TRAINING DESIGN

PROPOSED INSTRUCTIONAL DESIGN TEMPLATE ON CHILD PROTECTION TRAINING IN THE PEDIATRIC RESIDENCY CURRICULUM

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Introduction:

The Child Protection Network Philippines, Inc. presents this proposal integrating protection of children from abuse and neglect in the residency training for the approval of the Philippine Pediatrics Society, Inc. The commitment of both institutions to protect children from abuse and neglect, preserve, and promote their holistic development matches the global call for transformative health professions education. The course design is tailored to follow the national and international qualifications standards for Level 8 credentials in the Philippine Qualifications Framework.

The course design includes learning outcomes, minimum subject matter and instructional resources, and performance assessment following the outcome-based education curriculum design. Accredited individual training institutions are presented this template to help them implement the program while remaining true and faithful to their respective philosophies and core values.

Rationale:

Child protection refers to "preventing and responding to violence, exploitation and abuse against children – including commercial sexual exploitation, trafficking, child labor and harmful traditional practices, such as female genital mutilation/cutting and child marriage." (UNICEF, 2016).

In the Philippines, doctors lag behind social workers, lawyers, judges and police officers in terms of their knowledge, skills and attitudes toward child protection. Since 2000, the Child Protection Network (CPN), in collaboration with its partner agencies have been conducting intensive trainings and on-the-job programs for these other professionals. Even though the child abuse and neglect curriculum has been introduced in the training of undergraduate medical students, further focused training is needed to ensure adequate competency in the management and prevention of cases of abuse and neglect. Since pediatricians directly interact and handle children and their families, they are the front-liners in the protection of children; however, studies have shown that may not be well- prepared for such cases.

A review of the Philippine Pediatric Society, ICD-10 Registry from January 1, 2006 to December 1, 2009 on the number of children who were abused or maltreated showed only a total of 15 cases in 4 years: 4 Physical abuse, 4 sexual abuse and 7 other maltreatment syndromes. On the other hand, there were 32 infants (Under 12 months) with multiple fractures of the extremities, fractures of the skull and facial bones and 1,351 children under 3 years with head injuries. This data implies poor recognition and underreporting of possible child abuse cases. Furthermore, a study done by Dela Paz, Madrid and Tan (2007) among Pediatric chief residents in the National Capital Region (NCR) revealed that 95% of the pediatric training programs in NCR do not have an existing curricula on child abuse and neglect (CAN). Figures also showed that 48% of the chief residents perceived their residents as somewhat prepared in identifying and evaluating cases of CAN while 33% perceived their residents as not well prepared. The most common aspects of CAN training identified as needing improvement were dedicated time for training and expertise of the CAN providers. The same conclusion was found in one study done among medical doctors in the United States of America (USA). Blumenthal and Gokhale (2014) evaluated the preparedness of American physicians to handle certain types of patients and medical conditions. They found that 11-12% of primary care residents, which included pediatricians, were unprepared to handle domestic violence and child maltreatment cases. Another research showed that 52% out of the 200 surveyed pediatricians in Alabama, USA felt that they were not competent in conducting sexual abuse examinations, and 16% felt incompetent in examining physically abused children, despite the fact that 20-30% of the respondents were already involved in child abuse physical and anogenital examinations (Arnoid, et al., 2005).

Integrating child protection in the pediatric residency training is aligned with the overall goal of the training program of the Philippine Pediatric Society, Inc. of providing doctors with the opportunity to be proficient in the “preventive, promotive, curative and rehabilitative aspects in the practice of pediatrics (PPS, 2013).” This is also consistent with the objective of preparing future pediatricians for general practice. Given the increasing awareness towards child abuse and neglect, its increasing number of cases and its physical, mental, emotional and social effects on children victims, child protection issues will surely be a part of one’s pediatric practice. One should be ready to face any child abuse and neglect case in the future, because cases like these entail the help of any medical practitioner at any point in time, regardless of being involved in a government-run or private practice.

Module Description:

The module on child protection is just one of the many topics that a pediatric resident must learn during the three years of pediatric specialty training. This part of the training will focus on the recognition of the different types of child maltreatment in all pediatric cases that may be encountered in both the out-patient and in-patient setting. Once recognized, the module will also help the doctor learn the skills necessary in documenting these cases, as well as in providing the crucial frontline interventions for these children. Lastly, through the mixture of classroom-type activities and on the job patient encounters, the future pediatricians of the country will become advocates for the best interest of the Filipino child as well.

Learners:

This instructional design was made for doctors who will undergo the three-year pediatric residency training through the recommended curriculum of the Philippine Pediatric Society (PPS) at accredited training hospitals in the Philippines. The number of students may range from a minimum of 2 to a maximum of 25, depending on the training institution.

Setting:

This course design will be implemented by accredited hospitals that offer pediatric residency training in the Philippines. Since these training institutions are categorized into four levels based on the Philippine Pediatric Society Hospital Accreditation Board recommendation, how it will be integrated into their training program will rely on the number of trainees and the resources available. Training officers are encouraged to adopt the teaching and learning, as well as evaluation strategies that are relevant to their respective contexts.

The course design will require a meeting room or a conference room, as well as hospital clinics and wards for a variety of settings to learn application of concepts and skills.

It is recommended that the classroom-type activities, geared toward the acquisition of knowledge and skills on child protection, be introduced in the first year of residency training and reiterated throughout the rest of the three years of training. Application of learned concepts and skills will be through patient encounters in the clinics, emergency room and wards, which may begin during the first year of training, but this should be more evident in the second to third years.

Program Outcomes:

Let us insert here the general program outcomes of residency training in pediatrics if PPS already has these. Then we insert a sentence that these CAN learning outcomes are consistent and aligned with PPS.

At the end of the Pediatric Residency Training, the pediatric resident must be able to:

1. Recognize child abuse and neglect among pediatric patients in the out-patient and in-patient settings.
2. Document suspected child maltreatment cases that may be encountered in clinical practice.
3. Provide multi-disciplinary intervention to suspected abused and neglected children, through timely reporting to necessary agencies and referring to relevant disciplines and agencies.
4. Advocate for the best interest of the child at all times in clinical practice.

Instructional Design:

For each outcome, there will be at least two learning strategies that may be implemented. One is meant to provide the basic knowledge, skills and attitudes related to child protection, and the other is meant for their application in clinical practice during residency. Sometimes, different learning strategies may be presented, to serve as options; however, their implementation will depend on the resources and capability of the training institution. Assessment of achievement may include examinations, case conferences and case reports. The teaching and learning and assessment strategies may be spread out through the three- year pediatric residency program, as long as the outcomes are achieved by the end of training.

Outcome	Topic	Strategy	Time Allotted/ Resources Needed	Evaluation
Recognize child abuse and neglect among pediatric patients in the out-patient and in-patient settings.	1. Definition of Child Abuse and Neglect and Its Forms 2. Recognition of Child Abuse and Neglect a. Common Findings b. Physical and Mental Signs and Symptoms 3. Dynamics and Effects of Abuse	I. Independent Lectures (may also be merged as a differential in other pediatric conditions/diseases) OR 4Rs Training II. Patient Observation (Exposure to WCPU) AND/ OR Actual Patient Encounters at Home Institution (History-taking, Assisting in PE, Drafting Interventions)	I. -Total of 4 hours -Lecture Materials - AV Equipment - Meeting/ Conference Room - Journals and Readings Materials II. - May Vary (At least 1 day or 2 hours per encounter) - WCPU - Actual Patients Presenting with Suspicion of Abuse and Neglect - Out-patient clinics	Consultant-Facilitated Chart Review and Preceptorial every year At least 1 Case Presentation with Written Report every year for 3 years (1 type of CAN per year) Include in Exams and in PPS In-service Exam

Outcome	Topic	Strategy	Time Allotted/ Resources Needed	Evaluation
			- Hospital Wards/ Floors - Medical Supplies and Diagnostics	
Document suspected child maltreatment cases that may be encountered in clinical practice.	Charting a Suspected Victim of Abuse and Neglect 1. History-Taking 2. Physical and Anogenital exam 3. Photo documentation 4. Diagnostics and Evidence Collection	I. Independent Lecture OR 4Rs Training II. Patient Observation (Exposure to WCPU) AND/ OR Actual Patient Encounters at Home Institution (History-taking, assisting in PE, Drafting Interventions)	I. -Total of 2 hours -Lecture Materials - AV Equipment - Meeting/ Conference Room - Journals and Readings Materials II. - May Vary (At least 1 day or 2 hours per encounter) - WCPU - Actual Patients Presenting with Suspicion of Abuse and Neglect - Out-patient clinics - Hospital Wards/ Floors Medical Supplies and Diagnostics	Consultant-Facilitated Chart Review and Preceptorial every year At least 1 Case Presentation with Written Report every year for 3 years (1 type of CAN per year) Include in Exams and in PPS In-service Exam

Outcome	Topic	Strategy	Time Allotted/ Resources Needed	Evaluation
Provide multi-disciplinary intervention to suspected abused and neglected children, through timely reporting to necessary agencies and referring to relevant disciplines and agencies.	A. The Multi-Disciplinary Team Approach and Case Conference B. Legal Framework of Abuse C. The CSPC Protocol Highlights D. Anticipatory Guidance and Preventive Measures 1. Red Flags 2. Positive Discipline 3. Psychoeducation	I. Independent Lecture OR 4Rs Training II. Patient Observation (Exposure to WCPU) AND/ OR Actual Patient Encounters at Home Institution (History-taking, assisting in PE, Drafting Interventions) AND/ OR Preparing and Participating in a Multi-Disciplinary Case Conference	I. -Total of 5 hours -Lecture Materials - AV Equipment - Meeting/ Conference Room - Journals and Readings Materials II. May Vary (At least 1 day or 2 hours per encounter) - WCPU - Actual Patients Presenting with Suspicion of Abuse and Neglect - Out-patient clinics - Hospital Wards/ Floors - Medical Supplies and Diagnostics	At least 1 Consultant-Facilitated Case Review and Preceptorial every year At least 1 Case Presentation with Written Report every year for 3 years (1 type of CAN per year) 360 Evaluation from Partner Departments, Disciplines and Agencies (relating to handles cases) Include in Exams and in PPS In-service Exam
Advocate for the best interest of the child at all times in clinical practice.	A. Rights of the Child B. Burden of Abuse and Neglect C. Child Protection Policy	I. Independent Lecture OR 4RS Training OR	I. -Total of 5 hours -Lecture Materials - AV Equipment - Meeting/ Conference Room	At least 1 Consultant-Facilitated Case Review and Preceptorial every year At least 1 Case Presentation with Written

Outcome	Topic	Strategy	Time Allotted/ Resources Needed	Evaluation
		As part of Orientation Prior to Pediatric Residency Training II. Patient Observation (Exposure to WCPU) AND/ OR Actual Patient Encounters at Home Institution (History-taking, Assisting in PE, Drafting Interventions) AND/ OR Preparing and Participating in a Multi-disciplinary Case Conference	- Journals and Readings Materials II. - May Vary (At least 1 day or 2 hours per encounter) - WCPU - Actual Patients Presenting with Suspicion of Abuse and Neglect - Out-patient clinics - Hospital Wards/ Floors - Medical Supplies and Diagnostics	Report every year for 3 years (1 type of CAN per year) 360 Evaluation from Partner Departments, Disciplines and Agencies (relating to handles cases) OR Integrate in Community Pediatrics Project/ Program Include in Exams and in PPS In-service Exam

Teaching and Learning Strategies

1. *Independent Lectures*

   Resource speakers will educate the residents on relevant child protection topics that will serve as their foundational knowledge for future sessions and lessons. These lectures may or may not incorporate other teaching and learning strategies within sessions such as games, small group discussions and tutorials.

   Conscious effort is also placed in including child protection topics within lectures for other topics. An example would be including possible child abuse as a differential diagnosis in children with intracranial bleeding, or rule out the possibility of abuse in a child with multiple fractures due to osteogenesis imperfecta, or include inquiries on discipline techniques and parenting strategies in the history- taking lecture.

2. *4Rs Training*

Also known as EnTHAWC (Enhanced Training in Handling Abused Women and Children), it is a 2-and-a-half-day training course that utilizes lectures and workshops. The lectures provide the child protection foundation of the learners, while the workshops provide an opportunity for the learners to apply the concepts they have learned through small group case discussions. The training typically involves social workers, police officers and medical practitioners, since it emphasizes the importance of the multi-disciplinary approach in handling cases of abuse within the community.

3. *Patient Observation and Actual Patient Encounters (CPU Exposure)*

   A once a week- two to four-week rotation at the nearest child protection unit within the vicinity of the home training hospital of the residents, that will give them the opportunity to observe how to handle cases of child abuse and neglect, under the supervision of a child protection specialist. Interviewing and examination skills will be improved with actual patient encounters in their home institution. Compassion and willingness to help others are attitudes that will be developed through their face to face meeting with patients.

4. *Actual Patient Encounters (Home Institution)*

   Suspected cases abuse and neglect encountered at the out-patient, emergency, in-patient and community setting will help develop the skills of the residents in handling these cases, as well as provide them with the opportunity to apply the 4Rs of child abuse and neglect management (recognition, recording, reporting and referral). Processing of the case will be done with the consultant in charge during the chart review preceptorial.

5. *Observation/ Conduct of a Multidisciplinary Case Conference*

   An important aspect of working in child protection is learning to coordinate and work with other disciplines. Problematic cases will entail meetings with different government and non-government personalities such as social worker, police officers, lawyers, teachers, and others, depending on the need of the case. These people will come together in a case conference to discuss and decide on important matters related to the case at hand. Trainees will observe and eventually, will be called to attend and even facilitate their own case conference if they encounter difficult cases.

Evaluation Strategies

1. *Consultant-Facilitated Case Review and Preceptorial*

   A one on one session with a consultant to discuss the case encountered by the pediatric resident. The process followed by the trainee in handling the patient will be evaluated, together with the application of the 4Rs of child abuse and neglect management in the case. The consultant provides feedback regarding the performance of the trainee, and discusses areas where improvement can be done. Attitude demonstrated by the trainee should also be observed by the consultant.

   It is recommended to conduct at least one preceptorial a year through the three-year residency training, covering at least one type of child abuse and neglect per preceptorial.

2. *Case Presentation with Written Report*

A case of child abuse and neglect will be presented to a big group or audience. The audience may be members of the Department, Hospital Staff or fellow doctors who are members of a Consortium. A written report should also be generated by the resident- presenter, which will also be evaluated by a consultant.

The resident should present at least one case per year for three years, covering at least one type of abuse per case presentation.

3. *360 Evaluation from Partner Departments, Disciplines and Agencies*

   Relevant partners will evaluate how knowledge, skills and attitudes of the resident while handling a case of suspected abuse and neglect. Partners may include the patient, the medical social worker, inter and intra-departmental doctors and nurses, local government agencies and police officers. A 360 evaluation gives the evaluator a glimpse of the performance of the trainee in actual office or on the job setting.

4. *Integrate in Community Pediatrics Project/ Program*

   Prevention of abuse and neglect can be done through advocacy work in the community. Screening for possible abuse and neglect among patients encountered in the community can also be done in conjunction with the community rotation or project of the residents.

5. *Include in Exams and in PPS In-service Exam*

   Three to five case- based items will be included in the examination of the resident every year, and in the in-service PPS exam (WISE). Inclusion of abuse and neglect as a differential diagnosis among the relevant cases for discussion during the PPS Diplomate exam is also recommended.

APPENDIX A

LIST OF RESOURCES FOR REFERENCE

A. Books and Manuals

1. Madrid, B. and Tan M. (2014). Abused & Neglected Children. In X. Navarro, A. Bauzon, J. Aquilar, & O. Malanyaon (Eds.), *Fundamentals of pediatrics: competency-based*. Quezon City, Philippines: C&E Publishing Inc.
2. Madrid, B. (2014). Environmental Influences. In X. Navarro, A. Bauzon, J. Aquilar, & O. Malanyaon (Eds.), *Fundamentals of pediatrics: competency-based*. Quezon City, Philippines: C&E Publishing Inc.
3. Tan, M. (2014). Sexual Abuse of Children. In X. Navarro, A. Bauzon, J. Aquilar, & O. Malanyaon (Eds.), *Fundamentals of pediatrics: competency-based*. Quezon City, Philippines: C&E Publishing Inc.
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5. Child Maltreatment Medico-Legal and Terminology. 4th Edition, 2015: CPN. www.childprotectionnetwork.org
6. The DNA Manual from DNA Analysis Laboratory. National Science Research Institute, 2004: UP.
7. Protocol for Care Management of Child Victims of Abuse, Neglect and Exploitation. 2013: UNICEF and CPN. www.childprotectionnetwork.org
8. Crosson-Tower C. Understanding child abuse and neglect. Ninth edition, 2014: USA.
9. A Physician's Guide to Protecting Child-Abuse Patients' Confidentiality. 1998: UP. www.childprotectionnetwork.org
10. The Care Continuum for Child Abuse and Neglect. 2001: UP. www.childprotectionnetwork.org

B. Journals

1. Jenny M, MD, Crawford-Jakubiak J and COMMITTEE ON CHILD ABUSE AND NEGLECT. The Evaluation of Children in the Primary Care Setting When Sexual Abuse Is Suspected. PEDIATRICS Volume 132, Number 2, e-559-e567, August 2013. doi:10.1542/peds.2013-1741. http://pediatrics.aappublications.org/content/pediatrics/132/2/e558.full.pd
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3. Hibbard, R, Barlow, J, MacMillan,H. the Committee on Child Abuse and Neglect and AMERICAN ACADEMY OF CHILD AND ADOLESCENT PSYCHIATRY, Child Maltreatment and Violence Committee. Psychological Maltreatment. Pediatrics

2012;130:372–378. www.pediatrics.org/cgi/doi/10.1542/peds.2012-1552

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6. Kemp AM, et al. *Bruising in children who are assessed for suspected physical abuse.* Archives of Diseases in Childhood. 2014;99:108–113.
7. Maguire, S. *Which injuries indicate physical abuse*. Archives of Diseases in Childhood Educators and Practitioners Edition. 2010 95: 170-177.
8. Adams J, Botash A and Kellogg N. *Differences in hymenal morphology between adolescent girls with and without a history of consensual sexual intercourse.* Archives of Pediatric and Adolescent Medicine. 2004;158:280-285.
9. Adams JA, Kellogg ND, Farst KJ, Harper NS, Palusci VJ, Frasier LD, Levitt CJ, Shapiro RA, Moles RL, Starling SP, Updated Guidelines for the Medical Assessment and Care of Children Who May Have Been Sexually Abused, Journal of Pediatric and Adolescent Gynecology (2016), DOI: http://dx.doi.org/10.1016/j.jpag.2015.01.007. http://www.jpagonline.org/article/S1083-3188(15)00030-3/fulltext
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14. Smith DW, Letourneau EJ, Saunders BE, Kilpatrick DG, Resnick HS and Best CL. *Delay in disclosure in childhood rape: results from a national survey.* Child Abuse and Neglect 2000:24 (2); 273–287.
15. Norman RE, Byambaa M, De R, Butchart A, Scott J, et al. (2012) The Long-Term Health Consequences of Child Physical Abuse, Emotional Abuse, and Neglect: A Systematic Review and Meta-Analysis. PLoS Med 9(11): e1001349.
16. Kellogg N and Committee on Child Abuse and Neglect. *Clinical report the evaluation of sexual behaviors in children.* Pediatrics 2009;124;992-998.
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18. Madrid, BJ. *Child abuse in the Philippines: Updates for pediatricians.* The Philippine Journal of Pediatrics April 2012:60 (1); 5-10.
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APPENDIX B

SAMPLE GRADING SHEET FOR HISTORY- TAKING

Name of Trainee:
Date:
Evaluator:

Instructions: Check the column marked PERFORMED if the parameter was observed and NOT PERFORMED if it was missed during the actual interview of the trainee with a patient.

PARAMETER The interviewer:	PERFORMED	NOT PERFORMED	REMARKS
Greets the patient and family warmly			
Introduces self & role on healthcare team			
Builds rapport with patient			
Assesses the development of the child			
Asks opening questions properly			
Asks open ended questions			
Actively listens to what the patient narrates			
Does not ask presumptive/leading questions			
Speaks in language appropriate for caregiver/child's education level			
Asks for clarification if necessary			
Uses silence appropriately			
Handles difficult situations appropriately			
Asks caregiver/child if he/she has any questions, concerns, or any additional history they want to add			
Closes interview with appropriate gestures or statements			

Note: The maximum preferred score for this exercise is 14. However, a score of 10 can be considered satisfactory. Trainees whose scores are below 10 are advised to consult the preceptor and review the history taking process. Trainees may take this exam again after the consultation.

APPENDIX C

SAMPLE GRADING SHEET FOR PHYSICAL AND ANOGENITAL EXAM

Name of Trainee:
Date:
Evaluator:

Instructions: Check the column marked PERFORMED if the parameter was observed and NOT PERFORMED if it was missed during the actual interview of the trainee with a patient.

CRITERIA	PERFORMED	NOT PERFORMED	REMARKS
Greets the patient and family warmly			
Describes the examination procedure to the patient and the family using language appropriate for the level of the child and/or caregiver			
Assures the patient of confidentiality and privacy during the examination			
Instructs the child that he/ she has control over the examination process, and can opt to stop it anytime			
Asks for the verbal consent of the child to perform the examination			
Asks if the presence of the caregiver is necessary			
Asks if photodocumentation can be done			
Performs a complete and thorough systemic physical examination of the patient			
Prepares and gently positions the child for the anogenital examination			
Documents all physical and anogenital findings in the chart			
Orders necessary diagnostic procedures			

CRITERIA	PERFORMED	NOT PERFORMED	REMARKS
Properly interprets and explains examination findings to the patient and to the caregiver using appropriate language			
Discusses the multi-disciplinary and holistic management plan with the patient and caregiver			
Refers to relevant disciplines and agencies			
Handles difficult situations appropriately			
Asks caregiver/child if he/she has any questions, concerns, or any additional information they want to add			
Closes the consult with appropriate gestures or statements			

Note: The maximum preferred score for this exercise is 17. However, a score of 14 can be considered satisfactory. Trainees whose scores are below 14 are advised to consult the preceptor and review the history taking process. Trainees may take this exam again after the consultation.

APPENDIX D

SAMPLE GRADING SHEET FOR CASE PRESENTATION

Name of Trainee: Date:
Topic:
Evaluator:

INSTRUCTION: Please mark with a check (✓) the score that most accurately describes your evaluation of the student.

KNOWLEDGE	Weight (70%)	1 Strongly disagree	2	3	4	5 Strongly agree	Remarks
Elicited a complete, expanded and relevant history a. History included 5 Ws of CAN history-taking b. Recognized red flags in the history, or symptoms and signs of possible CAN c. Inquired about safety concerns about the child	*20*						
Performed a complete and accurate physical and anogenital exam a. Recorded and reported pertinent positives and negatives of the examination b. Recognized examination findings related to CAN	*15*						
Explained interpretation of integrated history and PE findings	*10*						
Generated the most plausible working impression	*5*						
Formulated an appropriate management plan a. Multi-disciplinary b. Addressed mental health and safety issues c. Referred to relevant disciplines and agencies	*10*						
Answered questions pertinent to the case adequately	*5*						
Utilized medical literature to further understand the case	*5*						

SKILLS	Weight (15%)	1 Strongly disagree	2	3	4	5 Strongly agree	Remarks
Orally presented the case in an systematic, patient-centered, and clear manner	*5*						
Used visual aids that are appropriate and with clear content, while ensuring the privacy and confidentiality of the patient	*5*						
Demonstrated good communication skills (language fluency, continuous and logical flow of discussion, eye contact with the audience)	*5*						

ATTITUDE	Weight (15%)	1 Strongly disagree	2	3	4	5 Strongly agree	Remarks
Genuine interest in the case and in the patient through an active presentation	*5*						
Demonstrated respect for the patient and family members	*5*						
Good time management (punctual, finished presentation on time, allotted sufficient time for important points)	*5*						

APPENDIX E

ENTHAWC (4RS) TRAINING FACILITATOR'S BRIEF

ENHANCED TRAINING IN HANDLING ABUSED WOMEN AND CHILDREN

OVERVIEW

The Enhanced Training in Handling Abused Women and Children (EnTHAWC) is a 2.5-day continuing professional development program (CPD) for physicians, social workers, police officers, mental health professionals, nurses, lawyers, and other allied health professionals involved in women and child protection work. This is highly recommended for all human resources for health from government, non-government organizations (NGOs), and private institutions.

EnTHAWC is compliant with outcome-based education (OBE) training design mandated by the Professional Regulation Commission. It models the integration of the following programs:

1. Problem Based Training Manual on the 4Rs (Recognizing, Recording, Reporting, and Referral) of Women and Children Abuse Cases for Pediatric, Obstetrical and Gynecological Residency Program currently being managed by the Family Health Office (FHO), Department of Health
2. Problem Based Training Manual on Protection of Women and Children from Domestic Violence for Other Hospital Personnel currently being managed by the Family Health Office, Department of Health
3. Multidisciplinary Team Training on Violence Against Women and Children currently being managed by the Child Protection Network, Inc. (CPN)
4. Administrative Order 2013-0011: Revised Policy on the Establishment of Women and Their Children Protection Units in all Government Hospitals being implemented by the Department of Health (DOH)

LEARNING OUTCOMES

Given actual clients, professionals who have competed EnTHAWC should be able to demonstrate the following learning outcomes and competency standards:

Learning Outcomes	Competency Standards
1. Professionally manage clients	1. Elicit age-appropriate and accurate history / gather relevant and accurate data to establish abuse 2. Perform comprehensive physical examination 3. Determine necessary diagnostic tests 4. Arrive at correct diagnosis and differentials 5. Perform accurate clinical procedures 6. Formulate an effective and evidence-based treatment and management plan 7. Coach the clients and their support persons or families on effective rehabilitation and therapy 8. Accomplish the standardized documentations in handling the case 9. Refer to appropriate offices and professionals
2. Communicate effectively	10. Establish effective rapport 11. Explain clearly the management plan to the clients and their support persons 12. Effectively convert professional findings and recommendations to lay language that the clients and the general public can understand 13. Develop effective information and education communication resources especially designed for target clients and communities 14. Submit comprehensive documents as required by the Women and Children Protection Unit (WCPU) and other agencies

TRAINING OBJECTIVES

Physicians who complete this training should be able to:

1. Recognize abuse in clients through:
    a. Proper children- and women-sensitive history taking
    b. Systematic physical examination

2. Record all the pertinent information in establishing the presence and validity of abuse
3. Formulate a medical management plan
4. Use multidisciplinary approach in handling clients

Social workers who complete this training should be able to:

1. Recognize abuse in clients through:
    a. Eliciting relevant information
    b. Determining safety and risk factors
2. Formulate an assessment and appropriate plan of management
3. Produce an accurate social case report
4. Use multidisciplinary approach in handling clients

Police officers who complete this training should be able to:

1. Recognize abuse in clients through:
    a. Ask developmentally-appropriate and gender-sensitive questions
    b. Identify evidence with probative value
2. Produce accurate and court-admissible sworn statement and affidavits
3. Assist victims, families, and other members of the multidisciplinary team in handling domestic violence cases

TRAINING SCHEDULE

DAY 1:

Theme: Children and Women Abuse: what it is, what to do with it, what can be immediately done?

Chief Facilitator:

Day / Time	Activities	Persons Responsible
8:00-8:30	Arrival and registration of participants	
8:30-8:45	EnTHAWC Pretest	

Day / Time	Activities	Persons Responsible
8:45-9:00	Overview of EnTHAWC and Orientation to the Program, to CPU Levels and to the House Rules	
9:00-10:00	Recognizing child abuse: facts, forms, origin, and spread	
10:00-10:15	BREAK	
10:15-11:15	Recognizing abuse of women: facts, forms, origin, and spread	
11:15-12:00	WORKSHOP 1: Grouping and announcement of Small Group Discussion 1 (SGD1) tasks	All EnTHAWC trainers as facilitators
12:00-1:00	LUNCH BREAK	
1:00- 2:00	WORKSHOP 1: Plenary 1 of SGD1 (Presentation of SGD1 Outputs)	All EnTHAWC trainers as facilitators
2:00-2:30	The Multidisciplinary Team Approach	
2:30-3:00	The CSPC Protocol on Case Management	
3:00-3:15	BREAK	
3:15-4:15	Ensuring the Safety of the Child Victim: Safety and Risk Assessment of Children	
4:15-4:45	Ensuring the Safety of the Woman Victim: VAWC Case Management and Safety Planning	
4:45-5:00	Day 1 Evaluation	Chief Facilitator

DAY 2:

Theme: Children and Women Abuse: not just a medical problem

Chief Facilitator:

Day / Time	Activities	Persons Responsible
8:00-8:30	Review-Preview	Chief Facilitator
8:30-9:30	Effects of Abuse on Women and Children	
9:30-10:15	Guidelines in Interviewing survivors of abuse + Video on Joint Interview	
10:15-10:30	BREAK	
10:30-11:30	WORKSHOP 2 Parallel Sessions: 1. Interviewing Eloisa 2. Interviewing Rosa 3. Interviewing the Tres Marias 4. Handling the case of Basti	All participants and EnTHAWC trainers as facilitators
11:30-12:30	The legal framework for women and children	
12:30-1:30	LUNCH BREAK	
1:30-2:45	Parallel Sessions in 3 separate break-out rooms: 1. How to make a social case study report 2. How to make a sworn statement 3. Charting a victim of women and children abuse (History, PE and Photodocumentation)	SW Facilitators Legal Facilitators Medical Facilitators
2:45-3:30	Development of a case conference and multidisciplinary management plans Lecture and Demo of a Case Conference	
3:30-3:45	BREAK	
3:45-4:45	WORKSHOP 3:	All participants and EnTHAWC trainers as facilitators

Day / Time	Activities	Persons Responsible
	Multidisciplinary case conference and Formulation of a multidisciplinary management plan	
4:45-5:00	Day 2 Evaluation	Chief Facilitator

Day 3:

Theme: Translating the patients into women and children abuse cases

Chief Facilitator:

Day / Time	Activities	Persons Responsible
8:00-8:30	Review/preview	
8:30-11:30 with running break	WORKSHOP 3: Plenary 2: Presentation and critique of all drafted MDT management plans	All participants and EnTHAWC facilitators
11:30-12:00	EnTHAWC posttest	
12:00-12:30	1. Announcement of Best Case Presentation 2. Day 3 and Course evaluations 3. Final Challenges 4. Closing ceremony	Chief Facilitator

APPENDIX F

SAMPLE CASE PRECEPTORIAL AND POSSIBLE ANSWERS

STORY OF BASTI

Basti, a three-year-old child, was rushed by his mother to the emergency room because of loss of consciousness. At the emergency room, the doctors noted swollen genitalia and bruises all over his body. Work-up showed intracranial bleeding and cerebral edema, unexplained fractures of long bone and posterior rib vertebrae, and blunt abdominal injury. Basti was admitted at the Pediatric ICU.

A joint interview was conducted by the doctor and social worker. According to the Jinky, his mother, Basti fell from his bicycle and she found him bruised and unconscious.

Jinky, and Manny, the stepfather, are the sole caretakers/guardians of Basti. The relationship of Jinky and Manny has been kept a secret from their families for fear of disapproval. They do not go out of the house so they are unknown in the community. The social workers were not able to gather any information during the collateral interviews in the community.

Jinky took care of Basti while he was confined in the ward for several months. However, after some time, she insisted on taking Basti out of the hospital. Due to lack of other relatives who can take care of Basti, Jinky remained to be the caretaker despite high suspicion that she was the one who abused her son. The hospital requested the LSWDO to issue a document that can be attached on his chart, stating that he is under protective custody until further intervention is taken to ensure his safety.

The doctors are having problems keeping the child in the hospital because all necessary medical work-ups have been done but no alternative placement has been found. The severity of the injuries has caused severe disabilities. Basti does not talk, is unable to sit up on his own and is fed through a nasogastric tube. He will need special care for the rest of his life.

Meanwhile, Jinky has become difficult to deal with and threatens to leave against medical advice. She said that WCPU has no right to hold Basti because they have no proof that she is the perpetrator nor was there any case filed against her.

Is this a case of child abuse and neglect or not? If yes, what type?

If you ever encounter this case in the ward, what would be your long term and short term multi-disciplinary interventions for Basti?

Sample Answer Key:

ISSUES/ PROBLEMS	INTERVENTIONS	PERSON RESPONSIBLE	TIME FRAME	RESOURCES NEEDED
Physical abuse	File a case Investigation Identification of investigator	Police officer	Immediate	Birth cert Medicolegal report Lab exams and imaging procedure results Affidavit of attending physicians, nurses, other witnesses Investigator's affidavit complaint
Safety	Safety and risk assessment - Home visit - Neighbor interviews - Identification of supportive relatives Protective custody and filing for involuntary commitment Long term placement of child and home care	LGU Social worker	Immediate Immediate Long term	 Birth cert Social case study report Medicolegal report List of temporary shelters List of agencies/shelters for children with chronic medical conditions
Parenting capability of parents	Referral for psychiatric evaluation Parenting classes/seminar	Psychiatrist/psychologist LGU Social worker	Immediate Immediate	 Parenting capability assessment report

Medical condition	Continuous medical follow up (Neurodevelopmental; orthopedics; pediatrics; rehab med) Medicines and other rehabilitation services Case conference every 3 months	Attending physicians and specialists MSS Therapists LGU social workers Physicians, specialists, social worker, police officers	Immediate and long term Immediate Long term Long term	Further lab work ups Funds Therapy centers