

THE CARE CONTINUUM FOR CHILD ABUSE AND NEGLECT

A Physician's Guide



Manila, Philippines 2001

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OVERVIEW

Child abuse is a complex, multifactorial problem

- a medical diagnostic category – not just a phenomenon
- a violation of child rights – not just a societal taboo
- a grievous crime – not just a misdemeanor
- a family cancer – not just an isolated one-child problem

A multifactorial problem requires the framework of a multifactorial solution

- a multifactorial problem requires comprehensive, rather than piecemeal solutions
- a multifactorial problem is never solved without the full participation of numerous disciplines

A multifactorial solution requires a multidisciplinary continuum of care

- integrated intervention and prevention
- integrated governance and research
- focus on immediate, needs-driven care with all due respect for and caution given to possible negative outcomes for children left untreated

The multidisciplinary care continuum requires coordination and built-in discipline-specific accountability to attain excellence

- designated leadership and accountability
- true collaboration marked by initiatives and innovation
- formal structures and partnerships facilitating multidisciplinary action and versatile innovation

Key strategies of the care continuum

- to provide specific treatment, partnerships and care strategies for children
- to provide a model for working together in the best interest of the child

The care continuum's common purpose is the child

- to not only end nightmares, but to allow children to dream again
- to create a culture of care

The care continuum for child abuse in the Philippines is an emerging collaborative asset

- standards set forth in this document represent the best learning from Filipino and international specialists in child protection
- the emerging multi-disciplinary partnerships represent the potential to affect broad-scale change
- much remains to be done

THE INTEGRATED CARE CONTINUUM

an evolving active template

TOWARDS SYNERGISTIC STRENGTHS THROUGH

INTERVENTION

in the service of abused children



I Early Detection or Suspicion	II Reporting and Referral	III Multidisciplinary Evaluation and Diagnosis	IV Multidisciplinary Care	V Causality Management
<ul style="list-style-type: none"> • Surveillance strategies • Detection strategies • Curricular reform • Public awareness programs • Awareness programs for children 	<ul style="list-style-type: none"> • Reporting guidelines • Reporting and referral network 	<ul style="list-style-type: none"> • Coordinated multidisciplinary evaluation • Nationwide regional WCPU system • Interdisciplinary suspicious death review team • Professional specialty consultation 	<ul style="list-style-type: none"> • Integrated multidisciplinary case management <ul style="list-style-type: none"> -Physical health -Mental health -Safety care -Child development • Nationwide regional WCPU system • Reintegration care 	<ul style="list-style-type: none"> • Identification and minimization of causal factors • Administration of justice and the law • Perpetrator case management

FOR CHILD ABUSE AND NEGLECT

for innovation and standards of excellence

COORDINATED MAXIMIZATION OF RESOURCES

PREVENTION

in the service of all children



I

Awareness and Empowerment of Children

- Increase access to necessary services and resources for children
- Develop educational children's programs

II

Developing Family Support

- Family support strategies and advocacy
- Link child abuse prevention programs with risk factor reduction programs
- Identify and manage spousal abuse

III

Involvement of All Professionals

- Develop awareness programs for professionals about their roles in child abuse prevention
- Involve key professional groups in child abuse prevention efforts

IV

Developing Community Support

- Mobilize Barangay infrastructure to strengthen community-family interaction
- Establish community volunteer networks in collaboration with child abuse professionals
- Increase awareness of child abuse within the community
- Establish and support safer neighborhoods and a violence-free culture

SPANNING THE CARE CONTINUUM: GOVERNANCE, TRAINING AND RESEARCH

essential components of care continuum mobilization

GOVERNANCE

ascertaining effectiveness and accountability

I

Defining a National Agenda

- Commitment to professional standards and credentialing
- Facilitated case-consultation and peer-review system
- Advocacy for child protection issues
- Interdisciplinary evaluation and collaborative planning

II

Realizing a National Agenda

- Oversight of child protection services
- Resource coordination and asset maximization

TRAINING AND RESEARCH

infrastructure development through expertise and knowledge

I

Educating Professionals

- Interdisciplinary training
- Integrated profession-specific curricula

II

Advancing the Profession

- Facilitated information dissemination
- Cooperative database and resource network
- Research initiatives on best practices and infrastructure needs

STATEMENT OF INTENT

The Care Continuum

Grounded in a common concern for the best interests of abused and neglected children, the care continuum is designed to guide physicians in their efforts to work with and on behalf of children, and to forge different programs into a unified, synergistic effort.

Defining the care continuum – inspiring excellence through multidisciplinary cooperation

The care continuum for child abuse and neglect offers physicians a framework that organizes the multidisciplinary care necessary for abused children and their families and, given the constraints of finite resources and many needs, provides a cohesive plan for multiple disciplines to work in a coordinated and non-overlapping manner.

In all areas of the care continuum, we uphold the tenets of the ***United Nations Convention on the Rights of the Child***, which asserts the basic rights of every child.

Applying the framework – enhancing the system

This operational guide for physicians integrates the framework of the care continuum into current Philippine laws and existing infrastructure for dealing with child abuse in a manner that fosters excellence and encourages flexibility for case-specific needs.

The guide focuses upon the role of the physician in the care continuum and the interaction between physicians and other care continuum professionals. Further, the guide includes approved medical mandates for treating child abuse and encourages physicians to be at the fulcrum of care as well as to participate in the improvement of the system.

Towards initiatives, not rules

It is our hope that this guide will serve as a useful tool for those advocating for positive changes in the Filipino child protection system at all levels, regardless of discipline, specialty or region.

METHODOLOGY

Integrating published research and first-hand experiences

The care continuum and proposed application presented in this guide derive from careful analysis of child abuse and neglect literature and the experiences of the first four years of the University of the Philippines, Philippine General Hospital Child Protection Unit (UP-PGH CPU). Proven strategies and protocols for care delivery from other child abuse medical programs in the Philippines and in other countries including the US and UK, also influenced the care continuum and the recommended framework for its application.

Multiple testing

As a concept, the care continuum was tested for comprehensiveness among established professional leaders in the field of child abuse treatment and prevention, and field-tested for operational content at the PGH-CPU.

Limitations

The care continuum is evolving and refinements to the framework are inevitable.

The Philippine infrastructure for child abuse – laws, professional mandates, agencies and taskforces – is also evolving. Operational specifics will change.

The first-hand experiences of the PGH-CPU limit this study to offering guidelines designed specifically for physicians. However, the care continuum framework could be applied to other professions with revisions specific to different professional groups.

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CHILD ABUSE STATISTICS — PHILIPPINES

Of 32 million children:¹

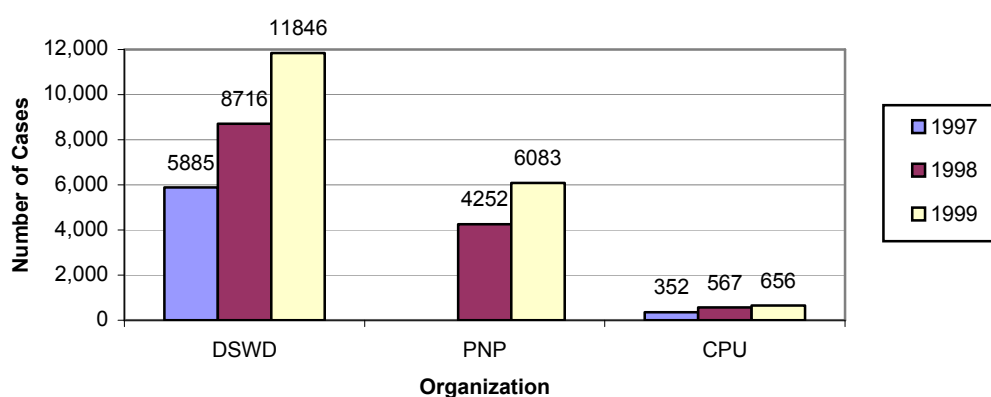
18,000 are abused²

60,000 are prostituted³

44,000 live on the streets⁴

5 million work as child laborers⁵

Child Abuse Statistics 1997-1999



FURTHER CHILD ABUSE STATISTICS			
CATEGORY	DSWD ⁶ (1997-1999)	PNP ⁷ (1998-1999)	CPU ⁸ (1997-1999)
TOTAL NUMBER OF ABUSED CHILDREN	26,446 ⁹	10,335	1,575
SEXUALLY ABUSED ¹⁰	11,262	7,149 ¹¹	1,033
PHYSICALLY ABUSED	4,085	2,072	211
PHYSICALLY AND SEXUALLY ABUSED	Not available	Not available	75
NEGLECTED	5,331	124	46
UNABLE TO VALIDATE	Not available	Not available	210

¹ UNICEF. "State of the World's Children 2001." <http://www.unicef.org/sowc01/tables/#> (1 February 2001).

² DSWD and PNP statistics, 1999.

³ ECPAT, 1996. "Facts and Figures." <http://www.childprotection.org.ph/factsfigures/index.html> (1 February 2001).

⁴ National Report on Follow-up to the World Summit for Children-Child Protection Issues. *Council for the Welfare of Children*, 2001.

⁵ UNICEF, 1995. "Facts and Figures." <http://www.childprotection.org.ph/factsfigures/index.html> (1 February 2001).

⁶ Department of Social Welfare and Development.

⁷ Philippine National Police.

⁸ University of the Philippines-Philippine General Hospital Child Protection Unit.

⁹ Includes abandoned children, child laborers, child trafficking and victims of armed conflict.

¹⁰ Includes victims of pedophilia, pornography, and prostitution.

¹¹ Includes rape and acts of lasciviousness.

SECTION I

INTERVENTION

in the service of abused children

I Early Detection or Suspicion

- Surveillance strategies
- Detection strategies
- Curricular reform
- Public awareness programs
- Awareness programs for children

II Reporting and Referral

- Reporting guidelines
- Reporting and referral network

III Multidisciplinary Evaluation and Diagnosis

- Coordinated multidisciplinary evaluation
- Nationwide regional WCPU system
- Interdisciplinary suspicious death review team
- Professional specialty consultation

IV Multidisciplinary Care

- Integrated multidisciplinary case management
 - Physical health
 - Mental health
 - Safety care
 - Child development
- Nationwide regional WCPU system
- Reintegration care

V Causality Management

- Identification and minimization of causal factors
- Administration of justice and the law
- Perpetrator case management

I

EARLY DETECTION OR SUSPICION

identifying all potentially maltreated children

- A. Surveillance Strategies
- B. Detection Strategies
- C. Curricular Reform
- D. Public Awareness Programs
- E. Awareness Programs for Children

OBSERVATIONS ON EARLY DETECTION OR SUSPICION

Surveillance and Detection Strategies

Observation #1: Effective early detection requires professionals and citizens alike to be aware that child abuse can occur anywhere and to any child.

Observation #2: Proven surveillance and detection strategies should be incorporated as routine components when interacting with or providing services to children.

Curricular Reform

Observation #3: Educating professionals is a key component to early detection. Professional education must occur at all levels.

Observation #4: The lack of consistent instruction in medical schools leaves most physicians inadequately prepared to diagnose child abuse. Physicians, regardless of specialty, should pursue continuing education courses that teach them to recognize child abuse. Not all physicians need to become child abuse experts, but all should be able to identify the signs of possible abuse.

Public Awareness Programs

Observation #5: Physician participation in educating the general public and professionals about child abuse is important. Physicians can partner with the media, NGOs and government organizations to train the public about the medical consequences of child abuse.

Awareness Programs for Children

Observation #6: Children should be taught to recognize and report abuse to an adult.

A. Surveillance Strategies

Goal: Establish a protocol for monitoring and evaluating at-risk children.

Rationale: The risks for reabuse and abuse of high-risk children are high and need to be curtailed.

“According to studies in both the US and the UK, previously identified maltreated children have a 16 to 30 percent chance of being re-abused.” (Jones, D.P., *et al.*, 1987 and 1995)

“Children experiencing multiple recurrences compared to no recurrences or one recurrence may represent a special at-risk population.” (Luke, J.D., *et al.*, 1999)

Analysis of Status Quo:

Surveillance Provides First Line of Defense

Effective child abuse surveillance allows physicians to detect, and perhaps even prevent, abuse.

Need for Migration from Sporadic to Systemic Surveillance

Current surveillance efforts are conducted on an individual basis by physicians, social workers, teachers, and other child care professionals. These efforts can be made more effective through coordinated, system-wide surveillance.

Need for Specific Attention to High-Risk Children

High-risk or previously abused children rarely receive the additional surveillance they need. Children are typically identified as high-risk because their family situations resemble those of many previously abused children. Identification of risk factors and effective surveillance of children can prevent a majority of abuse cases.

Proposed Strategies and Guidelines:

Physicians

1. Train physicians to identify at-risk and abused children.
2. Establish protocols in hospitals and clinics requiring mandatory screening for abused and high-risk children.
3. Include child abuse awareness questions on medical board examinations

Physicians and Other Care Continuum Professionals

4. Link medical surveillance efforts with a multidisciplinary surveillance network that utilizes the skills of all professionals to screen for child abuse risk and reabuse.

Key Players in Multidisciplinary Surveillance Network

<u>Medical</u>	<u>Other</u>
Pediatricians	Barangays
CPUs	Social Workers
Hospitals	Family Courts
Medical Specialists	Teachers
Other Physicians	Families
Nurses	Friends
Health Workers	

Screening At-Risk Children

Risk Factors Include:

- ✓ Abused siblings
- ✓ Dire poverty
- ✓ Family with domestic violence, drug/alcohol abuse, or poor access to community support services
- ✓ Frequent contact with perpetrator
- ✓ Mental or physical disability
- ✓ Previous abuse
- ✓ Teen parents

Physician Monitoring of At-Risk Children

- Establish periodic contact or follow-up with at-risk children and their families.
- Contact members of surveillance network, requesting them to monitor at-risk children in other environs.
- Promptly report suspicious behavior, injury or disclosure.

B. Detection Strategies in Routine Child-Care Services

Goal: Incorporate child abuse screenings into routine child-care services.

Rationale: Early detection can be life-saving as abused children often present with symptoms or injuries without reporting abuse.

Analysis of Status Quo:

When Utilized, Screening Protocols Can Effectively Identify Abuse

Although sporadic, screenings conducted on an individual basis by physicians, social workers, teachers, and other child care professionals can detect the early signs of abuse. Hospitals, physicians and health care institutions can increase the consistency and effectiveness of screenings by incorporating them into “standard operating procedures.”

Pediatricians Have Regular Access to Parents and Children

“Parents report more cases of violence than pediatricians detect. Pediatricians should ask parents directly about domestic violence...” (Kerker, *et al.*, 2000)

“The pediatrician often is the first professional with whom a child has contact when an allegation of abuse is made.” (Frasier, L.D., 1997)

Pediatrician access to parents and children makes child abuse detection an essential component of routine examinations. Strengthening current pediatric detection will facilitate the entry of more children into the care continuum at the onset of abuse.

Physicians of Varying Specialties Come into Contact with Abused Children

“The urologist must routinely examine the anogenital area of children during routine urethral evaluation and include child sexual abuse as part of the routine urological history.” (Hinds and Baskin, 1999)

“Families will benefit from routine violence screening and interventions in pediatric emergency departments.” (Duffy, *et al.*, 1999)

“Physicians and dentists should recognize the oral and dental aspects of physical and sexual abuse, their role in evaluating such conditions, and their responsibility to report suspected cases of abuse and neglect.”
(American Academy of Pediatric Dentistry, 1999)

Other medical specialties have an important, but often neglected, role in child abuse detection. Effective pediatric-medical specialty cooperation facilitates early detection.

Proposed Strategies and Guidelines:

Physicians

1. Train physicians (of varying specialties) caring for children to screen for signs of abuse. Routine screening conducted by all physicians results in greater recognition of abused children and the potential for high impact from routine activity.

Hospitals

2. Establish protocols in hospitals and clinics to screen for child abuse. Screening for child abuse should be integrated into routine child-services, particularly in situations where the likelihood of abused children presenting is high.
3. Encourage pediatric-medical specialist cooperation in child abuse detection. Coordinated detection allows medical specialists to refer suspicions of child abuse to the pediatrician or vice versa for an accurate diagnosis and quick entry into the care continuum.

PROFESSIONAL ACTIVITIES AND CHILD-SERVICES THAT PROVIDE OPPORTUNITIES TO DETECT CHILD ABUSE

PHYSICIANS AND HEALTH PROFESSIONALS	TEACHERS AND EDUCATION PROFESSIONALS	OTHER PROFESSIONALS
<ul style="list-style-type: none"> • Routine medical and dental check-ups • All emergency department visits • Immunization campaigns • Pre-natal visits • Delivery of unwanted children • Psychiatric and psychological evaluations • Health care home visits • Consultations for head trauma; fractures in all non-ambulatory children 	<ul style="list-style-type: none"> • Yearly school check-ups • Guidance counselor visits/ consultations • Evaluation for truancy or poor school performance • Review of writing and/or art compositions that reveal disclosure of abuse • Class discussions on social values, health and safety 	<ul style="list-style-type: none"> • Investigation of violence in the home • Investigation and adjudication of juvenile and family court cases • Activities with street children • Investigation of drug and/or alcohol abusers • Investigation of child deaths occurring at home

The examples below show how different care continuum professionals can improve detection strategies for child abuse.

Implementation Example: Physicians and Health Professionals

After a four-week rotation at the UP-PGH CPU, PGH residents demonstrated a greater awareness of child abuse, which resulted in a dramatic increase in the number of referrals of suspected child abuse from the emergency room. Likewise, trained residents began incorporating child abuse screening questions into all medical intakes, thus increasing the likelihood of early discovery.

Implementation Example: Teachers and Education Professionals

In Baguio City, the NGO Child and Family Services trained staff and students how to identify child abuse. As a result:

- Staff implemented strategies learned in training
- Children learned that staff were “safe” confidants
- Training made it easier for children to disclose and staff to respond

Prior to training, staff reported no cases of abuse; subsequent to training, staff identified eight cases of sexual abuse. (Advisory Board Foundation, *Children at Risk*, 1997)

Implementation Example: Preparing Court Officials

Once informed of medical complications resulting from abuse, a presiding judge in a juvenile case referred the juvenile for evaluation at the PGH-CPU. Abuse was confirmed and the child received services from the CPU and other agencies.

C. Curricular Integration

Goal: Incorporate child abuse into medical school curricula across the country.

Rationale: An integrated child abuse curriculum during early professional development provides the necessary preparedness to detect child abuse.

Analysis of Status Quo:

Medical Schools Have Begun Curricular Reform

Half of the medical schools in the Philippines incorporate child abuse studies into their curricula, but the amount and quality of instruction varies greatly by school.¹²

“Continuing medical education of physicians is critical to the early detection and treatment of child abuse. Continuing education combined with structured records may lead to an improvement in physicians’ documentation of child abuse.” (Socolar, *et al.*, 1998).

Proposed Strategies and Guidelines:

Medical Schools

1. Integrate child abuse lectures into degree curricula at key educational levels for all physicians.

SAMPLE FIRST YEAR CURRICULUM FOR MEDICAL STUDENTS ¹³				
Year Level I				
Objective 1	To be aware of family and domestic violence and to appreciate gender issues within and outside the medical profession			
Contents	Strategies and Activities	Responsible Departments	Resources	Evaluation
<ul style="list-style-type: none"> Defining child abuse Domestic/ Family violence in different areas Human behavior Gender issues 	<ul style="list-style-type: none"> Lectures Community immersion Films Role playing Small group discussions Case discussions 	<ul style="list-style-type: none"> Psychiatry Preventive medicine Anatomy 	<ul style="list-style-type: none"> Statistics Slides and videos Case studies Handouts 	<ul style="list-style-type: none"> Written examinations Case reports Reflections

¹² Survey from the Association of Philippine Medical Colleges Workshop on Integrating Child Abuse into the Undergraduate Medical Curricula. (February 2000).

¹³ Sample Curriculum from the APMC Workshop: “Integrating Child Abuse into the Undergraduate Medical Curricula.” (May 1999). Contact The Advisory Board Foundation for a complete copy of these proceedings.

D. Public Awareness Campaigns

Goal: Physicians actively participate in educating the general population about child abuse and the role of ordinary citizens in reporting suspected child abuse cases.

Rationale: Raising public awareness is a successful strategy in the mobilization towards the resolution of child abuse.

Analysis of Status Quo:

Consultant Role of Physician Hinders Physician Leadership Potential

Physicians currently serve as consultants for child abuse awareness campaigns, parental education programs and community outreach programs. Physicians can increase their involvement by leading campaigns that address the medical manifestations of child abuse.

Proposed Strategies and Guidelines:

Physicians

1. Physicians work with media, government and NGOs to design and implement messages for awareness campaigns addressing the physical signs and medical complications of child abuse. Physician involvement is essential in the following areas:
 - How to recognize abuse
 - Where to seek help
 - The importance of child abuse prevention in protecting children's health
2. Physicians provide case-study materials for child abuse awareness programs targeting professionals involved in child-services.

The following example shows how physicians and the media can cooperate to increase public awareness of child abuse.

IMPLEMENTATION EXAMPLE: CPU/BANTAY BATA COLLABORATION

After a recent case of fatal Shaken Baby Syndrome (SBS), the PGH-CPU realized the need to educate parents and other child caretakers about the dangers of SBS. The CPU partnered with Bantay Bata 163 to produce a public service message about SBS and how to prevent this type of abuse. CPU was able to offer the medical content of the message and Bantay Bata produced and aired the message on television

E. Awareness Programs for Children

Goal: Empower children to recognize dangerous situations and abusive actions and report abuse to an adult.

Rationale: Children can be an effective tool for early child abuse detection and subsequent entry into the care continuum.

Analysis of Status Quo:

Awareness Programs Sporadic

Some organizations, such as Barangays, day care centers and schools, conduct awareness programs, but implementation varies greatly by organization and region.

Physician Underinvolvement in Awareness

Many physicians have not included or addressed child abuse awareness in all patient consultations and community programs in which they participate.

Proposed Strategies and Guidelines:

Physicians

1. Encourage physicians to educate young patients about abuse, specifically what constitutes abuse and where to go if they are in danger of or are being abused.

Physicians and Care Continuum Professionals

2. Encourage physicians and other child abuse professionals to participate in and contribute their expertise to abuse education projects occurring outside of their daily activities—e.g., in the Barangays, schools, churches and in the media.
3. Conduct evaluations of existing programs to identify those most successful in educating children and involving physicians and other medical professions in education and outreach.

Hospitals

4. Implement hospital-based awareness programs through outpatient clinics, child development clinics, and ambulatory pediatric clinics.

II

SYSTEMATIZED REPORTING AND REFERRAL

ensuring rapid integration into the continuum of care

- A. Reporting Guidelines
- B. Reporting and Referral Network

OBSERVATIONS ON REPORTING AND REFERRAL

Reporting Guidelines

Observation #1: Citizens and agencies that receive referrals can fulfill the reporting mandate. Guidelines for timeliness in reporting are outlined in the reporting laws.

Observation #2: Barangays/BCPCs, WCPUs, and LGUs need to define their reporting and referral protocols according to their resources and put in place strategies to quickly and effectively report abuse and refer children and families to available services. Inter-agency care continuum teamwork is critical.

Reporting and Referral Network

Observation #3: A systematized reporting and referral system shared by agencies working with abused or potentially abused children is critical for quick-response care for child abuse.

Observation #4: A needs-based reporting and referral protocol for triaging patients, filling medical and safety needs of the abused child and satisfying the reporting requirements of RA 7610 needs to be developed.

Observation #5: Install coherent and non-overlapping databases to facilitate governance-pertinent research drawn from reporting data.

LEGAL MANDATE TO REPORT:

LEGAL REPORTING MANDATE FOR ALL CITIZENS

REPORTING

Anyone who believes that a child has been abused may report the abuse orally or in writing to any of the following institutions (RA 7610, IRR, Sec. 3):

- The Department of Social Welfare and Development
- Local government unit social welfare offices
- The Violence Against Women and Children's Division of the National Bureau of Investigation
- Women and Children's Desks of the Philippine National Police
- Barangay Councils for the Protection of Children
- The Commission on Human Rights Child Rights Center

LEGAL REPORTING MANDATE FOR HEALTH CARE PROFESSIONALS

MANDATORY REPORTING

“The head of any public or private hospital, medical clinic and similar institution, as well as the attending physician and nurse, shall report, either orally or in writing, to the Department [DSWD] the examination and/or treatment of a child who appears to have suffered abuse within forty-eight hours (48) from knowledge of the same.” (RA 7610, IRR, Sec. 4)

“Identification and reporting of suspected cases of maltreatment are important precursors to intervention, as maltreating parents do not self-refer for treatment...”
(Warner-Rogers, *et al.*, 1996)

AN OVERVIEW

LEGAL REPORTING MANDATE FOR GOVERNMENT WORKERS

DUTY OF GOVERNMENT WORKERS

“It shall be the duty of all teachers and administrators in public schools, probation officers, government lawyers, law enforcement officers, barangay officials, corrections officers, and other government officials and employees whose work involves dealing with children to report all incidents of possible child abuse...” (RA 7610, IRR, Sec. 5)

LEGAL RAMIFICATIONS AND PROTECTION

FAILURE TO REPORT

“Failure of the individuals mentioned in Section 4 above and the administrator or head of the hospital, clinic or similar institution concerned to report a possible case of child abuse shall be punishable with a fine of not more than two thousand pesos.” (RA 7610, IRR, Sec. 6)

IMMUNITY FOR THOSE REPORTING ABUSE

“A person who, acting in good faith, shall report a case of child abuse shall be free from any civil or administrative liability arising there from. There shall be a presumption that any such person acted in good faith.” (RA 7610, IRR, Sec. 7)

Improved recording of child abuse incidences should be a priority so that prevention strategies can be appropriately targeted and outcomes monitored.”
(Herman-Gidens, *et al.*, 1999)

A. Guidelines for Implementing National Reporting Laws

Goal: All hospitals, schools, and public institutions serving children implement protocols governing the reporting of child abuse cases.

Rationale: Ambiguity or uncertainty about how to file a child abuse report could be the difference between life and death. Protocols and implementation strategies determined before an abused child presents allow physicians to quickly treat and protect the well-being of the child.

Analysis of Status Quo:

Child Abuse Reporting Limited

Lack of knowledge of the law, fear of involvement with the courts, non-recognition of child abuse, and fear of reprisal limit the use and implementation of child abuse reporting.

Proposed Strategies and Guidelines:

All Care Continuum Professionals

PROPOSED RESPONSIBILITIES FOR ALL INSTITUTIONS CARING FOR CHILDREN

- *Know which of the six mandated reporting agencies will respond rapidly and effectively.* In every region and municipality the effectiveness of each reporting agency varies greatly. All institutions should know where to send reports prior to working with an abused child.
- *Do not just report, follow-up.* Many reported cases never receive any attention. Therefore, the reporting party needs to follow-up and ensure the child is being cared for or refer the child to another mandated agency.

REPORTING GUIDELINES FOR HOSPITALS¹⁴

Hospital Guidelines for Hospitals with a CPU

- Establish hospital-wide protocol requiring referral of all cases of abuse to the CPU.
- CPU reports case to the most responsive reporting agency in its area.
- CPU coordinates care with reporting agency and other care continuum partners to ensure full care for the child and family.

Hospital Guidelines for Hospitals without a CPU

- Designate person in charge of receiving all reports of child abuse.
- Establish hospital-wide protocol requiring reporting of all cases of abuse to designated person
- Designated person determines the most responsive reporting agency for the area (DSWD, LGU, or other authorized reporting agency).
- Designated person reports cases to mandated reporting agency and ensures that this agency assumes responsibility for case.

¹⁴ Please refer to Appendix A for sample reporting forms for CPUs and other medical institutions.

B. Systematized Reporting and Referral Network

Goal: Establish a systematized, versatile and inclusive network for reporting and referring child abuse cases.

Rationale: Although medical institutions can establish reporting protocols, a network is necessary in order to operationalize these protocols. A coordinated network for reporting and referral will ensure that the necessary resources and services are mobilized for the care of the child and his or her family.

Analysis of Status Quo:

Anyone Can Make a Report

Professionals, friends and family members can all make a suspected child abuse report to the government agencies mandated to receive child abuse reports.

Anyone Can Make a Referral

Anyone can make a referral for an abused child to receive services such as medical, social and investigative services.

Reporting and Referring Do Not Require Filing a Case

Individuals making reports or referrals are simply notifying care continuum professionals that a child requires their services. It is the child or mandated government agency that files a case.

Current Physician Reporting and Referral Sporadic

Individual physicians and hospitals have different criteria for reporting abuse. Although physicians have a legal mandate to report all cases of suspected abuse to the proper authorities, regardless of whether or not the cases have been confirmed, many physicians only report abuse when they are certain that it has occurred.

The role of the local government units in treating child abuse is increasing¹⁵

DSWD and LGU Share Legal Mandate

Local Government Unit social welfare officers have the same legal mandate as DSWD social workers to remove children from their homes or place children in protective custody.

LGU Code of 1997 (RA 7160, Section 17)

¹⁵ Please see Appendix A for further description of the responsibilities of the DSWD and LGUs.

Devolving Responsibilities of DSWD...

- ✓ In 2001, DSWD ceases to offer direct services
- ✓ Moving forward, DSWD is focused on providing technical expertise, conducting research, and giving other organizational assistance to LGUs

...Parallels/Coincides with Increased Responsibilities of LGU

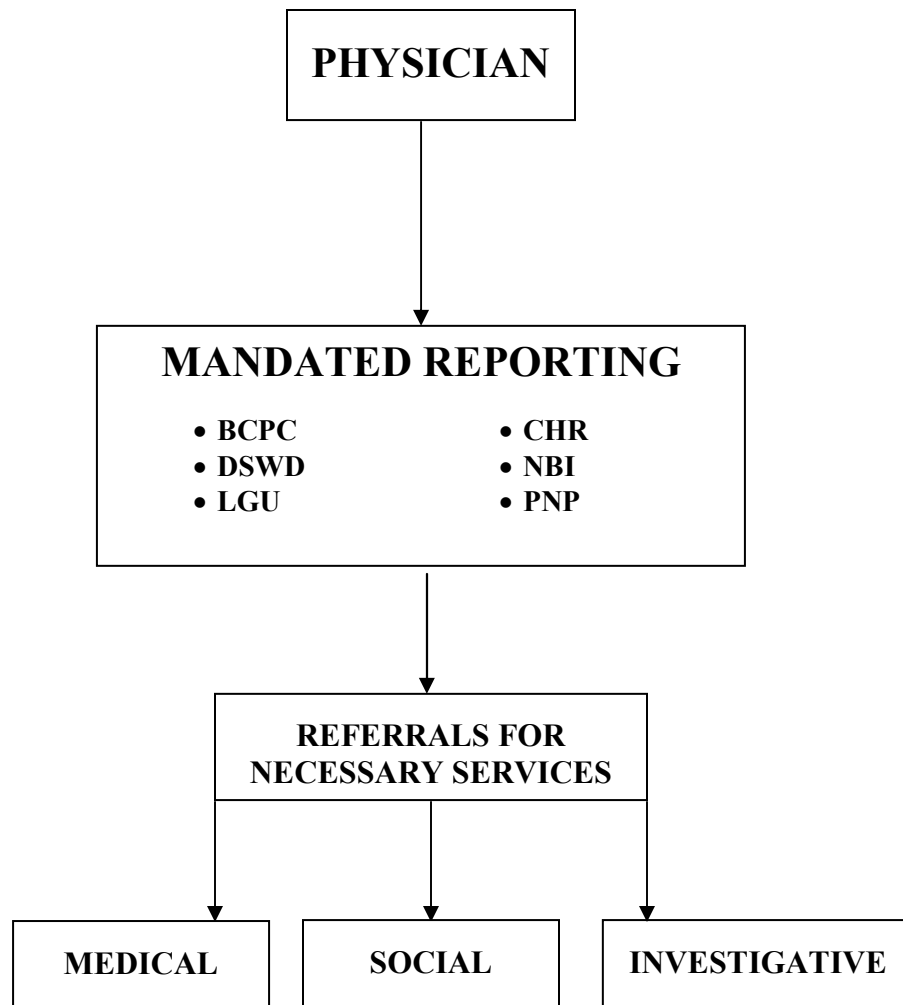
- ✓ Mission: “to promote poverty alleviation and the empowerment of disadvantaged families and communities through the provision of assistance to LGUs, NGOs, GOs, and people’s organizations.”
- ✓ In 2001, LGUs will begin to provide services once provided by the DSWD, such as direct care for abused children, as well as continue previous services.

Proposed Strategies and Guidelines:

Physicians and WCPUs

1. Physician's first priority is to assess medical needs and treat any life-threatening conditions. This process could be assisted by a triage component to patient screening.
2. Physician then reports abuse to a mandated agency, in accordance with RA 7610.
3. Physician refers child for medical specialty evaluations or non-medical services. Referrals should be made to the agencies that can best assist the child. The child's needs determine the referral points. For example:
 - a. For medical care refer to: any physician, emergency department or CPU
 - b. For safety and emergency placement refer to: LGU, DSWD, NGO
 - c. For filing a case refer to: police, NBI, prosecutor's office, DOJ taskforce
4. In remote areas or areas without WCPUs, it becomes critical for physicians (pediatricians, family practitioners, or municipal health officers) to work together to create the most extensive reporting and referral network possible.
5. The reporting mandate is fulfilled with a report to any one designated agency. Agencies then assume the responsibility for inter-agency coordination of data sharing and database tracking.

REPORTING AND REFERRAL FOR PHYSICIANS



* Physicians have a responsibility to follow-up their reports and refer elsewhere if the mandated agency is not responding adequately to the suspected child abuse report.

III

MULTIDISCIPLINARY EVALUATION AND DIAGNOSIS

*a quick, coordinated and child-friendly response to
child abuse*

- A. Coordinated Multidisciplinary Evaluation
- B. Nationwide Regional WCPU System
- C. Interdisciplinary Suspicious Death Review Team
- D. Professional Specialty Consultation

OBSERVATIONS ON MULTIDISCIPLINARY EVALUATION AND DIAGNOSIS

Coordinated Multidisciplinary Evaluation

Observation #1: Medical professionals must treat child abuse as a diagnosis and perform the necessary examinations and tests to make an accurate diagnosis.

Nationwide Regional WCPU System

Observation #2: Medical professionals, social workers, and law enforcement officers need to work together for effective evaluation and diagnosis.

Observation #3: A “one-stop-shop” Child Protection Unit that provides evaluation, diagnosis and investigation services in one location is an ideal way to care for abused children. Although current legislation calls for the creation of these units, many still lack adequate funding.

Interdisciplinary Suspicious Death Review Team

Observation #4: A child abuse suspicious death investigator needs to receive specialized training about child abuse in order to conduct the most thorough and effective investigation.

Observation #5: Hospitals and medical institutions should strive to perform autopsies for cases of suspected abuse because some types of abuse cannot be accurately determined without an autopsy. Failure to perform an autopsy may put siblings or other children at risk for abuse.

Professional Specialty Consultation

Observation #6: An abused child may have to consult many different medical specialists in order to receive the best possible medical care. Every CPU or hospital needs an established referral structure for medical specialist in order to facilitate medical management of the child. Specialists receiving child abuse referrals need to be aware of the signs of abuse that are specific to their specialties.

A. Coordinated Multidisciplinary Evaluation

Goal: Establish a coordinated, immediate and child-friendly system of evaluation that facilitates the thorough multidisciplinary evaluation and identification of child abuse without retraumatizing the child.

Rationale: Accurate identification of abused children is critical in obtaining necessary care and reintegration services for the child.

Analysis of Status Quo:

WCPU's Enhance Multidisciplinary Cooperation

The emergence of WCPUs in DOH hospitals has helped physicians to coordinate medical evaluation with critical social, risk and psychiatric evaluations. These professionals place great emphasis on ensuring that the evaluation process is non-traumatizing for the child. Outside WCPUs, this type of coordinated, non-traumatizing evaluation is difficult.

Training is a Critical Component of Multidisciplinary Evaluation

Trained child protection specialists provide children with non-traumatizing clinical evaluations and diagnoses. Untrained physicians may not fully understand the intricacies of the child abuse medical diagnosis and how to perform a thorough physical examination without retraumatizing the abused child (i.e. a non-invasive examination). The following chart illustrates the many variables involved in diagnosing child abuse:

THE CONCEPT OF CHILD ABUSE AS A DIAGNOSTIC CATEGORY¹⁶

MEDICAL/ NEUROLOGICAL	COGNITIVE/ INTELLECTUAL	SOCIAL/ BEHAVIORAL	PSYCHOLOGICAL/ EMOTIONAL
<ul style="list-style-type: none"> • Brain damage/dysfunction • Burns • Death • Fractures • Gene expression changes • Mental retardation • Minor injuries • Neurobiological effects • Physical handicaps • Sexually transmitted diseases • Speech defects • Weakened immune system 	<ul style="list-style-type: none"> • Academic skills deficit • Inattention • Learning disorders • Lowered IQ • Mental retardation • Poor reading ability • Poor school performance • School drop-out 	<ul style="list-style-type: none"> • Aggression • Alcohol abuse • Crime and violence • Delinquency • Drug abuse • Promiscuity • Prostitution • Running away • Teenage pregnancy • Truancy 	<ul style="list-style-type: none"> • Anxiety • Borderline personality disorder • Depression • Dissociation • Hostility • Low self-esteem • Multiple personality disorder • Poor coping skills • Post-traumatic stress disorder • Somatization disorder • Stress • Suicide attempts

¹⁶ "Understanding the Consequences of Childhood Victimization." Reece, R.M., ed. *Treatment of Child Abuse: Common Ground for Mental Health, Medicine and Legal Practitioners*. Baltimore: Johns Hopkins University Press, 2000.

MANDATE FOR MINIMIZING RETRAUMATIZATION:
UNITED NATIONS CONVENTION ON THE RIGHTS OF THE CHILD

The United Nations Convention on the Rights of the Child – to which the Philippines is a signatory – states that “state parties shall take all appropriate measures to promote physical and psychological recovery and social integration of a child victim of any form of neglect, exploitation or abuse. Such recovery and reintegration shall take place in an environment which fosters the health, self-respect and dignity of the child.” (UN CRC, Article 39).

Proposed Strategies and Guidelines:

Integrated intervention requires multidisciplinary evaluation that is coordinated, comprehensive, and nontraumatizing. This is achieved through the following:

1. Effectively preparing physicians for their role in evaluation

- Staff WCPUs with physicians, particularly child abuse specialists, to provide thorough evaluation of child’s needs.
- Train all child abuse specialists in child abuse diagnosis.
- Understand the critical role of differential diagnosis in medical evaluation and diagnosis due to the complex nature of child abuse and the many “faces” and mimickers of abuse.
- Prevent misdiagnoses of child abuse, which can be as damaging as overlooking instances of abuse.

“[for child sexual abuse], the diagnostic accuracy of the colposcopic photographs is sufficiently high to warrant continued use of medical photography for documentation and peer review.” (Muram, D. *et al.*, 1999)

2. Integrating multiple disciplines into evaluation

- Train appropriate professionals to conduct concurrent medical, social and psychological evaluations. Coordinate evaluation to produce accurate diagnoses and outline necessary services. Such multidisciplinary cooperation will maximize the expertise of each discipline while allowing for coordinated and non-traumatizing care.
- Encourage care continuum professionals to reach consensus on the responsibilities for which each is fully accountable. Designated agencies should make available their official reports so that other members of the care continuum team can use the information in their respective assessments and recommendations for treatment.

PROPOSAL: TEMPLATE FOR MULTIDISCIPLINARY COORDINATION

	WHO	WHAT	HOW
INTERVIEW	<ul style="list-style-type: none"> Physicians, social workers or police officers trained in interviewing children 	<ul style="list-style-type: none"> Interview patient and caregiver Prepare findings for use in court 	<ul style="list-style-type: none"> Ensure the least number of interviews Follow protocol to share information between all care continuum partners involved in the case
MEDICAL EVALUATION	<ul style="list-style-type: none"> Trained child abuse specialists 	<ul style="list-style-type: none"> Conduct an examination to document child’s physical health, injuries, development and signs of abuse. Evidence from this exam, including colposcopic pictures and a rape kit, may be used in court. 	<ul style="list-style-type: none"> Follow a protocol which emphasizes evidence preservation and the welfare of the child
RISK ASSESSMENT	<ul style="list-style-type: none"> Physicians, social workers, NGOs and law enforcement officers 	<ul style="list-style-type: none"> Evaluate several risk factors including: <ul style="list-style-type: none"> Child’s behavior Seriousness of abuse Reports of previous abuse Vulnerability of child Access of perpetrator to child Safety of child and family Family support network and needs. 	<ul style="list-style-type: none"> Without placing blame, evaluate the best interests of the child Conduct evaluation of child and family on a regular basis until case is closed
MENTAL HEALTH	<ul style="list-style-type: none"> Psychiatrists and psychologists 	<ul style="list-style-type: none"> Conduct a mental health examination and screen for post-traumatic stress disorder and other psychological problems Provide counseling for child and family 	<ul style="list-style-type: none"> Provide counseling focused upon healing the child and family
LAW ENFORCEMENT	<ul style="list-style-type: none"> Law enforcement officers 	<ul style="list-style-type: none"> Conduct crime scene investigation Preserve evidence Investigate alleged perpetrator Participate in criminal proceedings, as required Provide for family safety 	<ul style="list-style-type: none"> Conduct a prompt and thorough investigation that serves the best interests of the child Preserve any and all evidence Ensure proper analysis of evidence

B. Nationwide WCPU System

Goal: Provide universal access to the care continuum for all potentially abused children and their families through regional Women and Children's Protection Units (WCPUs).

Rationale: A nationwide regional WCPU system can provide comprehensive care for abused children, which is fundamental to the provision of basic health care services for children.

Analysis of Status Quo:

There is a Strong Legal Mandate for Women and Children's Protection Units

RAPE VICTIM ASSISTANCE AND PREVENTION ACT OF 1998 RA 8505

- Under RA 8505, the **DSWD, DOH, DILG, DOJ**, and a **lead non-government organization** “shall establish in every province and city a rape crisis center located in a government hospital or health clinic or in any suitable place” responsible for:
 - Providing raped women and children and their families with psychological counseling, medical and health services, including medico-legal examination
 - Securing free legal assistance or service, when necessary, for raped women and children
 - Ensuring the privacy and safety of raped women and children
 - Developing and undertaking a training program for law enforcement officers, public prosecutors, lawyers, medico-legal officers, social workers, and barangay officials
- The **DOH** has made a firm commitment to creating WCPUs in all DOH hospitals to address the medical and psychological needs of victims of violence.¹⁷
- A WCPU Training Task Force,¹⁸ in partnership with the University of the Philippines Manila, UP College of Medicine, PGH, and The Advisory Board Foundation, has been formed to further develop sixteen regional WCPUs.
- Under **RA 8505**, Section 57, the **PNP** has established Women and Children's Desks in all police stations. The PNP has opened a Women's Crisis and Child Protection Center (WCCPC) at Camp Crame, Quezon City to provide multidisciplinary child protection services and investigations for child abuse and domestic violence cases.¹⁹

¹⁷ Department Circular No. 47, s.1997 and Administrative Order No. 1-B, s.1997.

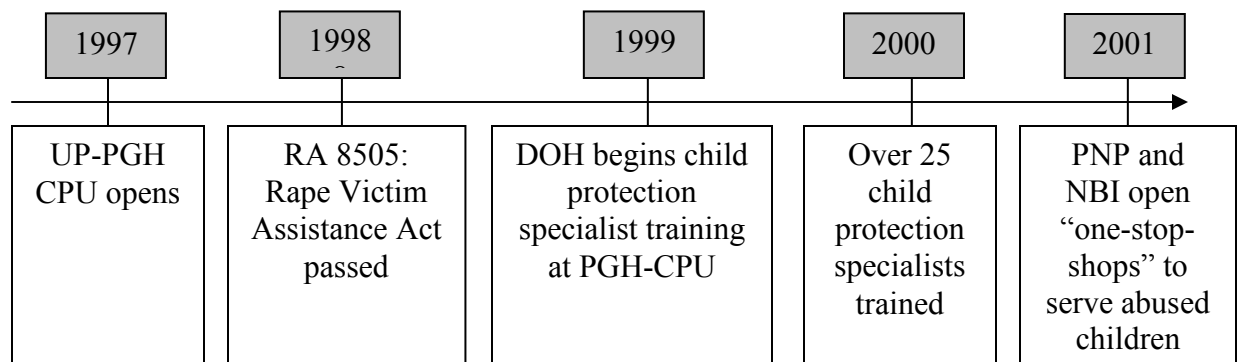
¹⁸ Department Order 110-B s.1999 and a Memorandum of Agreement signed June 9, 1999.

¹⁹ Pursuant to the Memorandum of Agreement signed with the University of the Philippines Manila and The Advisory Board Foundation on July 19, 1999.

Not Just Rape Centers

Although RA 8505 only provides help for rape victims, the centers introduced by the NBI, PNP and DOH are integrated CPUs that provide multidisciplinary services for all types of abuse.

RECENT WCPU IMPLEMENTATION



Proposed Strategies and Guidelines:

Care Continuum Professionals

1. Maximize resources by combining medical, social and law enforcement professionals in one facility. Different agencies can share operational costs.
2. Strategically place units throughout country. WCPUs should not be clustered around Metro Manila. One CPU should serve a catchment of 2 million people. Child protection specialists should see enough patients to maintain their expertise in the field.
3. Continue child protection specialist training. A core group of specialists throughout the country will serve as resources in enhancing the profession.

C. Interdisciplinary Suspicious Death Review Team

Goal: Establish a protocol for evaluating suspicious deaths and performing autopsies when medically mandated.

Rationale: Many suspicious deaths cannot be properly diagnosed without an autopsy. When autopsies are not performed, child abuse cases may go undetected, possibly placing siblings and spouses at high-risk for abuse.

Analysis of *Status Quo*:

EXISTING AUTOPSY LAWS

“Health officers, medical officers of law enforcement agencies, and members of the medical staff of DOH-accredited hospitals are authorized to perform autopsies.” (Presidential Decree 856, Section 95)

“If the person who issues a death certificate has reasons to believe or suspect that the cause of death was due to violence or crime, he shall notify immediately the local authorities concerned. In this case the deceased shall not be buried until permission is obtained from the provincial or city fiscal. If these officials are not available the permission shall be obtained from any government official authorized by law.” (Sanitation Code Presidential Decree 856, Section 91f) ²⁰

“The Provincial Fiscal shall also cause to be investigated the cause of sudden death which have not been satisfactorily explained and when there is suspicion that the cause arose from the unlawful acts or omissions of other persons, or from foul play.” (RA 732)

APPLICATION OF EXISTING LAWS IN CASES OF SUSPECTED ABUSE

- Authorized institutions may perform autopsies with parental consent.
- In the absence of parental consent, the provincial or city fiscal, mayor, local police authorities concerned, or court of law can authorized a medical institution to perform an autopsy.

²⁰ Please see also RA 409, Sections 34 and 38, as amended by RA 193.

Proposed Strategies and Guidelines:

To apply the required vigilance for fatal child abuse cases, establish a community "Suspicious Death Review Team." Suspicious Death Review Teams have been created in other countries in order to systematically review suspicious child deaths.

STRUCTURE AND DESIGN OF SUSPICIOUS DEATH REVIEW TEAMS

Purpose:

- 1) Determine cause of death for children under 18
- 2) Analyze circumstances surrounding or contributing to suspicious deaths
- 3) Ascertain necessary changes in laws, policies and practices that will prevent child fatalities

Members can include, but are not limited, to the following:

- 1) DSWD or LGU case manager or social worker
- 2) Medical professional
- 3) Medical examiner or coroner
- 4) Prosecutor
- 5) Representative from Mayor's office
- 6) Police officer or investigator

Duties:

- 1) Each member must supply all the necessary information to conduct a review
- 2) Mobilize quickly, within 24 hours in most cases
- 3) Review suspicious deaths
- 4) Report findings to necessary authorities and act quickly

IMPORTANCE OF A REVIEW TEAM

- *Determine Cause of Death.* Decide if the cause of death was due to abuse.
- *Save Siblings.* Although the child may have died, a review will help to protect siblings and other children from possible similar abuse.
- *Detect Domestic Violence.* Since child abuse and spousal abuse are closely linked, identification of fatal child abuse might also identify cases of spousal abuse.
- *Education of Care Continuum Professionals.* The review team can determine if the death could have been prevented by earlier intervention by child protection professionals.
- *Determine New Trends.* The study of autopsy trends may identify the need for new protocols and policies for treatment and prevention.
- *Foster Inter-Agency Cooperation.* Through quick mobilization and required teamwork, these teams embody the multidisciplinary cooperation required by the care continuum.

D. Professional Specialty Consultations

Goal: To arrive at an accurate diagnosis of child abuse based on the contributions of multiple medical specialists.

Rationale: Similar to other complex diagnostic categories, the many variations in the presentation of child physical and sexual abuse and neglect necessitate input from medical specialists.

Analysis of Status Quo:

Specialist Referrals Vary at Different Hospitals

Very few specialists are trained in child abuse and are wary of participating in cases that may result in legal action.

Proposed Strategies and Guidelines:

Physicians

1. Depending upon presenting signs and symptoms, the child should receive attention from any one of the following medical specialties:
 - Genetics
 - Neurology
 - Obstetrics/Gynecology
 - Ophthalmology
 - Orthopedics
 - Otorhinolaryngology
 - Pathology
 - Psychiatry
 - Radiology
 - Surgery

2. Ensure specialty consultations follow a protocol.
 - Hospitals identify specialists capable and willing to treat abused children.
 - Hospitals establish protocols to refer abuse cases to trained specialists.
 - Specialists and attending physician should work in close consultation for an accurate diagnosis and effective treatment or referral to CPU.

IV

MULTIDISCIPLINARY CARE

providing comprehensive care for child and family

- A. Integrated Multidisciplinary Case Management
 - Physical health
 - Mental health
 - Safety care
 - Child development
- B. Nationwide Regional WCPU System
- C. Reintegration Care

OBSERVATIONS ON MULTIDISCIPLINARY CARE

Integrated Multidisciplinary Case Management

Observation #1: Abused children must receive all of the services outlined in the care continuum in order to prevent abuse from reoccurring and adversely affecting the child, family and community.

Observation #2: Design systems that emphasize feasibility and versatility while maintaining world-class standards of excellence.

Observation #3: The services provided by the care continuum require a team-based approach to patient care. An overall case manager may not be able to ensure that a child receives all the services necessary for total reintegration.

Nationwide Regional WCPU System/Reintegration Care

Observation #4: Child abuse, like tuberculosis or pneumonia, is a major public health issue that requires government planning and intervention in order to establish a nationwide child protection system.

Observation #5: The complexities of child abuse require multidisciplinary care provided along a time continuum – crisis, intermediate and follow-up care.

A. Integrated Multidisciplinary Case Management

Goal: Establish effective multidisciplinary case management.

Rationale: Care continuum professionals need to work seamlessly to provide the best possible care for the abused child so that the child and family feel supported and recovery can begin immediately.

Analysis of Status Quo:

Multidisciplinary Case Management Varies Greatly by Region

In Metro Manila and a few other large cities in the Philippines, there are multiple examples of CPUs, NGOs and government agencies working together to provide for the care needs of their patients.

“By working together, with a shared orientation to the best interests of the children, they can intervene earlier and more effectively.”
(Marans, *et al.*, 1998)

“The [British] Department of Health needs to develop a child protection system that relies on good interprofessional communication.” (Munro, E., 1998)

Proposed Strategies and Guidelines:

Physicians

1. The pediatrician plays a critical role in the multidisciplinary care team.

“The pediatrician is widely recognized as an expert in children’s health and development and he can effectively use his position to influence the management of cases and thereby the outcome, by actively participating in treatment decisions and making and providing close follow-up in a limited but important way.” (Fischler, R.A., 1984)

Care Continuum Professionals

2. Physicians, social workers, law enforcement officials, psychiatrists, psychologists, health care professionals and other relevant professionals actively engage in care.
3. Relevant disciplines provide leadership and are held accountable for the best possible care for abused children who require their services.
4. Although all professionals work together as a case management team, different disciplines will provide leadership on issues involving their specific discipline.

For example:

POINT IN CARE CONTINUUM	LEAD PROFESSIONALS
<p>Multidisciplinary Evaluation, Diagnosis and Care</p>	<ul style="list-style-type: none"> • Child abuse specialists (MD, social worker, or nurse) • Government or NGO social workers
<p>Causality Management</p>	<ul style="list-style-type: none"> • Family Courts (judges, prosecutors, social workers) • Law enforcement officers • Child abuse specialists • Government or NGO social workers

5. Care continuum professionals need to focus on integrated intervention involving medical, social, psychological and law enforcement agencies. Emphasis should not be placed on investigation, as in other countries, but rather on the total care for the child and family.

“Once the problem of child abuse was recognized in the 1960s, mandatory reporting was instituted to develop public health mechanisms for intervention. But the approaches taken then were inadequate, and as sexual abuse of children was acknowledged, social service agencies gradually devolved from providing help to simply investigating, a trend that has contributed to the present emergency situation.”
 (Krugman, R.D., 1995)

The table below is an illustration of a proposed checklist for a case management team. The team can include, but is not limited to, the following professionals:

- CPU representative
- Social worker (government or NGO)
- Investigative agency (if involved)

CHECKLIST FOR CASE MANAGEMENT TEAM

CRISIS CARE	INTERMEDIARY CARE	FOLLOW-UP CARE
<ul style="list-style-type: none"> • Provide child with immediate child-safe and child-friendly environment. • Immediate team assessment of medical and safety needs to provide necessary crisis care. • Provide crisis counseling for child and family. • Ensure family safety without breach of perpetrator legal rights. 	<ul style="list-style-type: none"> • Begin to normalize child’s environment, placing child in a safe home. • Create total intervention plan. • Provide mental and medical health care. • Mobilize necessary resources to address family needs. 	<ul style="list-style-type: none"> • Address and resolve issue of child’s permanent home. Options include: to place in a permanent residential facility, reunite with parents or find adoptive or foster parents. • Review intervention plans and provide follow-up care and continued surveillance. • If needed, provide continued medical and mental health care. • Ensure child’s reintegration into family or new living environment. • Evaluate child’s reintegration into schools and community.

B. Nationwide Regional WCPU System

Goal: Create universal access to a Child Protection Unit for all potentially abused children.

Rationale: A nationwide WCPU system addresses the problem of child abuse as an acute public health problem with social and legal ramifications.

Analysis of Status Quo:

Nationwide CPU Network

The Department of Health initiated the establishment of nation-wide WCPUs. All 16 regions of the Philippines will have strategically placed WCPUs to provide services for abused children.

Proposed Strategies and Guidelines:

Physicians and WCPUs

1. Practicing physicians should become acquainted with their regional WCPU for referral of suspected child abuse cases.
2. WCPUs have significant roles to fulfill in intervention care beyond just evaluation and diagnosis. The table below illustrates these responsibilities and the role of each professional in providing multidisciplinary care for the child.

MULTIDISCIPLINARY TEAM		
PROFESSION	ROLE PLAYED	RESPONSIBILITY
PHYSICIAN	Lead	Immediate and long-term medical care
	Advise	Temporary placement if child's safety is at risk
	Lead	Continuous evaluation of child development
	Participate	Case conferences with all agencies involved
	Advise	Reintegration care
NURSE	Lead and/or provide	Immediate and long-term medical care
	Participate	Case conferences with all agencies involved
SOCIAL WORKER	Lead	Temporary placement if child's safety is at risk
	Lead	Case conferences with all agencies involved
	Lead	Reintegration care
MENTAL HEALTH	Lead	Mental health care and counseling
	Participate	Case conferences with all agencies involved
	Advise	Reintegration care

C. Reintegration Care

Goal: To provide non-traumatic, safe, and timely reintegration into home, school and social life.

Rationale: Normalization of children's situations is essential to their continued development.

Analysis of Status Quo:

Reintegration Care Varies by Case

The amount and quality of reintegration care varies greatly by region. Full reintegration care, which assures the safety, development and medical and mental health care of the child over time, needs to be provided nationwide.

Proposed Strategies and Guidelines:

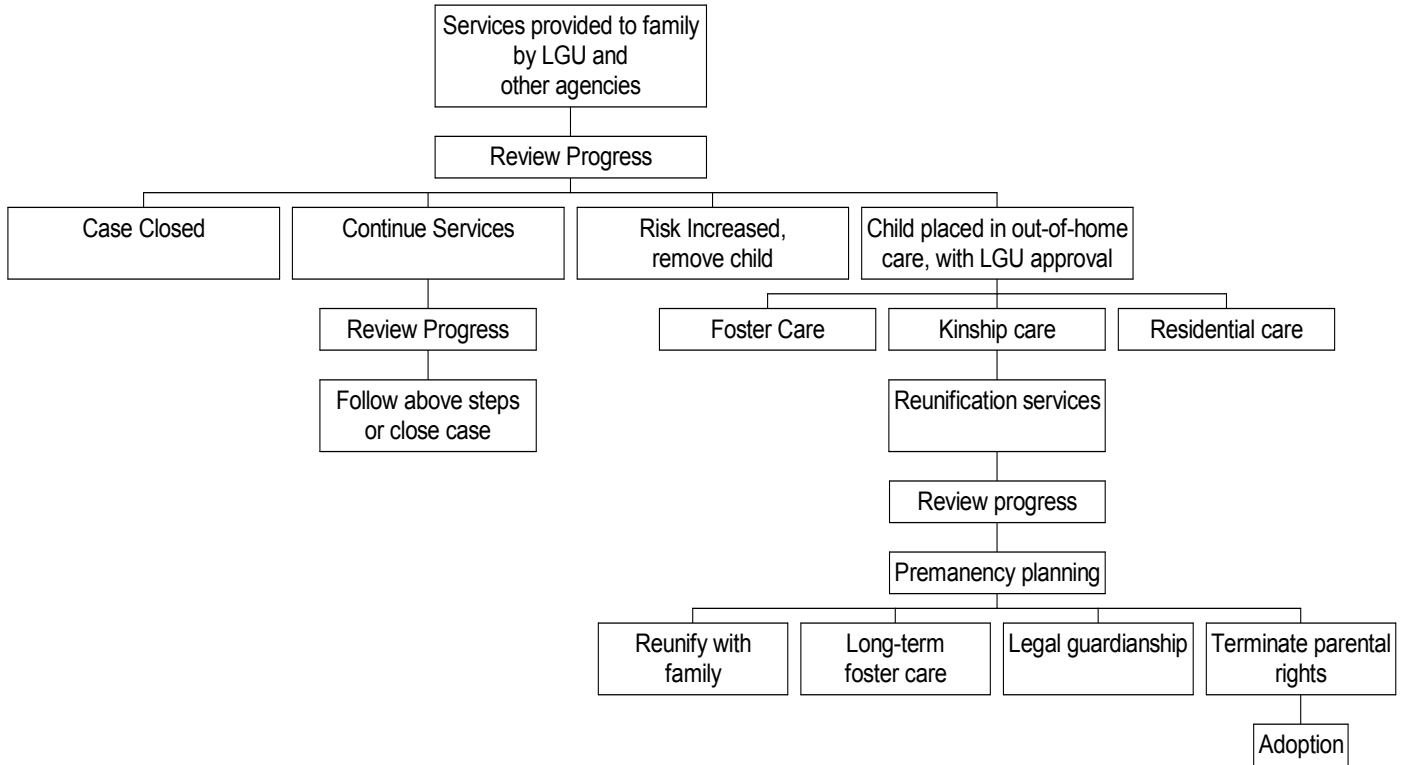
Physicians

1. Physicians play a key role in reintegration plans by overseeing recovery from the biological impacts of child abuse on the child – bodily injury (when present), development, stress disorders, cognitive function, injury, and molecular stress responses.

Other Child Protection Professionals

2. Legal and judicial proceedings are a part of the care continuum. Professionals involved in legal and judicial processes need to ensure that all proceedings are child-friendly and contribute to the over-all care of the child as defined by the care continuum.
3. When cases are filed with the police or prosecutor, reintegration care needs to include child witness preparation and counseling during judicial proceedings. Psychologists and psychiatrists are particularly crucial at this stage.
4. CPU staff and judges should work together to monitor the progress of cases and intervene if it appears likely that the child could be in danger of being reabused.
5. Placing children in a safe environment is of paramount concern. Effective placement requires multidisciplinary mobilization and cooperation.

MODEL REINTEGRATION PLAN FOR CHILD PLACEMENT



V

CAUSALITY MANAGEMENT

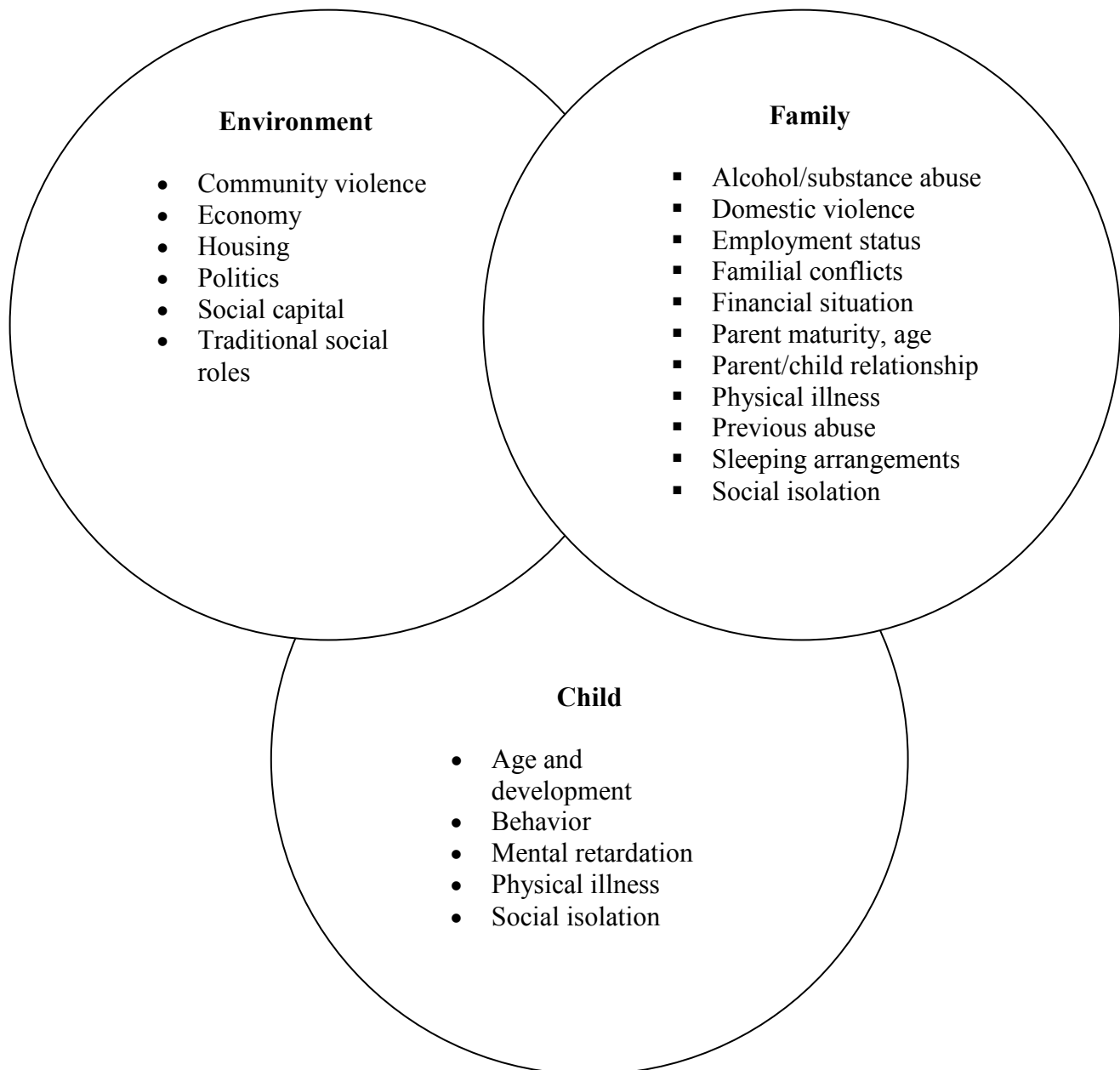
integrated intervention-prevention

- A. Identification and Minimization of Causal Factors
- B. Administration of Justice and the Law
- C. Perpetrator Case Management

CAUSAL FACTORS LINKED

Causality management involves active identification of the causal factors for abuse and the creation of a plan to address these factors. A common causal factor in child abuse cases is the perpetrator. In some cases, the perpetrator is the only causal factor and causality management is limited to perpetrator case management. In most cases, however, the perpetrator is not the only causal factor. The illustration below shows the most common causal factors and illustrates the inter-related nature of most causal factors. Causal factor management requires multidisciplinary care and attention to the child, family and environment.

Interconnectivity of Causal Factors



OBSERVATIONS ON CAUSALITY MANAGEMENT

Identification and Minimization of Causal Factors

Observation #1: Causal factors are unique for each case of child abuse. Together, care continuum professionals must assess causal factors and work to eliminate them.

Administration of Justice and the Law

Observation #2: Courts should certify expert child abuse witnesses.

Observation #3: The best interests of the child should be taken into consideration when administering justice.

Perpetrator Case Management

Observation #4: Perpetrator management must include legal action and rehabilitation. Juvenile offenders must be treated differently than adult offenders.

Observation #5: Beyond perpetrator management, the justice system contributes to the care continuum for child abuse by ensuring a child-friendly family court process and ensuring – by example – the re-establishment of trust in authority.

A. Case-Specific Determination and Management of Causal Factors

Goal: Identify causal factors and work with child and family to eliminate them.

Rationale: Reabuse can only be prevented through the elimination of causal factors.

Analysis of Status Quo:

Current Causal Factor Management Focused Upon Perpetrator Prosecution

Although perpetrator prosecution is important in many cases, perpetrator prosecution alone does not constitute complete management of causal factors. The child’s family and environment may also contribute to causal factors. An investment in programs and services to increase the ability of a community or family to reduce the chances of abuse is an investment in the “social capital” of the community.

“Social capital describes the benefits that are derived from personal social relationships (within families and communities) and social affiliations. Those interested in the healthy development of children, particularly children most at risk for poor developmental outcomes, must search for new and creative ways of supporting interpersonal relationships and strengthening the communities in which families carry out the daily activities of their lives.” (Runyan, *et al.*, 1998)

Proposed Strategies and Guidelines:

1. Causality management by professionals and communities should follow the logical processes of identification, coordinated planning and operationalization.

CAUSALITY MANAGEMENT BY PROFESSIONALS AND COMMUNITIES

	PHYSICIAN	SOCIAL WORKER	LAW ENFORCEMENT	MENTAL HEALTH	BARANGAY
PARENT AND FAMILY (NON-PERPETRATOR)	<ul style="list-style-type: none"> Child development education 	<ul style="list-style-type: none"> Family support (day care, financial aid, etc.) Housing Education for entire family Livelihood Battered women care 	<ul style="list-style-type: none"> Safety 	<ul style="list-style-type: none"> Therapy or counseling for parents 	<ul style="list-style-type: none"> Community support for parents Education Home visitation Community activities
CHILD	<ul style="list-style-type: none"> Medical care and necessary referrals 	<ul style="list-style-type: none"> Appropriate referrals for services 	<ul style="list-style-type: none"> Safety 	<ul style="list-style-type: none"> Therapy or counseling for child 	<ul style="list-style-type: none"> Activities for children outside of school
ENVIRONMENT	<ul style="list-style-type: none"> Advocacy for medical and other services 	<ul style="list-style-type: none"> Advocacy for above services Housing 	<ul style="list-style-type: none"> Safety of neighborhoods 	<ul style="list-style-type: none"> Advocacy for mental health and other services 	<ul style="list-style-type: none"> Safety of neighborhoods Community building activities Advocacy for services

B. Justice and the Law

Goal: To provide fair, expedient and non-traumatizing legal proceedings for the child.

Rationale: The courtroom environment (and other environments in which legal proceedings take place) should foster, rather than threaten, the child's sense of well-being.

Analysis of Status Quo:

THE COURT SYSTEM AND CHILDREN²¹

Under RA 8369, The Family Courts Acts of 1997, the Family Courts will have full jurisdiction over all cases involving children. The implementation of RA 8369 began in early 2000. The family courts will have the following jurisdiction for child abuse cases:

- Petitions for guardianship and custody of children
- Cases of domestic violence against children
- Any violations of RA 7610 (“Special Protection of Children Against Child Abuse, Exploitation and Discrimination Act”)

Under RA 7610, all courts have the following responsibilities:

- Give precedence to child abuse cases over all other cases (except election and habeas corpus cases)
- Child abuse cases should begin within three days from the date the accused is arraigned

Physicians Participate in the Legal Process as Experts and Lay Witnesses

Currently, child abuse specialists testify in court as expert witnesses while other physicians participate in the legal system as lay witnesses. Expert and lay witnesses are defined as the following:

- **Expert witnesses** have skills or specialized knowledge that can enlighten the court on matters it does not ordinarily understand. Experts draw conclusions from facts rather than testify on a recollection of events. Before expressing an opinion, experts' credentials - such as education, special study, training, and work experience in the relevant field - must first be established. Expert witnesses, for example, could be child abuse experts testifying on their findings or specialists testifying on their areas of expertise (i.e. radiologists, neurologists, psychiatrists, etc.). Attainment of an M.D. does not automatically qualify an expert physician.
- **Lay witnesses** are called upon more for recollections of events than for opinions about a set of facts.

²¹ Further discussion of the legal process and court system can be found in Appendix C.

Proposed Strategies and Guidelines:

Physicians

1. A physician's testimony in court is not just a fulfillment of a subpoena, but also a key resolution instrument for the abused child. Fear of testifying in court is common among physicians. However, adherence to the following protocols will assist physicians on preparing court testimony.
 - a) *Be Prepared.* Physicians should be familiar with the details of the case, what the patient looks like and the medical findings. They should bring the medical certificate and any pictures or case charts that support the findings in the medical certificate.²²
 - b) *Anticipate.* Physicians should anticipate unusual questions for difficult cases and bring appropriate documentation necessary to answer any questions.
 - c) *Think.* Physicians should allow themselves time to think about all questions. They should not feel rushed to answer questions.
 - d) *Ask for clarification.* Physicians should not hesitate to ask the questioning attorney or judge for clarification of their questions.
 - e) *Do not be pushed.* Physicians should not be pushed to commit to opinions beyond the medical findings if the evidence does not indicate a definitive answer.
 - f) *Give an opinion.* Whether there are definitive or normal findings, physicians should be prepared to explain medical findings and answer why they believe these findings are correct. If necessary, they should bring medical literature supporting the diagnosis.

Judiciary

2. Just as an ideal medical evaluation is based on child-friendly policies, ideal Family Court protocols should be guided by child-friendly policies.
3. The role of the judiciary in the care continuum is important not just to causality management, but also to the resolution and healing of the abused child. Aside from the administration of justice, the experience with court officers and judges can contribute to the healing process for the abused child.

Physician's Role in Child Video Testimony

The Supreme Court has recently approved a new Rule of Court that would allow a child to testify via live video from a location other than the courtroom. The goal of this new rule is to minimize the retraumatization of the child while still respecting the rights of the accused to be able to question the child. (Supreme Court – A.M. No. 00-4-07-SC)

²² Please see Appendix C for a sample medico-legal certificate and medico-legal terms.

C. Case Specific Management of Perpetrator

Goal: Fair representation and rehabilitation for the offender, especially juvenile offenders.

Rationale: Many perpetrators either never go to jail or serve less than life sentences. As a result, perpetrators need rehabilitation so that they do not commit acts of reabuse.

Analysis of Status Quo:

Limited Rehabilitation Services

Due to a lack of rehabilitation facilities, current perpetrator management focuses upon the trial of the perpetrator, rather than rehabilitation.

“Due to the high rate of recidivism among child molesters and rapists, active steps need to be taken to ensure that the perpetrator receives the support that he or she needs for full rehabilitation.” (Prentky, *et al.*, 1997)

Emphasis Needed in Rehabilitation of Juvenile Perpetrators

Providing mental health services, as done at the PGH-CPU, contributes significantly to rehabilitation of juvenile offenders – as they are children too. These services, however, are rare and greater availability of juvenile perpetrator rehabilitation services would prevent juvenile perpetrators from repeating their crimes.

Proposed Strategies and Guidelines:

1. Care continuum professionals should provide differential management of minor and adult perpetrators as stipulated in PD 603. The chart on the opposite page outlines strategies for differential management.

DIFFERENTIAL MANAGEMENT OF MINOR AND ADULT PERPETRATORS

	MINOR	ADULT
LEGAL ACTION	<ul style="list-style-type: none"> • Under PD 603, juvenile offenders (9-21 years old) can have their sentences suspended until they are 21 years old and committed to the care of the DSWD or another responsible agency. At the age of 21, the courts will decide whether or not to continue the case. • Minor should be treated in a manner consistent with the CRC • Minor should not receive capital punishment or life imprisonment as indicated in the CRC • Minor should have alternative to traditional court proceedings 	<ul style="list-style-type: none"> • Prosecution of crime according to the law
REHABILITATION	<ul style="list-style-type: none"> • Psychotherapy • Alcohol and substance abuse rehabilitation • Education and vocation programs • Alternative to institutional care • Other necessary services 	<ul style="list-style-type: none"> • In cases of the rape of a child under seven or familial rape, the penalty is death, which precludes rehabilitation • Psychotherapy • Alcohol and substance abuse rehabilitation • Other necessary services

SECTION II

PREVENTION

in the service of all children

I

Awareness and Empowerment of Children

- Increase access to necessary services and resources for children
- Develop educational children's programs

II

Developing Family Support

- Family support strategies and advocacy
- Link child abuse prevention programs with risk factor reduction programs
- Identify and manage spousal abuse

III

Involvement of All Professionals

- Develop awareness programs for professionals about their roles in child abuse prevention
- Involve key professional groups in child abuse prevention efforts

IV

Developing Community Support

- Mobilize Barangay infrastructure to strengthen community-family interaction
- Establish community volunteer networks in collaboration with child abuse professionals
- Increase awareness of child abuse within the community
- Establish and support safer neighborhoods and a violence-free culture

OBSERVATIONS ON PREVENTION

Awareness and Empowerment of Children

Observation #1: Successful prevention strengthens family and community connections and support.

Observation #2: Physicians can pro-actively identify families who may be at-risk for abuse and mobilize community resources to provide support before abuse occurs.

Developing Family Support

Observation #3: Physicians can prevent some forms of abuse by educating new parents about topics such as child development, health care, nutrition and mother-infant bonding.

Observation #4: Child safety issues (past medical history, social history and family history) should be integrated into all medical interviews and examinations.

Involvement of All Professionals

Observation #5: Physician professional groups play an important role in educating their members about child abuse and its prevention.

Observation #6: Community networks that utilize the Barangay infrastructure to coordinate volunteers and child services create a safety-net for children within the community while also strengthening the community.

Developing Community Support

Observation #7: Communities with increased awareness of child abuse are better equipped to prevent abuse from occurring.

Observation #8: Communities require violence-free neighborhoods to foster healthy child development and interaction between children and adults.

I

AWARENESS AND EMPOWERMENT OF CHILDREN

providing resources for the underserved

- A. Increase Access to Necessary Services and Resources for Children
- B. Develop Educational Children's Programs

A. Increase Access to Necessary Services and Resources for Children

Goal: Provide children with adequate health care and an education while meeting their basic needs for growth and development.

Rationale: Children have the right to “the highest attainable standard of health and to facilities for the treatment of illness and rehabilitation of health...[and] elementary [education that is] compulsory and available free to all.” (Articles 24 and 28 of the UN Convention on the Rights of the Child) Although a causal link cannot be established between poverty and child abuse, poverty certainly exacerbates abuse when it occurs and is one of the many risk factors for abuse. Therefore, addressing a child’s need for basic services reduces some risk for abuse as well as upholds the basic rights of the child.

Analysis of Status Quo:

Barangay Health Centers

These centers, when established in the individual Barangays, offer basic health care and health education to the members of the Barangays.

Early Childhood Development Program

There are programs run by the DSWD that provide day care and health services for preschool-aged children. These programs are not nationwide.

NGOs

Many NGOs offer health care, day care and educational services to poor children. However, the availability of NGO services varies directly with the population of the area being served.

Public Hospitals

Department of Health and other public hospitals across the country offer medical care according to the patient’s ability to pay.

Public Schools

Public schools employ nurses to perform health screenings. The availability of nurses and regularity of health screenings vary greatly by school.

Proposed Strategies and Guidelines:

Physicians

1. Whenever possible, provide necessary services and resources for children.

According to the UN Convention on the Rights of the Child, necessary services and resources include:

- Housing, food and clothing
- Basic health care
- Education (books, uniform and supplies to be able to attend a public school)
- Recreation

How can a physician help?

Physicians routinely working with patients who do not have access to the above services should familiarize themselves with local resources and be able to give referrals to their patients when they know of an NGO or GO that can help provide the necessary services or resources.

C. Develop Educational Children's Programs

Goal: Empower children to recognize dangerous situations and abusive actions and report to an adult.

Rationale: Children who understand what actions constitute abuse are more likely to report abuse before it becomes chronic and causes long-term medical and psychological complications.

Analysis of Status Quo:

Awareness Programs Based Primarily in Schools

Child abuse awareness programs are run through schools and Early Childhood Development programs. Program implementation varies greatly by school and region.

Many Physicians Not Actively Involved in Educational Children's Programs

Although physicians, particularly pediatricians, play a vital role in monitoring child development, they do not traditionally incorporate child abuse awareness messages into their regular office visits. As child abuse can severely affect a child's development, it is an important aspect of physician education.

Proposed Strategies and Guidelines:

Care Continuum Professionals

In child abuse cases, the perpetrator's access to the child can be inhibited by increasing the child's resistance and by constructing a safe environment. This translates into prevention programs that target both the child and her family and community. The following are some guidelines for increasing a child's resistance to child abuse:

1. Mainstream prevention awareness programs into daily activities for children, e.g., schools, visits to the physician and Barangay and other community activities.
2. Teach recognition of abuse, interpersonal skills, values, parenting, sexuality and the rights of children in all levels of education.
3. Involve teachers, parents and community members in child abuse prevention training.
4. Develop relevant and innovative educational programs for children living in the streets and working as child laborers.
5. Immediately identify and manage behavioral problems such as aggression and bullying.
6. Emphasize a child's interpersonal development in prevention programs.

II

DEVELOPING FAMILY SUPPORT

strengthening families to prevent abuse

- A. Family Support Strategies and Advocacy
- B. Link Child Abuse Prevention Programs with Risk Factor Reduction Programs
- C. Identify and Manage Spousal Abuse

A. Family Support Strategies and Advocacy

Goal: Eliminate child abuse risk factors by supporting families and intervening when necessary.

Rationale: Mobilization to support families before child abuse occurs is a fundamental element of successful child abuse prevention as it focuses upon the early detection and elimination of child abuse risk factors before abuse becomes severe or chronic.

Analysis of Status Quo:

Families in Need Require Community Support

Families lacking support from the community are more likely to be overwhelmed by the responsibilities of raising children. Families with large numbers of children run greater risks of abusing their children, and families with less financial and educational resources also require additional support.

“Multidisciplinary, community-based models of service delivery contribute to a more effective and compassionate response to vulnerable families.” (Onyskiw JE *et al.*, 1999)

Proposed Strategies and Guidelines:

Family support strategies include the following services and programs for all parents:

✓ **Indicates areas in which physicians can be involved**

- ✓ *Counseling:* Identify parents with psychological or substance abuse problems and refer them to rehabilitation units.
- ✓ *Education about alternative discipline:* Physicians, particularly pediatricians, have the opportunity to educate parents about alternative discipline before an infant leaves the hospital. In cases of at-home births, pediatricians can educate parents about discipline during routine check-ups.
- ✓ *Education of new parents regarding:*²³
 - Breastfeeding
 - Developmental abilities of children
 - Discipline
 - Ensuring a child's safety
 - Nutrition and feeding problems
 - Prenatal care
- ✓ *Encourage bonding:* Place the infant and mother in the same room to increase mother-child bonding. Physicians can also monitor bonding during follow-up visits.
- ✓ *Family planning:* Physicians can educate parents about family planning options and make referrals to sources that offer more detailed family planning information.
- ✓ *Home visitation programs:* Physicians, Barangay health workers or NGO staff members need to conduct regular visits to new parents to discuss proper child care, check the baby's health and nutrition, offer support for the parents, and make referrals for other services as necessary.
- *Livelihood skills training*
- ✓ *Parenting classes:* for all parents (not just new parents).
- *Respite care/day care*

²³ Helfer, M.E., et al. *The Battered Child* 5th ed. Chicago: University of Chicago Press, 1997.
and Bethea, L. "Primary Prevention of Child Abuse." *American Family Physician* 59. (1999): 1577-1585.

B. Link Child Abuse Prevention Programs with Risk Factor Reduction Programs

Goal: Link child abuse prevention programs with existing risk factor management programs for children.

Rationale: Current risk factor programs identify children at risk for problems such as substance abuse, malnutrition and other public health concerns. Coordination between existing risk factor programs and child abuse prevention programs would address many of the core causality issues of child abuse.

Analysis of Status Quo:

Programs Designed to Support Children at High Risk for Abuse Often Fail to Address Abuse Directly

Current programs identifying risk factors for problems such as drug and alcohol abuse are based in schools, Barangay Health Centers and hospitals. The substance and scope of these programs varies greatly by institution.

Physician Involvement Limited

Pediatricians are the primary physicians involved in programs designed to identify risk factors for abuse. However, other medical disciplines can also screen for child abuse risk factors.

Proposed Strategies and Guidelines:

Physicians and specialists can play key roles in designing and contributing to prevention programs. The following chart shows common risk factor prevention programs that also address issues of child abuse as well as the relevant physicians who are involved with these programs.

RISK FACTOR PROGRAM	PHYSICIAN'S ROLE
Program for teenage mothers	<i>Pediatrician and Ob-Gyn.</i> Educate teenage mothers about taking care of themselves and their children. Provide follow-up health care for mother and children. Refer to other resources.
Health care for premature babies	<i>Pediatrician.</i> Encourage parent-infant bonding and provide frequent follow-up medical care.
Monitoring vulnerable children (mentally retarded, chronically ill, ADD, etc)	<i>All physicians treating vulnerable children.</i> Work with social worker to provide respite care and relief for parents if child requires special care. Link parents to support groups and monitor for signs of abuse.
Monitoring the children of high-risk parents (parents in rehabilitation, chronically ill, etc.)	<i>All physicians.</i> Ensure the well-being of high-risk children by regularly evaluating them for signs of abuse.
Monitoring malnourished children	<i>All physicians, particularly Barangay Health Center physicians.</i> Malnourished children are often neglected and could also be physically or sexually abused. Monitoring may be best achieved through a home visitation program.

C. Identify and Manage Spousal Abuse

Goal: Provide for the well-being of children of adult domestic violence victims through support of battered women and their families.

Rationale: The safety of children is integrally tied to the safety of their mothers.

“Families with an incident case of spouse abuse identified during the study period were twice as likely to have a substantiated report of child abuse...”
(Rumm, *et al.*, 2000)

Analysis of *Status Quo*:

Environment Affects Risk of Abuse

Children who live in a house where spousal abuse occurs are at a higher risk for emotional, social and cognitive problems. These may include post-traumatic stress disorder, poor self-esteem, aggressive behavior, poor school performance and psychosomatic illness.

Case Study: Domestic Violence in the Philippines

In a study done in an urban community in Manila, 47.2 percent of the 1,000 women respondents had experienced psychological and physical violence from their partners. Eighty percent of the 1,000 index children experienced psychological aggression, 80 percent were recipients of corporal punishment and 23 percent were victims of physical abuse.
(Ramiro, Madrid and Amarillo, 1999)

In the PGH-CPU, 41% of patients presenting in 2000 came from a house where spousal or previous child abuse occurred.²⁴

²⁴ UP-PGH CPU statistics.

Proposed Strategies and Guidelines:

WCPUs

1. Ensure collaboration between domestic violence specialists and child protection specialists.

Protocols and Training

2. Establish protocols and training to enable physicians to identify and respond to victims of domestic violence.

Family Courts

3. Design and enforce protective orders that comprehensively address the safety needs of battered women and their children.

Shelters

4. Establish programs that provide support and safety to both mothers and children, such as shelters that allow mothers and children to live together.

Curricular Integration

5. Curricular integration of anti-violence programs into the curricula of elementary and high school students. These programs should include modules on gender socialization, conflict resolution, dating and intimate relationships.

III

INVOLVEMENT OF ALL PROFESSIONALS

*strengthening multidisciplinary collaboration through
awareness and education*

- A. Develop Awareness Programs for Professionals About their Roles in Child Abuse Prevention
- B. Involve Key Professional Groups in Child Abuse Prevention Efforts

A. Develop Awareness Programs for Professionals About Their Roles in Child Abuse Prevention

Goal: Enable professionals working with children to recognize at-risk children in order to prevent abuse before it occurs.

Rationale: Physicians, social workers, teachers and other professionals who regularly work with children are often the first people who may recognize the risk factors that can lead to abuse.

Analysis of Status Quo:

Professional Training Limited

Some professional training is provided at undergraduate levels but this training does not permeate all professions.

Nationwide Training Programs Do Not Emphasize Prevention

Training programs are conducted throughout the country by government agencies and NGOs to educate professionals about child abuse intervention. However, exposure to prevention education and information about identifying at-risk children is limited.

Proposed Strategies and Guidelines:

Medical Professionals

1. Integrate compulsory child abuse prevention education into undergraduate and graduate level medical education.
2. Incorporate family violence and child abuse awareness questions into medical board examinations.
3. Increase networking between professionals to share resources, conduct multidisciplinary trainings and create protocols for working together to prevent abuse.

B. Involvement Of Key Professional Groups in Child Abuse

Goal: Encourage professional groups to serve as leaders in child abuse prevention education efforts through life-long professional education initiatives.

Rationale: Training physicians and medical professionals in child abuse prevention strategies begins during their general education in professional schools. Training must continue through the efforts of professional groups who provide postgraduate training and certification for medical professionals.

Analysis of Status Quo:

Medical Professional Groups Working Towards Greater Awareness

Medical groups such as the Philippine Pediatric Society, the Philippine Ambulatory Pediatrics Association, and the Association of Philippine Medical Colleges train physicians at the undergraduate, graduate and postgraduate levels about their roles in preventing child abuse through early identification of risk factors.

Proposed Strategies and Guidelines:

Professional physicians' groups can involve their members through the following child abuse prevention efforts:

- Participating in or offering lectures and seminars addressing child abuse prevention
- Participating in or teaching compulsory postgraduate courses concerning child abuse prevention
- Acquiring or providing certification establishing professionals as child abuse specialists
- Sharing resources with physicians and other professional organizations on child abuse prevention initiatives

IV

DEVELOPING COMMUNITY SUPPORT

investing in neighborhoods to prevent abuse

- A. Mobilize Barangay Infrastructure to Strengthen Community-Family Interaction
- B. Establish Community Volunteer Networks in Collaboration with Child Abuse Professionals
- C. Increase Awareness of Child Abuse within the Community
- D. Establish and Support Safer Neighborhoods and a Violence-Free Culture

A. Mobilization of Barangay Infrastructure to Strengthen Community-Family Interaction

Goal: Fully utilize the Barangay as a resource for preventing child abuse.

Rationale: As the smallest governmental unit and the one with almost daily interaction with its constituents, the Barangay can serve as the first line of defense in preventing child abuse.

Analysis of Status Quo:

Barangay Councils for the Protection of Children as Key Partners for Physicians

The Child and Youth Welfare Code of 1974 (Presidential Decree 603) encourages every Barangay council to establish a BCPC. These councils coordinate with the Council for the Welfare of Children in developing and implementing plans for the promotion of child and youth welfare. The BCPCs consist of volunteers from the community, representatives from government and private agencies, and a representative youth from the barangay.

THE ROLE OF BCPCs

- Protecting and assisting abandoned or abused children and dependents
- Coordinating the activities of organizations devoted to the welfare of children
- Holding classes and seminars on the proper rearing of children and on developing a positive parent-child relationship
- Distributing to parents available literature and other information on child guidance
- Assisting parents of children with behavioral problems in securing expert guidance and counseling from governmental agencies and NGOs
- Promoting the health of children

(Presidential Decree 603)

THE FIFTH COUNTRY PROGRAMME FOR CHILDREN

Under the Fifth Country Programme for Children (CPC V), UNICEF and the Philippine Government have outlined a strategy for advancing the welfare of Filipino children. Under this five-year plan, one of the highest articulated priorities in child protection is to enhance the BCPC system.

“As child abuse occurs largely at home and in communities, a major thrust will be to promote responsible and effective families and facilitate the establishment of Barangay Councils for the Protection of Children and Barangay Human Rights Action Centers. Community volunteers will be trained and support will be given to development of competencies of service providers for law enforcement, juvenile justice, psychosocial interventions, prevention and detection of disabilities, community-based rehabilitation for abused children and life skills education for children and youth out of school.”

(Fifth Country Programme for Children)

Proposed Strategies and Guidelines:

Physicians

1. Cooperate actively with local BCPCs to prevent of child abuse.
2. Help organize BCPCs and serve as a key resource for BCPCs in the fulfillment of common mandates towards child health.
3. Encourage Barangay activities for youth, i.e. sports and other recreation activities.
4. Revive the “bayanihan spirit” in assisting in community-building and supporting families in acute need.

B. Establish Community Volunteer Networks in Collaboration with Child Abuse Professionals

Goal: Establish a network of community volunteers, including members of churches and civic organizations, and child abuse specialists, working together for the prevention of child abuse.

Rationale: Participation in prevention begins, and is most effective at, the community level.

Analysis of Status Quo:

Limited Physician Involvement in Community-Building

Volunteer physician involvement in the community varies greatly among individual physicians. Traditionally, physicians work with local governments through community medicine programs or local NGOs that offer services for children.

Proposed Strategies and Guidelines:

Active participation in community collaborative projects fulfills the health care delivery mandate of all physicians. Physician involvement also provides long-lasting, intangible benefits to community members who can learn from physicians. Physicians can participate in community volunteer networks in the following manner:

1. Contribute to Barangay health centers as medical partners.
2. Provide training for Barangay health workers on basic health and child abuse.
3. Volunteer in schools to provide health care and health care education.
4. Lecture on preventing abuse, parenting, child development, nutrition, and family planning at community organizations.
5. Advocate for the establishment of needed services in the community, such as adult education classes, day care centers, and activity centers where parents can meet.
6. Facilitate referral of families to available community resources.

C. Increase Awareness of Child Abuse in the Community

Goal: Educate the entire community about what constitutes child abuse and teach communities that everyone is responsible for preventing abuse, not just immediate families.

Rationale: Types of abuse for which the abuser is contrite afterwards can be prevented through better education and awareness. To be most effective, this education should start at the community level. Increased community awareness may make it difficult for abusers to continue their abuse or it may prompt a member of the community to report the abuse.

Analysis of Status Quo:

Child Abuse Reports on the Rise

Child abuse awareness is increasing, as exhibited by the rising number of child abuse cases reported across the country every year. This can be attributed largely to increasing awareness about child abuse and how to report it.

Proposed Strategies and Guidelines:

Physicians play large roles in educating parents about what actions of theirs can cause unintended abuse. Physicians should work with community NGOs and Barangays to educate the community about the following:

- Dangers of shaken baby syndrome and how to handle infants and children properly
- Developmental abilities of children
- Developmental needs of children
- Proper nutrition for children
- General health care
- Where and how to report suspected abuse

D. Establish and Support Safer Neighborhoods and a Violence-Free Culture

Goal: Foster a culture that rejects violence of any kind.

Rationale: Children living in areas with high crime rates are not only more frequently exposed to violence, but are also more likely to be victims of child abuse and neglect at home due to the prevalence of substance abuse, domestic violence and unemployment in high-crime areas.²⁵

Analysis of Status Quo:

Documented Evidence of Greater Domestic Violence in Violent Neighborhoods
Witnessing violence both in the home and in the larger community traumatizes children.²⁶

Proposed Strategies and Guidelines for:

Physicians can participate in violence-free community development in the following ways:

1. Advocate for “safe areas” in the neighborhood where children can play and interact with other children.
2. Stimulate neighborhoods to form neighborhood watch groups.
3. Foster development of more comprehensive services from a wide range of public and private agencies.
4. Support violence-free media programs or decreased violence in mass media.

²⁵ Ramiro, L.S., B.J. Madrid, and M.L. Amarillo. “Domestic Violence in Urban Filipino Families.” Manila: Worldsafe, 1999.

²⁶ *ibid.*

SECTION III

GOVERNANCE

ascertaining effectiveness and accountability

I

Defining a National Agenda

- Commitment to professional standards and credentialing
- Facilitated case-consultation and peer-review system
- Advocacy for child-protection issues
- Interdisciplinary evaluation and collaborative planning

II

Realizing a National Agenda

- Oversight of child protection services
- Resource coordination and asset maximization

OBSERVATIONS ON GOVERNANCE

Defining and Realizing a National Agenda

Observation #1: Physicians can work with government agencies and professional societies to create professional standards and certification processes.

Observation #2: Effective child protection physicians participate in case consultations and peer reviews with their child protection colleagues.

Observation #3: Physician advocacy for child protection issues is crucial for medical issues affecting children.

Observation #4: An ombudsman appointed by the president or Congress would enhance child protection oversight by reviewing cases and pinpointing weaknesses in the system.

Observation #5: An effective child protection system requires cooperation between government agencies and other private organizations in order to maximize resources and skills.

I

DEFINING A NATIONAL AGENDA

identifying infrastructure needs for abused children

- A. Commitment to Professional Standards and Credentialing
- B. Facilitated Case-Consultation and Peer-Review System
- C. Advocacy for Child Protection Issues
- D. Interdisciplinary Evaluation and Collaborative Planning

A. Commitment to Professional Standards and Credentialing

Goal: Establish a certification system for child abuse specialists and expert witnesses in multiple disciplines.

Rationale:

Certified professionals committed to continuing education and peer consultation will provide experience and insight in the areas of the care continuum demanding their involvement. As child abuse is a medical diagnosis with consequences that affect the child, family and various participating systems, professionals need to meet certain standards of diagnostic competency.

“Medical expertise is maintained through professional activities such as clinical practice, consultation and peer review.” (Adams *et al.* 1999)

Analysis of Status Quo:

Child Protection Specialist Training

The University of the Philippines-Manila and the Philippine General Hospital, in conjunction with the DOH and PNP, conduct a six-week intensive training program for child protection specialists. Specialists who graduate from this program are expected to return to their home regions and offer training and consultation for other professionals working with children. Trained specialists remain in communication with each other for peer review, case consultation and updates on the latest research findings.

NBI and PNP

Training initiatives by the NBI and PNP established training programs at their respective headquarters in Metro Manila to train medico-legal officers about the diagnosis and treatment of child abuse.

Proposed Strategies and Guidelines:

Professional Society Certification: Professional societies, such as the Philippine Pediatric Society, can certify child abuse specialists and child protection units.

Court Acknowledgement of Certification: Judges can acknowledge child protection specialists by recognizing them as expert witnesses in their courts.²⁷ Expert witnesses contrast with lay witnesses, who may also be physicians, because their training and experience requires that they offer both facts and opinions to the court. Lay witnesses offer only facts about a case.²⁸

²⁷ Myers, J.E.B. “Evidence in Child Abuse and Neglect Cases.” 3rd ed. New York: John Wiley and Sons: New York, 1997.

²⁸ *ibid.*

B. Facilitated Case-Consultation and Peer-Review System

Goal: Create a network of child protection specialists.

Rationale: Interdisciplinary networks of trained, dedicated child protection specialists can best serve children and enhance their knowledge and skills through peer reviews and case consultations. Case consultation and peer review systems are requirements for world-class standards in the medical evaluation of child abuse.

Analysis of Status Quo:

Case Consultation and Peer Review Not New Concepts in Medical Profession

Case consultation and peer review systems are already part of other medical specialties and are recognized as good medical practice.

Annual Meeting is a Key Component of Case Review

DOH child protection specialists participate in an annual meeting to review cases and discuss innovations in the field of child protection.

Proposed Strategies and Guidelines:

1. Implement inter- and intra-professional communication by taking advantage of established technology such as faxes, email, Internet and teleconferencing.
2. Strengthen accreditation, peer review and case consultation systems as outlined in the chart below.

WHAT	HOW
Expert Witnesses	Physicians as “experts” may have two fora: <ul style="list-style-type: none"> • As expert witnesses: appearing alone to give testimony and expert opinion in court for a specific case • As a body of experts who can influence the judiciary/criminal justice system by making direct recommendations, raising the standard of the profession and accrediting experts. Physicians can also serve on a panel of expert witnesses to advise judges in child abuse cases. Responsibilities would include working together as an expert panel to interpret medical findings, colposcopic pictures and other evidence and to make unified recommendations to the judge about the medical findings of a specific case.
Peer Reviews	Child abuse specialists throughout the Philippines with the capability to take colposcopic pictures can consult with each other about their findings and discuss difficult cases in order to reach a consensus about findings. The process facilitates learning and broadens expertise.
Case Consultations	As care continuum professionals, physicians are available for case consultations with other care continuum professionals. Examiners in remote areas and those seeing only a small number of cases consult with experienced child protection specialists when faced with difficult cases. This also helps isolated doctors feel comfortable with the impressions reached and to feel supported in their diagnoses.

C. Advocacy for Child Protection Issues

Goal: Formulate and implement policies, laws and procedures that protect children’s health and safety.

Rationale: Advocacy for child protection issues will strengthen the care continuum for children by making services accessible, affordable and of the highest quality.

Analysis of Status Quo:

Physician Advocacy Broad

Physicians are currently involved in many areas of advocacy, from patient rights to legislation to protect children.

Proposed Strategies and Guidelines:

Physician advocacy permeates all areas of the care continuum that demand physician involvement. Advocacy includes influencing policy as well as lobbying lawmakers for positive changes to the system. The following issues involve physicians:

ADVOCACY AREA	AREA OF CARE CONTINUUM ²⁹
<ul style="list-style-type: none"> Enforcement of patient’s right to confidentiality³⁰ 	All areas
<ul style="list-style-type: none"> Curricular reform to include child abuse in the medical curricula of all medical schools 	Early Detection and Prevention
<ul style="list-style-type: none"> Hospital Guidelines for reporting abuse 	Reporting and Referral
<ul style="list-style-type: none"> Protocol for autopsies for suspicious deaths 	Multidisciplinary Evaluation and Diagnosis
<ul style="list-style-type: none"> Formulation of a Suspicious Death Review Team 	Multidisciplinary Evaluation and Diagnosis
<ul style="list-style-type: none"> Define the chain of evidence for cases where physicians must gather evidence (for example, rape) 	Causality Management
<ul style="list-style-type: none"> Rehabilitation for minor perpetrators 	Causality Management
<ul style="list-style-type: none"> Universal medical care for children and their families 	Causality Management/Prevention
<ul style="list-style-type: none"> Provision of necessary social services to prevent abuse 	Prevention

²⁹ Please refer to the specific section of the care continuum for more detail on advocacy efforts.

³⁰ “A Physician’s Guide to Protecting Child Abuse Patients’ Confidentiality.” Manila: The Advisory Board Foundation, 1998.

D. Interdisciplinary Evaluation and Collaborative Planning

Goal: Child protection professionals work together with the government to evaluate the effectiveness of the child protection system and strive to make changes while ensuring multidisciplinary cooperation.

Rationale: Various government and non-government task forces have duties that overlap with one another. Through interdisciplinary cooperation and planning, these groups can provide the best resources for children and care continuum professionals.

Analysis of Status Quo:

Multiple Agencies Involved in Caring for Children

The following government agencies currently work with physicians and other care continuum professionals to offer optimal care for children:

- Barangay Health Centers
- Council for the Welfare of Children
- Department of Health
- Department of Justice
- Department of Social Welfare and Development
- Family Courts
- Government hospitals
- Local government units
- National Bureau of Investigation
- NGOs
- Police
- Supreme Court

Proposed Strategies and Guidelines:

Physicians can work with the above agencies through the following initiatives:

1. *Task forces:* Task forces must both plan and implement strategies for multidisciplinary collaboration.
2. *Training:* Physicians can both participate in interdisciplinary training and conduct training for all of the above agencies and organizations about the medical aspects of child abuse.
3. *Protocols:* Repeatedly occurring situations require the implementation of protocols to react swiftly and efficiently. Such situations include cases of suspicious death, high risk cases, and cases that need continuous monitoring. Protocols between physicians and some of the above agencies will ensure high-quality, timely care for the child.

II

REALIZING A NATIONAL AGENDA

establishing infrastructure for long-term change

- A. Oversight of Child Protection Services
- B. Resource Coordination and Asset Maximization

A. Oversight of Child Protection Services

Goal: Develop effective, coordinated, and accountable child protection services.

Rationale: All care continuum professionals must take the lead in the parts of the care continuum requiring their expertise. Government agencies, such as the DOH and DSWD, ensure the full participation of care continuum professionals through oversight of child protection services.

Analysis of Status Quo:

The chart below shows the individual and collective roles of care continuum professionals in caring for abused children.

MULTIDISCIPLINARY TEAM			
PROFESSIONAL	GOVERNMENT OVERSIGHT AGENCY	ROLE PLAYED	RESPONSIBILITY
PHYSICIAN	<ul style="list-style-type: none"> • DOH • LGU 	Lead	Immediate and long-term medical care
		Advise	Temporary placement if child's safety is at risk
		Lead	Continuous evaluation of child development
		Participate	Case conferences with all agencies involved
		Participate	Reintegration care
NURSE	<ul style="list-style-type: none"> • DOH • LGU 	Lead and/ or provide	Immediate and long-term medical care
		Participate	Case conferences with all agencies involved
SOCIAL WORKER	<ul style="list-style-type: none"> • LGU • DSWD • Family Court 	Lead	Temporary placement if child's safety is at risk
		Lead	Case conferences with all agencies involved in case
		Lead	Reintegration care
MENTAL HEALTH	<ul style="list-style-type: none"> • DOH • LGU • DSWD • Family Court 	Lead	Mental health care and counseling
		Participate	Case conferences with all agencies involved in case
		Participate	Reintegration care

Proposed Strategies and Guidelines:

Ombudsman for Children

What is an Ombudsman?

An ombudsman for child protection is a third party appointed by the president, Congress or an oversight agency who investigates the effectiveness of the child protection system.

What are the Responsibilities of an Ombudsman?³¹

1. Monitor and ensure compliance with child protection laws, rules and policies.
2. Monitor the placement and treatment of children in protective custody.
3. Exercise power independently of the departments that are being monitored.
4. Report to the executive or legislative branches of government on the effectiveness of the system, problems and concerns, and make recommendations for laws, rules, or regulations that would help children.

What Authority Does an Ombudsman Have?

An ombudsman has the following areas of authority:

1. Investigate
2. Hold hearings
3. Petition courts on behalf of children
4. Access to all records necessary for an investigation

“A Children’s Ombudsman can improve the child welfare system based on complaint investigation. States and other jurisdictions should consider the institution of an Ombudsman’s office for a variety of areas, including child protective services, foster care, and adoption.”
(Bearup and Palusci, 1999)

³¹ Bearup, R.S. and V.J. Palusci. “Improving Child Welfare Through a Children’s Ombudsman.” *Child Abuse and Neglect* 23(5). (1999): 449-157.

B. Resource Coordination and Asset Maximization

Goal: Maximize resources by utilizing existing systems and networks to create a multisectoral child abuse system that delivers complete care continuum services to abused children and their families.

Rationale: With limited resources, programs should be coordinated between disciplines and government and non-government agencies in order to maximize and enhance services for children.

Analysis of Status Quo:

Filipino Government Welcomes NGO Participation

The Filipino government has embraced the concept of asset maximization by increasing their partnerships with NGOs to deliver services. The government has also made efforts to coordinate resources across agencies to avoid duplicating services and training for child abuse professionals.

Private/NGO Training Initiatives for Government Employees

Many training sessions conducted by government organizations have been sponsored by organizations such as UNICEF, the British Government, the Royal Netherlands government, and other interested public and private institutions.

Proposed Strategies and Guidelines:

Care Continuum Professionals

1. Public WCPUs can seek support from private NGOs and other funding agencies.
2. Training programs should ideally serve as many participants as possible, thus maximizing resources. Coordination across government and private sectors will ensure maximum capacity at training sessions.

Case Example: DSWD's Quick Response Team

Who: Volunteer physicians, counselors, lawyers, psychiatrists, psychologists, teachers and other care continuum professionals

What: A team of volunteers and government professionals that can be mobilized when a child abuse case is reported. For example, if a child needs medical care, a physician is contacted, if she needs legal assistance, a lawyer or court-appointed special advocate is called. These professionals then meet together to discuss the progress of cases and make further referrals as necessary.

Where: Throughout the Philippines

Conclusion: Limited resources produced an innovative solution to providing immediate care for abused children. This strategy not only serves the best interests of the child but also utilizes community resources and increases community support for child abuse prevention and intervention initiatives.

SECTION IV

TRAINING AND RESEARCH

infrastructure development through expertise and knowledge

I

Educating Professionals

- Interdisciplinary training
- Integrated profession-specific curricula

II

Advancing the Profession

- Facilitated information dissemination
- Cooperative database and resource network
- Research initiatives on best practices and infrastructure needs

OBSERVATIONS ON TRAINING AND RESEARCH

Educating Professionals

Observation #1: Physicians both participate and provide training on preventing, recognizing, reporting and treating child abuse.

Observation #2: Interdisciplinary coordination of curricular content will facilitate future professional coordination and collaboration in the care continuum.

Observation #3: Physicians should be familiar with child abuse resources in their communities, as well as national and international research and initiatives.

Advancing the Profession

Observation #4: A centralized database containing nationwide child abuse statistics is necessary for research and program-planning purposes.

Observation #5: Physician participation in child abuse research initiatives is crucial to enhancing the medical care for abused children.

I

EDUCATING PROFESSIONALS

*bringing care continuum professionals together
through training and awareness*

- A. Interdisciplinary Training
- B. Integrated Profession-Specific Curricula

A. Interdisciplinary Training

Goal: Train all physicians about their roles in caring for abused children and how they can cooperate with other care continuum professionals.

Rationale: Interdisciplinary training allows all care continuum partners to understand the roles of each professional providing services for children.

Analysis of Status Quo:

Surge in the Number of Multidisciplinary Training Sessions in Past Two Years

Many multidisciplinary training sessions have been conducted by organizations such as the DSWD, the Philippine Judicial Academy and other NGOs and government agencies.

Proposed Strategies and Guidelines:

The chart below outlines ways in which physicians can work with other care continuum professionals to give and receive training regarding the treatment of child abuse.

INTERDISCIPLINARY TRAINING OPPORTUNITIES FOR PHYSICIANS	
GIVE TRAINING	
Training	Participants
Medico-legal terminology	all care continuum professionals, particularly judges, lawyers and policemen
Recognizing child abuse	all care continuum professionals
Developmental stages of children	all professionals and parents
RECEIVE TRAINING	
Training	Participants
Rules of court and laws and issuances pertaining to children	Physicians and all other care continuum professionals
Conducting an effective risk assessment	Physicians and social workers
Interviewing children	Physicians, social workers and law enforcement officers
How to run a multidisciplinary Child Protection Unit	Physicians, social workers, nurses and law enforcement officers

B. Integrated Profession-Specific Curricula

Goal: Integrate child abuse prevention curricula into all medical professions.

Rationale: Education about child abuse that begins in professional schools and is reinforced in postgraduate training allows the true integration of the complex issues of child abuse into the professional mindset. Professional education at all levels is critical to the future development and improvement of the care continuum for child abuse.

Analysis of Status Quo:

Medical Schools Have Not Begun Implementation

Many medical school curricular reforms have focused upon intervention, not prevention.

Proposed Strategies and Guidelines:

NOTE: See Early Detection or Suspicion for further details about curricular integration of child maltreatment into medical school curricula.

1. Develop specialty-specific training curricula (e.g., curricula for orthopedic surgeons, emergency room physicians, family court judges, and child abuse specialists).
2. Coordinate inter-disciplinary curricula across disciplines to facilitate future professional coordination and prevention initiatives.
3. Incorporate recognition of child abuse and strategy concepts into curriculum to enhance innovation towards child abuse initiatives within the medical profession.
4. Emphasize innovation and clinical exposure to child abuse and risk factors for child abuse, not just didactic pedagogy.
5. Include in curricular content modules the roles of other care continuum professionals and how care continuum professionals should work together.

“Educational interventions that target recognition of abuse are essential to improve the ability of physicians who screen children and intervene when sexual abuse is suspected.” (Leder, M.R. *et al.*, 1999)

II

ADVANCING THE PROFESSION

developing child abuse as a medical sub-specialty

- A. Facilitated Information Dissemination
- B. Cooperative Database and Resource Network
- C. Research Initiatives on Best Practices and Infrastructure Needs

A. Facilitated Information Dissemination

Goal: Ensure that all physicians have access to up-to-date information about child protection -- both Philippine-specific and international information.

Rationale: The field of child protection is constantly developing. For physicians, new studies about the medical findings for child abuse appear each year. Access to this information is critical to accurately diagnose child abuse.

Analysis of Status Quo: Currently, information is distributed through the following media:

Child Protection Web Site: www.childprotection.org.ph contains databases of child abuse studies, laws, and contacts as well as a list of events related to child protection.

Philippine Resource Network: A group of NGOs and government organizations (GOs) that maintain the above web site. Any information to post on the website should be forwarded to the following members of the Resource Network:

Child Protection Unit
Telephone: 526-8418
Email: cpu@advisory.ngo.ph

Psychosocial Trauma and Human Rights
Program of UP-CIDS
Telephone: 435-6890
Email: pstcids@info.com.ph

Council for the Welfare of Children: Responsible for information dissemination throughout the country. Contact information:

CWC Building, 10 Apo Street
Sta. Mesa Heights
Quezon City

Telephone Numbers: 743-8375 / 740-8863 /
781-1035 / 781-1033
Facsimile: 740-8863 / 743-8374
e-mail: cwc@info.com.ph

Other NGOs and GOs: Produce independent studies and disseminate to care continuum partners.

Proposed Strategies and Guidelines:

Physician can participate in all of the above (or similar) networks. Further emphasis is needed in the area of information dissemination within the medical community about the following:

- Resources for physicians to make referrals to patients who may be abused
- Latest literature on conducting medical examinations, interviews and gathering medico-legal evidence
- Other professionals who can assist physicians in providing care for abused children

B. Cooperative Database and Resource Network

Goal: Establish a central database that records national child abuse data and a network of accessible resources.

Rationale: Care continuum professionals should have immediate access to accurate statistics and the resources they need to help children and to learn more about child protection.

Analysis of Status Quo:

Statistics Gathered by a Wide Variety of Agencies

Currently, child abuse statistics are gathered by each of the following institutions:

- Commission on Human Rights
- Department of Health
- Department of Social Welfare and Development
- Local government units (varies by LGU)
- National Bureau of Investigation
- Philippine National Police

Proposed Strategies and Guidelines:

Government Agencies

1. **National Coordination:** One agency, such as the National Statistics Board, should be responsible for collecting data on child abuse from around the country. The collection of these data would then be coordinated, eliminating duplication of entries.

Hospitals

2. **Medical Profession:** Hospitals should collect basic child abuse statistics to report to an agency in charge of collecting nationwide data as well as its own set of statistics about abuse for use with policy and research within the hospital. Child abuse statistics can then be collated by the DOH for nationwide health-care policy decisions.

“In the US, database research has been utilized to observe highly consistent child abuse recurrence patterns, abuse risk factors, and other correlations between child abuse and living situations. The integrity of these and other studies, however, relies on the dependability of the data and the large sample size that is collected across the country.” (Luke, *et al.*, 1999)

C. Research Initiatives on Best Practices and Infrastructure Needs

Goal: Utilize careful documentation and research and evaluate the effectiveness of current child protection strategies, and introduce innovative new strategies for combating child abuse.

Rationale: The delivery of services for abused children can be improved only through directed research.

Analysis of Status Quo:

NGOs, GOs, the Academe, and POs Have Played an Active Role in Researching Child Abuse

The website “www.chilprotection.org.ph” contains a thorough listing of studies conducted in the Philippines about child abuse and contains an on-line database of child protection-related publications.

Proposed Strategies and Guidelines:

GOs, NGOs and the academe must continue ongoing research projects and work together to devise a prioritized research agenda. Research should span from studies of best practices, analyses of the infrastructure needs of the Philippines, and quantitative and qualitative studies looking at the effects of child abuse from medical, social and psychological perspectives.

“Epidemiologic and longitudinal, prospective, controlled studies sensitive to cultural and developmental differences are needed to illuminate the national history of posttraumatic stress disorder and to show how trauma and its response interact with family, school and community factors....[this has] promising profound implications for society, such data would enable mental health professionals, educators and policy makers to develop standards for prevention, detection, and intervention to optimize children’s developmental trajectory.”

(Schwarz, E.D. *et al.*, 1998)

Appendix A

Sample Child Abuse Report Forms

SAMPLE: SPECIALIZED CHILD ABUSE REPORT

PATIENT INFORMATION				
Patient's name	<input type="checkbox"/> female <input type="checkbox"/> male	Date of report		
DOB and age: Born / / _____ years old	Reporting physician			
Primary diagnosis	<input type="checkbox"/> Physical abuse <input type="checkbox"/> Sexual abuse <input type="checkbox"/> Neglect	Reporting Social Worker		
Present location of child				
Child's school			Grade & teacher	
INCIDENT & PERPETRATOR				
Alleged Perpetrator		Identity <input type="checkbox"/> known <input type="checkbox"/> unknown	<input type="checkbox"/> male <input type="checkbox"/> female	
Full name & nickname		Age: _____ (yrs)	Relationship to Child:	
Current location of alleged perpetrator	<input type="checkbox"/> unknown <input type="checkbox"/> other known location _____			
Alleged perpetrator's address or location				
Abusive Incident		<input type="checkbox"/> Single abusive episode	<input type="checkbox"/> Multiple Episodes	<input type="checkbox"/> Chronic abuse over time
Date & time of incident	<input type="checkbox"/> Unknown	Was abuse witnessed? <input type="checkbox"/> no <input type="checkbox"/> yes, by: _____ Name, relation to child		
Location of incident (city)			<input type="checkbox"/> School	<input type="checkbox"/> Home
FAMILY & HOUSEHOLD COMPOSITION				
Relation to child	Name	Gender	Age	Contact information (home address, school, employer)
Mother		<input type="checkbox"/> male <input type="checkbox"/> female		
Father		<input type="checkbox"/> male <input type="checkbox"/> female		
		<input type="checkbox"/> male <input type="checkbox"/> female		
		<input type="checkbox"/> male <input type="checkbox"/> female		
PHYSICIAN'S FINDINGS				
INTERVIEW	Summarize what the abused child or the person accompanying the child said happened:			
MEDICAL FINDINGS				
PLAN OF ACTION				

SAMPLE: BASIC CHILD ABUSE REPORT
(FOR NON-CPU PHYSICIAN AND NON-MEDICAL PROFESSIONALS)

CHILD ABUSE REPORT			
DATE		REPORT TO (list all if > 1)	
REPORT FROM		PREPARED BY	
PROFESSION		INSTITUTION	
ADDRESS		TEL/FAX/ EMAIL	
NAME OF CHILD		NICKNAME	
SEX	<input type="checkbox"/> M <input type="checkbox"/> F		
AGE		BIRTHDATE	
SCHOOL		GRADE	
ADDRESS		PARENTS/ GUARDIAN	
REASON FOR REPORT	<input type="checkbox"/> suspect physical abuse <input type="checkbox"/> suspect sexual abuse <input type="checkbox"/> suspect neglect <input type="checkbox"/> abandonment <input type="checkbox"/> other, please describe		
FINDINGS OR OBSERVATIONS			
OTHER COMMENTS			

Appendix B

The Role of the Department of Social Welfare and Development and Local
Government Units

THE DSWD AND DEVOLUTION

As the devolution of power in Philippine government agencies is gradually implemented, physicians may find themselves working more closely with LGU social welfare offices than the DSWD.

DSWD SHIFTS FOCUS FROM IMPLEMENTATION TO OVERSIGHT

Under devolution, the Department of Social Welfare and Development has modified its role in child protection. The DSWD will move away from the direct implementation of child protection services and instead direct their resources in support of other public and private institutions that serve children.

New Mission Statement: “To promote poverty alleviation and the empowerment of disadvantaged families and communities through the provision of assistance to local government units, non-government organizations, other government agencies, and people’s organizations.”

By the year 2001, the DSWD will no longer provide direct services. It will devolve these responsibilities to the LGUs and NGOs and focus upon the provision of technical expertise, research, and other forms of organizational assistance.

Under this new paradigm for the DSWD, the LGU social welfare offices will become the physicians’ most active government partners in protecting children. In its new role, the DSWD is likely to provide increased monitoring of child protection services and research on abuse in the Philippines.

Local Government Unit social welfare officers have the same legal mandate as DSWD social workers to remove children from their homes or place children in protective custody.¹

The Local Government Code of 1991 (Republic Act 7160, section 17)

Appendix C

- Navigating the Courts
- Legal Definition of Rape
- Medico-Legal Certificate for Physicians

NAVIGATING THE COURTS

Although physicians are neutral witnesses, representing neither prosecution nor defense, it is important to be familiar with the procedures followed by prosecutors and defense lawyers. Prosecutors fall into the following groups:

- **State Prosecutors:** located in the Prosecution Staff of the Department of Justice, they may prosecute cases anywhere in the Philippines
- **City Prosecutors** (formerly known as city fiscals): located in each chartered city, they may prosecute cases only within that city
- **Prosecutors:** located in each province, they may prosecute cases only within that province

Defense lawyers fall into the following categories:

- **Private:** hired by the perpetrator
- **Public:** appointed by the government

CRIMINAL PROSECUTION³²

The following is a summary of the procedures followed after a case has been filed and until it reaches trial.

An **inquest** is an informal and summary investigation conducted by a public prosecutor in criminal cases involving persons arrested and detained without the benefit of a warrant of arrest issued by the court. The inquest proceedings begin when law enforcement officers present the Inquest Officer with an affidavit of arrest, an investigation report, the statement of the complainant and witnesses and other evidence gathered by the police.

A **preliminary investigation** seeks to determine whether there is sufficient evidence to engender a well-grounded belief that the respondent is guilty of a crime and should be held for trial.

An **information/complaint** is an official accusation or charge.

An **arraignment** is a mandatory requirement through which the accused is informed in open court of the charge against him by the reading of the information or complaint. The accused responds with a plea of guilty or not guilty.

During the **trial**, the prosecutor presents the evidence against the accused, usually through the testimony of witnesses, documents, and physical evidence of commission of the crime. The accused is allowed to mount a defense, usually through similar forms of testimony and evidence.

³² RA 7610, Section 29.

OTHER RESPONSIBILITIES OF JUDGES AND PROSECUTORS

- Protecting the child from “undue and sensationalized” publicity or media coverage³³
- Discouraging improper withdrawal of charges³⁴
- Referring child abuse cases to the DSWD and/or LGU social workers
- Placing the child under protective custody, if necessary
- Preventing the child from re-traumatization in court

³³ RA 7610, Section 29.

³⁴ Physicians should familiarize themselves with the Child Abuse Accommodation Syndrome, which provides an understanding why children sometimes feel pressured to retract accusations of abuse against close relatives and neighbors or cast blame on themselves for the abuse. Given that child abuse is a public crime under RA 7610, the state may still theoretically pursue a criminal case against the alleged perpetrator even after a child retracts.

WHAT IS RAPE?

Under RA 8353, rape occurs when a man has “carnal knowledge” of a woman under any of the following circumstances:³⁵

- through force, threat, or intimidation;
- when the offended party is deprived of reason or is otherwise unconscious;
- by means of fraudulent machination or grave abuse of authority; or
- when the offended party is under twelve years of age or is demented, even though none of the circumstances mentioned above are present. A child under 12 is not considered capable of “consenting” to sexual intercourse.

MANDATORY DEATH PENALTY FOR INCESTUOUS RAPE OF CHILDREN

Under the Anti-Rape Law of 1997 (Republic Act 8353, Article 266-B), the death penalty shall be imposed if the crime of rape is committed:³⁶

- when the victim is under eighteen (18) years of age, and the offender is a parent, ascendant, step-parent, guardian, relative by consanguinity or affinity within the third civil degree, or the common-law spouse of the parent of the victim; or
- when the victim is a child below seven (7) years old.

Other conditions in which the death penalty applies:³⁷

- when the offender knew of the mental disability, emotional disorder and/or physical handicap of the offended party at the time of the commission of the crime.

TESTIMONY ALONE, WITHOUT MEDICAL EVIDENCE, CAN LEAD TO CONVICTION

“The rape victim’s testimony, standing alone, can be made the basis of the accused’s prosecution and conviction, if such testimony meets the test of credibility.”

People vs. Corea, 269 SCRA 76

³⁵ In rape, the important consideration is not the emission of semen but the penetration of the female genitalia by the male organ. (People v. Galleno, p. 761.) While complete penetration may not have been accomplished...slight penetration of the labia still constitutes rape (People vs. Borja, 267 SCRA 370; People vs. Andan, 269 SCRA 95; People vs. De La Pena, 276 SCRA 558; and People vs. Catromero, 280 SCRA 421) Rape also need not involve the penis. Rape is defined as “an act of sexual assault by inserting the penis into another person’s mouth or anal orifice, or any instrument or object, into the genital or anal orifice of another person.” (RA 8353, Section 2, Article 266-A). The Department of Justice has clarified that a finger is considered an “object” for the purposes of this definition.

³⁶ Please see also the Revised Penal Code, Title Eleven, Chapter Two, Article 335 and Republic Act 7610, Article III, Section 5b.

³⁷ *ibid.*

The following is a copy of a Medico-Legal report including the instructions for accomplishing the report.

PATIENT'S NAME		AGE		DOB		SEX	
PATIENT'S ADDRESS							
CIVIL STATUS		OCCUPATION		NATIONALITY			
REQUESTING PARTY		PLACE, TIME AND DATE OF EXAMINATION					
<input type="checkbox"/> Acute Evidentiary Examination (within 72 Hours of incident)				<input type="checkbox"/> Non-acute examination			
Findings							
GENERAL PHYSICAL EXAMINATION							
HEIGHT		WEIGHT		TANNER STAGE			
GENERAL SURVEY	(No/Mild/ Moderate/Severe) Stunting		(No/Mild/ Moderate/Severe) Wasting				
	Ambulant/non-ambulant: Respiratory distress/not in respiratory distress: Other:						
MENTAL STATUS	Orientation as to time, place, person: Consciousness, demeanor:						
PERTINENT PHYSICAL FINDINGS/PHYSICAL INJURIES	Any injuries noted in the body, signs of pregnancy, hygiene, remarks and other abnormalities:						
ANO-GENITAL EXAMINATION							
EXTERNAL GENITALIA	Female: Pubic hair, Labia minora, labia majora, mons pubis, posterior forchette Male: pubic hair, penis, scrotum, circumcision Male and Female: Tanner Stage; Injury/ no evident injury at the time of examination						
URETHRA AND PERIURETHRAL AREA	Injury/ no evident injury at the time of examination						
PERIHYMENAL AREA AND FOSSA NAVICULARIS	Injury/ no evident injury at the time of examination						
HYMEN	Shape(crescentic/annular/fimbriated/septate/cribriform/imperforate);Tanner Stage Injury/ no evident injury at the time of examination						
PERINEUM	Injury/ no evident injury at the time of examination						
DISCHARGE	Present/absent, description (IE and speculum exam refer to protocol)						
IE AND SPECULUM EXAM	Refer to protocol						
ANAL EXAMINATION	Injury/ no evident injury at the time of examination (describe location)						
REMARKS							
FORENSIC EVIDENCE COLLECTED	Specimens submitted						
LABORATORY EXAMINATION (EXAM AND RESULT)	<input type="checkbox"/> Semen swab for cases within 72 hours (mouth, vaginal, perianal, anal swab) <input type="checkbox"/> TMG (wet mount, KOH prep & Gram stain) and Culture when resources are available <input type="checkbox"/> DNA when resources are available <input type="checkbox"/> Drug Test <input type="checkbox"/> Pregnancy test/Ultrasound <input type="checkbox"/> Serum exam (VDRL, Hepatitis B , HIV)						
IMPRESSIONS							
<input type="checkbox"/> Normal (class I) <input type="checkbox"/> Normal Variant or non-specific findings (class II) <input type="checkbox"/> Suggestive of Abuse (class III) <input type="checkbox"/> Clear Evidence of Blunt Force or Penetrating Trauma (class IV) Normal / non specific findings do not prove nor disprove the disclosure of sexual abuse							

The following document can be submitted with the medico-legal report as an explanation for non-medical professionals about the findings detailed in the medical certificate.

TANNER STAGES	
BREASTS	<ul style="list-style-type: none"> I. Preadolescent II. Breast budding III. Continued enlargement IV. Areola and papilla form secondary mound V. Mature female breasts
PENIS	<ul style="list-style-type: none"> I. Preadolescent II. Enlargement, change in texture III. Growth in length and circumference IV. Further development of glans penis, darkening of scrotal skin V. Adult genitalia
HYMEN	<ul style="list-style-type: none"> I. Thin hymen, fine blood vessel pattern in vestibule, pink color, small labia minora II. Less prominent vascular pattern due to slightly thickened hymen and vestibule tissue III. Thick hymen, superficial vessels not seen, small labia minora, clear vaginal discharge IV. Redundant hymen with thick projections, adipose tissue below skin of textured vestibule, more elastic hymen, pigmented labia minora (clefts deepen, hymen begins to look like a flower with petals) V. Long, rugated labia minora, secretions
MALE AND FEMALE GENITALIA	<ul style="list-style-type: none"> I. Preadolescent no sexual hair II. Sparce, pigmented long, straight, mainly along labia and at base of penis III. Darker, coarser, curlier IV. Adult, but decreased distribution V. Adult in quantity and type with spread to medial thighs

CLASSIFICATION SYSTEM FOR IMPRESSIONS³⁸

<p>CLASS I: NORMAL</p>	<ol style="list-style-type: none"> 1. Peri-urethral (or vestibular bands) 2. Longitudinal intravaginal ridges or columns 3. Hymenal tags 4. Hymenal bump or mound 5. Linea vestibularis 6. Hymenal cleft/notch in the anterior (superior) half of the hymenal rim, on or above the 3 o'clock- 9 o'clock line, patient supine 7. External hymenal ridge
<p>CLASS II: NORMAL VARIANT OR NON-SPECIFIC FINDING</p>	<p><i>Findings that may be the result of sexual abuse, depending on the timing of the examination with respect to the abuse, but which may also be due to other causes, or may be variants of normal.</i></p> <ol style="list-style-type: none"> 1. Septate hymen (normal variant) 2. Failure of midline fusion (normal variant) 3. Groove in the fossa in a pubertal female (normal variant) 4. Diastasis ani (normal variant) 5. Perianal skin tag (normal variant) 6. Increased peri-anal skin pigmentation (normal variant) <p><i>The remaining findings are non-specific for abuse:</i></p> <ol style="list-style-type: none"> 7. Erythema (redness) of the vestibule or peri-anal tissues (may be due to irritants, infection or trauma) 8. Increased vascularity (dilation of existing blood vessels) of vestibule (may be due to local irritants) 9. Labial adhesions (may be due to irritation or rubbing) 10. Vaginal discharge (many causes) 11. Friability of the posterior fourchette or commissure (may be due to irritation, infection, or may be caused by examiner's traction on the labia majora) 12. "Thickened hymen" (may be due to estrogen effect, folded edge of hymen, swelling from infection, or swelling from trauma) 13. Apparent genital warts (may be skin tags or warts not of the genital type, may be Condyloma accuminata which was acquired from perinatal transmission or other non-sexual transmission) 14. Anal fissures (usually due to constipation or peri-anal irritation) 15. Flattened anal folds (may be due to relaxation of the external sphincter) 16. Anal dilation with stool present (a normal reflex) 17. Venous congestion, or venous pooling (usually due to positioning of child, also seen in constipation) 18. Vaginal bleeding (may be from other sources, such as urethra, or may be due to vaginal infections, vaginal foreign body, or accidental trauma)

³⁸ Adams, J. "Evolution of a Classification Scale: Medical Evaluation of Suspected Child Sexual Abuse." University of California, San Diego Medical Center, 2000.

CLASSIFICATION SYSTEM FOR IMPRESSIONS

<p>CLASS III: SUGGESTIVE OF ABUSE</p>	<p><i>Findings that have been noted in children with documented abuse, and may be suggestive of abuse, but for which insufficient data exists to indicate that abuse is the only cause. History is crucial in determining overall significance.</i></p> <ol style="list-style-type: none"> 1. Marked, immediate dilation of the anus, with no stool visible or palpable in the rectal vault, when the child is examined in the knee-chest position, provided there is no history of encopresis, chronic constipation, neurological deficits, or sedation 2. Hymenal notch/cleft in the posterior (inferior) portion of the hymenal rim, extending nearly to the vaginal floor. (Often an artifact of examination technique, but if persistent in all examination positions, may be due to previous blunt force or penetrating trauma). 3. Acute abrasions, lacerations or bruising of labia, peri-hymenal tissues, or perineum (may be from accidental trauma, or may be due to dermatological conditions such as lichen sclerosus or hemangiomas) 4. Scar or fresh laceration of the posterior fourchette, not involving the hymen (may be caused by accidental injury) 5. Peri-anal scar (rare, may be due to other medical conditions such as Crohn’s Disease, or from previous medical procedures)
<p>CLASS IV: CLEAR EVIDENCE OF BLUNT FORCE OR PENETRATING TRAUMA</p>	<p><i>Findings which can have no explanation other than trauma to the hymen or peri-anal tissues</i></p> <ol style="list-style-type: none"> 1. Laceration of the hymen, acute. 2. Ecchymosis (bruising) on the hymen. 3. Peri-anal lacerations extending deep to the external anal sphincter. 4. Hymenal transection (healed). An area where the hymen has been torn through, to the base, so there is no hymenal tissue remaining between the vaginal wall and the fossa or vestibular wall. 5. Absence of hymenal tissue. Wide areas in the posterior (inferior) half of the hymenal rim with an absence of hymenal tissues, extending to the base of the hymen, which is confirmed in the knee-chest position.

Appendix D

Other Resources of The Advisory Board Foundation

Examining the Mandatory Death Penalty for Familial Child Rape Perpetrators, 2001

- A review of the death penalty as applied in cases of familial rape and its affect upon the children and families involved in these cases

Children’s Resource Guide, 1999

- A list of NGOs and GOs that provide assistance for children
- An online version of this guide can be found at www.childprotection.org.ph

The Interpretation and Limits of Medical Evidence in Child Abuse Cases, 1999

- A guide for physicians and legal professionals for interpreting the medical findings of child abuse in a legal setting

CPU Operational Handbook, 1999

- A comprehensive guide to the elements necessary for establishing a Child Protection Unit

A Physician’s Guide to Protecting Child Abuse Patients’ Confidentiality, 1998

- Media policies for physicians to ensure the confidential treatment of child abuse patients

A Physician’s Guide to National Laws Concerning Child Abuse, 1997

- A guide for physicians on the laws that govern their work with abused children

**Any of the above publications may be obtained through contacting
The Advisory Board Foundation at abf@advisory.ngo.ph**

Appendix E

List of Abbreviations

LIST OF ABBREVIATIONS

BCPC	Barangay Council for the Protection of Children
BHRAC	Barangay Human Rights Action Center
CHR	Commission on Human Rights
CPC	Country Program for Children
CPU	Child Protection Unit
CWC	Council for the Welfare of Children
DECS	Department of Education, Culture and Sports
DILG	Department of Interior and Local Government
DOH	Department of Health
DOJ	Department of Justice
DSWD	Department of Social Welfare and Development
ECD	Early Childhood Development
EO	Executive Order
GO	Government Organization
IRR	Implementing Rules and Regulations (for a law)
LGU	Local Government Unit
NBI	National Bureau of Investigation
NGO	Non-Government Organization
PD	Presidential Decree
PGH	Philippine General Hospital
PNP	Philippine National Police
PO	Peoples Organization
RA	Republic Act
SCSPC	Special Committee for the Special Protection of Children (under RA 7610)
SIDS	Sudden Infant Death Syndrome
SSCD	Social Service and Counseling Division (family courts)
VAWC	Violence Against Women and Children Division of the NBI
WCCPC	Women's Crisis and Child Protection Center (PNP)
WCPU	Women and Children's Protection Unit (DOH)

SOME IMPORTANT LAWS AND DECREES

CRC	United Nations Convention on the Rights of the Child
RA 7160	The Local Government Code of 1991
RA 7610	Special Protection of Children Against Child Abuse, Exploitation and Discrimination
RA 8369	Family Courts Act of 1997
RA 8505	Rape Victim Assistance and Prevention Act of 1998
PD 603	The Child and Youth Welfare Code

Appendix F

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