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Building a collaborative path: A twelve-step framework to combat child sexual abuse in every community

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ABSTRACT

This discussion paper addresses the lack of standardized frameworks for multidisciplinary teams (MDTs) to respond to child sexual abuse (CSA) in resource-constrained settings, including lower- and middle-income countries (LMICs). While collaborative approaches are linked to improved justice and outcomes for victims, many such settings lack structured, coordinated models to guide such responses. To address this gap, members of the International Society for the Prevention of Child Abuse and Neglect (ISPCAN), in collaboration with Mission Kids Child Advocacy Center, initiated a project to develop a framework for collaborative CSA response. This paper offers a reflective discussion and conceptual overview of the framework's development, which was informed by: a comprehensive scoping review; guidance from a global Steering Committee of child maltreatment experts, reviewers, and advisors (N = 18) from countries including Austria, Georgia, Israel, Jamaica, New Zealand, Oman, South Africa, Sweden, Switzerland, and the United States; survey responses from 334 child protection practitioners across 87 resource-constrained settings; and focus group discussions with some of these practitioners in Albania, Botswana, Bosnia and Herzegovina, Croatia, India, Israel, Kosovo, Nigeria, Pakistan, Slovenia, and Uganda. The resulting twelve-step framework is child-centered, trauma-informed, and adaptable, designed for use where traditional models like Children's Advocacy Centers (CACs) may not be viable. It promotes local collaboration, supports both short- and long-term goals, and includes supplementary tools, such as a resource guide and a customizable, fillable planning template, to help MDTs tailor their response to local realities. This framework offers both foundational guidance and practical support for strengthening CSA responses in resource-constrained settings.

1. Introduction

Collaborative responses such as multi-disciplinary teams (MDTs), Child Advocacy Centers (CACs), and Barnahus models have been developed to respond to child sexual abuse (CSA). An MDT brings together professionals from various disciplines with distinct roles and expertise to communicate and collaborate while maintaining their independent functions to work toward a shared goal (Martin et al., 2022;

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Taberna et al., 2020). The CAC model, emerging in the 1980s in the United States of America (U.S.), was created as a response to the shortcomings of traditional child protection and law enforcement responses to CSA (Herbert & Bromfield, 2015). It is an evidence-based model that incorporates MDTs, among other elements, to improve case coordination and support for victims and their families (Tener et al., 2019). Although services may vary by center, accreditation by the National Children's Alliance is based on ten core standards, including multidisciplinary collaboration, forensic interviewing, victim support and advocacy, a child-centered environment, access to mental and medical health services, case review and tracking, cultural competence and diversity, and organizational capacity (Herbert & Bromfield, 2015).

Meanwhile, the Barnahus model, or "Children's House," was first established in Iceland in the 1990s and has since influenced similar initiatives across Europe (Johansson et al., 2017a, 2017b; Johansson et al., 2024). Inspired by the CAC model, Barnahus also follows a multidisciplinary, child-centered approach and emphasizes minimizing secondary victimization (Johansson et al., 2017b). However, a distinctive feature of the Nordic Barnahus model is that children are not required to testify in court. Instead, their testimony is typically obtained through a recorded interview, conducted in a child-friendly setting, aiming to reduce trauma and stress for the child while upholding their right to participate and the accused's right to a fair trial (Johansson et al., 2017b; Myklebust, 2017).

These collaborative models are implemented across many developed countries, including Sweden and the U.S., and they have often been shown to better outcomes and justice for CSA victims (e.g., Herbert & Bromfield, 2017; Hornor et al., 2022; Nwogu et al., 2016). However, in resource-constrained settings, professionals responding to CSA face several distinct challenges, including extreme poverty, a lack of knowledge, cultural beliefs that perpetuate the sexual abuse of children, limited resources, and insufficient human resources (Veenema et al., 2015). In this paper, the term "resource-constrained settings" refers not only to countries or regions, but also to specific communities. While it can include geographical areas such as lower- and middle-income countries (LMICs), it also encompasses marginalized or underserved populations within higher-income countries—for example, the Arab-Israeli community in Israel. In these settings, collaborative models like CACs or Barnahus, which are tailored for resource-rich contexts in many ways, may not yield similar results or be suitable in these settings. Specifically, a straightforward replication may not be feasible due to cost issues and a lack of expertise in many of these contexts in creating accredited CACs.

In addition, effective collaborative frameworks for responding to CSA in resource-constrained settings remain limited or problematic. For example, Boonzaaier et al. (2025), in a study conducted in South Africa, a low-income country, found that moral distress among child protection social workers was partly due to insufficient intersectional collaboration. Similarly, Ali et al. (2023) identified a lack of coordinated trauma care as a significant barrier to effective pediatric trauma management in LMICs. While some context-specific examples of collaborative efforts to address child abuse do exist in resource-constrained settings (e.g., Subramaniyan et al., 2017), there remains a need for a universal, adaptable framework that can be applied across diverse settings.

In response to the lack of a standardized collaborative framework for addressing CSA in resource-constrained settings, the authors of this discussion paper convened with colleagues from around the world to develop an adaptable, trauma-informed, and child-centered framework for these contexts. This process began with a comprehensive literature review, followed by the formation of an international Steering Committee, reviewers, and advisors, composed of child maltreatment experts from fields such as law enforcement, child protection, education, medicine, and others. A global survey was also disseminated to further inform this framework, collecting data from 334 child protection practitioners across 87 resource-constrained settings, and following this, focus group discussions were conducted with many of these practitioners.

This discussion paper presents a conceptual and structural overview of the process of building this framework. We begin by reviewing the existing literature, highlighting the importance of a collaborative response to CSA and the current absence of frameworks designed specifically for resource-constrained settings. We then describe the design, development, and structure of the resulting twelve-step framework that the authors and their colleagues created. The framework intends to guide MDTs responding to CSA in settings where CACs or Barnahus models may not be feasible due to contextual or resource limitations.

1.1. The right to a life without sexual abuse

The United Nations Convention on the Rights of the Child (UNCRC) is the most widely ratified international human rights treaty, signed by 196 countries, and fundamentally transforming how children are perceived and treated (United Nations, 1989). This treaty mandates the protection of children through means of social support programs, abuse prevention measures, and procedures for identifying, reporting, investigating, treating, and following up on abuse cases, with judicial involvement as needed (Article 19). A child victim of abuse is entitled to support for their recovery and social reintegration (Article 39). The treaty also underlines the protection of children's privacy (Article 16) and the importance of recognizing their voices in abuse cases (Article 12). Furthermore, the Convention outlines that effective reporting and investigation protocols must be established, and countries that have endorsed this convention are obligated to enact laws to uphold these articles.

Despite the endorsement of these rights by many countries, children remain unsafe globally and continue to experience abuse (Bajos et al., 2023; Hartill et al., 2021; Massullo et al., 2023; Mathews et al., 2023). The sexual abuse of children is a grave crime with enduring impacts on children's well-being and the broader communities in which they live (Amado et al., 2015; Russell et al., 2020). In 2021, an estimated 1 billion children were exposed to abuse, including CSA (World Health Organization, 2022). A systematic review and meta-analysis by Barth et al. (2013) of 55 studies from 24 countries worldwide found that CSA prevalence estimates ranged between 3 % and 17 % for boys and 8 % and 31 % for girls. Research indicates that some of the highest age-standardized prevalence rates of sexual violence against children are found in LMICs, for example, among females in India, Côte d'Ivoire, and the Solomon Islands, and among males in Haiti, Bangladesh, Nigeria, and Côte d'Ivoire (Cagney et al., 2025).

Indeed, Selengia et al.'s (2020) review of the prevalence of CSA in select countries in Africa and Asia found that, in Africa, CSA rates for females ranged from 2.1 % to 68.7 % in Tanzania and Ethiopia, respectively, and in Asia, from 3.3 % to 42.7 % in China and India, respectively. Meanwhile, for males in Africa, CSA rates ranged from 4.1 % to 60 % in South Africa and, in Asia, from 4.3 % to 58 % in Hong Kong and Sri Lanka, respectively (Selengia et al., 2020).

1.2. An optimal goal: A collaborative response

Given the prevalence and severity of CSA, addressing this issue is paramount. Existing research primarily focuses on the prevalence, causes, and consequences of CSA, as well as prevention efforts (Russell et al., 2020). There is a broad consensus that an effective response to CSA is critical, with a collaborative approach —also referred to as a multi-disciplinary or multi-sectoral approach—widely regarded as the ideal. Such an approach aims to improve response to and outcomes for child survivors of CSA, working to enhance communication, coordination, and partnership between key stakeholders (Newman & Dannenfelser, 2005; Westphaln et al., 2020). Established based on the principle of a collaborative response, CACs, and similar initiatives aim to enhance the process of addressing CSA for these children (Herbert & Bromfield, 2015). The first CAC was established in 1986 in the US to provide a

child-friendly space where children could be interviewed and relevant processes, including investigative, medical, and judicial, could be synchronized (Cross et al., 2008). To date, 961 centers have been certified by the National Children's Alliance (National Children's Alliance, 2019). Research shows that CACs and MDT-styled approaches to CSA may be beneficial in increasing prosecution rates of the alleged offenders, improving the rate of sexual abuse interview completion, and enhancing caregiver response satisfaction (Herbert & Bromfield, 2017; Hornor et al., 2022; Nwogu et al., 2016).

However, establishing, maintaining, and accrediting these centers can be costly and resource-intensive, requiring highly trained professionals from various disciplines. This poses significant challenges to implementing the CAC model in low socioeconomic countries and resource-constrained settings, where CSA prevalence rates are often higher. Relatedly, Russell et al.'s (2020) systematic review of CSA interventions in developing regions highlights that many efforts focus on school-based programs emphasizing knowledge and self-protection skills. These initiatives often lack a focus on reducing CSA prevalence, enhancing organizational safety, or ensuring practical application. This disparity underscores a notable gap in the literature regarding coordinated responses to CSA in developing countries. Further research is needed to adapt collaborative models like CACs to resource-constrained contexts, ensuring their feasibility and effectiveness in addressing CSA globally.

A recent scoping review of 66 English-language publications, including empirical studies (qualitative, quantitative, and mixed-method), non-empirical articles, case studies, and professional reflections, was conducted as part of the effort to inform the development of the collaborative response framework discussed in this paper (see Katz et al., 2025). The review examined global knowledge on collaborative responses (including MDTs, CACs, multi-agency teams, and others) to CSA and highlighted both the need for and benefits of such approaches, though implementation varies widely depending on local context. Positive outcomes associated with collaborative responses included fewer interviews for children, improved behavior and social functioning, increased access to mental health services, enhanced service delivery, and higher prosecution rates (Katz et al., 2025; National Children's Alliance, 2019). However, challenges such as limited resources, inadequate training, and intersectoral conflicts over roles and responsibilities were also reported. The review found no evidence of a flexible, adaptable collaborative response framework suitable for diverse resource-constrained settings; settings where such models are often most needed and where traditional CACs may not be viable. Moreover, findings revealed that there exist unjust distributions of child protection resources and that reaching remote and low-income areas is a barrier to providing collaborative responses.

1.3. A child-centered and trauma-informed approach

McLoughlin et al. (2020) aimed to identify key factors of effective child-centered practice in children's social services by consulting experienced practitioners and conducting a scoping review. Their findings highlight that child-centered services require practitioners who understand the importance of communicating with children in their language and understand their cultural context (McLoughlin et al., 2020). Granting children the opportunity to influence decisions affecting them and sharing information with them in an age-appropriate manner were factors found to encourage their participation, a cornerstone of the child-centered approach (McLoughlin et al., 2020). The study also underscores the importance of fostering relationships with family members who are valuable to the child and actively supporting families in their caregiving roles (McLoughlin et al., 2020). Continuous professional training and development, particularly training on effective and non-judgmental listening and communication, are critical for promoting best practices in child-centered care (McLoughlin et al., 2020). Furthermore, practitioners must address not only the immediate needs of the child but also their broader, long-term needs, facilitated by effective multi-professional collaboration (McLoughlin et al., 2020).

Trauma-informed approaches, which originated in North America, advocate for the recognition of the far-reaching consequences of trauma on individuals. This perspective shifts from asking, "What is wrong with you?" to "What happened to you?"—prioritizing recovery and the prevention of re-traumatization (Sweeney & Taggart, 2018, p.323; U.S. Department of Health and Human Services, 2014).

1.4. Promoting adaptive and collaborative responses for children who have experienced CSA in resource-constrained settings

Given the high prevalence of CSA in resource-constrained settings, the benefits of a collaborative response, and the lack of a framework and guidance for this response type in resource-constrained contexts, the authors of this discussion paper, which include members of the International Society for the Prevention of Child Abuse and Neglect (ISPCAN) in collaboration with Mission Kids Advocacy Center in the U.S., among others, launched a project to develop a flexible, child-centered, and user-friendly framework to respond collaboratively to CSA in these settings. This discussion paper introduces and describes this initiative. This project assembled a steering committee, essentially a global MDT, comprising child protection experts from diverse disciplines and regions, tasked with guiding and overseeing its execution. Specifically, professionals in the Committee, along with its reviewers and advisors (N = 18), came from Austria, Georgia, Israel, Jamaica, New Zealand, Oman, South Africa, Sweden, Switzerland, and the U.S. Their areas of expertise spanned multiple sectors, including nursing, law and justice, law enforcement, higher education, social work, governmental work, medicine, mental health, research, child protection, and non-governmental organization work.

This initiative aligns with the United Nations' 2030 Sustainable Development Goals, namely, to ensure good health and well-being for all by aiming to "end abuse, exploitation, trafficking and all forms of violence against, and torture of children." It also complements the INSPIRE strategy, which promotes improved coordination among stakeholders in addressing violence against children. Children who experience sexual abuse and do not receive timely, appropriate support are at increased risk of long-term negative impacts on their health and well-being. To address this, the ISPCAN Steering Committee, in collaboration with community stakeholders, developed a twelve-step collaborative response framework over two years. Designed for practitioners working with and responding to CSA in resource-constrained settings, the framework provides practical guidance for collaboratively responding to CSA reports in ways that protect child victims and support non-offending family members.

The subsequent section of this paper will detail the methodology used to collect data from practitioners and community stakeholders across several resource-constrained settings, which contributed to the development of the framework. It will also reflect on and discuss the freely available twelve-step framework created by the authors and their colleagues.

2. The twelve-step collaborative response framework to CSA in resource-constrained settings

2.1. The development of the collaborative response framework: Actions taken

This project received ethical approval from Tel Aviv University in 2022. Following this, a comprehensive scoping review was conducted by the authors (see Katz et al., 2025), as mentioned earlier, to evaluate existing knowledge and research on the focus topic: collaborative responses to CSA in resource-constrained settings. The review provided an overview of the field's current state and identified gaps requiring further attention. Subsequently, a steering committee was assembled,

comprising invited experts in child maltreatment whose insights informed the framework's development.

The next wave of data collection proceeded in two phases to refine the framework further. First, an online survey was distributed to ISPCAN members and their networks, including first responders and academics in resource-constrained settings. The survey explored a) existing CSA response practices, b) available resources, c) community strengths and needs, and d) interest in developing a collaborative CSA response framework in these settings. Participants (N = 334) in 87 resource-constrained settings completed surveys, and the Steering Committee analyzed the survey data to extract key themes. Major challenges reported by participants included child-unfriendly services, unsupportive police and allied health services, and overall poor and inconsistent systemic coordination. One of the solutions suggested by participants included a child-friendly and trauma-informed centralized CSA unit, further confirming the need for the twelve-step framework developed and presented hereafter.

The second phase of data collection involved virtual focus groups with child protection professionals involved in child protection systems. The focus groups were composed of professionals who had participated in the survey earlier and had agreed to be contacted regarding forming a focus group in their community and to gather schedule meetings. Participants included individuals from Albania, Botswana, Bosnia and Herzegovina, Croatia, India, Israel, Kosovo, Nigeria, Pakistan, Slovenia, and Uganda. These sessions, facilitated by child welfare experts and moderators, gathered insights into local challenges to implementing a collaborative response to CSA. Using findings from the literature review, survey data, focus group discussions, and the expertise of the Steering Committee (and its reviewers and advisors), the twelve-step framework was developed. Finally, the completed framework was shared with research participants for feedback, allowing them to comment on its accuracy and relevance. The seven outlined actions taken to develop this framework are visually depicted in Fig. 1 below.

It is important to note that a key principle of this twelve-step framework, alongside the emphasis on collaborative response, is prioritizing the child's best interests. The framework adopts a child-centered and trauma-informed approach, ensuring that the child is not only protected but also empowered throughout the process. This approach promotes collaboration with the child and ensures that they receive a quality response from various systems while minimizing the risk of re-traumatization (Sweeney, 2021). Designed for flexibility and adaptability, the framework is particularly valuable for MDTs operating in resource-constrained settings but may be implemented in diverse contexts. It leverages existing resources, which may not include the full complement of the disciplines typically required for a CAC response. Consequently, protocols developed for MDTs based on this framework will be customized to address the specific needs of their local contexts. In addition to the twelve-step framework, which serves as a set of adaptable guidelines, supplementary resources are provided to support its implementation. These include a resource guide with links to materials categorized by discipline and a modifiable, fillable form to assist MDTs in developing collaborative response plans suited to their local environments (see Supplementary Material 1). This ensures that the framework serves as a foundational tool and a customizable guide for effective child protection strategies. The twelve steps are presented as considerations, recognizing that the feasibility of implementation will depend on available human and financial resources. However, the framework provides a roadmap for MDTs to utilize their current resources effectively and work toward aspirational goals.

2.2. *The twelve steps outlined in the collaborative response framework*

The following section outlines general considerations important in each of the twelve steps of the collaborative response framework. These steps provide practical and flexible guidance for implementing a child-centered, trauma-informed, and coordinated approach to responding to CSA in resource-constrained settings. In addition, Supplementary Material 1, includes a customizable, fillable planning template, which is the form intended for use by MDTs in such settings. The twelve steps are also visually depicted in Fig. 2 below.

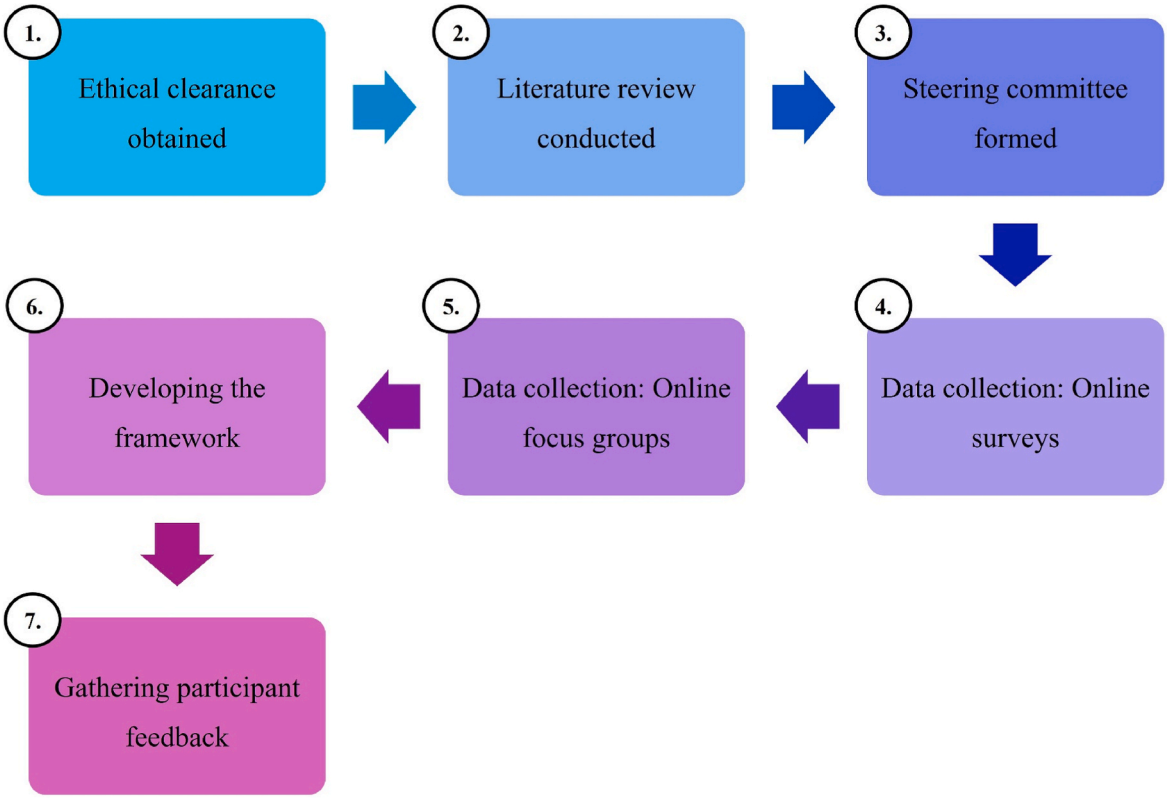

Fig. 1. The actions taken in developing the collaborative response framework to CSA in resource-constrained settings.

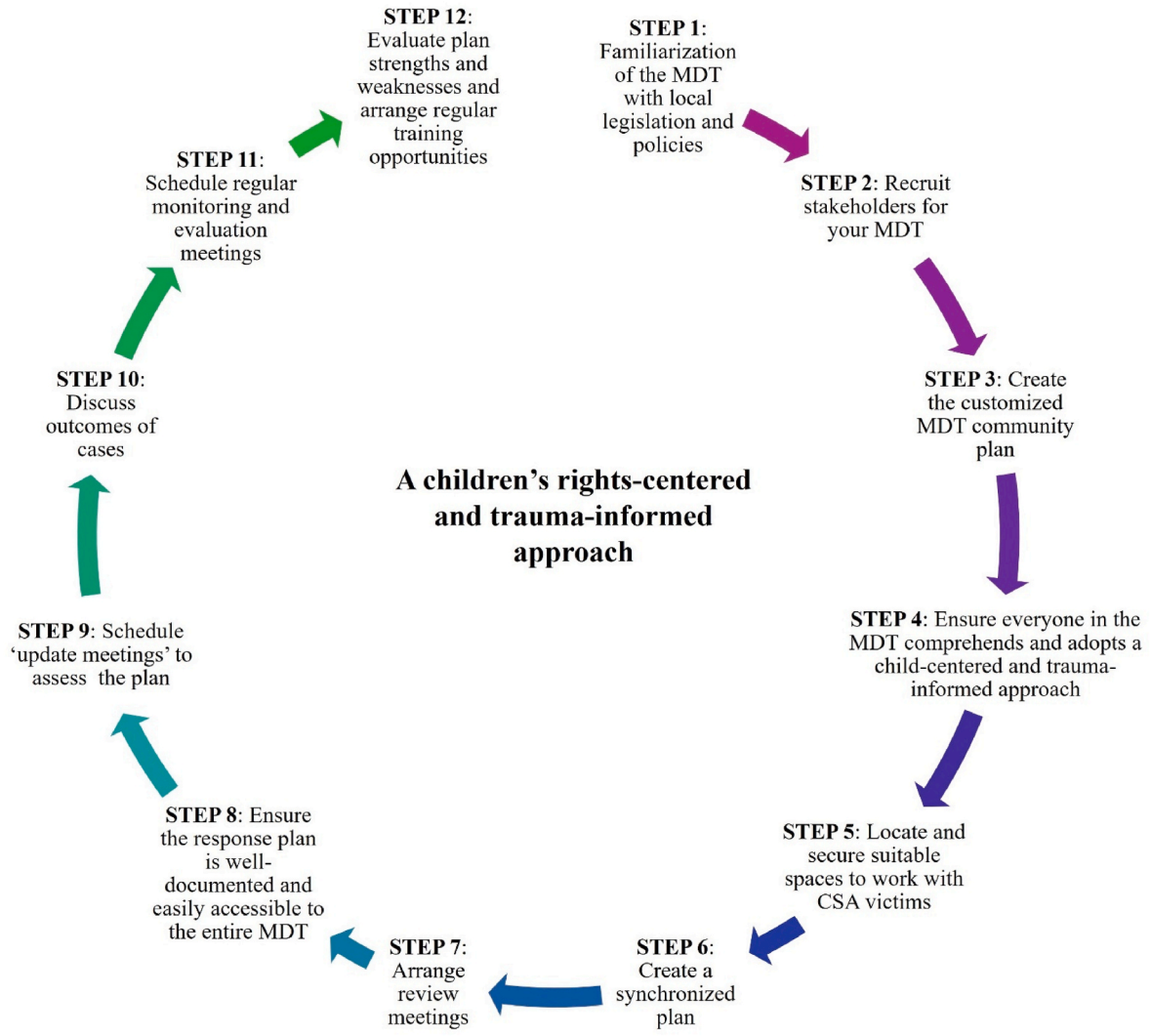

Fig. 2. The twelve-step collaborative framework for responding to CSA in resource-constrained settings.

1 Familiarization of the MDT with local legislation and policies.

Each MDT should begin by identifying all laws and policies related to CSA and relevant criminal procedures in their context. Additionally, they should clearly outline the scope of these laws and ensure that all team members are well-informed. This ensures that their efforts leverage mandated resources effectively and that the roles and responsibilities of involved agencies are clearly understood.

2 Recruit stakeholders for your MDT.

Identify community leaders and invite existing stakeholders in child protection who are willing to join the MDT responsible for implementing this collaborative response framework. Assess the skills and expertise of each stakeholder to assign roles and coordinate tasks effectively. A key distinction between this framework and a CAC response lies in the composition of the MDT. In resource-constrained settings, the team may lack representation from all essential disciplines typically required for an MDT response in a CAC (i.e., prosecutor, police, child protective services, mental health, medical, victim advocate, and the forensic interviewer) and might include additional, non-traditional agencies unique to the specific context. By fostering collaboration among existing agencies and individuals, even if some of the disciplines considered "essential" in a CAC are missing, the framework maximizes the use of local resources and ensures that responses are culturally appropriate and sensitive to the community's needs.

It is important to note that since the steering committee was only involved in the development of the framework, it will be up to each MDT to identify and recruit local community leaders and existing child protection stakeholders relevant to their context, to form part of the MDT towards the implementation of this framework. To avoid any tension resulting from hierarchical management strategies, inclusive decision-making and open communication that empower grassroots participation and esteem local voices must be integral to all decision-making processes by MDTs.

3 Create the customized MDT community plan.

Identified stakeholders from Step 2 must be contacted to arrange an initial meeting and explain the purpose of the collaborative response framework to create a joint vision and commitment. This meeting can also be used to identify other potential partners who could contribute to the success of the emerging MDT and invite those interested to have a dedicated role in the developing MDT plan. In this step, record the strengths and resources that each partner brings to the table and identify a responsible person or two to coordinate the implementation of the framework and the management of the MDT. Goals will be formulated during this step and training needs must be identified. All participating stakeholders must be able to 'leave their egos at the door' and always collaborate for the child's best interests.

4 Ensure everyone in the MDT comprehends and adopts a child-centered and trauma-informed approach.

Develop practice guidelines for and with the team that prioritizes the child's needs in all aspects of the response plan and encourages collaboration with the child and their non-offending family. Aspects such as the child's language, conveying belief in the child's account, ensuring the child understands the necessity of each step in the response plan, actively listening to the child, inviting the child to share their thoughts and needs, the type of questions asked, and the number of interviews conducted can all be discussed and agreed upon during this step. Please see Supplementary Material 1 for guidance on what is considered a child-centered and trauma-informed approach.

5 Locate and secure suitable spaces to work with CSA victims.

Identify a physical space, for instance, a local hospital, school, or any other safe space in the community that is accessible to the child. The space should allow the child to report and collaborate with the MDT and must be child-friendly, free from stigma, and represented by an MDT member. It may be located within the agency of a participating team member or in another community location that meets these criteria.

6 Create a synchronized plan.

The MDT will meet to create a written response plan, including creating a reporting protocol that works within the context of their community and MDT members, and consider the framework's fillable form—Supplementary Material 1—(intended to simplify the creation of their collaborative response plans to suit their local contexts) on the ISPCAN website. Topics to elaborate on in this plan include details on the reporting protocol, communication within the MDT, and, depending on the team members available, the legal, medical, mental health, child welfare, and law enforcement responses when a case of CSA is reported to the MDT.

7 Arrange review meetings.

Schedule regular meetings to discuss each case, monitor the needs of each victim, and invite more partners to collaborate and build strong relationships within the community regarding the healing and treatment of the CSA victim.

8 Ensure the response plan is well-documented and easily accessible to the entire MDT.

The written response plan must be available to all MDT members and include essential contact numbers, a list of resources, a flow sheet indicating each step of the response plan, and each member's roles and responsibilities.

9. Schedule 'update meetings' to assess the plan.

Plan meetings to monitor and evaluate the plan's use and success and assess the progress and weaknesses of the MDTs' functioning after successful and challenging cases. Create opportunities and safe spaces for team members to discuss challenges and identify areas of support needed.

10 Discuss outcomes of cases.

Maintain a record of the child's overall health and well-being and continue to train the non-offending family on how to best support and protect the child. Provide the family with education and mental health support services. It is important to note that the advice provided and the type of support that may be available will likely differ across contexts.

11 Schedule regular monitoring and evaluation meetings.

Arrange regular meetings to revise how the plan is working with time and what needs to be changed. Identify additional team members to support and expand the MDT and update contact and resource information.

12 Evaluate plan strengths and weaknesses and arrange regular training opportunities.

Evaluate child outcomes and celebrate successes as measured by your team. Identify and address ongoing training needs, create new training opportunities, and ensure debriefing sessions for team members. In this step, the team can also explore new resources and have reflective discussions about how local policies or laws must be changed to support them in their efforts to help CSA victims. If changes are needed regarding local policies or laws, identify a task team within the MDT to steer that process.

3. From framework to practice

This framework was specifically developed for professionals responding to CSA in resource-constrained settings, serving as a flexible blueprint that can be revised and adapted by MDTs based on their available resources, workforce, cultural practices, and legal contexts. Recognizing that "one size does *not* fit all," the framework emphasizes adaptability, encouraging tailored responses that are aligned with the local realities of each MDT. It is crucial for MDTs adopting this framework to thoroughly study its components, critically assess what will work best in their unique settings, and make informed decisions about its application as a team.

The framework is informed by an extensive literature review (see Katz et al., 2025) and empirical data gathered through surveys and focus groups involving stakeholders who work with CSA across resource-constrained settings globally. In addition to employing a top-down approach, this framework was developed using bottom-up knowledge by actively engaging local input, including virtual focus groups conducted with child protection professionals in resource-constrained settings. This process ensures that the final product is both relevant and feasible for those who will use it. Guided by a steering committee of international child protection experts, the framework embodies the principle of being "by the community, for the community," enhancing its integrity and applicability across diverse contexts. Its collaborative foundation bolsters its credibility and makes it a valuable resource for MDTs working in varied environments.

Because this framework strongly advocates for a child-centered and trauma-informed approach, it is essential that the implementing MDTs arrange comprehensive training for all team members to ensure they adopt this ethos and align their specific roles accordingly. This initial training will enhance the effectiveness of interventions and foster partnership within the team, ensuring that the child's needs are at the center of every response. The MDTs are encouraged to focus on their strengths and opportunities rather than what they lack, leveraging these assets as they adapt the framework to their lived realities and legal contexts. Training can be done by different team members so that all members understand the expertise, strengths, and limitations that each team member brings. A tailored response is critical for teams operating in resource-constrained settings to ensure that the collaborative approach remains both feasible and effective.

To promote long-term sustainability, MDTs may benefit from designating individuals responsible for monitoring training needs and advocating for ongoing professional development. This ensures that the team's capacity remains strong and that the collaborative response remains efficient over time. Alongside the framework, a resource guide is also included to support teams and, in some cases, direct them to additional training opportunities that might be available.

An important next step for this initiative is the evaluation of the framework through pilot studies in resource-constrained settings. These pilots will evaluate the framework's flexibility, feasibility, and effectiveness in promoting a collaborative response while reducing siloed operations in resource-constrained settings. The evaluation will also examine the framework's impact on the involved professionals (professional and personal impact) and, most importantly, whether its implementation leads to improved outcomes for CSA victims and supportive non-offending family members. Such assessments will be crucial to refining the framework and ensuring its adaptability across various resource-constrained settings. Ultimately, this framework bridges the gap between research and practical application, facilitating the shift from discourse to meaningful action.

4. Concluding remarks and future directions

The development of this framework represents a significant first step toward creating a structured, adaptable approach for MDTs addressing CSA in resource-constrained settings. This framework offers a child-centered, trauma-informed, and collaborative response that can be customized to the unique contexts of various regions. However, the development of this collaborative framework marks only the start of this important process of transforming responses to CSA in resource-constrained settings.

The next critical phase involves international collaboration and joint efforts to ensure that this framework is rigorously evaluated in real-world settings and then disseminated and implemented successfully. Only through this global collaboration and coordination will we be able to refine and validate the framework's effectiveness and suitability, ensuring that all children, regardless of where they live, receive the protection and support they need. As the response to CSA improves at the community level, ideally, the outcomes for children will improve and prevention and policies will improve over time.

As this framework is piloted and adapted globally, the ultimate goal is to foster a comprehensive, quality response from all systems involved in child protection, especially in resource-constrained settings, where children are more vulnerable. This effort aligns with the universal recognition of every child's right to live a life free from violence, access justice, and have their fundamental rights fulfilled. Through sustained commitment, cross-border cooperation, and continuous evaluation, we move closer to a future where every child is safeguarded, their voices are heard, and their well-being is prioritized. The hope is that these collective actions will set a global standard for protecting vulnerable children and promoting their right to a life free from abuse and trauma.

CRediT authorship contribution statement

Abbie Newman: Writing – review & editing, Writing – original draft, Visualization, Supervision, Project administration, Conceptualization. **Pragathi Tummala:** Writing – review & editing, Writing – original draft, Visualization, Supervision, Project administration, Conceptualization. **Elmien Crofford:** Writing – review & editing, Writing – original draft, Visualization, Supervision, Project administration, Conceptualization. **Esther Deblinger:** Visualization, Validation, Methodology, Investigation, Formal analysis, Data curation, Conceptualization. **Chris Graveson:** Visualization, Validation, Methodology, Investigation, Formal analysis, Data curation, Conceptualization. **Jordan Greenbaum:** Visualization, Validation, Methodology, Investigation, Formal analysis, Data curation, Conceptualization. **Diahann Harrison:** Visualization, Validation, Methodology, Investigation, Formal analysis, Data curation, Conceptualization. **Renate Winter:** Visualization, Validation, Methodology, Investigation, Formal analysis, Data curation, Conceptualization. **Carmit Katz:** Writing – review & editing, Writing – original draft, Visualization, Validation, Supervision, Software, Resources, Project administration, Methodology, Investigation, Formal analysis, Data curation, Conceptualization.

Declaration of generative AI in scientific writing

During the preparation of this work the authors used ChatGPT in order to improve the article's readability and language. After using this tool, the authors reviewed and edited the content as needed and take full responsibility for the content of the publication.

Declaration of competing interest

The authors declare that they have no known competing financial interests or personal relationships that could have appeared to influence the work reported in this paper.

Appendix B. Supplementary data

Supplementary data related to this article can be found at https://doi.org/10.1016/j.chipro.2025.100204.

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