SITUATIONAL ANALYSIS OF MEDICO-LEGAL AND HEALTH SERVICES FOR VICTIMS OF SEXUAL VIOLENCE*

By the Sexual Violence Research Institute

ABSTRACT

This article is based on a research on services and facilities available in the country for victims of sexual violence and the access and process of the delivery of such services and facilities. It analyzes the situation at the macro- and micro levels by utilizing data from the national and provincial governments for the macro analysis and the facilities of three samples sites (Manila, Sorsogon, and Oriental Mindoro) for the micro-perspective.

I. Introduction

Sexual violence constitutes a significant health and security concern that affects men and women throughout their lifetime. Studies conducted in different countries found that up to 36% of girls and 29% of boys have suffered from child sexual abuse. The magnitude of sexual coercion in adolescence is often similarly high: up to 46% female and 20% male adolescents have experienced coerced sex, depending on the country of study. Rape and domestic violence account for an estimated 5-16% of the healthy years of life lost to women of reproductive age. Population-based studies report that between 12 and 25% of women have experienced attempted or completed forced sex by an intimate partner or ex-partner at some time in their lives.

Sexual violence has a significant impact on the physical and mental health of the victims. Its health consequences among

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others, include unwanted pregnancy, genito-urinary disorders, sexually transmitted diseases, HIV/AIDS, mental health sequellae, self-inflicted injuries, and adoption of high-risk behaviors such as multiple sexual partners and drug use.

The health care sector plays an important role in the recognition, documentation and response to individual cases of sexual assault. Persons who suffer from sexual violence often seek medical assistance, even without disclosure of the sexual assault, and are often taken to a health facility for examination after reporting it to the police.

Health care workers can provide comprehensive, gender-sensitive health services to victims of sexual violence to manage the physical and mental consequences of the assault. Such services include pregnancy testing, STI testing and prophylaxis, treatment of injuries, and psychosocial counseling. Related health assistance that may be provided to the victims are referrals to social welfare and legal aid as well as collection and documentation of forensic evidence for the purposes of prosecution.

A panel of experts at the International Meeting on Indicators of quality medico-legal services for persons who experienced sexual violence, organized by WHO in Geneva in March 2002, developed a series of health service objectives for the care of persons who experienced sexual violence. These include:

- Improve health status
- Ensure adequate documentation of evidence
- Ensure satisfaction of client expectations and
- Ensure involvement of community

Although it is recognized that there may be variation between countries in the formulation of service objectives, the WHO initiative on the health sector response to sexual violence has adopted these objectives as its guiding framework.

II. Background of the Study

This research was part of a proposal on research priorities developed by the Sexual Violence Research Initiative. It was taken up by WHO because it fits within institutional priorities for the development of normative guidance in the area of sexual violence.

This proposal is for a study which will describe the structure and processes of sexual assault services in developing country settings. The study results will serve as the basis for the development of standards for good quality medico-legal and health services for persons who have experienced sexual violence.

In the Philippines, the magnitude of the problem of sexual violence is serious. In 2001, the Philippine National Police recorded 7, 594 cases of sexual violence, 65% (4, 597) of which were committed against children, and 35% (2,637) against women.

In 1999, the University of the Philippines Center for Women's Studies (UPCWS) and the Consuelo Zobel Alger Foundation completed a survey of 111 organizations that carry out different types of programs for women and girls in difficult situations. The study showed that most of the programs are on the delivery of welfare services, education and health. There is lack of legal assistance and a dearth of gender-sensitive and professionally-trained service providers (Guerrero and Llaguno, 2002). In 2002, UPCWS again undertook a study in cooperation with the Department of Health's Women's Health and Safe Motherhood Program on selected cases of good practice of intervention programs to prevent and eliminate violence against women and children. However, as far as the health care delivery system's response to this problem is concerned, there has been no systematic nationwide study to assess the practice and availability of medico-legal services to victim-survivors of sexual violence. This study is the first attempt to provide a situational analysis of medico-legal and health services to persons who experienced sexual violence.

In order to put such medico-legal and health services in the context of the current general health delivery system, a brief description of the health sector shall be discussed. The Philippine health delivery system is decentralized ever since health services were devolved to the local governments in 1993 as mandated by the Local Government Code of 1991. With the devolution, provincial and district hospitals are operated and maintained by the provincial or city government while the Rural Health Units (RHU) also known as the Municipal Health Offices, and the barangay health stations (BHS) are under the management of the municipal office. The latter two health centers offer primary care while secondary health care is offered at the level of the district or provincial hospitals. Because the LGUs have autonomy in managing the health service delivery in their area of jurisdiction, there is no uniformity of health care across the country. However, in 1999, the Department of Health launched the *Sentrong Sigla* ("Centers of Vitality") movement which fosters collaboration with the local government units in providing quality health services within a devolved health system. Under this program, compliance with national standards set by DOH in eight areas of quality earns the health unit the status of "Center of Vitality." There are different sets of standards for rural health units and barangay health centers, both of which are primary care facilities, and for the provincial/city or district health hospitals The eight areas of quality are:

- infrastructure and amenities (clean water and functional toilets)
- basic health services
- attitudes and behavior of health workers
- human resources
- equipment and laboratory capability
- sufficient drugs, medicines and supplies

- a health information system
- community intervention

Basic health services include expanded program of immunization, disease surveillance, control of acute respiratory infection and diarrheal diseases, micronutrients supplementation/ nutrition, family planning program, tuberculosis control, STI/ AIDS control and prevention, environmental sanitation, cervical cancer screening, maternal care. Expected attitudes and behavior of health workers include being women-friendly as manifested by maintaining a women's desk at the hospital's out-patient department and emergency room among others. As of 2003, the DOH has awarded the "Sentrong Sigla" status to 331 barangay (village) health stations, 1,394 rural health units and 97 district and provincial hospitals.

III. Study Objectives

The general study goal is to obtain data on the medico-legal and health services provided to victims of sexual violence through:

1. Documentation of the structure and resources of the health sector response to sexual violence
2. Documentation of the process of service delivery

The specific study objectives are:

Macro-level:

1. To identify any dedicated health services for persons who experienced sexual violence, and to describe these services;
2. To determine the nature of facilities providing sexual assault services, to measure the number of facilities where services are provided and the number of services per 100,000 population;

3. To determine which health workers provide forensic examination services and measure the number of trained forensic examiners per 100,000 population;
4. To determine the duration, nature and content of basic training curricula planned for forensic examiners;
5. To describe the geographical distribution of medico-legal services and determine the proportion of the population who do not live within 5km, 10km and 20km of a service;
6. To identify policies on sexual assault and determine their availability at a facility level;
7. To understand the organizational, financing and accountability structure of medico-legal services at national, provincial and district/regional level and to describe the structure and nature of supervision and any accreditation system for medico-legal service providers;
8. To determine the cost (and affordability) of accessing health services and medico-legal examination after sexual assault;
9. To describe the extent to which the different needs of women, men and children who are victims of sexual violence are addressed in training, sexual assault policies and in service provision;
10. To describe the processes followed to maintain the chain of evidence, package and transport evidence to laboratories;
11. To describe the number of laboratories available to carry out analyses of forensic evidence and the range of relevant services available in the laboratories.

Micro (facility) level:

1. To describe the physical infrastructure and equipment available at the facility level:

a. To describe the place of waiting for examination, waiting after examination and the facility available for the

examination with particular emphasis on its privacy and procedures followed to prevent contact with the perpetrator;

b. To describe the nature of equipment and supplies (including medication) available at the facility level to provide medico-legal services to persons who experienced sexual violence and to assess the adequacy of the equipment for the level of care provided.

2. *To assess the organizational structure of a representative sample of facilities and determine their links to external structures:*

   a. To describe possible impediments to access to the facilities including opening hours, after hours arrangements, waiting times, disabled access, transport arrangements to and from the police, access to services in appropriate languages, acceptability of services and the extent to which health facilities are accessed prior to approaching the police and whether victims are allowed access to care without going first to the police;
   b. To describe mechanisms to guarantee the safety of service providers and clients and the frequency of problems of safety related to sexual assault care and processes of managing incidents;
   c. To assess the availability of information materials for patients on sexual assault, the examination, choices and sources of further support at the facility level;
   d. To determine the existence and nature of mechanisms of accountability to service users, sexual assault NGOs and the local community that are in place at the facility level.

3. *To describe the process of service provision in a representative sample of facilities and to assess the interpersonal dimension of service provision:*

a. To describe the attitudes of staff providing sexual assault care towards sexual assault victims;
b. To determine the nature of the interpersonal dimension of care, including the extent of information and choice provided to clients, the extent to which their rights are respected, and the availability of chaperones during service provision;
c. To determine the number of sexual assault medico-legal examinations performed by staff providing this service per year;
d. To describe problems encountered with collection of medico-legal evidence including those related to rape kits (where available);
e. To describe the proportion of examiners who have given evidence in court on sexual assault cases in the past year and problems encountered;
f. To describe indicators of the competence of staff providing sexual assault care, including pregnancy prevention and STI treatment, injury management, follow up arrangements, psychological support, adequacy of documentation of forensic evidence;
g. To assess the extent to which referrals to the police and sources of psychological support form part of the regular service provision process and the nature of intersectoral relationships;
h. To determine the satisfaction of clients with the services delivered and the main problems identified by clients with health services related to sexual assault;
i. To determine the use and familiarity of service providers with national, provincial and/or district policy on sexual violence, and whether they have been trained in its use.

IV. Study Methods

The study was carried out at two levels: the government level (national and provincial) and the facility level, using multiple research methods. The study methods were developed at an international meeting of experts sponsored by WHO, and are also based on the experience of the South African Gender-based Violence and Health Initiative in South Africa, and the National Institute of Legal medicine and Forensic Sciences in Bogotá, Colombia.

For the macro-level study, data were collected from the Department of Health and the National Bureau of Investigation, through the administration of a standard questionnaire, followed up by a face-to-face interview.

The micro-level study was conducted at representative sample of facilities in three sites: Manila as the capital city and, Sorsogon and Oriental Mindoro as the provinces which represent the country as a whole.

At the facility level, three data collection instruments were used: one is a facility checklist of the availability and quality of the examination room, equipment and supplies, the second is a questionnaire addressed to the service managers and the third, a questionnaire administered to the service providers in the same facility. Interviews with client proxies represented by staff from other service organizations involved with sexual assault management such as the police, the social welfare sector and NGOs were also carried out to generate perspectives from service users of the health and medico-legal facilities.

Sampling Strategy

Overall sampling of study sites

There were three sites selected for the conduct of this research exercise: Manila as the capital city and Sorsogon and Oriental Mindoro as the representative under-resourced provinces.

Based on the Family Income and Expenditures Survey in 2000, Sorsogon and Oriental Mindoro are among the 44 poorest provinces in the country. Both provinces are located in the Luzon islands, where more than half (56.0 percent) of the Philippine population reside. The remainder of the country's populace is almost equally distributed between Mindanao (23.7 percent) and the Visayan islands (20.3 percent).

Accessibility of the region and security concerns prevented the researchers from selecting study sites in the Visayan and Mindanao islands. On the other hand, the central Luzon provinces are regarded as industrialized and currently industrializing, while those in the upper north are generally mountainous and inaccessible.

Data on selected demographic indices among the three study sites and that of the country's is relatively comparable.

Table 1. Comparison of demographic data: Philippines, Manila, Sorsogon and Oriental Mindoro, May 2000

Criteria	Philippines	Manila	Sorsogon	Oriental Mindoro
Population size	76,504,077	1,581,082	650,535	681,818
Population growth rate	2.36%	-0.97%	2.04%	2.46%
Average household size	5.0 persons	4.71 persons	5.19 persons	5.07 persons
Sex ratio	101.439	5.0510	6.0710	3.34
Dependency Ratio	69.04	50.81	86.08	81.64

The city of Manila accounts for 2.07% of the country's total population while the two provinces contribute relatively similar population proportions. Sorsogon shares 0.85% of the 76.5 million Philippine population and Oriental Mindoro, 0.89%.

As for average annual growth, the rate for Oriental Mindoro is slightly higher than the national rate of 2.36%. The population

growth rate for Sorsogon is much lower and that of the capital city slowed down to –0.97% for the period 1995-2000.

In the two provinces, data on sex ratio suggests that there are more males for every 100 females, fairly similar to the Philippines' 101.43. On the other hand, females outnumber the males in the city of Manila.

The dependency ratio for Sorsogon and Oriental Mindoro is much higher than that of the capital city's and the whole country's, and thus reflects the economic situation of the province. This means that every 100 members of the economically productive age-group (15-64 years) will have to support more than 80 dependents (0-14 and 65+ years).

Macro-level

Representatives who hold key positions in the Department of Health, the National Bureau of Investigation, and the Philippine National Police were selected through convenience sampling and interviewed using the standard questionnaires for the national and provincial levels.

Micro-level

In order to obtain a sample of facilities in the three selected study sites namely, Manila, Sorsogon and Oriental Mindoro, the cluster sampling technique was employed. The health and/or medico-legal facility itself is regarded as the sampling unit or the unit of analysis. Such facilities include hospitals, primary health care clinics and specialty clinics that provide services concerned with sexual assault management.

A sampling frame which includes the list of such facilities was created for each study site. From this, the sample to be included in the study was randomly selected in consultation with the guidelines provided in the research protocol.

In each site, three hospitals (one tertiary/regional hospital and two secondary/district hospitals) and one medico-legal facility if applicable, were chosen at random from the list. Within the vicinity of these facilities, client proxies from other service organizations such as a police officer, a social worker and an NGO representative were also selected.

Limitations of the Study

Due to limited resources, the study was restricted to sampling only three provinces considered to be representative.

Data Analysis

A database was constructed with Epi-Info 6 to compile the questionnaire results that were obtained from the closed-ended questions. A set of data analysis tables was provided by the Steering Committee to guide country investigators in the implementation of cross-tabs of selected variables, and to ensure that a common analysis is carried out throughout the countries. Descriptive analysis was carried out for the results at the micro and macro level. The open-ended questions were extracted and analyzed through content analysis.

Data on the location and quantity of services was provided to a local center specialized in the use of Geographical Information Systems, which calculated the percentage of population who live within a radius of the facilities, and mapped the availability of services.

V. Study Results

There were a total of 81 respondents interviewed for this study, five and 76 at the national/provincial and facility levels, respectively. Table 2 shows the breakdown of respondents at the national/provincial and facility levels, respectively.

Table 2. Respondent types by study site

Study Site	Respondents						TOTAL
	National Provincial Representatives	Facility Managers	Forensic Examiners	Medical Doctors	Registered Nurses	Client Proxis	
Manila	2	8	2	5	7	8	32
Oriental Mindoro	1	2	0	5	6	10	24
Sorsogon	2	3	0	6	6	13	30
TOTAL	5	8	2	16	19	31	81

This paper shall present and discuss the results of the macro-level study and the micro-level study in separate sections. The former reflects the overview of services available and existing policies affecting the delivery of services while the latter reflects the actual implementation of the health and medico-legal services at the community level in three different regions of the country.

Macro-level Study

The leading national institutions that provide health and medico-legal (forensic) services to persons who experienced sexual violence are the government-run hospitals under the Department of Health, the medico-legal facilities of National Bureau of Investigation (NBI) and the Philippine National Police (PNP). The Department of Social Welfare and Development (DSWD) also runs community-based and institution-based programs which offer crisis management and temporary shelter for the immediate protection of women in crisis. However, the DSWD coordinates with the DOH in providing for health and medico-legal services to persons who experienced sexual violence.

The services of the three leading institutions will be described in detail below:

Department of Health

The Department of Health is part of the executive branch of the government and is the lead agency for the health sector. Its mandate is to provide policy direction and plans for health programs and services. With the devolution of health to local governments, most direct services are under the responsibility of the local government units (LGUs) although the DOH maintains specialty centers, regional hospitals and medical centers. The responsibilities of the DOH include:

- Health research and development
- Health surveillance and information system
- Resource generation for priority health services
- Technical assistance and logistics support to local health services
- Human resource capability-building on health
- Health promotion and advocacy
- Direct service delivery for specialized health care
- Health care financing
- Health emergency preparedness and response
- Monitoring, assessment and evaluation of the health situation
- Quality assurance for health care
- Networking for sectoral actions on health

The concept of a hospital-based crisis center germinated in 1993 when the National Commission on the Role of Filipino Women convened a technical working group (TWG) on violence against women (VAW) composed of non-government organizations such as Women's Crisis Center, PILIPINA, KALAKASAN, KANLUNGAN, and University of the Philippines Center for Integrative and Development Studies. The TWG analyzed the

situation then and eventually recommended multi-disciplinary, multi-level responses to VAW that included medical, legal, shelter and other psychosocial needs of victim-survivors. They also suggested the collaboration of women NGOs, which provide feminist crisis intervention services, and the government agencies, which can provide resources for the delivery of services. (Guerrero and Llaguno, 2002) Thus was born Project HAVEN—Hospital Assisted Crisis Intervention for Women Survivors of a Violent Environment.

Project HAVEN became operational in 1995 under the leadership of the Women's Crisis Center, a women's NGO which pioneered crisis intervention for women survivors of abuse, in collaboration with the Department of Health. It was piloted at the East Avenue Medical Center (EAMC), a government hospital in the national capital region. The project was later renamed "Women and Children's Crisis Care and Protection Unit (WCCPU - EAMC)" when it was institutionalized.

A year after Project HAVEN's operation, the DOH piloted a purely GO-based Women's Desk in five government hospitals. In 1997, then President of the Philippines Fidel Ramos issued a memorandum entitled "A Call to Action against Domestic Violence." This directive led to the issuance of an administrative order (AO No. 1-Bs) by the DOH mandating all DOH-retained hospitals to establish Women and Children Protection Units (WCPU).

To date, there are supposedly 44 WCPUs in the DOH-retained regional and specialty hospitals all over the country. Seed funding was provided for the establishment of such facilities but the funding for their continuous operation are shouldered by the respective hospitals. The WCPUs' goal is to provide holistic, gender-sensitive care to women and children who are victims and survivors of violence. The specific objectives are:

- To ensure that women and children who consult the DOH hospitals due to violence are **treated** with utmost **care, concern and understanding (attitude);**
- To create and sustain an environment within the hospital setting that is **sensitive and friendly** to women and children (**attitude**);
- To develop a systematic, gender sensitive **documentation and monitoring system;**
- To **coordinate** with other government and non-government institutions and organizations for a more organized approach to address other non-medical needs of victims and survivors of violence.

Ideally, The WCPUs should have five main components in recognition of the multidisciplinary and collaborative approach to VAW. The components are:

1) **Medical, surgical, psychological and other health services** which feature 24-hour service, a holding and processing area for victims and survivors of violence, a standard clinical protocol in examination and management and a gender-sensitive recording system;
2) **Networking mechanism** with other GOs, and NGOs to ensure holistic and integrated approach to VAW;
3) **Training** program that addresses human resource development which the DOH undertakes with the University of the Philippines — Philippine General Hospital (UP- PGH) Child Protection Unit (CPU) and Women's Desk. (PGH, although a state hospital and considered as the premiere tertiary hospital in the country, is part of the University of the Philippines System. It is not directly under the DOH, and is therefore not counted in the 44 WCPUs of DOH-retained hospitals.)

4) **Research and Documentation** of experiences to serve as inputs for further studies, policy and program improvement;
5) **Information and Advocacy** campaigns by developing communication materials aimed at raising awareness on and preventing VAWC.

The WCPUs are supposed to be headed by the Chief of Clinics and staffed by an obstetrician- gynecologist, a pediatrician, a nurse, a social worker and a psychiatrist or psychologist or counselor. The gynecologists, pediatricians and the nurses are the ones usually sent by their respective hospitals to receive forensic training from the government.

Most WCPUs may be classified as special examination suites while three of the 44 centers are considered one-stop shops or national resource centers—one per major island group. These are the WCPUs in Baguio General Hospital (Northern Luzon), Vicente Sotto Memorial Medical Center (Central Visayas) and Davao Medical Center (Southern Mindanao).

The DOH has established a Women's Health and Development Program to provide technical assistance and policy directions to the WCPUs in the different DOH-retained hospitals. This program was established in 1998 with the aim of examining not only biological but also socio-cultural factors to understand health needs of women. Its task is to ensure that all DOH programs and services have gender perspective.

The policies are disseminated to provincial authorities through the regional health offices of the department. The DOH also provides technical assistance and training to the local government units in their health programs. Since the health services are devolved from the provincial level down, the DOH policies are only applicable up to the regional level. It is up to the LGUs to adopt and adapt the policies to their own areas of jurisdiction.

The implementation of these guidelines and the monitoring of services demonstrate the huge gap between policy and reality. The DOH admits that it lacks a monitoring team or system that will ensure proper implementation of the hospital based-crisis center. There have been reports that some hospitals do not comply with the administrative order (AO No. 1-Bs), even if they claim to have an existing women's desk. In 2001, 14 out of the supposedly 44 WCPU's submitted an annual report to the Department of Health.

Clinical Management

On the clinical management of persons who experienced sexual violence, the DOH adopts the PGH — CPU and PGH-Women's Desk protocols, which is not specific to sexual violence but VAWC in general, for children and women, respectively. The respondent stated that the same protocols apply to men theoretically; however, most WCPUs have encountered none or very few male clients. While there is expectation that such protocol may address men's needs, such consideration was not made by the authors of the protocol. These protocols address forensic examination, short-term health care and psychological counseling and long-term health care. The use of these protocols is part of the training that PGH — CPU and Women's Desk conducts for the DOH-WCPU doctors and nurses.

According to DOH, for women and men, a gynecologist with forensic training is the one authorized to conduct forensic examination. For children victims, the examination is performed by a pediatrician with forensic training. As mentioned, they follow the protocol of the PGH — Child Protection Unit, presented on the following page.

For adult women patients, the DOH WCPUs are supposed to follow the protocol developed by the PGH Women's Desk, presented here.

CHILD PROTECTION UNIT – PHILIPPINE GENERAL HOSPITAL
Overview of Patient Care

PATIENT INTAKE

- Patient and guardian greeted by CPU receptionist
- Guardian completes consent form
- Physician and social worker interview caretaker
- Nurse plays with child in play room

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FORENSIC INTERVIEW

- Physician conducts forensic interview that is both child-friendly and non-retraumatizing, and in adherence with legal guidelines for collecting evidence
- Social worker listens to interview behind one-way mirror and takes notes. Social worker transcribes interview when necessary
- Interviews may also be recorded by a video camera located on the other side of the one-way mirror. This video may then be presented in a court of law

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MEDICAL EXAMINATION

- Physician performs non-traumatizing medical examination that adheres to legal requirements for evidence collection, including colposcopic pictures
- Physician also examines patient for medical problems not associated with abuse
- Physician devises and implements a medical treatment plan
- When necessary, referrals are made for medical services not provided by CPU, such as pediatric developmental assessment and other medical sub-specialties
- Medicine, food, clothes and transportation provided as needed

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RISK ASSESSMENT

- Social worker and physician conduct risk assessment for the child and family and decide on a plan of action that best protects the child and his or her family
- Social worker takes steps to implement the action plan, such as placing the child in a shelter or having the perpetrator apprehended
- Social worker and physician provide crisis counseling

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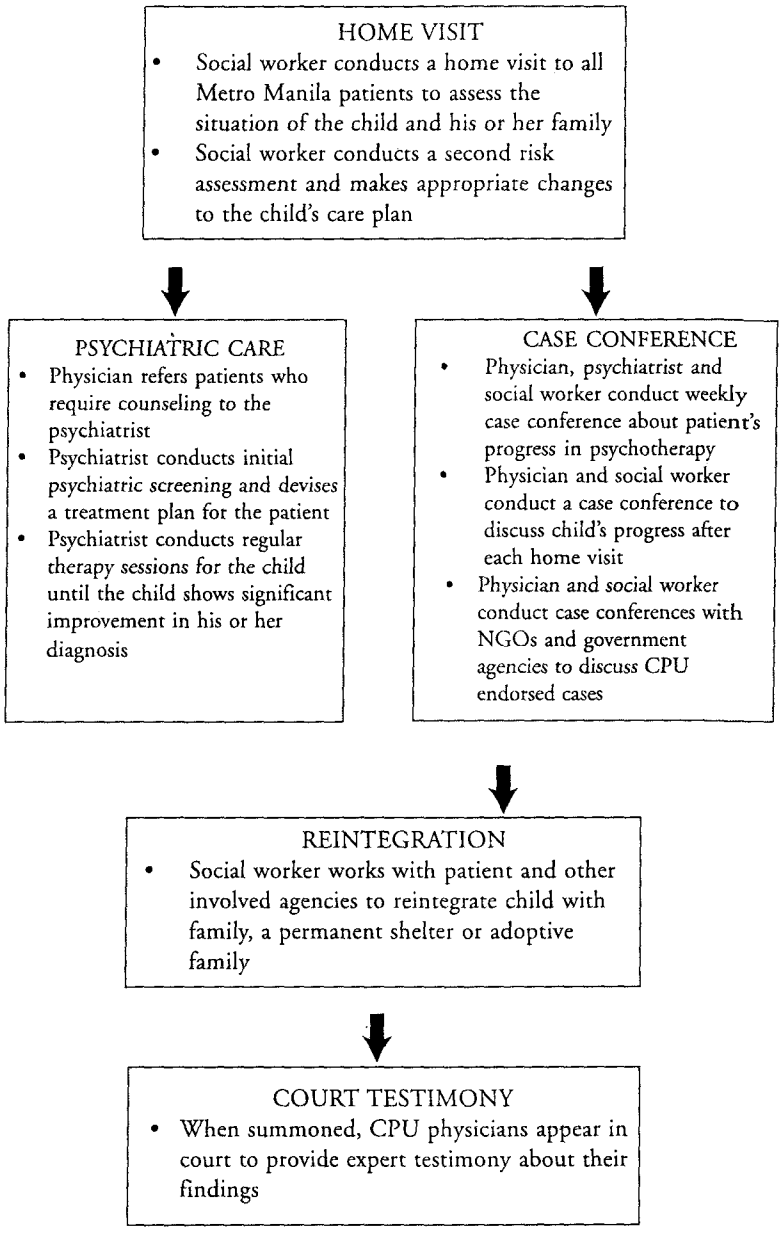
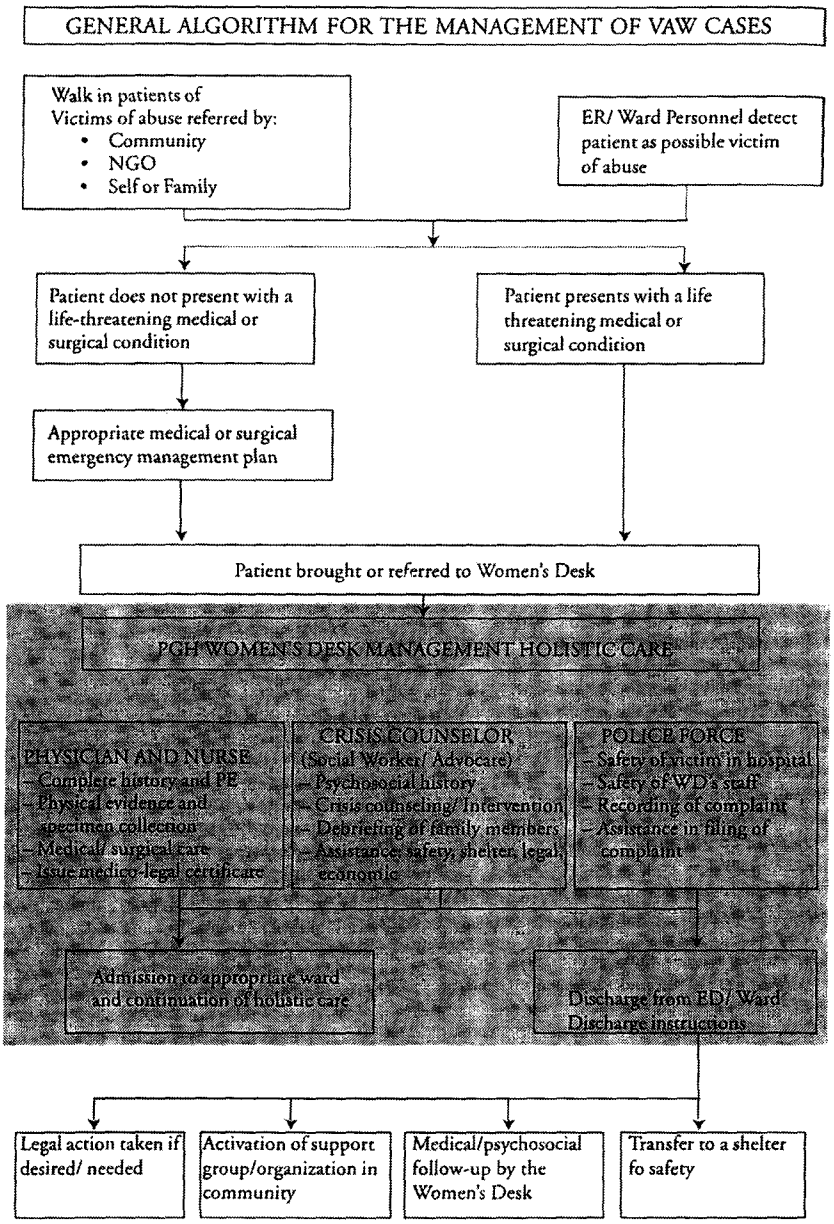

HOME VISIT
• Social worker conducts a home visit to all Metro Manila patients to assess the situation of the child and his or her family
• Social worker conducts a second risk assessment and makes appropriate changes to the child's care plan
PSYCHIATRIC CARE
• Physician refers patients who require counseling to the psychiatrist
• Psychiatrist conducts initial psychiatric screening and devises a treatment plan for the patient
• Psychiatrist conducts regular therapy sessions for the child until the child shows significant improvement in his or her diagnosis
CASE CONFERENCE
• Physician, psychiatrist and social worker conduct weekly case conference about patient's progress in psychotherapy
• Physician and social worker conduct a case conference to discuss child's progress after each home visit
• Physician and social worker conduct case conferences with NGOs and government agencies to discuss CPU endorsed cases
REINTEGRATION
• Social worker works with patient and other involved agencies to reintegrate child with family, a permanent shelter or adoptive family
COURT TESTIMONY
• When summoned, CPU physicians appear in court to provide expert testimony about their findings


GENERAL ALGORITHM FOR THE MANAGEMENT OF VAW CASES
Walk in patients of Victims of abuse referred by:
• Community
• NGO
• Self or Family
ER/ Ward Personnel detect patient as possible victim of abuse
Patient does not present with a life-threatening medical or surgical condition
Patient presents with a life threatening medical or surgical condition
Appropriate medical or surgical emergency management plan
Patient brought or referred to Women's Desk
PGH WOMEN'S DESK MANAGEMENT HOLISTIC CARE
PHYSICIAN AND NURSE
– Complete history and PE
– Physical evidence and specimen collection
– Medical/ surgical care
– Issue medico-legal certificate
CRISIS COUNSELOR (Social Worker/ Advocate)
– Psychosocial history
– Crisis counseling/ Intervention
– Debriefing of family members
– Assistance: safety, shelter, legal, economic
POLICE FORCE
– Safety of Victim in hospital
– Safety of WD's staff
– Recording of complaint
– Assistance in filing of complaint
Admission to appropriate ward and continuation of holistic care
Discharge from ED/ Ward Discharge instructions
Legal action taken if desired/ needed
Activation of support group/organization in community
Medical/psychosocial follow-up by the Women's Desk
Transfer to a shelter fo safety

Training for forensic examiners

As mentioned, the Department of Health has an existing partnership with the Child Protection Unit of UP-PGH in training government health workers on providing health/ medico-legal services to child victim-survivors of sexual violence. The memorandum of agreement between the two institutions which was signed in 1999, states that the CPU will train DOH physicians around the country to become Child Protection Specialists. One pediatrician and one obstetrician — gynecologist from each of the 16 regions in the Philippines will undergo six-week in-service training at the Philippine General Hospital. The trainings are co-funded by the DOH and the Advisory Board Foundation. To date, a total of twenty-five (25) physicians have successfully completed the training program.

Health professionals — physicians and nurses with forensic training, gynecologists, emergency room doctors and nurses and general practitioners — also undergo training on gender-based violence. The Department of Health collaborates with the Philippine General Hospital Women's Desk for the delivery of the in-service training on gender-based violence and medical management. Some hospitals also initiate gender-sensitivity training for their own staff. Some schools provide undergraduate training on gender-based violence and/ or brief rotations in medico-legal institutions such as the Philippine National Police Crime Laboratory. An undergraduate curriculum on VAWC for nurses and doctors has been piloted in Siliman University and Cebu Doctors College, respectively, and launched in October 2000.

To ensure the continuation of the in-service training, and to monitor the implementation of the required services, the Department of Health hosts quarterly round table discussions with the representatives of each WCPU. However, attendance

in these quarterly meetings is sometimes less than satisfactory. As a result, monitoring and updating on the status of most WCPUs are not properly conducted.

The DOH also has a *Doctors to the Barrios* program where medical doctors are sent to far-flung areas to serve as municipal health officers (MHO). Prior to their deployment, the doctors receive training on various health concerns including handling of medico-legal cases. The training on providing medico-legal services is also given to the MHOs and hospital chiefs of staff of pilot provinces. It is a ten-day training seminar conducted by the Medico-legal division of the National Bureau of Investigation.

The general objective of the medico-legal training is *to increase and update the technical knowledge, skills, and abilities of the Health Officers of the local government units on Legal Medicine/ Forensic Science as well as to equip them with sufficient legal background to enable them to assist the courts in litigations regarding forensic expertise.* The course includes topics such as legal medicine, deception detection, polygraph, medico-legal investigation and documentation, autopsy, deaths (including judicial deaths), physical injuries and trauma in general, asphyxia, forensic chemistry, firearm wounds, dactyloscopy, DNA collection, preparation and interpretation; medico-genital examination and sex crimes, crimes against person, medical jurisprudence, court proceedings in medico-legal areas and malpractice in general. The course ends with a moot court.

The topic of sex crimes (including medico-genital examination and DNA analysis) takes up one day of the ten-day training program. Sub-topics include virginity and defloration, child abuse and situation, characteristics of child abuse, manifestations of victims of child abuse, medico-legal examination of a victim of child abuse — RA 7610.

Equipment

When the WCPUs were established, 22 colposcopes were purchased and distributed to 22 WCPUs all over the country. The physicians are trained by the PGH- CPU on the use of this instrument. However, to date, most of the colposcopes are not working anymore and the warranty has lapsed already. While the hospitals are supposed to maintain the equipment, the respondent cited that the individual hospitals lack funds for them either.

Attitudes

The DOH respondent believes that aside from poverty which is an indirect cause of the sexual violence in society, the problem is also cultural — Filipino women are subservient, silent due to fear, and ignorant of their rights.

The Department of Health sees that the health care workers' primary role in attending to a victim of sexual violence is to provide psychosocial processing and counseling. The respondent believes that the victims come for solace. Physical assistance comes secondary to the psychological support. The respondent also believes that they are advocates of women's health and rights in the prevention of sexual violence which they fulfill through information campaigns.

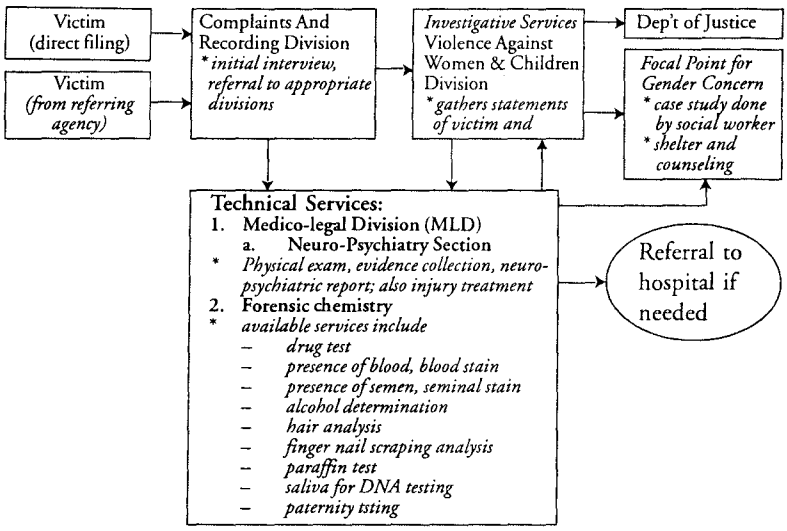
The three main problems that the health sector faces in responding to cases of sexual violence are lack of preparation or competency of health care workers, inadequacy of networking at the local level resulting to lack of long term assistance for the victim-survivors, and lack of specific health facilities for victim-survivors of abuse.

The DOH also sees a lack of attention and response given to the possibility of contracting sexually – transmitted infection especially HIV as a result of sexual violence.

National Bureau of Investigation

The National Bureau of Investigation (NBI) is a centralized government agency providing investigative services for crimes, abuse, discrimination and exploitation. Alongside these services, the agency also provides technical service such as forensic chemistry, neuro-psychiatry and other medico-legal services. Although the main task of the medico-legal division is examination of the victim-survivor and gathering of evidence, it also offers first aid treatment of injuries whether or not evidence collection will be carried out. If the client requires more specialized management, they are referred to a hospital at this point. The bureau also has a focal point for gender concern, managed by a social worker, which coordinates the provision of other services that a client may need, including shelter and counseling. However, in the written standard operating procedure, the provision of legal rights counseling or legal information is not mentioned.

Standard Operating Procedure in the NBI HQ



The NBI has its central office in the City of Manila and it maintains four (4) other "one-stop shops" and nine (9) small clinics with designated medical specialists in the following provinces. The funding for their operation comes from the national government.

Table 3. NBI Medico-legal Facilities

Facility	Luzon	Visayas	Mindanao
One-stop shops	National Capital Region (Manila) Tuguegarao-Isabela Baguio City, Mt. Province	Iloilo	Cagayan de Oro
Small Clinics	La Union Pampanga Bicol Caraga	Cebu Leyte	Davao Cotabato Zamboanga

For those areas without one-stop shops or clinics such as Region IV or Southern Tagalog Region, the NBI has a lone designated medico-legal officer (MLO) who handles the cases in all the nine provinces of the region. The office does not have the proper equipment and furnishings so much so that there were times when the patients who had to be examined had to lie down on several chairs put together. The medico-legal office sees cases of women, children and men, although the latter is rare. To be able to receive medico-legal services from the NBI, a walk-in client has to obtain a written request from the NBI Regional Director's office or the police which will issue a request for a medico-legal examination and forward the same request to the ML officer. Medico-legal examination may be conducted independent of a police report or intention to file a case. Initial treatment of injuries, on the other hand, is not provided in the regional office since its task is limited to evidence collection.

The officer provides "forensic examination" consisting of the following steps: 1.) the MLO receives request for forensic examination, 2) the MLO conducts interview and obtains consent for the procedures/ examination, 3.) the MLO conducts medico-physico-genital exam 4.) MLO collects evidence 5.) MLO writes the report. For other health services that the client may require, they are referred to the hospital of their choice.

Clinical Management

Minimum procedure consists of physical and genital examination with patient's consent (or parental consent for minors) and other ancillary laboratory services. If the client goes to the clinic within 72 hours after the sexual assault or rape, a vaginal smear for semenology or semen analysis will be automatically performed. A swab for possible DNA analysis is taken. The respondent laments that there is lack of storage facilities in their center.

The smears are taken to the forensic laboratory by a registered nurse. Unfortunately, the unit lacks facilities for storage of evidence. The chain of custody is also challenged frequently owing to the lack of protocol. In the regional office (Reg IV), the forensic examiner himself delivers the specimen to the laboratory in Manila.

The forensic chemistry division carries out semen analysis and gram staining as part of the routine but DNA analysis is deferred until the court orders it or client requests it, owing to the prohibitive price of the procedure. If DNA analysis is requested, it would cost at least Php 12,000 (US$ 240.00).

The NBI- MLD at the headquarters has no rape kits as defined. Instead, materials for taking vaginal smears for semen and DNA analysis are provided. What these consist of was not specified, however. The standard forensic examination which

basically consist of physical examination and semen analysis is offered free of charge. In Region IV, The NBI MLO prescribes the gloves and glass slides needed for the examination and smear —the patients are thus expected to shoulder the costs of these materials.

The division does not have any other equipment like a working colposcope to aid its evidence collection.

The medico-legal division has a neuro-psychiatry section which carries out upon request psychological testing and mental status examination by a psychologist and a psychiatrist, respectively. The results of these two separate tests are consolidated into one Neuro-Psychiatric report.

For Region IV, the medico-legal office follows the same minimum procedure of securing consent for the medico-legal examination, history-taking, and "medico-physico-genital exam." The ML officer notes any external injuries, signs of hematoma, lacerations and the appearance of the genitalia. A swab is taken if the patient comes within 72 hours after the alleged attack. The examiner also conducts an internal examination. The office/ clinic is not equipped with a colposcope. Neither does it have the neuro-psychiatry section found in the headquarters. A report is written up by the ML officer after conducting the interview and the physico-genital examination.

Training

The NBI provides in-service course on forensic examination for medical doctors and nurses who join the Medico-legal division (MLD). The Bureau imposes no other special requirements/ prior training on any related specialty for the physicians who are admitted to the NBI save for passing the medical licensure exam given by the Professional Regulation Commission. The exposure training ranges between three to six months for doctors and is

handled by the Medico-legal division. The training program consists of hands-on training on performing medico-legal examinations, autopsy, preparing appropriate reports, and mock courts. There is no mechanism in place to monitor the adequacy of training and neither is there an accreditation system for forensic examiners except for a "Revalida" (revalidation) exam given at the end of the training. After passing the said examination, the medical doctor gains the title "Medico-Legal Officer" and may then be assigned to any NBI office in the country. There are no mechanisms in place to ensure the continuation of in-service training and the trainees are not given any incentives to attend in-service trainings. Promotion is largely based on the length of service rendered in the institution. The title of "Medico-Legal Officer II" may be awarded after two to three years.

The health professionals in the MLD such as the doctors and nurses with forensic training also undergo training on gender-based violence sponsored by non-government organizations or by the Bureau itself. It is a three-day in-service training with the objective of increasing awareness and sensitivity to gender-based issues.

Policies

The NBI follows RA 8505 — Rape Victims' Assistance Act which requires female victims to be seen by female doctors and in the absence of a female doctor, the victim may be examined by a male physician provided that a chaperone is present. In the NBI, there are four female physicians and five male doctors. The former are assigned to examine clients in the clinic while the latter are assigned to autopsies.

The NBI respondent is unaware if there are mechanisms in place to disseminate the policies to health care professionals.

Attitudes

The respondent from NBI HQ believes that one of the causes of sexual violence in the country is poverty. Poor economic conditions force people to share rooms and restrooms. As a result, sexual violence against vulnerable individuals is easily perpetrated. Economic pursuits in foreign lands tend to leave children without adequate protection, especially from the mother, making them more vulnerable to incest. Drugs and alcohol also influence the commission of sexual violence. The MLO from Region IV holds the same views and adds pornography to the list of causes of sexual violence in the country.

The NBI respondent said that the NBI's role is not on the prevention of sexual violence per se but in the intervention or management of victim-survivors. The NBI does not initiate campaigns against sexual violence. However, the respondent from Region IV believes that the flow of illicit drugs should be stopped first if the problem of sexual abuse is to be solved.

As for the NBI, non-reporting of cases by victims is seen as the main problem faced by the institution in providing medico-legal services to those who need them.

NBI would like to raise the issue of lack of reagents for laboratory screening for sexually transmitted diseases among victim-survivors. Likewise, there is no funding for advocacy campaigns against sexual violence. The Bureau would also like to strengthen the follow up of cases by social workers.

The Philippine National Police

There are two pathways by which a victim — survivor of sexual violence can access medico-legal services from the Philippine National Police. The first one is through the Women's and Children's Desk located at the local police stations, and the

second one is through the Women's Crisis and Child Protection Center located at the PNP Headquarters.

An overview of the development of medico-legal services for women and children victim-survivors of sexual violence is presented below, culled from the official website of the Philippine National Police (PNP):

Addressing women and children concerns was given premium in the area of law enforcement and community relations by the Philippine National Police ever since the National Police Commission issued a **Memorandum Circular Number 92-010,** which paved the way for the establishment of the **Child and Youth Relations Section (CYRS)** in highly urbanized cities, including Metro Manila, and the designation of Child and Youth Relations Officer in other police stations nationwide.

Awareness of the alarming number of the victimization of children and young women due to sexual exploitation resulted in the enactment of **RA 7610** (*Special Protection of Children Against Child Abuse, Exploitation and Discrimination Act)* on 17 June 1992. The PNP forged a working partnership with other concerned government agencies, particularly the Social Welfare and Justice Departments as well as non-government organizations to raise the consciousness of the police force about the rights of women and children and the necessary police intervention for the protection of these rights, especially from exploitation, harm and danger.

Soon came the establishment in 1993 of the first Women's Desk in Quezon City, which was a project of the Directorate for Police Community Relations and the National Commission on the Role of Filipino Women with NGO participation. This project was replicated in other major cities and spread like wildfire across the other parts of the country even before **RA 8551,** otherwise known as the *PNP Reform and Reorganization Act of*

1998, was enacted. Title VII of the law amplified the institutionalization of the **Management of Cases of Children in Especially Difficult Circumstances** which contains certain procedures in the handling of children's cases. It was published in 1992. The PNP Directorate for Investigation and Detective Management has also published the **PNP Handbook on Child Abuse and Neglect** which deals further on the child interview techniques and the dynamics of child sexual abuse and its medico-legal implications which the police should also be aware of.

In June 1997, the Women's Desk and the Child and Youth Relations Section (CYRS) were merged into one, now the **Women and Children's Desk** in order to strengthen and optimize the utilization of policewomen in responding to cases and concerns of women and children. The structural make-up of the Women and Children's Desk was concretized by the activation of the **Women and Children Concerns Division (WCCD)** under the Directorate for Police Community Relations (DPCR) following the issuance of **PNP Memorandum Circular Number 97-001** dated September 1997.

The WCCD has since been an effective component of the PNP exercising supervision, monitoring and evaluation, providing policy direction, and formulating programs and projects geared towards the effective operationalization of the Women and Children's Desks. In January 1998, the PNP adopted a data monitoring system on cases involving women and children victims of abuse and violence with the end in view of establishing a profile of all these cases that would subsequently serve as basis for PNP policy issuance and program formulation for women and children. (http://www.pnp.gov.ph/lib_&_ref/WomensDesk.htm)

Women and children victim-survivors of sexual violence who come to the local police stations for assistance (especially those

outside Metro Manila) are attended to by the local Women and Children's Desk and may be referred to the hospital of choice or the nearest PNP Crime Laboratory for medico-legal examination. The Crime Laboratories are located in the PNP Headquarters, eight Technical Divisions, five NCR District Offices, 15 Regional Offices, and several Provincial and City Field Offices. The functions of the Crime Laboratory include:

Forensic examination on all physical evidences such as;

a. Medico-legal examination
b. Forensic examination
c. Forensic Document Analysis
d. Forensic Personal Identification through Dactyloscopy of Fingerprint examination and identification
e. Ballistics examination and Identification
f. Forensic Photography
g. Polygraph on lie detection test
h. Composite Criminal Illustration
i. Scene of Crime processing on Operation (SOCO)
j. DNA examination (future capability)

As of 2000, there were a total of 1,490 Women and Children's Desks for 95% of all police stations established nationwide as of this date. In 2003, the Women and Children's Desk was transferred to the Directorate for Investigation and Detective Management.

The other medico-legal facility within the police force is the **Women's Crisis and Child Protection Center** (WCCPC). It was activated in January 2001 at the PNP National Headquarters in Camp Crame under the Directorate for Police Community Relations with the vision to "investigate, safeguard, assist and provide multi-disciplinary treatment to woman and children victims of abuse and violence...with the end in view of helping

ensure the victim's rehabilitation, recovery and reintegration into the community and of serving the ends of justice." The composite team is composed of police professionals from the Criminal Investigation and Detection Group, Crime Laboratory and Health Services. This project was jointly initiated by the PNP, the Philippine General Hospital, and the Advisory Board Foundation, a Washington-based NGO which is closely working with the PGH in the area of child abuse treatment. The Royal Netherlands Embassy and the United Nations Children's Fund provided some equipment necessary for its operation.

The services offered in the WCCPC are:

a. Appropriate police investigation of all cases involving violence against women and children (VAWC);
b. Highest standards of medico-legal, psychological/ psychiatric and counseling services to victims of VAWC;
c. Collection and preservation of evidence for use in the prosecution of VAWC cases;
d. Prevention of retraumatization of VAWC victims by providing them optimum professional care and attention;
e. Assistance in providing intervention to victims of VAWC for their rehabilitation, recovery and subsequent reintegration into the community;
f. Coordination with other agencies concerned with the protection of women and children;
g. Filing of VAWC cases with the courts;
h. Tracking and follow-up of cases.

PNP Circular Number 2001-002 Dated January 16, 2001 specifies that procedures of VAWC cases referred by the local police to Camp Crame for medico-legal examination will be as follows:

- If sexual/ physical abuse against children — referred to WCCPC;
- If sexual abuse against women — referred to WCCPC;
- If other forms of abuse/ crimes against women — referred to Crime Laboratory.

In 2003, the unit was transferred to the Directorate for Investigation and Detective Management.

Subsequent discussions on the management, training, equipment and attitudes will be largely based on the experience of the PNP WCCPC at the National Headquarters in Camp Crame.

Clinical Management

According to the PNP respondents, in general, most victims usually go first to the barangay office since most of the victims do not know the proper steps to follow. The barangay officer directs them to proper channels. However, most of the clients at the PNP WCCPC/ Crime Lab Headquarters are referred from the police, Women's Crisis Center, DSWD, *Bantay Bata* and directly from barangays. The choice of facility accessed by the victim-survivors depends on the specialty of the services offered or the proximity to the victim. In the past twelve months, WCCPC has seen around 200 patients, averaging around 1-5 patients in a day. This facility is open on weekdays only, from 8 am to 5 pm.

The PNP- WCCPC physicians consider a person who has suffered sexual violence to be a serious medical case. This, to them, is the reason why the rape crisis centers are located very near the emergency rooms of the hospitals. Thus, they provide health care independent of forensic exam. A police report is not a requirement for receiving a medico-legal examination. These services are given free of charge.

Although the WCCPC is housed in the PNP General Hospital, the clients cannot access the medical services of this hospital since it is exclusive to members of the PNP and their dependents. There are instances when the medico-legal officers have to bring the client to East Avenue Medical Center (or client's hospital of choice) for tertiary level treatment. In such cases, the ML officer accompanies the patient to the hospital so he can perform the forensic exam simultaneously with the health care management. Chaperones are also available during the forensic or medical examination. Those who can act as chaperones are sexual violence care advocate (CPU nurse, doctor, investigator), social worker, mental health care practitioner, police, relative or friend of the client.

Informed consent is always secured prior to forensic examination. In getting the consent, the step by step procedure is disclosed to the client. According to the respondent, the current standard operating procedure for forensic examination of acute cases is to "first obtain a swab then test for presence of spermatozoa. The cotton applicator sticks are sent to the DNA laboratory where they are stored and examined/analyzed only after a court order." The Crime Laboratory used to have a free supply of the reagent acid phosphatase from the Federal Bureau of Investigation. It was used to determine the presence of spermatozoa, a test routinely done for acute cases (within 72 hours after sexual assault).

The forensic evidence is properly labeled and signed by the doctor with date and time. It is placed in a filing cabinet that is locked and opened only upon court order. An evidence custodian is in charge of the storage. The clients' records are also kept in a locked filing cabinet to which even doctors have limited access.

Although the ML examiners regularly raise the issue of HIV with the clients, no further services are provided. The respondents

claim that they lack training regarding counseling on HIV. They neither have an institution to refer patients to. As for testing of other STI's, the physicians get a sample of vaginal/ penile discharge and make a request for laboratory examination for gonorrhea, chlamydia or trichomonas. It is up to the client to bring the specimen to their laboratory of choice as this service is not available in the facility. Sexually transmitted infection prophylaxis is regularly provided. Treatment plans for medical-follow up of victims are developed, especially for those who contracted STI's.

The issue of pregnancy with female victims-survivors is also regularly raised. The physicians ask and discuss about contraceptive use, and conduct pregnancy testing if necessary. They offer emergency contraception, "even if the Department of Health Secretary is against it."

Assessment of the victim's psychological state is also one of the services provided. Counseling is provided although more difficult cases are referred to National Center for Mental Health, the Women's Crisis Center or a feminist counselor

The clients are regularly referred to the police, legal aid (such as Women's Legal Bureau, Women's League, Integrated Bar of the Philippines), social services for any pertinent assistance they may need. The clients are given information on the services available, follow-up required and community resources available. The information is printed in brochures which are distributed in the PNP Women's Desks.

The PNP medico-legal examiners give frequent evidence/ expert testimony in court. They attend an average of 8-15 court hearings in a month. The problems they encounter include frequent postponement of hearings due to absence of fiscals, lack of transportation to the different regional trial courts. The respondents lament that there are fiscals (prosecutors) who do

not know how to ask questions to medico-legal expert witnesses. For example, there are lawyers who ask if the patient was raped. The ML officer explained that physicians do not make a diagnosis of rape. It is the court that can determine such.

The respondent further stressed that the medico-legal exam will only corroborate the disclosure of the victim. As such, it is dispensable. Therefore, the respondent maintained that the one important "tool" is the testimony of the victim.

Equipment

A working colposcope donated by the Advisory Board Foundation is available at the PNP WCCPC for examination and documentation. Although there are no rape kits available for collecting evidence, WCCPC has a supply of cotton swabs and manila envelopes and paper bags. They collect articles of clothing, which are air dried and stored and preserved in envelopes or paper bags.

Policies and Protocols

WCCPC has adopted the policies and protocols of the Philippine General Hospital.

Training

The medico-legal officers of WCCPC undergo a one-year in-service course on medico-legal issues including gender and sexual violence. The training is provided by the institution as well as by non-government organizations such as Women's Crisis Center, Lunduyan Foundation and UNICEF. The PGH- CPU also conducts training on child protection. WCCPC also provides lectures and training to other organizations on these matters.

Attitudes

The health care providers from PNP-Crime Lab see sexual violence as all of the following: health problem, criminal justice problem, social problem and psychosocial problem. They consider a person who has suffered sexual violence to be a serious medical case — citing this view as the logic behind building the rape crisis centers (or women and child protection units) very near the emergency rooms in most hospitals with such facilities. Moreover, they believe that aside from providing medical care, they are also advocates —fulfilling this role by providing lectures to health and NGO workers on sexual violence issues

First Points of Entry into the Formal Helping System

According to the macro level respondents from the DOH and the NBI, the possible first points of entry into the formal helping system for men, women and children are:

- NBI;
- government-designated health centers for victims of violence, tertiary and regional hospitals;
- police facilities for victims of violence such as the Crime Laboratory of the Philippine National Police.

They may also go directly to the police stations and the court (sic) (i.e., fiscal's office). However, from PNP's experience, most victims do not know the proper steps to follow and they often approach the barangay office first (village council) to ask where they should go next.

In contrast, according to the micro-level respondents of the survey (i.e., service providers and client proxies) the initial points of entry chosen by victims of sexual attacks are the police (22 out of 68), the social worker (21 out of 68) and medico-legal

facilities (11 out of 68). Other first points of entry indicated by the respondents include: rural health units, barangay offices and nearest hospitals. The table below tallies by type of respondent the top five entry-points accessed by sexual violence victim-survivors.

Most of the victim-survivors, in the opinion of macro-level respondents, go to the government-run designated health centers because of the clients' low-income status. However, it should be noted that one limitation of this study is that only government hospitals were sampled. Therefore, the behavior of victim-survivors of higher socio-economic status cannot be adequately described since most of them go to private hospitals.

The availability of specialized services or designated health centers for victims of sexual violence in the DOH — retained hospitals such as the regional hospitals also determine the type of facility accessed by victim-survivors. Proximity of facilities is also a substantial factor in the choice of the facility approached. If the victim-survivors wished to register a case, they most often go to the medico-legal offices or police facilities for victims of violence.

All respondents claim that the same services and processes apply to men and children alike. They however noted they rarely encounter male complainants.

As for Region IV, the NBI ML Officer stated that most victim-survivors go to the district hospital first or in private hospitals for medical treatment. They also approach the DSWD for assistance. However, if the victim-survivors wish to register a case, they approach the NBI office in the region or go directly to the PNP Crime Laboratory in Manila. The NBI Medico-legal officer also often advises the clients to go directly to the NBI headquarters in Manila arguing that the services there are more complete. (The provinces in the Southern Tagalog Region,

except the islands of Palawan, Romblon and Mindoro and Marinduque, are few hours away from Metro Manila by land transportation). The choice of facilities approached by clients largely depends on their proximity to the people.

Table 4 lists the top three factors determining the entry-points into the formal helping system, according to micro-level respondents:

These results conform to the criteria used by the victims to decide where to go initially after the sexual attack, as identified by the respondents on the victims' behalf. The number of service providers and client proxies (24 out of 67) who answered specialty of service as a basis for choosing first points of entry is comparable with those who indicated legal requirements for a sexual violence case (23 out of 67). Other responses include: availability of medical doctors, and "approachability" of the staff.

Micro-level

Types of facilities surveyed

Of the eight health facilities, three are tertiary hospitals, three district hospitals, one secondary hospital and, one designated health center for victims of sexual violence. The funding source of these facilities is either the national, provincial, or city government, as they are all public in nature. Some facility managers expressed that they also receive fiscal support from donor and insurance agencies, while one of them indicated providing out-of-pocket funds.

It should be stressed that the health facilities sampled for the micro-level study are not under the Department of Health since the health system is devolved to the local government units starting from the provincial level down to the small village health stations.

All the facilities sampled offer acute health care, according to the service managers. Four of them claim that they offer

forensic examination services (i.e. evidence collection and analysis) and one, long-term health care (i.e. psychological counseling) to victims of sexual assaults. It is clear that provision of forensic services is not provided for in half of the facilities sampled for this study. Also, this data reveal that health care for cases concerning sexual violence are not being given much attention, as represented by the non-specialized and short-term service provision to the victims.

Table 4.
Services offered according to facility managers (n = 8)

Types of services	YES	NO	OTHERS*
HIV testing	2	5	1
HIV counseling	4	3	1
Anti-retrovirals (drug therapy for AIDS)	2	5	1
Counseling on pregnancy	6	1	1
Emergency contraception	1	6	1
Abortion counseling	2	5	1
STI screening	4	3	1
STI treatment	4	2	2
Counseling	5	1	2
Referrals to other sectors	7	0	1
*Response includes *don't know* and *no reply*			

There's no common protocol, therefore, no consciousness to meet minimum procedural requirements. This is clearly reflected by the results of the types of services provided, according to facility managers. Only half of those interviewed routinely provided STI screening and HIV testing.

Where victims go first and why

According to the service providers and client proxies, the initial points of entry chosen by victims of sexual attacks are the police (22 out of 68), the social worker (21 out of 68) and

Table 5. First points of entry for sexual violence victims by respondent type

First Points of Entry	Medical Doctors	Forensic Examiners	Registered Nurses	Client Proxies	% (over n=68)
Police	5	2	3	12	41.2%
Social worker	3	0	3	15	30.9%
Medico-legal facility (i.e. NBI)	0	1	6	4	16.2%
Police facilities (i.e. PNP Women's desk)	2	1	2	2	10.3%
District hospital	3	0	1	2	8.8%

medico-legal facilities (11 out of 68). Other first points of entry indicated by the respondents include: rural health units, barangay offices and nearest hospitals.

These results conform with the criteria used by the victims to decide where to go initially after the sexual attack, as identified by the respondents on the victims' behalf. The number of service providers and client proxies (24 out of 67) who answered specialty of service as a basis for choosing first points of entry is comparable with those who indicated legal requirements for a sexual violence case (23 out of 67). These results, however, do not indicate that those who considered legal requirements as a criteria for selection actually file cases against their attackers. Other responses include: availability of medical doctors, and "approachability" of the staff.

Table 6. Criteria for selecting first points of entry

Criteria	% (over n=67)
Specialty of the service (health, forensic,..)	35.8%
Legal requirements for a sexual violence case	34.3%
Proximity	28.4%

Process

Table 7. Persons who escort victims to the service facility

Persons escorting victims	% (over n=68)
Family	88.2%
Social welfare representatives	47.1%
Friend	45.6%
On their own	27.9%
Police	23.5%

Sixty out of the 68 respondents (88.2%) point to family members as the key persons who accompany sexual violence victims to service facilities. Other persons who escort the victims include teachers and barangay officials. About sixty percent (40 out of 68) claim that victims come to their facility before going to the police, which may lend explanation to the lower response rate regarding police representatives as companions of victims seeking health care assistance.

Among the 37 health practitioners interviewed, 32 (86.5%) do not require a police report before administering medical examinations and 36 (97.3%) claim that sexual violence victims are clinically attended to free of charge.

This study revealed that the range of waiting time before a victim of sexual violence is given medical attention is from 0-4 hours, as per availability of the examining physician. Approximately 25% of the service providers replied that victims on the average, wait for about five minutes (9 out of 37) to 30 minutes (9 out of 34), before being examined.

Only 21.6% (8 out of 37) of the service providers require informed consent from the victims before administering medical examinations. The remaining 78.4% either do not demand written consent forms or had no reply to this question. It is alarming that only a small minority are conscious of the need for securing informed consent from victims, whether verbal or

written. Some responses indicate a misconception that consent is implied upon the victim's presentation to a facility whereas informed consent, in a strict sense requires that the procedures to be undertaken are fully understood and accepted by the client-victim.

Content of care

The data shows that more than half of the health care providers raise issues which are of significant concern to sexually abused persons. Of the 37 health care professionals, 51.4% (19 out of 37) regularly raise the issue of HIV/AIDS, 61.1% (22 of 36) raise the issue of pregnancy with female victims and 56.8% (21 of 37 raise the issue of STIs with victims of sexual violence. A detailed description of the health services rendered by physicians and nurses to victims are summarized on the table below.

Table 8. Medical care provided by health practitioners (over n=37)

Type of medical care	% YES	% NO	% OTHERS*
HIV and related issues	51.4	29.7	18.9
Offer HIV counseling	27.0	29.7	43.2
Offer HIV testing	10.8	45.9	43.2
Advise client where to go for HIV test	32.4	24.3	43.2
Offer anti-retrovirals	00.0	56.8	43.2
Pregnancy and related issues**	61.1	25.0	13.9
Ask and discuss contraceptive use	16.2	59.5	24.3
Discuss pregnancy testing	56.8	18.9	24.3
Offer emergency contraceptives	2.70	73.0	24.3
Provide abortion counseling	2.70	73.0	24.3
STI and related issues	56.8	32.4	10.8
STI screening	37.8	48.6	13.5
STI prophylaxis	5.4	81.1	13.5
Referral for STI treatment	29.7	56.8	13.5

* Response includes *don't know* and *no reply*

** n = 36

A little more than half of respondents claim raising the issue of HIV, pregnancy and STI. However, on further questioning, very few provide specific services such as counseling, testing and other long-term follow up services. At present, the respondents seem to have no consensus on giving rape victims options on emergency contraception because official DOH policy has prohibited the use of such. Some service providers have resorted to prescribing high dose estrogen-progesterone preparations as emergency contraceptive measures.

The results suggest that the service staff are conscious about the more sensitive health issues vis-à-vis sexual violence. However, lack of drugs, reagents, referral information and other essential resources impede the delivery of such services. Regarding the aspect of pregnancy, the figures clearly reflect the Catholic leaning of the respondents (i.e. against contraceptive use and abortion).

Majority of the service providers (almost 75%) assess the psychological state of victims and nearly 65% (24 of 37) provide counselling to the victims, indicating that they indeed, are sensitive to the psychosocial dimensions of sexual violence. Furthermore, about 81% (30 of 37 respondents) refer victims to other sectors, particularly to social services and mental health professionals. For assistance in other matters, the victims are referred to either of the following: NBI, NGOs, Camp Crame, PNP Desk Offices.

Of the 37 respondents, 20 (54.1%) expressed that they provide information supports to sexual violence victims on the procedures followed, required follow-up and available community resources, while 19 (51.4%) do not regularly develop a treatment plan for medical follow-up of sexual violence victims. It should be noted that over half of the providers seem concerned with providing necessary information to victims. However, despite the providers' concerns over the psychological state of victims,

non-participation in the development of a treatment plan may indicate they are not as active in the rehabilitation process of the victims.

Equipment

The table below shows that equipment and other items related to health service delivery for sexually-abused persons is limited in supply. Only two facilities have possession of a "rape kit" in their facility, particularly the medico-legal service facility in the capital and a provincial tertiary hospital. Inexpensive items essential for evidence collection such as combs, tweezers, paper sheets and paper bags are generally lacking as well. Drugs for the treatment of STIs, anti-retrovirals and emergency contraceptives are available in less than half of the facilities sampled for this study and service managers noted that such drugs are in rare supply. Certainly, these data have significant implications on the quality and extent of health assistance that can be provided to victims of sexual violence.

Table 9. Percentage (%) of facilities possessing item by study site

Items	Capital city (n=3)	Provinces (n=5)	TOTAL (n=8)
Equipment			
1. Magnifying glass (or colposcope)	25.0	25.0	50.0
2. Access to an autoclave to sterilize equipment	37.5	62.5	100.0
3. Microscope	37.5	62.5	100.0
4. "Rape Kit" for collection of forensic evidence	12.5	12.5	25.0
5. Speculum	37.5	62.5	100.0
6. Comb for collecting foreign matter in pubic hair	12.5	25.0	37.5
7. Syringes and needles	37.5	62.5	100.0
8. Tubes for collecting blood	37.5	62.5	100.0
9. Glass slides for preparing wet and/or dry mounts (for sperm)	37.5	62.5	100.0

Table 9 continuation

10. Swabs for collecting samples	37.5	62.5	100.0
11. Laboratory containers for transporting swabs	25.0	50.0	75.0
12. Urine specimen containers	37.5	62.5	100.0
13. Toludine blue solution (1%) as colorant, and acetic acid (1%) as decolorant	12.5	37.5	50.0
14. Tweezers/ scissors for collecting foreign debris on skin	12.5	50.0	72.5
15. Paper sheet for collecting debris as the survivor undresses	12.5	25.0	37.5
16. Tape measure for measuring the size of bruises, lacerations, etc.	37.5	62.5	100.0
17. Paper bags for collection of evidence	12.5	25.0	37.5
18. Supplies for universal precautions from contamination	0.0	12.5	12.5
19. Resuscitation equipment for anaphylactic reactions	25.0	50.0	75.0
20. Sterile medical instruments (kit) for repair of tears and suture material	25.0	62.5	87.5
21. Spare items of clothing to replace those that are torn or taken for evidence	12.5	12.5	25.0
22. Sanitary supplies (pads or local cloths)	12.5	62.5	75.0
23. Gauzes and other wound treatment supplies	37.5	62.5	100.0
24. Pregnancy tests	37.5	62.5	100.0
25. Pregnancy calculator disk to determine the age of a pregnancy	25.0	50.0	75.0
26. Examination gloves	37.5	62.5	100.0
Drugs			
27. For treatment of STIs (Doxycyclin, Clindomycin)	25.0	25.0	50.0
28. Anti-retrovirals (Acyclosin)	12.5	0.0	12.5
29. Emergency contraception (pills, i.e. Depo-provera)	25.0	12.5	37.5
30. Tetanus toxoid, tetanus immuno-globulin	25.0	50.0	75.0
31. Hepatitis B vaccine	25.0	25.0	50.0
32. Pain relief (e.g. paracetamol)	37.5	50.0	87.5
33. Anxiolytic (e.g. diazepam)	25.0	37.5	62.5
34. Sedative for children (e.g. diazepam)	25.0	25.0	50.0
35. Local anaesthetic for suturing	25.0	62.5	87.5
36. Antibiotics for wound care	37.5	50.0	87.5
Administrative supplies			
37. Medical chart with pictograms	37.5	37.5	75.0

Table 9 continuation

38. Forms for recording post-rape care	0.0	50.0	50.0
39. Consent forms	37.5	62.5	100.0
40. Information pamphlets for post-rape care (for survivor)	12.5	12.5	25.0
41. List of names and addresses of referral sites	25.0	50.0	75.0
42. Surveillance forms to record basic data about client cases	12.5	37.5	50.0
43. Computer to manage client information and facility statistics	12.5	25.0	37.5
44. Refrigerator/ freezer to store forensic evidence (please specify if freezer available)	12.5	37.5	50.0
45. Safe locked filing space to keep confidential records	12.5	37.5	50.0

Policies and protocol

About 35.1% (13 of 37)of the service providers claim that there is a policy that guides their work on sexual violence, while only 27% (10 of 37) use a service protocol in the provision of services for victims of sexual attacks. These figures do not seem to match the response of the facility managers, half of whom indicated that there is such a policy, while five out of the eight managers maintained the presence of a service protocol. The disagreement between the responses may be attributed to the lack of service staff training on the use of the aforementioned procedure, as well as the inefficient information dissemination processes.

Safety

Five of the eight facility managers reported that there have been incidences of violence registered within their services facilities; however, half of them signified the lack of standard procedures to respond to such occurrences. Furthermore, safety mechanisms against violent incidents within the premises seem to be deficient, according to five of the respondents.

Table 10. Availability of safety measures by study site

Safety measures	Capital city (n=3)	Provinces (n=5)	TOTAL (n=8)
1. Guards	25.0	62.5	87.5
2. Alarms	25.0	25.0	50.0
3. Portable phones	25.0	50.0	75.0
4. Restricted public access	25.0	37.5	62.5
5. Separation of victim and perpetrator in waiting area	25.0	50.0	75.0
6. Separation of victim and perpetrator in exam area	25.0	50.0	75.0

It should be noted that all the facilities sampled for this study are not completely equipped with the safety measures indicated in the preceding table. It seems, too, that victims are not guaranteed safety from perpetrators, both in the waiting and examination areas. Such conditions may pose more stress on victims and may hinder the treatment process.

Attitudes

Table 11. Categorization of sexual violence by respondent type

Category	Medical Doctors	Forensic Examiners	Registered Nurses	Client Proxies	% (over n=68)
Social problem	15	2	16	27	88.2%
Criminal justice problem	13	2	17	25	83.8%
Health problem	9	1	15	15	58.8%

It is interesting to note that more health service providers regard sexual violence as a social and criminal justice problem rather than a health problem. These views certainly have implications on health service delivery, such that health care provision may not be deemed by the providers as a primary response to sexual violence cases. In addition, one nurse perceive sexual violence as a " family problem".

Training

More than 75% (28 out of 37) of the health practitioners had no training on sexual violence. The rest responded that they had relevant training of the following types: post-graduate courses, in-service training, cross project visits and seminar. According to them, the topics covered in the course include among others: human sexuality, psychosocial aspects of sexual violence, counseling and referral procedure. Health providers from the local government units acknowledged major lack of training on sexual violence, particularly on forensic services such as evidence collection and documentation, as well as issues concerning the criminal justice system.

Multi-sectoral collaboration

Majority of the respondents expressed satisfaction on the assistance and provided by the judiciary, police and health sector. However, such comments do not translate to adequate performance of the aforementioned agencies in responding to matters concerning sexual violence.

V. DISCUSSION

The Referral System

- Most of the service providers are sensitive to the psychosocial consequences that sexual attacks can inflict on victims but they do not develop a treatment plan for patients.
- The victims and their relatives are able to identify the agencies that could be of assistance to them when faced with circumstances pertaining to sexual violence, such as the police and health care facilities. The referral system

regarding cases of sexual abuse, however, needs to be adequately defined and the role to be played by each sector has to be made clear to all stakeholders. It has been observed that on some occasions, there is some level of unnecessary duplication in the services rendered by the police and the medico-legal facility. Such inefficiencies in service delivery certainly impose undue burden and inconvenience to the victims.

- **Safety and Injury Prevention**
  Most of the facilities are ill equipped to protect survivors and their families from reprisals and possible addition to their trauma. Such a state of affairs creats a chilling effect on would be complainants. Unless this is prioritized this crime will continue to be underreported.

- **Improvement of survivor's health status**
  The present state of health service provision on sexual violence cases seems deficient in significantly improving the victims' health status. There are several concerns that demand adequate attention before convalescence in the victims' condition can be achieved, specifically on matters related to resource availability and prevention of STD especially HIV infection. The lack of adequate materials and supplies compromise the quality of health care that can be delivered to clients.

- **Ensuring adequate documentation of evidence**
  The primary factor that has been observed to hinder adequate evidence documentation is the delayed reporting of cases, which took several years for some victims. Under such circumstances, it is nearly impossible to collect useful data that could substantiate the occurrence of the attack, also taking into consideration the absence of equipment

and the inability of most victims to access services that involve costly expenses.

Another problem that has to be addressed is the need for a storage provisions that will secure the evidence. Because of the lack of storage facilities the chain of evidence is not sufficiently guaranteed.

- **Ensuring client satisfaction**
  It seems that victims, as well as their relatives are not well-informed on the procedure to follow. Because of this, they are also uncertain about their expectations with regards the roles different agencies play in the processing and management of their complaints
- **Ensuring community involvement**
  From the study, community involvement seems to begin and end with the assistance of barangay representatives in the reporting of sexual violence cases. Moreover, in situations when perpetrators are related to victims, community members seem hesitant to involve themselves in the issue.

VI. CONCLUSIONS AND RECOMMENDATIONS

The majority of victims obviously proceed to police stations, special police facilities and government social workers on matters concerning sexual violence. This suggests an overwhelming perception that sexual violence is primarily a criminal justice and social concern rather than a health issue. Therefore, if priorities were to be addressed, the study clearly indicates the need to further systematize and enhance capacities for therapeutic interventions among non-health sectors (i.e. police, social workers). Such efforts must highlight the fact that sexual violence

has possible long-term health consequences and that it is not solely a criminal justice or social issue.

Considering that the entry points into the formal helping system is at the local government level and proximity being one of major factors in utilization of facilities, there should be an effort to advocate and provide support for the training of LGU service providers. It may be that the regional referral centers (WCPUs in regional hospitals) are not sufficient to meet the needs of the victim-survivors.

The huge involvement of family members as persons who escort victims to service facility, is confirmed by the study. This indicates the need to improve family education and management in any future medical protocol/ standards. However, the possibility that family members are also perpetrators should be considered especially in cases of children victims. In such instances, children victims should be interviewed alone whenever possible. These ethical issues in the management of survivors need to be emphasized and addressed in the design of the protocols and training curriculum.

A positive point is that most of the service providers claim rendering psychosocial care and referring clients to social services and mental health professionals. This affirmative attitude is a good opportunity to review and enhance the capacities for providing psychosocial services. It should be noted though, that the study does not include information on the nature of these services as well as the extent of their effectiveness. There are ongoing efforts to disseminate information and train legal and health professionals on documentation and management of survivors of violence within both government and non-government sectors. However, the study observed that these training programs are not well coordinated and are lacking in standardization and proper accreditation.

It can also be concluded from the study that safety measures are inadequate, both in the capital city and the provinces. This raises the issue of what should be the minimum requirements for opening a facility considering victim and caregiver safety is a responsibility of the agency/institution tasked to render medico-legal services.

Protection from STD and HIV infection need to be seriously addressed. While service providers claim to talk about this with the victims, the information given greatly vary in quality, depth and extent. Difficulties related to active intervention have been associated with current government policies on contraception.

The existence of a sufficient number of progressive and responsive legal frameworks indicates that the Philippines has the basic ingredients for a process that can lead to the formulation of a standardized national protocol for preventive and rehabilitative programs on sexual violence. There is, however, a need to enhance greater interaction and coordination among these different initiatives towards standardization and sustained monitoring. The process of designing a national protocol is deemed to be the most important mechanism towards this end. Such a process should:

- consider international and national frameworks and standards;
- elaborate various medical and legal interfaces and issues related to sexual violence and prevention; and
- manage and build a consensus on minimum standards, procedures and indicators.

While laws related to sexual violence are provided for in the legal system, the study noted that there is a huge gap between these provisions and actual implementation.

These gaps consist of a lack of a feedback mechanism on client/patient and community satisfaction services provided, absence of validated parameters for evaluation, and non-existence of a monitoring and assessment scheme of state compliance with these legal provisions.

No doubt, among developing countries the Philippines can be said to be ahead in initiating services addressing both medical and legal concerns in the care of survivors of violence against women.

What seems to be lacking is a process of ensuring the accountability and sustainability of these services. To this end, it suggested that stakeholders address the following issues:

- development of a professionally competent human resource pool;
- standardization of professional practice codes with penalties for malpractice;
- creation of regulatory and certifying boards;
- formulation of requirements for continued accreditation;
- provision of a continuing medical and legal education;
- development of systems and structures for ensuring standardized and adequate services and training as well as strict adherence to implementing rules and regulations at all levels;
- creation of a national council that is multidisciplinary and multi-sectoral in nature which will direct and coordinate policy and advocacy on both preventive and restorative levels as well as set standards, and monitor implementation within the reality of the devolved structure of relevant government agencies; and
- making available adequate logistical support.

Reference

Guerrero, Sylvia H. and Laguno, Jennifer Romero, Eds. *Intervening to Stop Violence and Empower Women and Children*: Selected Case of Good Practice. UPCWS and DOH, 2002.