with small group activities to better observe students, and collaborate with them to develop other types of alert systems for children/adolescents to use during the online classes.

➤ Mapping any places and people that girls, boys, and safe caregivers/trusted adults still access and when they go to those places to support entry point creation. To the extent possible, children, adolescents, and trustworthy allies (e.g., youth groups/networks, women-led organizations, disability-focused organizations, community-based child protection networks) should be included in this process. Once these locations and individuals are mapped, CP and GBV actors can work to place staff, child/adolescent/family help desks, "suggestion" boxes, or other safe alert systems in those spaces, including training on safe referrals as needed.

➤ Doing an analysis of cases within a specific context (for example, via GBVIMS data) to better understand any trends in the cases being reported. Based on these trends, CP and GBV coordination groups and service providers can develop strategies to prevent or mitigate harm and increase accessibility to services.

➤ Creating or linking to existing GBV and/or child hotlines and helplines. Please see Section 7 of the CP AoR Child Protection Resource Menu for COVID-19 for helpful guidance on child helplines. Additional guidance notes on remote service delivery, including the distinctions between hotlines and helplines, are currently under development by UNICEF and partners, and will accompany the GBVIMS Steering Committee's series of video shorts and podcasts for guidance on remote GBV case management in the context of the COVID-19 response.

Guidance for New Cases

➤ For new cases that come through GBV or child hotlines/helplines, it is important to recognize that this one call may be the only opportunity to speak with the child/adolescent survivor or individual calling on behalf of that child/adolescent, so it is critical to focus on urgent needs and what can feasibly be done during this call (e.g., health and safety planning). For more information, please see the child helpline guidance in the CP AoR's COVID-19 Resource Menu as well as Episode 4 – *Taking a Crisis Call* of the GBVIMS Steering Committee's COVID-19 series noted above.

➤ As part of standard protocol for new cases, caseworkers should check-in with their supervisors as soon as a new case is received to discuss the best next steps (upholding confidentiality). Key questions supervisors should walk caseworkers through (in order) are provided below. For cases received through hotlines/helplines, supervisors should not expect caseworkers to have answers to all questions.
  • When was the case received and what was the referral source and type of disclosure?
  • What is the child/adolescent's gender, age, caregiving/family situation, and legal status (e.g., refugee, national, etc.)? Is there anything else important to know about the child or adolescent (e.g., disability, language, marital status, health concerns, etc.)?

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[10] *Programming with adolescent boys to promote gender-equitable masculinities: A rigorous review* provides a useful evaluation matrix of 34 boys, masculinities, and gender equality programs across 24 lower middle income countries with information on outcomes in terms of attitudes, practices, and well-being.

- Is the child/adolescent in a safe place/with a safe person? *If the answer is no, walk through safety planning with the caseworker.*
- Is anyone in the family sick or at high risk of being infected w/ COVID-19?
- What happened (i.e., briefly describe the incident with "need to know" information)?
- What is the caseworker most concerned about?
- What steps has the caseworker already taken/what are the next steps? *Make sure to discuss risks associated with each next step, including mandatory reporting, as well as available/accessible service modalities (e.g., face-to-face case management, remote service delivery, etc.) and come to an agreement on a plan.*
- Does the caseworker have everything s/he needs to carry out the next steps? *Be sure to consider COVID-19 guidance for keeping staff and survivors safe (e.g., infection prevention and control, safe devices, etc.).*
- What can the supervisor help the caseworker with?
- When will the supervisor and caseworker be in touch again?

➢ Supervisors must also establish clear protocols for intake of new cases [taking into consideration shifts in the context to deliver case management](#)[11] (e.g., movement/gathering restrictions, changes to caseworker schedules, location for service delivery/remote service delivery, availability of materials/resources, data management, etc.) as well as:
- How the case was disclosed or referred;
- The child or adolescent's age, developmental stage, gender, type of sexual violence, caregiving situation/ support system, disability status, and compounding protection issues;
- The child/adolescent survivor's and/or safe caregiver/trusted adult's gender preference for the caseworker (where there is no preference, default to female caseworkers/service providers);
- The capacity of the organization's case management team's capacity to respond within the COVID-19 context;
- The capacity of other CP and/or GBV case management agencies to respond within the COVID-19 context (inclusive of considerations for staff safety, well-being, and comfort in responding); and
- Availability and accessibility of wraparound services (e.g., health, MHPSS, ASRH, alternative care, cash, etc.).

➢ These protocols should be documented, shared with case management teams, and integrated into existing case management SOPs (or they can serve as a starting point for eventual development of case management SOPs if these do not yet exist).

Guidance for Existing Cases
➢ Following the inter-agency GBV and CP COVID-19 case management guidance, supervisors should meet with each caseworker as soon as possible (preferably face to face if feasible) to review all cases, prioritizing cases of child and adolescent survivors to determine how to best proceed in light of COVID-19. <u>All cases of child/adolescent sexual violence are high risk; each child/adolescent survivor, however, will be in a different stage of the healing and case management process and therefore require different frequency and modality of follow-up</u>. Please see page 2 of the [COVID-19 CP Case Management Guidance](#) for key questions supervisors and caseworkers should discuss to help determine the best and safest way forward for each case.

➢ If existing cases must be reassigned, the caseworker must discuss this with the child/adolescent survivor and/or safe caregiver/trusted adult, obtain their consent/assent, and support the transition (e.g., preparing the child/adolescent survivor for the transition, facilitating an introductory meeting with the new caseworker, etc.). The child/adolescent survivor's gender preferences for caseworkers should be taken into consideration for all case transfers.

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[11] Please see page 2 of *[Case Management, GBVIMS/GBVIMS+ and the COVID-19 Pandemic](#) for* key considerations for when deciding on the most appropriate modality for case management.

- Caseworkers must meet (in person if feasible; otherwise, remotely) with each child/adolescent survivor (and/or their safe caregiver/trusted adult as needed) to discuss COVID-19 and:
  - Assess the risk and feasibility of different service modalities[12] (e.g., in person at women and girl safe spaces or another safe location, remote service delivery, engagement of trained community volunteers – it is imperative that risks are carefully assessed and mitigation measures put in place for this option, etc.);
  - Develop a plan for how to continue services, taking into consideration the risk assessment as well as how to safely stay in touch since the COVID-19 context will continue to evolve;
  - Adapt the safety plan as needed based on the shifts in context and situation in the home due to COVID-19 (additional guidance on safety planning provided below);
  - Discuss and agree upon any changes to the case plan given that wraparound services may be suspended, operating at reduced hours, no longer safe to attend, etc.; and
  - Agree on the next date, time, and modality to connect.

- While the points above can be discussed directly with older adolescents (ages 15-17) and safe caregivers/trusted adults, it is recommended to use a child-friendly assessment and planning tool such as *The Three Houses Tool* when working with younger children (ages 6-14). Additional guidance by age/developmental stage is provided below.

- If caseworkers are not able to meet in-person or remotely with their cases as described above, it is recommended to review the *Entry Points for Disclosure/Early Detection* above for ideas on how to safely reach the child/adolescent survivor and/or their safe caregiver/trusted adult.

Safety Planning
- It is of critical importance to adapt safety plans according to the shifts in the context and situation in the child/adolescent survivor's home due to COVID-19. Key questions to consider are:
  - **Will the child/adolescent survivor be isolated at home with their perpetrator if the government issues lockdown orders?** If yes:
    - **Can an alternative safe place be identified for where the child/adolescent survivor can stay with their safe caregiver/trusted adult?** *E.g., other family members, neighbors, safe houses, etc.*
    - **If there is no alternative space, what harm reduction strategies can you equip the child/adolescent survivor and the safe caregiver/trusted adult with?** *E.g., sleeping next to the safe caregiver/trusted adult and other strategies to not be alone with the perpetrator, identifying the safest room to stay in, thinking through an escape plan, etc.*
  - **Are there any changes in the child/adolescent survivor's risk and protective factors? How can these be integrated into the safety plan?** *For example, if the perpetrator is someone in the home, the risk to the child/adolescent survivor may increase with lockdown measures; however, protective factors may also increase if other family members will also be at home more often.*
  - **Does the household have enough food and water and supplies in the house to last at least two weeks?** *A risk mitigation approach should be used when discussing with child/adolescent survivors and safe caregivers/trusted adults what supplies may be needed, including those required for menstrual hygiene management (e.g., sanitary pads, soap, underwear, etc.), prescription medications, etc. Be sure to also discuss how access to food, water, and supplies can be ensured.*
  - **If medical attention is required, how will the child/adolescent survivor and/or safe caregiver/trusted adult access health services?** *Be sure to also discuss what documents and resources they might need to access these services.*
  - **If the safe caregiver/trusted adult falls ill due to COVID-19, who else can the child/adolescent survivor turn to for help?** *Revisit social safety mapping with the child/adolescent survivor and safe caregiver/trusted adult; consider service providers, community-based structures (e.g., women-led organizations, youth networks), faith groups, community volunteers, etc. who may be providing routine services or check-ins.*

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[12] Please see the *GBVIMS COVID-19 Series Episode 3: Pre-requisites to shift to remote case management over the phone* for key considerations on determining the appropriateness of remote service delivery. UNICEF's *Not just hotlines and mobile phones: GBV Service provision during COVID-19* also offers guidance and ideas for contexts where helplines, hotlines, and mobile phones are not accessible.

- **Who can the child/adolescent survivor and/or safe caregiver/trusted adult call for help and how will this be done?** *If phone is an option, make sure to safely store important numbers using code if needed, and to make sure the phone is charged and with credits. If phone is not an option, discuss how to access help – e.g., running to a trusted person in the community or a nearby shop where they feel comfortable, signaling for help to other service providers during routine activities (e.g., food distribution, water points, etc.), availability of transportation, etc. Use of [The Safety House](#) (for younger children) or social and/or community mapping such as [People in Our Lives/People in My Life](#) (for adolescents) may help if the child/adolescent survivor and/or safe caregiver/trusted adult are having difficulty thinking of options.*
- **If the child/adolescent survivor and the safe caregiver/trusted adult decide to leave, what documents and items will they need?** *Make sure these are stored in a safe place that is easily accessible and if possible hidden from the perpetrator.*
- **Are there any other concerns held by the child/adolescent survivor and/or safe caregiver/trusted adult that have not been discussed?** *Remember, child/adolescent survivors know their situations best, so give space to discuss any concerns they may have that have not been addressed.*

➢ While the questions above can be discussed directly with older adolescents[13] and safe caregivers/trusted adults, it is recommended to use a child-friendly safety planning tool such as [The Safety House](#) when working with younger children.

➢ Once these questions have been discussed, make sure to come up with a simple safety plan that has clear action steps and review the plan together with the child/adolescent survivor and safe caregiver/trusted adult a number of times until it is memorized. Check-in on the plan during each subsequent meeting.

Remote Service Delivery
Prior to engaging in remote service delivery – i.e., services that are delivered over a technology platform rather than in person[14] – supervisors together with program leadership must first determine if remote service delivery is possible, and if so, the types of technology options that will be offered (e.g., hotlines, helplines, chat/SMS, etc.) and the types of services provided on these. [Techsafety.org](#) provides [helpful guidance on assessing readiness for remote (or "digital") services](#) as well as [best practices and policies for organization/agency use of technology](#).[15] Please also watch or listen to the [GBVIMS Steering Committee's series of video shorts and podcasts for guidance on remote GBV case management in the context of the COVID-19 response](#) as these lay a good foundation for remote service delivery. Keep in mind, however, that the GBVIMS resources were developed predominantly for remote GBV case management with adult women and adolescent girl survivors of GBV. Please also see section 6 of the [CP AoR CP Resource Menu for COVID-19](#) for additional guidance from the CP sector, and in particular the [CP Case Management Guidance for Remote Phone Follow-up in COVID-19 from the CP Case Management Task Force in Lebanon](#) as well as the annex on remote supervision.

➢ Caseworkers must first discuss and agree on remote service delivery as a feasible, safe, and acceptable option with the child/ adolescent and their safe caregivers or other trust adult[16], and then get informed consent/assent a at the start of every remote session/meeting.

➢ For remote sessions, it is important to: use simple communication following the best practices for communicating with child and adolescent survivors; prepare children/adolescents and their safe caregivers/trusted adults for what
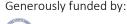
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[13] *[Safety Planning During COVID-19: Key Considerations When Delivering Remote Phone Based GBV Case Management](#)* may also be appropriate and useful for adolescent girls and married girls experiencing IPV as well as older adolescents more generally.

[14] For more information please see the IRC's *[Guidelines for Mobile and Remote GBV Service Delivery](#)*.

[15] The *[Operational Handbook for Child Online Safety Centres](#)* also provides helpful guidance on necessary support and resources for child helplines and remote services.

[16] Caseworkers should take into consideration the gender of the child/adolescent when discussing safety, feasibility, and accessibility of remote service delivery given that access to technology has been found to be markedly impacted by gender, with girls having less access than boys due to barriers such as social disapproval, prohibitive costs, perception of appropriateness, technical literacy, etc. Please see *[Safety planning for technology: displaced women and girls' interactions with information and communication technology in Lebanon and harm reduction considerations for humanitarian settings](#)* for more information.

to expect; and have clear protocols for what to do if the situation becomes unsafe (e.g. code word, changing subject rapidly).

➢ <u>Caseworkers should not attempt to accomplish everything in a remote session that they would in a face-to-face meeting</u>; rather, remote sessions should be used to check-in and provide any new information regarding COVID-19 and impact on services, give space and listen to whatever the child/adolescent and/or safe caregiver/trusted adult are bringing up, and discuss strategies and solutions as needed.

➢ The table below provides some key considerations for remote service delivery with child and adolescent survivors by age/developmental stage.

Age Group	Consent/Assent	Remote Service Delivery	Length of Time[17]	Communication Techniques by Age[18,19]
0-5	**Safe caregiver/trusted adult[20]**: get written informed consent; if written is not feasible/safe, then get verbal consent and document if safe documentation is possible[21] **Child**: explain what is happening in a way the child understands	**Phone**: with the safe caregiver/trusted adult; children ages 3-5 can join for a quick hello/check-in **Video**: with the safe caregiver/trusted adult; children ages 0-5 can join part of the time for a check-in and so caseworkers can observe how children are doing **Chat/SMS**: for quick check-ins or short discussions with the safe caregiver/trusted adult on secure platform and with clear safety protocols in place (e.g., immediately deleting messages, code words/language, etc.)	0-15 minutes	**0-2**: play by copying sounds and expressions, taking turns leading/following; if infant/toddler is not engaged, let it be **3-5**: focus on what the child is playing with and that they are interested in; share jokes; if on video use emotion cards, puppets, do "show and tell" with favorite toys, and play "I spy"
6-11	**Safe caregiver/trusted adult**: same as above for age group 0-5 **Child/adolescent**: get verbal informed assent and document if safe documentation is possible[22]	**Phone/Video**: with the child/adolescent; safe caregiver/trusted adult can join by request of the child/adolescent; provide regular updates to safe caregiver/trusted adult on child/adolescent's progress **Chat/SMS**: follow guidance for age group 0-5; quick check-ins directly with children/ adolescents also feasible	10-30 minutes	**6-7**: follow 3-5 guidance above **8-11**: focus on the child/ adolescent's interests; share jokes/riddles; play "would you rather" or "20 questions"; use emotion cards if on video

[17] The guidance generally is to account for 2-3 minutes by the child/adolescent's age. So, if a child is 5 years old, the maximum length of time for remote service delivery would be 10-15 minutes. Please see additional guidance here: https://blog.brainbalancecenters.com/normal-attention-span-expectations-by-age
[18] http://www.parentingpress.com/media/is-this-a-phase_excerpt2.html
[19] The techniques provided are suggestions and should be modified with games, activities, etc. appropriate for and familiar to the child/adolescent's context.
[20] If the child has no safe caregiver or another adult s/he trusts, the service provider (e.g., caseworker, health worker, etc.) may need to provide consent for the child. This should be discussed with supervisors as different contexts and organizations will have different policies and procedures.
[21] Please see the GBVIMS Steering Committee's COVID-19 Series Episode 6 on confidentiality and documentation for more information.
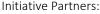[22] As above, please see the GBVIMS Steering Committee's COVID-19 Series Episode 6 on confidentiality and documentation for more information.

| 12-14 | **Safe caregiver/trusted adult**: same as above for age group 0-5
Adolescent: get written informed assent and document if safe documentation is possible[23] | **Phone/Video**: follow guidance for age group 6-11
Chat/SMS: for quick check-ins and short discussions with the adolescent on a secure platform and with clear safety protocols in place (e.g., immediately deleting messages w/ appropriate checks in place, code words/language, etc.); provide regular updates to safe caregiver/trusted adult on adolescent's progress | 20-40 minutes | Focus on what the adolescent is interested in; play "would you rather", "20 questions" or "two truths and a lie"; use emotion cards or ask adolescent to draw their emotions if on video; "fortunately/unfortunately" or other story-telling games; use or share stories |
| 15-17 | **Safe caregiver/trusted adult**: discuss first with adolescent and then seek informed consent as needed (will vary based on local laws and policies)
Adolescent: get written consent; if written is not feasible/safe, then get verbal consent and document if possible[24] | **Phone/Video**: with the child/adolescent; safe caregiver/trusted adult can join by request of the child/adolescent
Chat/SMS: for quick check-ins and short discussions with the adolescent on a secure platform and with clear safety protocols in place (e.g., immediately deleting messages, code words/language, etc.); if adolescent agrees, provide regular updates to safe caregiver/trusted adult on progress | 30-50 minutes | Give space for the adolescent to bring up what they would like to talk about; can use guidance for 12-14 above as needed |

➢ In contexts where children/adolescents have access to mobile devices and the internet, direct service providers should work with safe caregivers/trusted adults to talk to children/adolescents about cyber/internet safety and what to do if an incident or something they are uncomfortable with happens online. Please see useful guidance on cyber/internet safety by age here. Examples of child-/adolescent-friendly resources that can be shared directly with children/adolescents are https://www.thinkuknow.co.uk/ and https://kidshelpline.com.au/.

Psychosocial Support
➢ While it is possible to remotely facilitate the PSS interventions in *Caring for Child Survivors of Sexual Abuse: Guidelines for Health and Psychosocial Service Providers in Humanitarian Settings*[25] with child and adolescent survivors, it is recommended to focus on supporting the child/adolescent survivor's safe caregiver/trusted adult, recognizing that COVID-19 will likely put additional stressors on the safe caregiver/trusted adult, and that caregiver support following disclosure of sexual violence has consistently been identified as a protective factor associated with reduced level of negative impact[26]. The CP Case Management Task Force in Lebanon's Guidance for CP

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[23] As above, please see the GBVIMS Steering Committee's COVID-19 Series Episode 6 on confidentiality and documentation for more information.
[24] As above, please see the GBVIMS Steering Committee's COVID-19 Series Episode 6 on confidentiality and documentation for more information.
[25] Please see Chapter 6 of the CCS Guidelines; descriptions of each PSS intervention begin on page 200.
[26] Deblinger, E., Mannarion, A. P., and Cohen, J. A. (2015). *Child Sexual Abuse: A Primer for Treating Children, Adolescents, and Their Nonoffending Parents*. Oxford University Press, New York.

[Caseworkers on How Caregivers Can Support Children During COVID-19](#) provides useful guidance in this regard, with additional resources provided in Section 5 of the [CP AoR CP Resource Menu for COVID-19](#).

➢ While it may be difficult to ascertain how the safe caregiver/trusted adult and child/adolescent survivor are responding to this support when facilitated remotely, <u>be sure to listen carefully (and observe carefully if using video) for changes in voice and/or non-verbal behavior/communication</u> as over time caseworkers will be able to notice patterns that will help support the process.

➢ Where remote service delivery is not an option, caseworkers can develop together with or provide child/adolescent survivors and/or their safe caregivers/trusted adults a toolkit of activities (e.g., drawing, journaling, physical activities, breathing exercises), and also coordinate with wraparound child/adolescent programming (e.g., education, adolescent girls groups, boys clubs) to provide additional take-home materials or to have child/adolescent survivors participate in these programs if still operating[27].

Case Documentation/Data Management

➢ Please see [Episode 6 – *Confidentiality and Documentation*](#) of the GBVIMS Steering Committee's remote GBV case management series in the COVID-19 response for guidance on safe documentation and information management.

Supervision and Staff/Self Care

➢ Supervisors should continue to support caseworkers with remote supervision to help navigate these and other complex cases. In addition, staff- and self-care should be emphasized and modeled by supervisors. Please see the [International Federation of Red Cross and Red Crescent Societies' *Interim Guidance: Supportive Supervision for Volunteers providing Mental Health and Psychosocial Support during COVID-19*](#) and [*Episode 7 – Remote Supervision and Staff Care*](#) of the GBVIMS Steering Committee's remote GBV case management series in the COVID-19 response for additional guidance.

Coordination of Services [CP, GBV, and Other Sectors]

Coordination between CP and GBV service providers is essential in the evolving COVID-19 context to address gaps, maximize coverage, and minimize overlaps in support services for child and adolescent survivors of sexual violence. Recommended key actions for CP and GBV service providers (and other sectors as relevant) include but are not limited to:

➢ Share updated information about available services and changes to service delivery (e.g., mode, business operation hours, etc.) – being sure to include specialized services for child and adolescent survivors (e.g., case management teams trained in *[Caring for Child Survivors of Sexual Abuse](#)*, clinical services for child/adolescent survivors of sexual assault, adolescent sexual and reproductive health, child- and adolescent- friendly legal services, safe alternative care options, etc.) – to coordination groups for inclusion in service mapping and referral pathways.

➢ Focus on ensuring that child and adolescent survivors have access to support services throughout the COVID-19 phases. In locations where CP and GBV case management services both respond to child and adolescent survivors, these actors must together discuss and agree on adaptations to service provision to maximize available resources. This means amending existing Standard Operating Procedures or other coordination documents/field-level agreements; if these are not available, agree on how agencies will collaborate to mitigate the constraints to service delivery imposed by the COVID-19 response[28]. Coordination groups should assist in this process.

➢ Jointly develop the capacity CP and GBV case management actors on key considerations for child and adolescent survivors during COVID-19, inclusive of guidance on remote service delivery. Country-level case management working groups can support by organizing joint, inter-agency trainings for CP and GBV case management actors to review and contextualize the CASI COVID-19 guidance and develop capacity on gender, GBV, and child-/adolescent-

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[27] Please see [UNICEF and the IRC's *COVID-19 – GBV Risks to Adolescent Girls and Interventions to Protect and Empower Them*](#) for additional guidance.

[28] [The IRC's CCS Operational Guidance Package](#) may be useful in supporting CP and GBV case management actors operating in the same locations to think through coordination/collaboration. Please note that this is the pilot version of the Guidance Package and therefore has not been finalized nor adapted for COVID-19.

centered approaches, inclusive of sector- and context-specific good practices so that GBV and CP actors and learn from one another and integrate these practices when supporting child and adolescent survivors.

Collaboration between CP and GBV Coordination Groups

Collaboration between CP and GBV coordination groups is also essential in the evolving COVID-19 context to address gaps, maximize coverage, and minimize overlaps in support services for child and adolescent survivors of sexual violence. Recommended key actions for CP and GBV coordination groups include but are not limited to:

➢ Facilitate collaborative CP and GBV needs identification to ensure that context specific risks and vulnerabilities in relation to child/adolescent sexual violence are recognized and comprehensively addressed by relevant actors as the COVID-19 situation evolves.

➢ Support CP and GBV actors in joint service mapping and developing a joint GBV-CP referral pathway[29]. This should include current information on services for child and adolescent survivors (e.g., clinical care for child and adolescent survivors of sexual assault, adolescent sexual and reproductive health, child- and adolescent- friendly legal services, alternative care, safety/security, etc.). CP and GBV actors could begin by jointly reviewing the GBV service mapping with a child/adolescent lens and updating with additional relevant CP services (e.g., alternative care) and modifying the GBV referral pathways accordingly with the additional services and language specific to child and adolescent survivors (e.g., mandatory reporting, assent/consent, best interest, etc.).

➢ Jointly draft and provide key messages on child/adolescent sexual violence to other sectors to be integrated in their strategies and plans for risk communication and community engagement, inclusive of community outreach and training of frontline workers on safe referrals. Messages and methods of delivery must be age-, language-, and disability[30]-appropriate to reach all children and adolescents and their families, including marginalized groups (e.g., girls, ethnic or religious minorities, etc.). Coordinators can be conveners of these discussions with other sectors at the cluster/sector level, but each actor can also take these steps within their own organizations. Coordinators should also ensure inclusion of women's rights and gender equality organizations, disability-focused organizations, organizations that focus on marginalized groups, youth groups, and other relevant community-based/grassroots organizations.

➢ Include child and GBV helpline/hotline providers in the CP and GBV coordination mechanisms and in service mapping and referral pathways. Discuss with helpline/hotline providers their capacity to absorb an increased number of calls if hotline/helpline numbers are widely disseminated, and develop contingency plans as needed in case maximum capacity is reached. Also work with helpline/hotline providers to strengthen their referral pathways to CP and GBV services, as well as other services (e.g., food security, nutrition).

➢ Jointly develop advocacy messages to maintain essential services for child and adolescent survivors (e.g., case management, clinical care for sexual assault survivors, sexual reproductive health, women and girl friendly spaces, alternative care, safety/security actors who can intervene to remove perpetrators or child/adolescent survivors from the home, etc.) and make use of the different networks of CP and GBV actors for advocacy.

Contact Information

For any questions or feedback on this document as well as suggestions for additional guidance and tools, please contact Jennifer.Lee@rescue.org.