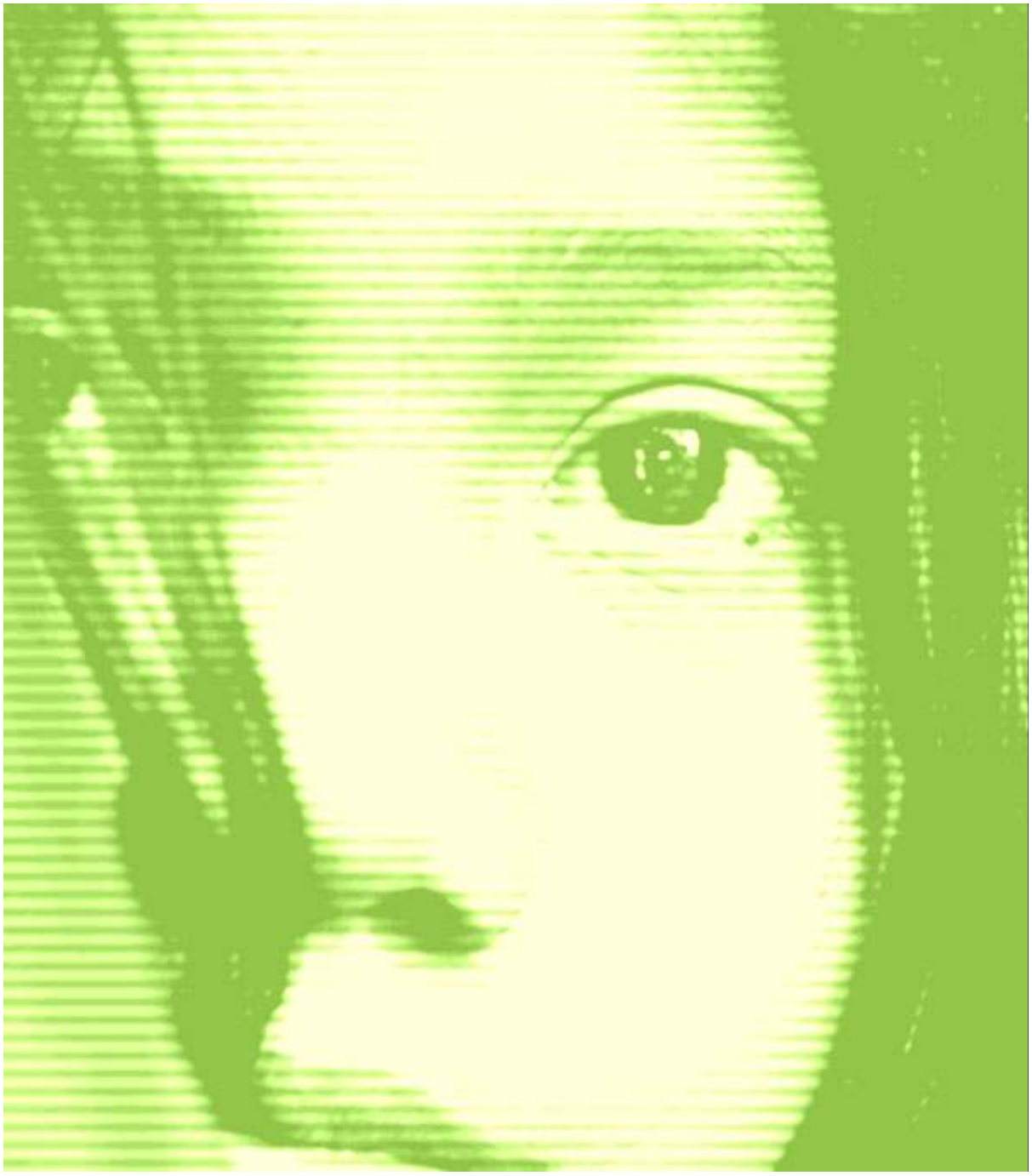
DEPARTMENT OF HEALTH

women & children protection units & health services



DOH

PERFORMANCE STANDARDS AND ASSESSMENT TOOLS FOR SERVICES ADDRESSING VIOLENCE AGAINST WOMEN IN THE PHILIPPINES

PERFORMANCE STANDARDS AND ASSESSMENT TOOLS FOR

women & children protection units (WCPUs)

Department of Health
National Commission on the Role of Filipino Women
United Nations Population Fund
2008

Performance Standards and
Assessment Tool for
Women and Children
Protection Units (WCPUs)

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Acknowledgment

The National Commission on the Role of Filipino Women, in partnership with frontline agencies conceptualized and developed performance standards to serve as indicators for the delivery of anti-VAW services of government agencies and LGUs. Partner agencies are DOJ, PNP, DOH, DILG, DSWD and the LGUs. Each of the performance standards is accompanied by an Assessment Tool. The Assessment Tool, which has the same parameters and indicators as the performance standards, aims to determine the degree that the set standards are adhered to.

The development and finalization of the performance standards for the Women and Children Protection Units (WCPUs) was a result of the concerted efforts of the Department of Health through the National Center for Disease Prevention and Control (NCDPC), the National Commission on the Role of Filipino Women (NCRFW) and some representatives from a few Metro Manila based WCPUs. The development of this tool was assisted by a consultant, Dr. Carolyn Sobritchea of the University of the Philippines Center for Women's Studies. The project was supported by the United Nations Population Fund (UNFPA).

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Acronyms

Agencies/organizations

DILG	Department of the Interior and Local Government
DMC	Davao Medical Center
DOJ	Department of Justice
DOH	Department of Health
DSWD	Department of Social Welfare and Development
EAMC	East Avenue Medical Center
NCRFW	National Commission on the Role of Filipino Women
PGH-CPU	Philippine General Hospital–Child Protection Unit
PNP	Philippine National Police
UNDP	United Nations Development Programme
UNFPA	United Nations Population Fund
UP	University of the Philippines
WCC	Women's Crisis Center
WCCCPU	Women and Children Crisis Care and Protection Unit
WCPD	Women and Children Protection Desk
WCPU	Women and Children Protection Unit

Others

AO	Administrative order
CEDAW	Convention on the Elimination of All Forms of Discrimination Against Women
CRC	Convention on the Rights of the Child
GAD	Gender and development
LGU	Local government unit
PPGD	Philippine Plan for Gender-Responsive Development
RA/IRR	Republic Act/Implementing Rules and Regulations
STI	Sexually transmitted infections
VAW/VAWC	Violence against women/violence against women and children

Executive Summary

Background

As signatory to international conventions and declarations upholding gender equality and women's human rights, the Philippines has passed several laws protecting women from that pervasive but hitherto unrecognized menace – gender-based violence, more specifically violence against women (VAW). As a result, the designated government agencies have begun to put up mechanisms to address VAW. Now the country is taking another step forward -- it has set a benchmark for addressing the problem by establishing performance standards on the delivery of anti-VAW services.

The development of the performance standards is a key component of the project of the National Commission on the Role of Filipino Women (NCRFW), "Strengthening Institutional Mechanisms in Mainstreaming Gender in Reproductive Health, Population and Anti-VAW Programs", funded by the United Nations Population Fund (UNFPA). Five priority agencies with anti-VAW services were enlisted for the first year of implementation – the Philippine National Police (PNP), Department of Social Welfare and Development (DSWD), Department of Health (DOH), Department of Justice (DOJ) and Department of Interior and Local Government (DILG),

Developing the standards took almost a year. Extensive research -- with review of existing literature including agency mandates -- along with fieldwork and consultations preceded the actual drafting. A consultant for each agency was engaged to review protocols and facilities, facilitate the assessment of services rendered to VAW victims/survivors, and draft the performance standards and assessment tools. To validate the consultant's baseline report and the draft standards and tools, focused group discussions were conducted by the NCRFW with the participation of direct service providers from each agency and some local government units (LGUs). The drafts were then endorsed to the individual agencies, through their respective focal persons, for review and adoption.

The result of the painstaking process described is this information package. The package consists of five sets of documents for each of the five service categories, represented by the government agency tasked primarily to render such type of service, as follows:

PNP for investigatory services or procedures
DOH for medical or hospital-based services
DSWD for psychosocial services
DOJ for legal/prosecution services
DILG and the LGUs for anti-VAW services at the barangay, municipal, city and provincial levels

Each set is introduced by an Overview, followed by the Performance Standards and a Baseline Report to put the standards in context. The standards are further recast into an Assessment Tool to guide compliance with the standards as well as generate data for monitoring and evaluation purposes. The data generated is also a tool for prioritization and planning particularly in the use of the GAD budget.

The Overview points out that although one does not have to go far to confirm that VAW is a reality for many Filipino women, official data available on the subject do not present a coherent picture that can be used to formulate more effective responses to the problem. Thus the need for systematized data gathering that would show not only the prevalence but also the nature of VAW cases and the impact in economic and psychosocial terms on individuals, families and the nation.

Benchmark for gender-responsive service

The Performance Standards form the centerpiece of the information package. The standards were developed (1) as a tool for direct service providers to respond effectively to cases of VAW, (2) as a means to gauge the level of compliance with national policies, (3) as basis for generating concrete data needed for program development and policy formulation, and (4) as advocacy tool for protecting women's human rights especially of VAW victims.

The standards specify what gender-responsive service to VAW victims/survivors entails, within the following parameters: policy; physical facilities; personnel; services; monitoring, evaluation and research; information and advocacy; and resources.

Anti-VAW initiatives, unless grounded on policy specific to the issue, are difficult to sustain especially with the persistence of values favoring male dominance and women's subordination. The standards require agencies to institute policies that provide for gender-responsive services to victims/survivors of VAW. This policy should be reflected in the vision, mission and goals of the agency.

The standards on physical facilities specify the structures, equipment and supplies needed to ensure that the confidentiality of VAW cases is maintained, that the required procedures are accomplished without delay, and that the special needs of the victim/survivor are met. Provision is also made for creating an atmosphere where complainants would feel safe and at ease, and not be discouraged from seeking help for their problem.

Enough personnel (and the corresponding plantilla positions) equipped with the right attitudes, ethical practices and habits of work, and trained in gender sensitivity/responsiveness as well as the particular aspects of their work related to the handling of VAW cases, comprise the basic standards on personnel. Other standards cover staff development, stress management activities, and pay incentives, among others.

The test of performance is in the effective delivery of the appropriate services. The standards on services not only detail the interventions needed – many of which are provided for by law, such as some protocols – but also emphasize that these should avoid causing further trauma to the victim/survivor. As with the other parameters, the standards on services seek to protect the privacy of the victim and the confidentiality of the case, and to provide for the victim's special needs. Note should be made of the importance of having a system of referrals to other service providers, since this helps to ensure that clients are given the assistance they need as soon as they need it.

As earlier pointed out, reliable data that would reveal the extent, nature and faces of VAW and provide direction to policy and program responses are currently lacking. Moreover, case monitoring goes a long

way in ensuring that protocols are observed, services are delivered, and VAW cases are given priority. The performance standards on monitoring, research and evaluation provide for such fundamentals as a database of reported cases including client/offender profiles, database on interventions and their outcomes, a feedback mechanism, and a mechanism for monitoring compliance with procedures and protocols.

The prevention of VAW is given emphasis in the standards on information and advocacy, which enjoin awareness raising on women's human rights and VAW-related issues, both with clients and service providers as well as the general public. Budget provision for VAW services and the development of linkages with anti-VAW partners are the focus of the standards on resources.

Legal bases

The performance standards proceed from legal mandates provided by national laws as well as various international conventions and declarations. These legal mandates and the existing services and operations of the agency relating to VAW are presented in the baseline report as the context in which the performance standards were developed.

Among the international instruments that have influenced national policy on the issue of women's human rights and VAW are the Universal Declaration of Human Rights, the Convention on the Elimination of All Forms of Discrimination against Women, the Declaration on the Elimination of Violence against Women and the Beijing Platform for Action. Philippine legislation pursuing these covenants include Republic Act (RA) 9262 (Anti-Violence against Women and their Children Act), RA 9208 (Anti-Trafficking in Persons Act), RA 8353 (Anti-Rape Law) and RA 8505 (Rape Victim's Assistance Act), and RA 7877 (Anti-Sexual Harassment Act). The agencies involved have accordingly come up with administrative issuances to carry out the provisions specific to them.

It may be noted from the discussion of services and operations that agencies have in different degrees started implementing the performance standards, since the protection of women's human rights is implicit in the Constitution and the laws against VAW have been in force for some time. Nonetheless, gaps exist between intended and actual services at the same time that these both fall short of the minimum ideal. Moreover, the mechanisms for systematized data gathering provided for in the standards still have to be put in place.

Making headway

An area where some headway has been made in complying with the legal mandate – apart from the policy-setting required to get things moving-- is the establishment of structures and mechanisms for dealing with VAW cases. For instance, the PNP has a division for women and children complaints and a quick-response unit – the Women Crisis and Child Protection Center (WCCPC) -- at the PNP General Hospital. The Center attends to women and children victims of abuse and violence. PNP has also established the Women and Children Protection Desk (WCPD) in almost all police stations throughout the country.

Categorized into community-based and center-based services, the DSWD's responses to VAW – family violence and maltreatment of children in particular – cover prevention, recovery and after-care. Center-

based services include the operation of residential care facilities throughout the country. In Metro Manila these are Marillac Hills for young women and HAVEN for all VAW victims/survivors including women with children.

The DOJ created a task force on women and children protection and another on anti-trafficking in persons, to handle the preliminary investigation and prosecution of relevant cases. As for the DOH, 44 of 77 DOH-retained hospitals have set up a Women and Children Protection Unit (WCPU) although these are in varying stages of operation.

As legally mandated, protocols for the issuance of barangay protection orders have been established. Functional anti-VAW desks/ centers have been set up in some LGUs.

Assessment tool, user's guide

Where the agency stands in its anti-VAW effort can be readily seen through the Assessment Tool. The five tools are: Investigation and Handling of VAW Cases (PNP), Assessment of a Hospital-Based WCPU (DOH), Assessment of Temporary Shelter or Residential Care Facility (DSWD), Prosecution and Handling of VAW cases (DOJ), and Services Addressing VAW for barangays, municipalities and cities, and provinces and highly urbanized cities.

A User's Guide explains the purpose of the assessment, the parameters and indicators, and the procedure for filling in the form. A scoring system makes it possible for the agency to rate the adequacy of its present anti-VAW efforts in percentage points. Users are also asked to comment on the tool as to clarity, relevance, and others.

The standards have much room for improvement and shall evolve as needs and capabilities change. What is important is that the components of responsive public service – policy mandate, the right perspectives and attitudes, concrete mechanisms and budgetary support, among others – are now in place.

And with such, the outlook for the VAW victim/survivor can finally shift from despair to hopefulness.

Part 1
Overview

Violence against women, or VAW, takes many forms and affects women in varying degrees. But one thing has become clear to those advocating for its eradication – VAW is gender-based, that is, it results from as well as perpetuates male privilege and power. Women, in short, are attacked simply because they are women.

Because male supremacy has been the norm, VAW for a long time was not visible, it remained unnamed. If someone went to the police to report that a man was hitting his wife, the matter would have been dismissed as "away mag-asawa" which police officers would rather not dip their noses into, other than giving the offender a stern reprimand. A male supervisor demanding sexual favors from a female subordinate was likely shrugged off as merely naughty -- the woman should even be flattered by the attention. There was no such thing as date rape, much less marital rape. It took a lot of lobbying to even have certain forms of VAW classified as "crimes against persons."

Despite strides made in consciousness-raising, VAW and the issues surrounding it remain a gray area for most Filipinos. This is seen in the sketchy data on VAW, reflecting not just the reluctance of victims/ survivors to report their situation partly because of ambivalence about the matter, but also the lack of responsive mechanisms – including systematized gathering and processing of data – for dealing with VAW cases.

VAW cases were reported to be mostly wife battering and rape. For the first three quarters of 2005 alone, 4,240 VAW cases were reported to the PNP.

Just the same, a picture comes out from available statistics. The National Commission on the Role of Filipino Women (NCRFW) in a 2005 publication says 2004 records of the Philippine National Police (PNP) show VAW cases reported to be mostly wife battering and rape. For the first three quarters of 2005 alone, 4,240 VAW cases were reported to the PNP.

The same publication notes a sevenfold rise in the number of VAW cases reported to the police from 1996 to 2004 – 1,100 and 7,383 respectively, with the highest number (10,343) reported in 2001. Physical injury cases that include wife battering complaints also went up during 1996 to 2001; however, these declined in 2002-2004. Similarly, rape complaints received by the police, including incestuous rape and attempted rape, climbed from 1996 to 2000 but declined in 2001-2004.

Evidently it is difficult if not impossible to draw conclusions from the available statistics, thus the need to undertake more systematic data gathering as an essential part of the anti-VAW services of each agency involved.

Seen in economic terms, the cost of domestic violence is far from negligible. For the Latin American region, this is 14.2 percent of the gross domestic product representing loss of productivity, medical and legal costs, and the associated stress on families, says the Inter-America Development Bank.

The World Bank in its 1993 annual report has no doubt that VAW retards human development:

- VAW is responsible for one out of every five healthy days of life lost to women of reproductive age. Rape and domestic violence are a major cause of death and disability among these women, and account for 5 percent of healthy years of life lost to women of reproductive age in demographically developing countries.
- The health burden from gender-based victimization among women 15-44 years old is comparable with that from HIV infection, tuberculosis, sepsis during childbirth, cancer and cardiovascular diseases.
- Violence is a risk factor for disease conditions such as sexually transmitted infections (STIs), depression and injuries, which makes women more vulnerable compared with men.

The 1995 Human Development Report of the United Nations Development Programme (UNDP) puts it another way: "If development is meant to widen opportunities for all people, then (the) continuing exclusion of women from many opportunities of life totally warps the process of development… There is no rationale for such continuing exclusion. Women are essential agents of political and economic change."

The Philippine Plan for Gender-Responsive Development (PPGD), 1995-2025, sums up VAW's impact on women: "(It) is in direct contradiction to national and social development goals. It exacts grave consequences on women's lives as individuals, and denies them options… It jeopardizes their health, human rights and capacity to participate, as well as contribute freely in society."

Certainly, much has changed since the concept of VAW – notably sexual victimization and wife battering -- began to take shape with the emergence of the global women's movement in the 1970s. International instruments protecting the human rights of women and children provided the basis for countries like the Philippines to adopt policies establishing VAW as a health, economic and human rights concern. As a result, not only have existing services been re-oriented and enhanced to respond to VAW, ways to address the problem more effectively and systematically continue to be explored.

However, the lack of gender sensitivity in general, combined with such problems as resource lack, operational difficulties and the need for coordinated action against VAW, have prevented agencies from providing more responsive services to VAW victims/survivors, much less mapping out strategies to eliminate VAW.

In 2005, the NCRFW and its primary partner agencies in the anti-VAW effort – the Department of the Interior and Local Government (DILG), Department of Social Welfare and Development (DSWD), Department of Health (DOH), Department of Justice (DOJ) and the Philippine National Police (PNP) – took the concrete step of developing performance standards for the service category they represent, so as to set a benchmark for anti-VAW services. The standards are anchored on international and national instruments promoting women's human rights, in particular the Anti-Violence Against Women and their Children Act of 2004 or Republic Act (RA) 9262 and the Anti-Trafficking in Persons Act of 2003 (RA 9208), along with the Anti-Rape Law (RA 8353) and its twin Rape Victim's Assistance Act (RA 8505).

This landmark step is what this publication is all about. The performance standards, along with the tools for assessing compliance with these standards, are presented for the ready reference primarily of those directly involved in serving victims/survivors. The standards have provision for data gathering and

feedback that are invaluable to developing more effective responses to the VAW issue.

Furthermore, the standards are set against the backdrop of what facilities and services exist for responding to VAW complaints and what problems are encountered. Anti-VAW policies and mandates as found in legislation and administrative issuances are also discussed to substantiate the basis for such standards.

At the least, this publication should eliminate the guesswork that all too frequently hampers effective delivery of services. It should also give specific direction to the anti-VAW effort, and serve as framework for the data gathering that is so vital to obtaining an accurate picture of VAW.

Of the 12 offices of the DOJ, the National Prosecution Service (NPS) has the specific mandate to investigate and prosecute all criminal offenses under the Revised Penal Code and special penal laws. It therefore has the greatest involvement in matters relating to VAW cases and is the primary focus of this report.

In the case of DOH, the analytical framework used for developing the performance standards for Women and Children Protection Units (WCPUs) is the systems approach or simply put the "input-process-output-outcome-impact" paradigm for program development/planning, monitoring and evaluation. Since RA 9262 is recent and hospitals are just beginning to establish their WCPU, this study tried to identify all the "inputs" and "processes" both ideal and actual, which should be put in place to achieve the goal of speedy but high quality response to cases of gender violence. In short, the initial set of performance standards for WCPUs must focus on input and process indicators. In the coming years, once the adequacy of inputs and processes has been achieved, then the performance standards can increasingly move towards the inclusion of output, outcome and impact indicators. However, it is extremely important that a comprehensive evaluation of implementation experiences by the different WCPUs must first be undertaken before outcome- and impact-based performance standards are developed.

For the baseline report, the DOH research team analyzed documents containing criteria for performance assessment, including administrative orders, accomplishment reports, and interview forms and other tools used by service providers. The team also interviewed DOH program officers, and service providers of the Philippine General Hospital (PGH) Child Protection Unit (CPU) and Women's Desk and the East Avenue Hospital WCPU, mainly on the criteria for monitoring and evaluating the WCPUs and the policies and mechanisms for setting performance standards. Participatory development of the broad criteria and relevant indicators for each criterion for assessing the performance standards of WCPU was done at the first meeting with partners in September 2005.

Part 2

The Performance Standards

The main purpose in developing a set of standards for the delivery of hospital-based services for women and children who survive acts of violence is to ensure that the needs of these survivors are attended to promptly and effectively. This will ultimately contribute to the realization of the country's goal of eliminating all forms of gender-based violence and promoting social justice. For the victims-survivors, the presence of high-quality service facilities will help them heal faster, recover from the trauma, and return to normal life.

Characteristics of a gender-responsive and child-friendly WCPU

Given the requirements of the law and current health and medical standards for the medical treatment and psycho-social recovery of VAW victims-survivors, all hospital-based WCPUs in the Philippines must have the following features:

A. Policy mandate

The establishment, operation and maintenance of the WCPU is based on a policy passed by the highest governing body of the hospital. Its vision, mission and scope of work is in accordance with the provisions of international and national laws as well as the administrative guidelines of the DOH.

- The WCPU is operating in accordance with RA 9262 and its IRR, and Administrative Order (AO) No. 1-B of the DOH.
- The DOH has a policy for the training of hospital personnel who can backstop and/or replace current WCPU service providers.

B. Physical space and arrangement

- The WCPU is located near the emergency room of the hospital and has two doors – entrance and exit – for the safety and security of clients.
- The Unit is spacious enough to accommodate all the services provided by the facility. To ensure privacy, there is a separate room for interviews and crisis counseling as well as medical examination.
- It has a reception area spacious enough to accommodate those waiting to be served including their companions. The reception area must have culture- and gender-sensitive information materials on VAW.
- The premises include a playroom for children with small chairs and tables and toys.

- There is adequate space for filing cabinets and other furniture/equipment that will ensure the security and confidentiality of files and records.

- The WCPU has its own toilet or comfort room or is near one.

- The Unit has the following fixtures:
  - » examination couch
  - » desk and chairs
  - » washing facilities with clean running water
  - » light source, and
  - » telephone line.

- Non-traumatizing supplies and equipment for medical examination are readily available. These include:
  - » a colposcope or digital camera (optional)
  - » video camera for recording the forensic interview (optional)
  - » rape kit
  - » speculum of different sizes
  - » blood tubes
  - » syringes, needles and sterile swabs
  - » tourniquet
  - » examination gloves
  - » pregnancy testing kits
  - » microscope slides
  - » measuring devices like rulers and calipers
  - » urine specimen containers
  - » plastic bags
  - » tweezers, scissors, comb
  - » sheets and blankets
  - » towels
  - » patient gowns
  - » sanitary items
  - » pens and pencils
  - » basic items like analgesics and medicines for STI prophylaxis
  - » labels, and
  - » consent form.

C. Personnel

C.1. Available personnel. The WCPU has trained and competent service providers, including at least one on call obstetrician-gynecologist, one pediatrician, a nurse, a psychiatrist/psychologist/counselor, and a social worker.

C.2. Attitudes, ethical practices, habits of work. WCPU service providers have the right attitude about their work and towards their clients. They follow the ethical guidelines of working in the best

interest of VAW victims/survivors and making sure that these are protected at all times from all kinds of harm. WCPU personnel possess the following qualities:

- Accepting and non-judgmental
- Sensitive and sincere
- Patient and understanding
- Observe confidentiality
- Show firm commitment to end VAW

C.3. Training. As relevant to their specialization, personnel are trained in the principles and methods of gender-sensitive medical and health care and treatment, in crisis and long-term counseling and support, in investigative interview techniques and in the collection of forensic evidence. They are familiar with the laws related to the handling of VAW cases.

The following training packages can adequately provide the skills and knowledge needed to operate a WCPU:

- Basic skills in gender-sensitive delivery of health services
  - » health care principles and methods
  - » crisis counseling
  - » forensic specimen collection/skills development on evidence collection and preservation (minimum of 10 hours)
  - » interviewing for collection of forensic evidence
  - » woman- and child-sensitive communication/interview techniques and methods of investigation

- Basic training on the VAW issue (minimum of 30 hours)
  - » gender analysis of the nature, extent and causes of VAWC
  - » analysis of the different forms of VAWC
  - » power dynamics
  - » gender sensitivity training

- Gender-sensitive crisis intervention (minimum of 30 hours)
  - » crisis theory in the context of VAWC
  - » crisis intervention in the context of VAWC
  - » networking
  - » qualities of a gender-sensitive service provider

- Medical and legal literacy related to VAWC (minimum of 30 hours)
  - » laws on women and children
  - » procedures
  - » basic medico-legal information

- Self-care training (minimum of 15 hours)
  - » stress management and stress management techniques

C.4. Continuing staff development. The WCPU undertakes continuous capacity building of its service providers. This is done through in-house training, participation in scientific conferences or short-term training programs here and abroad, and interagency meetings. Debriefing sessions are also held regularly to respond to the emotional needs of the service providers.

D. Services

D.1. Services. For a victim/survivor of gender violence to recover and to be able to seek justice, she must be provided with a wide array of interventions. The following services are available at the WCPU:

- medical examination and treatment
- laboratory tests
- issuance of medical certificate
- forensic interview
- crisis counseling
- mental/psychiatric care if needed
- provision of food, transportation, and medicine
- home visit
- surgery if needed
- other medical services
- court testimony

These services may be supplemented by the WCPU with social, economic, legal, police and related forms of assistance, either using its own resources or through a referral system. For the social services, the WCPU may provide such assistance as risk assessment and management, home visits for continued support of the client, livelihood assistance, educational support, parenting classes, and the formation of support groups for the clients and their family members. Case conferences involving all the service providers is a regular activity of all WCPUs.

D.2. Service procedures and protocols. The WCPU has a well-designed set of guidelines describing the processes or procedures which the victim and accompanying family members or guardians will have to undergo while in the care of the facility.

It has a protocol or set of ethical guidelines for doing interviews, medical examinations and other interventions. All the forms or questionnaires needed for the interviews and the documentation of cases are on hand.

The norms of gender sensitivity, a non-judgmental approach and a caring attitude underlie the relationship of all service providers with their clients. Conscientiousness about maintaining the confidentiality of sensitive information including the client's identity is also paramount. Not the least, service providers are willing and prepared to testify in court if necessary.

RA 9262 and the DOH through AO No. 1997 1-B require that the facility is open for 24 hours and that the consent of the victims and/or legal guardians (not implicated in the cases as the perpetrator) is sought before any service is provided. The timing of the service provided is very critical especially

for the physical examination, collection of forensic evidence and crisis counseling. But this is always dictated by what is best for the client, given her overall physical and emotional condition.

D. 3. Referral system/linkages. The WCPU maintains at all times a system for referring cases to other service units of government and the private sector, including the NGOs providing special services for VAW victims/survivors.

The important referral links include legal and paralegal assistance, police support, shelter (short- and long-term), and financial as well as livelihood support. Additionally, the service providers are linked with the various professional organizations (i.e. association of psychiatrists, social workers, physicians) for access to new approaches and information on VAWC interventions. The referral system is fully operational at all times. The list of collaborating organizations is updated regularly, and the cooperation agreements with them reviewed and strengthened periodically.

E. Monitoring, evaluation and research

The WCPU operates and maintains a database system not only for the safe and secure storage of records but also for the easy retrieval and processing of data for case conferences, case management, service performance review and for planning and program evaluation and improvement.
The database includes the profiles of the client and the perpetrator, the services provided and the results of the interventions. Service providers are able to use the data system readily to do research or studies that can enhance the work of the facility.

The WCPU maintains an efficient system of monitoring the performance of personnel and the status of clients. This is done through regular case management meetings. An effective database can generate adequate information to assess the effectiveness of WCPU services and their results and impacts.

F. Information and advocacy

The prevention of all forms of gender violence and the elimination of all instances of VAW is the most strategic component of the WCPU service package. The WCPU sees to it that easy-to-read, culture- and gender-sensitive information materials are made available to clients and their families. It ensures that awareness raising on VAW is done through the psycho-social services extended to the clients and the caring and concern shown to them, as well as through participation in advocacy activities and the holding of orientation seminars on the WCPU for other hospital personnel. The WCPU vision, mission and goals and policy guidelines are displayed prominently in the unit for easy reading by clients and as a constant reminder for WCPU personnel.

G. Financial resources, top-level management support

The WCPU has the full support of management, which translates into the continuous provision of financial and technical resources as well as development of enabling operational policies such as the allocation of a certain portion of the GAD budget (Section 64 of RA 9262) for the use of the facility. Management also facilitates the holding of gender sensitivity seminars and other skills enhancement workshops for WCPU health care providers and other hospital personnel.

Part 3

The Assessment Tool for WCPUS

The benchmark assessment tool for WCPUs translates the performance standards into a questionnaire format. It includes the parameter and indicators for determining the level of services provided: policy-related, physical facilities, personnel, resources, protocols, policy support, services and programs, information and advocacy, and monitoring and evaluation. The assessment tool is preceded by a User's Guide. Since the tool are self administered, the Guide will help the respondent answer each question more clearly. It also describes how the responses will be used in determining the level of services of each WCPU.

The User's Guide

Introduction

The Philippines is a state signatory to several international agreements, instruments and covenants that recognize basic women and children's rights. A state-party is mandated to institute and create internal mechanisms under its authority to enhance recognition of said rights through the passage of laws, rules and regulations aligned with international instruments and covenants. Based on these laws, administrative institutions are directed to craft positive and forward-looking responses to further address concerns on violence against women and children.

The National Commission on the Role of Filipino Women, in partnership with frontline agencies conceptualized and developed performance standards to serve as indicators for the delivery of anti-VAW services of government agencies and LGUs.

Partner agencies are DOJ, PNP, DOH, DILG, DSWD and the LGUs. Each of the performance standards is accompanied by an Assessment Tool. The Assessment Tool, which has the same parameters and indicators as the performance standards, aims to determine the degree that the set standards are adhered to.

Purpose of the assessment

A baseline application of the Assessment Tool was initially administered to partners in 2006 to serve as a basis for comparing improvements in services for VAW victims over time. A second administration of the Tool is expected to be done two-years after the initial baseline application and periodically thereafter.

Assessment will determine the adequacy and responsiveness of programs and services for victims of violence by concerned agencies and local government units. Results will inform planning, policy or program interventions required to meet the standards. Planned activities to achieve the standards could be included in the preparation of the agencies/LGU's/facility's GAD plan and budget.

The assessment tool

The assessment tool measures the extent of achievement of the performance standards set for government agencies providing services to victims of violence against women (VAW). The tool is one of a set of five different but parallel assessment tools intended for various services for victims provided by government agencies and local government units: a) medical/hospital-based services through the Women and Children Protection Units (WCPUs) in DOH-retained or supervised hospitals; b) psychosocial services through residential and community based facilities supervised or accredited by DSWD; c) investigation of cases of VAW conducted by the Philippine National Police; d) filing and prosecution services of VAW cases undertaken by the Department of Justice; and e) services provided by local government units at provincial down to barangay level.

The Assessment Tool is meant to be self-administered. The respondent can complete the questionnaire when convenient, work at his or her own pace and clarify certain information appearing to be confusing or vague. Additional information may be sought through research or further inquiry.

The accompanying User's Guide includes easy to follow instructions to guide the respondent/s in providing specific responses to the questions. It is also generic, i.e., it will be used for all the four assessment tools (excluding the DSWD's standard which has its own set of guidelines).

The assessment focus

Each of the performance standards has a corresponding assessment tool; one for each type of service for VAW victims mentioned above. Each tool specifies the parameters and indicators per service type.

The parameters include:

1. POLICY – the existence of a policy that articulates the legal or administrative basis, purpose and guidelines in providing the services to victims of violence;

2. PHYSICAL FACILITIES - the presence, quality and appropriateness of physical facilities used in the provision of services;

3. PERSONNEL - the presence or availability of competent service providers;

4. SERVICES - the presence or availability of services required, clear procedures and protocols and referral system;

5. MONITORING and EVALUATION SYSTEM - presence of a monitoring and evaluation system particularly the maintenance of a data base on case served;

6. ADVOCACY and INFORMATION - presence of advocacy and information materials on VAW, including leaflets, flowcharts, charts and other information materials that explain the services and ensure that service providers and clients understand and are able to execute proper procedures; and

7. RESOURCES - the presence and sustainability of resources, especially financial resources that ensure continuing provision of responsive service for victims.

Procedures in answering the tool

1. Respondent selection criteria. The assessment tool is self-administered. This means that all information shall come from the agency/LGU/facility representative tasked to answer the tool. This person should thus have a comprehensive knowledge of and is directly involved in the provision of services to victims/survivors in such capacity as supervisor, technical level officer, coordinator, etc, and/or has direct access to information or to persons in the best position to answer the questions. As needed, the respondent shall consult with other personnel in the best position to provide the most accurate and reliable information.

2. Before answering, respondent should read through the information requested by the tool and obtain relevant documents or references to answer the questions substantively and accurately. For instance, to answer the indicators in the first parameter (policy-related), the agency or facility's enabling policy should be available for review. For questions related to training, agency or facility records on training attended by service providers should be retrieved for reference. The respondent is given a period of one to two weeks to complete the assessment tool.

3. Fill in the information on name of agency, unit or facility being assessed as well as details about the respondent's name, position and contact numbers.

4. The tool consists of 7 columns:

   Column 1: Main parameters for assessment;
   Column 2-3 Indicators pertaining to the parameters;
   Column 4-6: Modes of responses to each indicator;
   Column 7: Remarks or additional information to further explain the answer.

5. Answer each indicator according to the 3 modes of responses:

   Yes – if respondent believes and has sufficient information and evidence to prove that the agency already ***fully complies*** with what is being asked;

   Partly – if respondent believes and has sufficient information and evidence to prove that the agency ***in some degree already complies*** with what is being asked;

   No – if respondent believes and has sufficient information and evidence to prove that the agency ***has not complied*** in any degree to what is being asked.

   In case where trainings or skills of service provider is concerned, a "Yes" response means that ***all*** officers/personnel have the required skills; "Partly" means that ***not all or only some*** officers/personnel have the required skill or training; and "No" means ***no one*** of the service providers has any of the required skill or training.

6. Whether the answer is **Yes**, **No** or **Partly**, use Column 6 to explain the answers or provide details. For example, for training undertaken by service providers, please provide names of trained service providers, title of training, duration and trainer. If the answer is "Partly" to the indicator on "presence of a separate room for interviewing", respondent can add, for example, that the room is also used as meeting room and is not always available for use. Use additional sheets if necessary to substantiate responses.

   The local IACATVAWC may also spearhead the assessment of the VAW services using the tools and may follow a time frame for conducting the assessment. Assessment is an evolving and enabling process. The conduct of the assessment shall be made at regular intervals every three to four years. At the initial stage or on the first year of the implementation of the assessment tool, dissemination of the tool and assessment may be conducted for an estimated period of four (4) months from the time of the implementation. A period of one to two weeks shall be allotted to the respondents for completion of the tool. Review and validation of the data shall be made within the first and second months after receipt of completed forms. Report preparation and eventual presentation to stakeholders of the results of the data shall be made within the year.

   Once an assessment tool is completed and submitted it shall undergo the following processes:

   a. Review of the completed assessment tools;
   b. Assessment tools that appear to be confusing, vague and unsubstantiated shall be validated.
   c. Validation will mean contacting the respondents, requesting for additional information and as needed visiting the area to substantiate or clarify responses.

For the succeeding assessment (or at least once every 3-4 years), the same procedure will be followed, taking into consideration the experience or lessons learned from the initial application. Assessment will be made until full compliance is achieved of the set performance standards by line agencies and LGUs involved in providing services for VAW victims.

Weight and scoring of responses

The parameters and indicators are considered as minimum requirements for an adequate and responsive service delivery for victims/survivors of VAW. They are thus given equal weights. This means that the 7 parameters are given equal points of 14.29% each to total 100%. Scoring shall be as follows:

Yes - 1 point
Partly - .5 points
No - 0 points

Maximum number of points corresponds to the number of indicators per tool. For each government agency, the number of indicators varies per set parameter. The computation of the rating is hereby represented in the following formula:

Aggregate points obtained

Maximum no. of points x 14.29 = Weighted score

Total of all weighted scores= Rating

The total score is the sum of all "YES" and "PARTLY" answers. Compute rating by dividing the total score by the maximum number of points obtained per parameter. For example: Total raw score- 20/33=.61 x 14.29%=8.72 is the weighted score. The weighted scores of the 7 parameters are then added up to obtain the rating. The rating description is found below.

Rating	Description	What this means
90-100% of maximum points	Almost full compliance with standards: Outstanding	Full compliance opens new areas for innovation and further enhancement of services; basis for replication and for raising the level of standards
80.-89.99%	Very satisfactory	Opportunities for fine tuning of services towards full compliance
70-79.99%	Satisfactory	Vast opportunities for improvement; basis in proposing programs and projects for funding from the GAD budget
50-69.99%	Promising	
Below 50%	Needs strengthening	

(Weighting of scores will be considered in view of the different expectations on agencies/LGUs. For example, since LGUs are expected to be strong on service delivery, more weights may be assigned to parameters and indicators on services)

Discussion of results

The framework of the discussion and analysis of results will be along identifying gaps in implementation with the end view of upgrading or standardizing programs and services. After the review and validation of the responses, assessment results should be discussed with the agency/LGU/facility. Possible action proposals, on an annual basis will be prepared and discussed to address identified gaps and to gradually move towards meeting the standards. These proposals may be incorporated in the agencies/LGU's GAD plan and budget.

Once agency/LGU concurs with the results, observations and recommendations, a summary report will be submitted to the national and local interagency councils on violence against women and their children (IACVAWC) and interagency councils against trafficking (IACAT).

On the whole, the results of this assessment will be used to-

1. identify the strong and weak points in the provision of services for victims
2. provide a basis in planning gender responsive programs and in prioritizing resources to meet the standards; and

3. serve as basis in improving or raising existing standards
4. promote and ensure more standardized and reliable services for victims of violence throughout the country.

Comments on the tool

Since this tool will be administered periodically, it will be continuously improved to increase its effectiveness in measuring the level of services for victims. The respondent is thus requested to express general or specific comments on the tool and on the experience gained in answering it. Respondent is encouraged to provide a specific comment if an indicator is unclear, too broad, or it is difficult to provide a simple "yes", "no" or "partly" response. If an indicator is irrelevant, unnecessary, or if the respondent wants to suggest an alternative indicator, etc. use the space provided for remarks, or separate a sheet(s) as needed.

ASSESSMENT TOOL FOR VAW-RELATED SERVICES
ASSESSMENT OF A HOSPITAL-BASED WCPU

Name of Hospital/WCPU: _____ Name of respondent: _____
Address: _____ Position_____ Contact number/s:_____

PARAMETERS	I#	INDICATORS[a]	Yes	Partly	No	Remarks
A. POLICY- RELATED	A.1	WCPU is operating in accordance with RA 9262 (Anti-Violence Against Women and their Children Act of 2004) and AO No. 1-B of DOH.				
N= 2	A.2	Agency has a policy for the training of hospital personnel who can backstop and/or replace current WCPU service providers.				
B. PHYSICAL FACILITIES **N=33**	B.1	WCPU clinic is located near the emergency room and has 2 doors (entrance & exit) for the safety needs of clients.				
	B.2	There is a separate room for interviews and crisis counseling, equipped with tables and chairs.				
	B.3	There is a children-friendly area with small chairs, tables, toys.				
	B.4	There is a comfortable reception area that can accommodate clients along with some of their family and friends.				
	B.5	WCPU has the following fixtures: ▪ Examination table				
	B.6	▪ Desk and chairs[a]				
	B.7	▪ Washing facilities and toilet with clean running water[a]				
	B.8	▪ Light source[a]				
	B.9	▪ Telephone line[a]				
	B.10	The Unit uses non-traumatizing medical examination equipment and general medical items for diagnosis and evidence collection ▪ Colposcope or digital camera (optional)				
	B.11	▪ Video camera for recording the forensic interview (optional)				
	B.12	▪ Rape kit (optional)				
	B.13	▪ Speculum, different sizes				
	B.14	▪ Blood tubes[a]				
	B.15	▪ Syringes, needles and sterile swabs[a]				
	B.16	▪ Tourniquet[a]				
	B.17	▪ Examination gloves[a]				
	B.18	▪ Pregnancy testing kits[a]				
	B.19	▪ Microscope slides[a]				
	B.20	▪ Measuring devices like rulers and calipers[a]				

[a] *Items with [a] are considered by WHO as essential for providing minimum level of service for victims of sexual violence (WHO Guidelines for Medico-Legal Care for Victims of Sexual Violence, 2003, p.25.*

PARAMETERS	I#	INDICATORS[a]	Yes	Partly	No	Remarks
	B.21	▪ Urine specimen containers[a]				
	B.22	▪ Plastic bags[a]				
	B.23	▪ Tweezers, scissors, comb[a]				
	B.24	▪ Sheets and blankets[a]				
	B.25	▪ Towels [a]				
	B.26	▪ Patient gowns[a]				
	B.27	▪ Sanitary items[a]				
	B.28	▪ Pens and pencils[a]				
	B.29	▪ Basic treatment items like analgesics, medicines for STI prophylaxis				
	B.30	▪ Labels[a]				
	B.31	▪ Consent form[a]				
	B.32	▪ Examination record[a]				
	B.33	Confidential files and records are stored in a secure place				
C. PERSONNEL N= 28 **C.1. Available personnel**	C.1	The following personnel are present/available: ▪ Obstetrician-gynecologist				
	C.2	▪ Pediatrician				
	C.3	▪ Nurse				
	C.4	▪ Social worker				
	C.5	▪ Crisis counselor, psychiatrist or psychologist				
C.2. Attitudes, ethical practices and habits of work	C.6	Personnel possess the following attitudes, ethics and habits of work: ▪ Accepting and non-judgmental				
	C.7	▪ Sensitive and sincere				
	C.8	▪ Patient and understanding				
	C.9	▪ Firmly committed to ending VAW and becoming an advocate for change				
	C.10	▪ Mindful about observing and safeguarding confidentiality				
	C.11	▪ Aware of and caring about one's self and needs as a human being				
C.3. Training **C.3.1. Basic training on forensic evidence collection**	C.12	Personnel have undergone training in the following: ▪ Forensic specimen collection/skills development on evidence collection and preservation (minimum of 10 hrs)				
	C.13	▪ Interviewing for collection of forensic evidence				
	C.14	▪ Investigative/interview techniques, ways of communicating that are child/woman-sensitive				

PARAMETERS	I#	INDICATORS[a]	Yes	Partly	No	Remarks
C.3.2. Basic training on VAW	C.15	Personnel have undergone basic VAW training (30 hours minimum) in such fields as: ▪ Gender analysis with focus on the nature, extent and causes of VAW				
	C.16	▪ Analysis of different forms of VAW				
	C.17	▪ Gender sensitivity training				
C.3.3. Gender-sensitive crisis intervention	C.18	Personnel have undergone training (30 hours minimum) in gender-sensitive approaches to crisis intervention, specifically: ▪ Crisis theory in the context of VAW				
	C.19	▪ Crisis intervention in the context of VAW				
	C.20	▪ Networking				
	C.21	▪ Qualities of a gender-sensitive service provider				
C.3.4. Medical and legal literacy related to VAWC	C.22	Personnel have undergone literacy training (30 hours minimum) on: ▪ laws on women and children,				
	C.23	▪ procedures, and				
	C.24	▪ basic medico-legal information.				
C.3.5. Self-care training	C.25	Personnel have undergone self-care training (30 hours minimum) on the principles and techniques of stress management.				
C. 4. Continuing staff development and debriefing sessions	C.26	There is a program for continuing staff development such as: ▪ In-house training or lectures (provided by hospital physicians, nurses, social workers)				
	C.27	▪ Participation in seminars and conferences organized by other groups, local and foreign				
	C.28	▪ Participation in debriefing sessions				
D. SERVICES **N=28** **D.1. Available services**	D.1	The following services are available: ▪ Medical examination and treatment				
	D.2	▪ Laboratory tests				
	D.3	▪ Issuance of medical certificate				
	D.4	▪ Forensic interview				
	D.5	▪ Crisis counseling				
	D.6	▪ Mental health/ psychiatric care				
	D.7	▪ Provision of food, transportation and medicine				
	D.8	▪ Home visit				
	D.9	▪ Surgery				
	D.10	▪ Other medical treatment				
	D.11	▪ Court testimony				

PARAMETERS	I#	INDICATORS[a]	Yes	Partly	No	Remarks
D.2. Service procedures and protocols	D.12	The following service procedures and protocols are observed: ▪ Consent for medical examination and related services is always sought (with consent form).				
	D.13	▪ Patients are informed of their rights and options to enable them to make an informed choice.				
	D.14	▪ Services are available round-the-clock.				
	D.15	▪ Multidisciplinary management, assessment, and monitoring of cases is undertaken.				
	D.16	▪ There are procedures for assessing the safety of patients.				
	D.17	▪ There are procedures for ensuring confidentiality of cases, anonymity of patients.				
	D.18	▪ There are procedures for providing assistance in court trials.				
D.3. Referral system/linkages	D.19	There is a referral service for the following: ▪ Legal and paralegal assistance				
	D.20	▪ Police assistance				
	D.21	▪ Shelter care (short-term); residential care (long-term) by DSWD				
	D.22	▪ Support of barangay officials				
	D.23	▪ Financial support through the social welfare program of the hospital				
	D.24	▪ Psychological/psychiatric services				
	D.25	▪ Other medical services not available in the hospital				
	D.26	▪ Participation in consultation meetings organized by DOH				
	D.27	▪ Links with NGOs/civic groups for supplemental support for clients				
	D.28	▪ Links with LGUs for supplemental support for clients				
E. Monitoring, evaluation and research **N=11** **E.1. Database of cases**	E.1	Database on cases includes data ▪ on patients,				
	E.2	▪ on perpetrator,				
	E.3	▪ on interventions, and				
	E.4	▪ on outcomes.				
	E.5	Intake forms are always available.				
E.2. System of monitoring of cases	E.6	There is a system for monitoring cases through ▪ home visits,				
	E.7	▪ case conferences, and				
	E.8	▪ consultation with partner/referral agencies.				
	E.9	Data are submitted to concerned agencies.				

PARAMETERS	I#	INDICATORS[a]	Yes	Partly	No	Remarks
E.3. Data use	E.10	Data are analyzed and used for policy and program development/improvement.				
E.4. Feedback mechanism	E.11	There is a mechanism for getting feedback from patients and other partners.				
F. INFORMATION AND ADVOCACY N=5	F.1	VAWC-related materials are found in the reception area and other appropriate places in the WCPU and the hospital.				
	F.2	The WCPU vision, mission, goals and policy guidelines are prominently displayed in a place within the unit for easy reading and referral of personnel and clients.				
	F.3	There is an operational advocacy program for VAWC prevention.				
	F.4	IEC materials are developed, printed and distributed.				
	F.5	Orientation seminars about the WCPU are held for other hospital personnel.				
G. FINANCIAL RESOURCES N=2	G.1	Financial resource/budget is adequate to ensure sustainability of the services.				
	G.2	WCPU expenses are part of the regular agency budget.				

Comments on the Assessment Tool:

Part 4

The Baseline Report

Legal Bases for Setting Performance Standards

International instruments

The criteria used in developing the performance standards for hospital-based WCPUs in the country come from international human rights instruments — the Convention on the Elimination of Discrimination Against Women (CEDAW) ratified by the Philippines in l981, and the Convention on the Rights of the Child (CRC) ratified in l990, among others. The right to health, security and safety are also mentioned in Article 25 of the Universal Declaration on Human Rights, Article 8 of the Declaration on the Right to Development, and Article 12 of the International Convention on Economic, Social and Cultural Rights.

Both the CEDAW and the CRC affirm that human rights are indivisible and interdependent. They are guided by broad concepts of human rights that go beyond civil and political rights and include core issues of economic survival, health education and the environment that affect the quality and daily life of women and children. Both instruments affirm the right to protection from battery and sexual abuse, including sexual trafficking. They call on State Parties to protect women and children from traditional practices that are inimical to their well-being.

The Declaration on the Elimination of Violence against Women was adopted by the United Nations General Assembly in l993. Article 1 defines "violence against women" as "any act of gender-based violence that results in, or is likely to result in, physical, sexual or psychological harm or suffering to women, including threats of such acts, coercion or arbitrary deprivation of liberty, whether occurring in public or in private life." Article 2 states that violence against women shall be understood to encompass, but not be limited to the following:

1. Physical, sexual and psychological violence occurring in the family, including battering, sexual abuse of female children in the household, dowry-related violence, marital rape, female genital mutilation and other traditional practices harmful to women, non-spousal violence and violence relating to exploitation

2. Physical, sexual and psychological violence occurring within the general community, including rape, sexual abuse, sexual harassment and intimidation at work, in educational institutions and elsewhere, trafficking in women and forced prostitution

3. Physical, sexual and psychological violence perpetrated or condoned by the State, wherever it occurs

The rights-based approach to human development focuses on the rights of holders and obligations of duty bearers. The rights holders are all the people – women and men, children, adolescents and adults

of all nationalities, ethnic background and social classes. Their responsibilities "include respecting and defending the rights of others, seeking the well-being of all, the support of justice and equality for all." (United Nations, Philippines 2002) The duty bearers, on the other hand, are those tasked to uphold the law and provide services in the most effective and efficient way. The normative contents of the right to health include:

1. **Availability.** This refers to the presence of health facilities, goods and services, their quantity and location, how sufficient are these for the population. For example, are there enough medicines? Are there enough doctors, nurses, midwives, health professionals?

2. **Accessibility.** This involves four aspects:

    a. **Non-discrimination.** Health facilities, goods and services must be accessible to all, especially the most vulnerable and marginalized.

    b. **Physical accessibility.** People must have safe physical access to a health center adequately equipped with health professionals, medicine and supplies. Provision should also be made for persons with disabilities to have access to the building and facilities.

    c. **Economic accessibility.** Health services including hospitalization, check-ups, medicine, etc. must be affordable. The cost of health care should be based on the principle of equity -- that poorer households should not be disproportionately burdened with health expenses compared with richer households.

    d. **Information accessibility.** The right to seek, receive and impart information and ideas concerning health issues must be upheld. The government is duty-bound, for instance, to disclose anything that could cause illness or a disease outbreak among the populace, and to carry out the necessary information campaign as part of its effort to deal with the problem.

3. **Acceptability.** All health facilities, goods and services must be respectful of medical ethics and culturally appropriate. This norm involves recognizing traditional alternative forms of medicine and health practices that do not cause harm. This also refers to being sensitive to people of different life cycles and gender, religious and cultural communities, and acceptance of indigenous or alternative health practices. Information programs should be so designed as to be more readily understood and appreciated by their target audience.

4.. **Quality.** Health facilities, goods and services must be scientifically and medically appropriate and of good quality. In the Philippines, it is the Professional Regulatory Board that sets the standards on the quality of nursing staff and health service professionals. The issue of waivers for a hospital's non-accountability for services has often been raised, although so far there has been no Philippine legislation on the issue. [1]

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1 Source: United Nations Philippines. 2002. *Rights-Based Development: Training Manual, pages 45-46.*

State obligations to eliminate gender-based violence

The tasks and responsibilities of government units with regard to the handling of VAW cases are well-defined by existing laws and enabling agency-level policies such as administrative orders. The Philippine government has passed a number of laws. These include the Anti-Violence Against Women and their Children Act of 2004 (RA 9262), the Anti-Trafficking in Persons Act of 2003 (RA 9208), the Anti-Rape Law (RA 8353) and the Rape Victim's Assistance Act (RA 8505). RA 7610 or the anti-child abuse law gives a comprehensive definition of child abuse and requires the creation of a comprehensive program to protect children from all forms of maltreatment, exploitation and discrimination.

Section 40 of RA 9262 specifies that the WCPU in DOH-retained hospitals or those managed by local government units (LGUs) or other government facilities shall provide the following health programs and services through a socialized scheme:

- Complete physical and medical examination
- Medical/surgical treatment
- Psychological and psychiatric evaluation and treatment
- Hospital confinement when necessary
- Referral to specialty hospital and other concerned agency, as needed
- Management of the reproductive health concerns of victims/survivors of VAWC
- If necessary, emergency assistance to the woman and her child/children, by contacting the DSWD or social worker of the LGU or the desk officer for people and children concerns protection.

The duties and functions of the health care providers, under the law, shall include, but not be limited to an attending physician, nurse, clinician, barangay health worker, therapist or counselor (Section 49). Case management shall include the following tasks:

- Properly document any of the victim/survivor's physical, emotional or psychological injuries; record her observations and any complaints she might have, as well as her emotional or psychological state; and note down the circumstances of the examination or visit.
- Automatically provide the victim/survivor, free of charge, a doctor's certificate concerning the examination or visit to the public hospital/clinic/rural health unit.
- Safeguard the records and make them available to the victim/survivor upon request, at actual cost.
- Provide the victim/survivor immediate and adequate notice of rights and remedies provided under RA 9262, and the services available to them.
- Provide emergency care.

DOH Guidelines

The specific policy that sets the standards for the establishment of WCPUs in all DOH-retained hospitals is AO No. 1-B. Passed in l997, this AO spells out the goal, objectives, components and institutional arrangements of the WCPUs.

The goal of the WCPU is "to provide holistic, gender-sensitive health care for women and children who are victims and survivors of violence." Among its objectives are the following:

1. To ensure that women and children treated at DOH hospitals for injuries due to violence are treated with utmost care, concern and understanding

2. To create and sustain an environment within the hospital setting that is sensitive and friendly to women and children

3. To develop a systematic, gender-sensitive documentation and monitoring system

4. To coordinate with other government and non-government institutions and organizations for a more organized approach to addressing other non-medical needs of victims and survivors of violence

The AO specifies that the problem of violence against women and children requires a multidisciplinary approach and must, therefore, have the following components: (1) medical, surgical, psychological and other health services; (2) a networking and referral mechanism; (3) basic and continuing training of service providers; (4) research for policy and program development; and (5) information dissemination and advocacy.

The basic requirements for the medical, surgical, psychological and other health services include (1) a 24-hour personalized care and service; (2) a holding and processing area for victims and survivors of violence; (3) a standard of patient's flow and clinical protocol for interviewing, physical examination and management; and (4) a gender-sensitive recording system that ensures utmost confidentiality.

In consonance with the aforementioned legal requirements, health, medical as well as social work professionals in the Philippines are required to follow a set of ethical guidelines or codes of conduct. This is based on the basic principle of doing "good" and upholding the best interest of their clients or patients. The World Health Organization (2003) asserts that the ethical principles that must guide the provision of services and care for victims and survivors of gender-based violence include the following:

1. **Autonomy.** The right of patients (or in the case of patients under 18 years of age, individuals acting for the child, i.e. parents or guardians) to make decisions on their own behalf. All steps must be taken to provide services that are based on the informed consent of the client and her/his legal non-abusive guardian.

2. **Beneficence**. The duty or obligation to act in the best interests of the patient. The medical, health, legal and other service professions have their specific guidelines in assessing what is in the best interest of a client

3. **Non-maleficence.** The duty or obligation to avoid causing harm to the client.

4. **Justice or fairness.** Doing and giving what is rightfully due.

Current status of WCPUs

As of 2005, only 44 out of 72 DOH-retained hospitals have women and children protection units/ services. These facilities, together with those established in provincial and municipal hospitals, are monitored by the DOH through the submission of a quarterly accomplishment report containing the following information: (1) activities completed (e.g. organizational/policies/development, training/ seminar/orientation, advocacy, networking activities); (2) target group; (3) number of participants; and (4) comments. For the VAWC incidence report, the information sought by the monitoring questionnaire includes the number of victims-survivors and perpetrators, type of abuse, age of victim/survivor and referral data. Because of lack of personnel and funds, however, these quarterly reports have not been consolidated into an annual report.

Because the DOH does not have the resources to monitor the 44 WCPUs firsthand (funding support for the units having stopped when external support ended), those interviewed for this study were not sure as to the actual state of said facilities. Aside from resource lack, problems identified by the DOH personnel were: the lack of direct authority to monitor the performance of DOH-devolved facilities; severe lack of medical personnel and financial resources of hospitals to comply with the requirements for setting up the WCPU; the low level of gender awareness or lack of gender sensitivity of WCPU personnel; and the lack of public concern about VAW as an issue.

Nonetheless, the DOH holds an annual meeting of WCPU representatives in which problems are brought out and ideas are exchanged. Donor institutions also perform project evaluations, which show that a number of the hospital-based WCPUs managed to generate enough resources and support to make their facilities fully operational. For example, the Child Protection Unit of the PGH has developed an integrated and multidisciplinary framework for the care and support of VAWC victims/survivors that has served as a model for many hospitals in the country and abroad.

The PGH Child Protection Unit

The PGH-CPU was established in l994 by a group of highly committed medical and paramedical personnel of the Department of Pediatrics, University of the Philippines (UP) College of Medicine. Its mission is to establish "a child-friendly unit using a multidisciplinary approach and networking in providing comprehensive medical and psychosocial services to abused children and their families to prevent further abuse and initiate the process of healing." In keeping with this mission, the unit strives to accomplish the following objectives: "(a) to provide round-the-clock diagnosis and intervention for abused children consistent with the highest standards of medical practice, (b) to establish a model unit composed of professionals in key medical and related disciplines linked through an effective working partnership with government and non-government organizations, (c) to design and implement a training program and curricula on child abuse; and (d) to create an infrastructure for clinical research on child abuse in order to devise strategies for intervention, program evaluation and prevention" (Guerrero and Sobritchea, 2002). At present, the PGH-CPU is jointly managed by the PGH and the UP Manila College of Medicine and funded by the Advisory Board Foundation (ABF), a US-based charity organization.

Over the years, the work of the CPU has been guided by a comprehensive and integrated action framework called the Care Continuum for Child Abuse and Neglect. The framework consists of four major strategies: intervention, prevention, governance, and training and research. The components of each strategy are as follows:

Major Strategies	Key Elements
Intervention	*Early detection or suspicion* • Surveillance strategies • Detection strategies • Curricular reform • Public awareness programs • Awareness programs for children *Reporting and referring* • Reporting guidelines • Reporting and referral network *Multidisciplinary evaluation and diagnosis* • Integrated multidisciplinary case management (physical health, mental health, safety care and child development) *Causality management* • Identification and minimization of causal factors • Administration of justice and the law • Perpetrator case management
Prevention	*Awareness and empowerment of children* • Increasing access to necessary services and resources for children • Developing educational children's programs *Developing family support* • Family support strategies and advocacy • Linking child abuse programs with risk factor reduction programs • Identifying and managing spousal abuse *Involvement of all professionals* • Developing awareness programs for professionals about their roles in child abuse prevention • Involving key professional groups in child abuse prevention efforts *Developing Community Support* • Mobilizing barangay resources infrastructure to strengthen community-family interaction • Establishing community volunteer networks in collaboration with professionals working on child abuse cases • Increasing awareness of child abuse within the community • Establishing and supporting safer neighborhoods and a violence-free culture

Governance	*Defining a national agenda* • Commitment to professional standards and credentialing • Facilitating case-consultation and peer review system • Advocacy for child protection issues • Interdisciplinary evaluation and collaborative planning *Realizing a national agenda* • Oversight of child protection services • Resource coordination and asset maximization
Training and research Infrastructure development through expertise and knowledge	*Educating professionals* • Interdisciplinary training • Integrated profession-specific curricula *Advancing the profession* • Facilitated information dissemination • Cooperative database and resource network • Research initiatives on best practices and infrastructure needs

According to its 2004 Annual Report, the PGH-CPU provides the following services and programs to its children-patients and their families:

- **Patient intake.** This service includes the following tasks: (1) completion of a consent form (for medical examination) by the guardian, (2) assignment by the nurse of a database case record for the patient, (3) interview with the caretaker/guardian by the physician and social worker, and (4) playing (by a nurse) with the child in the playroom and briefing the child on CPU procedures.

- **Forensic interview.** A physician conducts the forensic interview that is both child-friendly and non-traumatizing, and is in accordance with legal guidelines for collecting evidence. Meanwhile, a social worker in another room watches the proceedings through a monitor, video-documents the interview and takes notes. The taped interview is transcribed by the social worker if needed while the video documentation may be presented in court.

- **Medical examination and related services.** A physician performs non-traumatizing medical examination that adheres to legal requirements for evidence collection, including colposcopic pictures. The child may also be examined for medical problems not associated with abuse. A medical treatment plan is designed and implemented. When necessary, referrals are made for medical services not provided by the unit such as pediatric developmental assessment and other medical sub-specialties. Medicine, food, clothes and transportation are provided as needed.

- To ensure the wellbeing of the children, the CPU also provides regular checkups for possible recurrence of abuse and routine medical care like vaccination. It accepts referrals from other units for STI testing and treatment.

- **Safety assessment and crisis counseling.** A social worker and a physician make an assessment of the safety of the child and the family, and prepare an action plan to prevent the recurrence of abuse. The plan may include placing a child in a shelter or under the protective care of family members or a close relative while the case is under investigation. The child also undergoes crisis counseling.

- **Home Visit.** An integral component of the CPU service is the home visitation by a social worker of patients residing in Metro Manila to monitor their situation. A second risk assessment is made and the safety plan is modified if needed.

- **Mental health care.** The CPU also refers the child patient and the caregivers for mental health screening and psychological and psychiatric counseling, and designs a treatment plan if needed. Abuse-specific therapy for children includes: (1) individual psychotherapy and pharmacotherapy, (2) play therapy for younger children, (3) group therapy for older children and adolescents, (4) therapy for parents, (5) psycho-education, (6) parenting education, (7) family therapy and (8) therapy for children with problematic sexual behavior.

- **Case conference and management.** A multidisciplinary conference is regularly conducted by CPU personnel to monitor the progress of cases. Safety concerns, family condition, legal issues and other issues are discussed to improve case management.

- **Court testimony.** CPU physicians appear in court to provide expert testimony about their findings.

- **Other welfare assistance.** Other social services provided to child-patients include educational assistance to those coming from very poor families, credit for livelihood projects of the caretakers, and parenting classes.

- **In-house and extension training.** Over the years, the PGH-CPU has provided training on how to deal with child abuse cases for medical and paramedical personnel within and outside the UP, including its own staff. Its program is integrated with the undergraduate curriculum of the UP College of Medicine and with the residency and post residency training programs of Pediatrics and Psychiatry of the PGH. Among the courses it conducted in 2004 were: (1) training on the investigation of crimes involving women and children for the women and children desk officers of the PNP, (2) child-sensitive investigative interview techniques for NBI agents and doctors, and (3) courses for partner social workers (i.e. risk and safety assessment, child abuse case management, dynamics of victimization, related laws of child abuse, medical evaluation, referrals and networking) to strengthen their competence level in child abuse case management. For its own personnel, the CPU has the following staff development activities:

    1. **Physician's peer review.** The physicians meet each month to review colposcopic pictures of patients. At these meetings they are able to share their expertise, validate each other's interpretations of medical findings to guard against bias, and agree on measures to improve services.

2. **Social workers' peer review.** The social workers also meet each month to review cases and agree on the changes to be instituted for improving services. Other members of the CPU multidisciplinary team may be invited to these meetings, as the need arises.

3. **Self care.** A one-day stress management workshop is held twice a year by the social workers while the whole staff goes on a weekend retreat once a year.

4. **Participation in professional seminars and conferences.** CPU personnel are encouraged to attend skills enhancement courses. One social worker and one physician are sent each year to the San Diego Conference on Child and Family Maltreatment in the United States. Other training activities include the CPU-Network Conferences for Physicians and the Family Therapy Workshops for Social Workers.

5. **Sharing of expertise within the Unit.** With the representation of personnel from various disciplines, the CPU is in a best position to carry out the in-house sharing of knowledge and expertise. For example, in 2004 a forensic psychiatrist conducted lectures for CPU nurses on Introduction to Forensic Nursing.

Other WCPUs

Aside from the CPU and Women's Desk of the PGH, similar facilities have opened in other hospitals with a good track record of "growing up" pains and successes. These are the Davao Medical Center (DMC) WCPU and the Women and Children Crisis Care and Protection Unit (WCCCPU) of the East Avenue Hospital in Quezon City.

The WCPU of Davao Medical Center. Professor Jocelyn Caragay, in the book Intervening to Stop Violence and Empower Women Children (edited by Guerrero and Llaguno, 2002), describes this facility.

"This tertiary hospital is located in the center of Davao City; it has a 400-bed capacity. The functions of the DMC WCPU are as follows: "(a) Identify victims including those who may not readily give vital information in an atmosphere of concern while handling disclosure with confidentiality; (b) assess immediate safety of the victims, respecting the victim's own evaluation of her situation, (c) facilitate referrals to organizations, agencies and individuals who can help through an existing network of referrals for further medical evaluation, psychosocial processing, counseling and spiritual guidance, legal assistance, temporary shelter and assistance from other community sources; (d) generate active support for survivors and families; and (e) participate in advocacy to establish safer communities for women and children" (Caragay in Guerrero and Sobritchea, 2002).

"The unit is located within the emergency room (ER) complex, in an easily accessible but undisclosed area, having a passage door leading to the ER. It has an interview room, a lounge (where patients can stay while waiting for their turn to be served) and an examination room equipped with the colposcope, the "magic bed" – a small pull-out bed serving as the examination table, a play room and the equipment and file-storage room."

The services offered and procedures implemented include the following:

- **Getting the consent of the non-abusive parent or guardian for the victim to undergo the intervention process, including the medical examination.** This procedure is facilitated by the completion of the consent form.

- **Intake interview.** This is to establish the background of the client and the case (intake form and social worker form). For this interview, the victim/survivor has to be separated from the perpetrator. She is asked to relax in the playroom, and be familiar with the staff to facilitate disclosure.

- **Second interview.** This is undertaken to gather vital information about the abuse and establish the facts of the case/s of abuse (interview form).

  The process is known to be challenging and time consuming. Sometimes the child does not want to be interviewed, or several sessions – usually three to five -- may be required before disclosure is made. It is observed that children aged four and below are difficult to interview because they easily feel threatened. They can also be graphic in their description, as in"… may maputi at malagkit (whitish and slimy)… pinasukan ng kahoy (wood is inserted)…" On the other hand, a 15-year old client would not reveal who impregnated her, as she feels threatened and wants to avoid causing her mother pain.

- **Physical examination and diagnosis.** Actual examination is done to establish the abuse committed (medical exam and diagnosis form; summary of examination form). The procedure is explained to the victim who is given assurance that the speculum is only going to be inserted if there is vaginal bleeding or discharge.

- **Disclosure of the results of the physical examination and diagnosis.** The WCPU doctor sits down with the victim and/or her relative to explain the findings and diagnosis on her case.

- **Counseling of relatives.** Another important service provided by the unit is the counseling of relatives of the victim/survivor. This is done to inform them of the latter's medical and psychosocial status, help them go through the emotional stresses, and prepare them for future actions to resolve the case.

- **Follow-up examinations** including pregnancy test and test for sexually transmitted diseases

- **Referral for course/s of action.** Client is referred for appropriate services: these may be for legal assistance, psychiatric counseling, medical intervention, or other forms of follow-up (referral form, psychiatric referral form).

- **Medical intervention.** Cases for medical intervention are retained by the WCPU. There is an intervention form that takes note of all interventions conducted with every client. There is also a case-closed form for cases that are terminated.

Physically abused women brought to DMC's emergency room are treated, and referred to the WCPU for appropriate interventions. Starting with an intake interview, clients are likewise provided with counseling especially to determine immediate courses of action. They are referred for appropriate services when necessary, e.g. legal counseling, psychiatric counseling. The forms indicated above are also used as appropriate.

The WCCCPU of the East Avenue Medical Center

The WCCCPU of the East Avenue Medical Center (EAMC) is jointly managed by the Women's Crisis Center (WCC), a non-government organization, the Department of Obstetrics and Gynecology and the Department of Pediatrics. This arrangement, which is covered by a Memo of Agreement signed in 1999, provides that the psychosocial care will be provided by WCC whereas the medical care will be provided by the Departments of Obstetrics and Gynecology and Pediatrics of EAMC.

The WCCCPU started in 1994 as a project proposal to the NCRFW and DOH by the WCC and other women's organizations. One year later, President Ramos supported the project which was then called Project HAVEN (hospital-based assistance for women in violent environments) by allocating funds for the construction of the service center on the 7th floor of the EAMC. In 1999, Project HAVEN was renamed Women and Children Crisis Care and Protection Unit.

Service Components

- **Medical services.** The hospital staff takes the lead in providing medical services to the victim-survivor of violence. The client/survivor may come to the emergency room where she will be directed to the appropriate department – Surgery, Ophthalmology, Pediatrics or Obstetrics-Gynecology. The patient is interviewed and treated for injuries. The hospital intern who is trained to manage this kind of case then refers her to the Women's Crisis Center for other needs. Full documentation of the injuries and physical state of the patient is noted. Ideally, a medical certificate is released.

  For medico-legal cases, the patient is referred to the WCC-CPC in Camp Crame.

- **Psycho-social services.** The WCC provides the following support to victims/survivors:

  1. Crisis counseling for the abused women including risk assessment and identification of resources and support
  2. Medical referral for services that cannot be provided within the hospital like psychological and psychiatric assessment/services
  3. Legal referral for consultation and assistance
  4. Assessment and referral for shelter needs. The Center operates and manages a shelter facility but also facilitates referral to another shelter according the needs of the patient/client.

Other support services for survivors

The WCC conducts other activities to support or facilitate the recovery of survivors such as: (1) education activities like fora, seminars and workshops on violence against women, women's rights, assertiveness training and the like; (2) support group building for survivors; and (3) survivors' annual general assembly.

Based on the organization's experience in direct work with victim-survivors, the Center is also actively engaged in activities such as legal and policy reform and networking activities to advance the cause of survivors of violence.

- **Staff training**

  An orientation-training is held for new residents every year tackling such topics as: violence against women as a health issue, the nature and dynamics of abuse, clinical skills and the hospital protocol for such cases (attached is a sample training design). Non-medical personnel are likewise given an orientation on how to be sensitive to victim-survivors.

- **Documentation**

  A uniform intake form, called the VAW registry, records the entry of a VAW case. It serves as a full documentation of the medical and psycho-social interventions given to each client. These records as well as the master list of VAW clients are kept in the WCC office.

- **Program management**

  The steering committee meets periodically to plan, assess and monitor the implementation of the program. The WCC program leader reports to the hospital director regularly for updates and direction.

- **Strong points in implementation**

  There is smooth coordination among the different departments within the hospital in relation to service provision. There is division of work among the hospital departments as well as the hospital social welfare unit and the WCC, which writes a letter of endorsement to request for financial support for clients as needed.

Problems related to service delivery

1. Doctors hesitate or refuse to testify in court. They hesitate to perform medico-legal examinations knowing that they may be called to testify in court in the future. Doctors need to realize the value of this action and they need a support mechanism to do this type of service for survivors.

2. There is a need to ensure privacy of clients during intake interview at the ER. Clients/patients need to have a private space/room where they can talk freely about their real situation, needs and concerns. Doctors and the attending counselor and social workers have to be sensitive to the victim/survivor and her emotional state, and show utmost consideration.

3. Compared with others in the ER, some survivors may not look like they need immediate attention, so there is a tendency to make them wait. This is a mistake. They may have safety and security concerns that need to be looked into right away.

4. Because the hospital is now in the process of being privatized, financial assistance is becoming scarcer for victims/survivors who are poor. There is need for sustained financial support to indigents, especially women and children who are victims/survivors of violence and abuse.

5. VAW cases are attended to at the ER but service can still be improved. The hospital team can aspire for an interdisciplinary approach to case/patient management. The team can be composed of the attending doctor, the nurse, and the social worker/crisis counselor.

6. Incentives are lacking within the hospital for those involved in this type of work.

7. There is a shortage of free services like psychological assistance, legal services, and shelter for victims/survivors.

8. Mainstreaming of anti-VAW services still has to be formalized, for instance by placing the WCCCPU under the supervision of the hospital director.

9. There is a need for data collation and processing so that data can be utilized for purposes like advocacy, education or training, and fund raising.

DOH

PERFORMANCE STANDARDS AND ASSESSMENT TOOLS FOR SERVICES ADDRESSING VIOLENCE AGAINST WOMEN IN THE PHILIPPINES: Medical and medico legal services for hospital-based services for victim-survivors of VAW- Department of Health (DOH)

The standards for the delivery of hospital-based services through the women and children protection units (WCPUs) will help ensure that the needs of VAW victims-survivors are attended to promptly and effectively. The presence of high-quality service facilities will help survivors heal faster, recover from trauma and return to normal life.

This publication is part of a package consisting of five sets of performance standards for each of the five service categories, represented by government agencies tasked primarily to render such type of service, as follows:

Administrative Order No. 04 s. 2006 is the official policy issuance adopting the performance standards in the implementation of psycho-social services for VAW in centers and residential facilities. The DSWD standards will be used in accreditation of national, regional, and local VAW centers.

Investigation, rescue and handling of victims-survivors of VAW provided by the Philippine National Police (PNP) through its Women and Children Protection Desks (WCPD). The WCPD is a principal component of the different police stations nationwide mandated to attend to cases of violence against women and children, including minors who violate the law and those at risk of danger, harm and exploitation.

Prosecution and legal services for victims-survivors of VAW developed with the Department of Justice (DOJ) in consultation with the members of the DOJ Task Forces on Women and Children and Trafficking. The DOJ standards will ensure gender-sensitive handling and prosecution of VAW cases. It is applicable to national as well as regional and local prosecution offices.

LGU-based services, developed with the Department of the Interior and Local Government-National Barangay Operations Office (DILG-NBOO) sets the standards for, among others, the provision of devolved social welfare and health services for VAW in local government units. It contains three types of standards and assessment tools for the three different levels of LGUs Barangays, Municipal and Provincial/Highly Urbanized Cities

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