Philippine Obstetrical and Gynecological Society (Foundation), Inc.

HANDBOOK on GENDER-BASED VIOLENCE

1st Edition
November 2021

Task Force on Gender-Based Violence

PHILIPPINE OBSTETRICAL AND GYNECOLOGICAL SOCIETY (Foundation), INC.
http:// www.pogsinc.org

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Message

Gender-Based Violence (GBV) refers to acts of cruelty directed against individuals because of their gender. Majority of victims are women and girls so that one in every three women experiences sexual or physical violence in her lifetime.

Being a serious violation of human rights and a life-threatening women's health issue, the POGS took it responsibly upon itself to be in the forefront of the endeavor to address the issue of social injustice perpetrated against females.

It is therefore with effusive gratitude that I write this message to congratulate the POGS task force on GBV, through its inspiring founder, Dr Lyra Ruth Clemente-Chua, for the fulfilled task of coming up with a Handbook on Gender-Based Violence, that will provide the POGS Members with general as well as specific guidelines on how to handle a victim of brutality in the clinic and the legal implications of such action or medical service rendered.

Since its inception in 2003, the task force on GBV has single-handedly carried and courageously flaunted the banner of the POGS in all socio-relevant fora on women's healthcare, which loudly sends forth the strong and clear message of the Society to safeguard the basic human rights of every Filipino woman from threats and harms perpetrated against her gender or womanhood.

I share the pride with all the members of the task force for this valuable contribution of the group to the Society's defined mission and vision to promote the best quality of women's healthcare. I likewise share the same dream of all the task force members to witness the time when every hospital and health facility will have its own Violence Against Women and Children (VAWC) Desk.

Rest assured that the POGS will continue to maximize every opportune occasion to collaborate with all relevant government agencies and private institutions with aligned goals and perspectives to further advance this noble advocacy.

Three Cheers…One POGS!

Benjamin D. Cuenca, MD, FPOGS
POGS 2021 President

Message

In behalf of the members of POGS Board of Trustees led by President Benjamin J. Cuenca and the Members of the Committee on CPG, represented by yours truly and assisted by Managing Editor Dr. Kristine Therese R. Elises-Molon and Assistant Managing Editor Dr. Mikaela Erlinda Martinez-Bucu, allow me to express my whole-hearted pride in presenting this **HANDBOOK ON GENDER-BASED VIOLENCE**. I having nothing but immense appreciation and admiration for the work that the extremely dynamic members of the Task Force led by task force Head and Editor Madame President Dr. Lyra Ruth Clemente-Chua together with Assistant Editor Dr. Lynnette Lu-Lasala and the superbly qualified authors, who have taken upon themselves to initiate and complete the effort to come up with this precious body of work.

We express our gratitude to these men and women of varied and overflowing talents, who chose to share precious time, boundless gifts of competence, enormous perseverance and all the while working in the spirit of teamwork, and performing the mission with self-effacing humility. They seek no reward for themselves, but the overwhelming satisfaction they get is the provision of this document to help our POGS Colleagues, which eventually redounds to better care of our patients.

May all POGS members find this guide helpful as they go about the daily task of providing excellent health care.

Gil S. Gonzalez, M.D.
Chair, Committee on Clinical Practice Guidelines (2021)

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GENDER-BASED VIOLENCE

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INTRODUCTION

Lyra Ruth Clemente-Chua, MD, FPOGS
Project Director, Task Force on Gender-Based Violence

The history of the POGS Task Force on Gender-Based Violence (GBV) started in 2003 during my term as President of the Philippine Obstetrical & Gynecological Society (POGS). I beg the reader's indulgence as I record this account for posterity.

Increasing awareness among the POGS members was *the first step* for GBV, emphasizing that obstetricians and gynecologists are in in a privileged position. By virtue of our training and knowledge about the female reproductive tract, women have given us the privilege of viewing and palpating the most private parts of their bodies, a privilege sometimes not given even to their intimate partners.

In the past, our practice was confined to the biomedical aspects of women's health and disease, neglecting the fact that Gender-Based Violence, domestic violence (DV), and intimate partner violence (IPV) affects the health of women in various ways. Violence should be an issue for health care workers, because for many women who have been abused, health workers are the main and often, the only, point of contact with services which may be able to offer support and information. It has a direct, negative impact on several important health issues, including safe motherhood, family planning, and the prevention of sexually transmitted infections and HIV/AIDS.

Recognizing the need for POGS members to realize that domestic violence / Gender-Based Violence was a neglected aspect of women's health care in the Philippines, and that it played an important role in the general health of the woman, the 2003 POGS president (yours truly) created the *Ad hoc Committee for Violence Against Women (VAW)*, with the mandate to create awareness of this issue throughout all the POGS regions.

The Vision and Mission statement of the POGS was also crafted at this time, formalizing in a document the aims of the POGS Founding Fathers and subsequently its leaders, incorporating the upholding of reproductive rights in its mission. The phrase "to foster women's advocacy" in the original Vision & Mission statement was later modified to the phrase "to increase awareness of women's health issues through advocacy programs" in the updated version. The former has been immortalized in the POGS hymn which was composed a few years later.

Partnering with the then newly-formed arm of UNILAB for women's health care, Biofemme, this committee traveled to all the major regions of the Philippines holding one-day workshop-seminars for VAW.

From an Ad hoc committee, it evolved into the POGS Women's Advocacy Committee during the terms of successive POGS presidents, incorporating VAW with the other Reproductive Health components, thus affirming VAW in the POGS members' stream of consciousness. The milestones of this period:

1. 2003 – Creation of the Ad hoc committee on VAW, and including "women's advocacy" in the POGS Vision-Mission statement that was crafted.
2. 2004 – Start of country-wide awareness seminars, orientation courses, introductory workshops. Inclusion of VAW topics in lectures during POGS CME activities, conventions, & PBOG exams.
3. 2005 – Institutionalization of the Women's Advocacy Committee (WAC); First workshop with PBOG on integration of Reproductive Health (RH) & VAW into the residency training programs (with UNFPA). This partnership with UNFPA during the presidency of Dr. Evelyn Palaypayon with Dr. Rey de los Reyes as RH committee chair was soon followed by the integration of RH in the residency training program in 2006.
4. 2006 – Inclusion of RH in the revised PBOG manual and the PBOG certifying board exam blueprint. Establishment of referral networks, further strengthening WAC. Continued training of identified doctors who would become the point persons in the WAC. Also during this time, further future goals were drawn up:
    a. Partner with DOH, UNFPA, and NGOs like the UP-PGH Woman and Child Protection Unit (UP-PGH WCPU).
    b. Produce a handbook for VAW
    c. Produce a CPG for GBV
    d. Create a logo for the committee through a logo-making contest
    e. Plan for all Regional Directors (RDs) to appoint a chair for their regional WACs.

In 2008, the 1st edition of the Sourcebook on Gender-Based Violence compiled by Dr, Lylah D. Reyes was published, with support from UNFPA. A 2nd edition was published in 2012. Goal number "b" accomplished.

Subsequently, RH topics, specifically GBV, were incorporated in POGS annual convention, postgraduate coursed, workshop-seminars, and other CME activities of the POGS and the POGS-accredited institutions. Research was

encouraged to determine local prevalence and condition so f GBV. The committee was renamed the Reproductive Health Advocacy Committee.

The *next step* was integrating GBV in the POGS residency training curriculum:

1. 2011 Aug. 20 – the CREED Training of Trainors workshop was held with the theme "POGS Advocacy on Violence against Women and Children."
2. 2015 – the POGS GBV Task Force was formed, which then started developing the Instructional Design (ID) and modules for GBV which would then be incorporated in the PBOG training curriculum. This activity was done in partnership with the UNFPA and the Child Protection Network Inc (originally the UP-PGH WCPU). The ID was published in the POGS Annual Report for 2015.
3. 2016 – Finalized the ID and GBV modules during the 1st quarter which was then disseminated to PBOG during the 3rd quarter, still in continuing partnership with CPN and UNFPA. The Curriculum for Residency Training in Managing Victim-Survivors of Violence Against Women (VAWG), 2016 is an Outcomes-Based curriculum. At the end of the training, the trainees must be able to:

   a. Practice gender-sensitive and evidence-based strategies in caring for victim-survivors of VAWG.
   b. Demonstrate effective collaboration with government and non-government organizations that are relevant for the care of victim-survivors of VAWG.
   c. Create programs to promote advocacy on preventing violence against women and girls in the family and community.

The timelines are:

Preparatory years	2016-2017
Training of Trainors	2017-2018
Integration Period	2018-2021
Accreditation Year	2022

Accreditation visits by the Council for Resident' Education Enhancement and Development (CREED) will monitor compliance, and the Philippine Board of Obstetrics & Gynecology (PBOG) will evaluate compliance with the standards that have been set.

One more goal was met in 2017: In consonance with the DOH Administrative Order No. 2013-0011, which mandates that "the entire health sector, including DOH health care facilities, LGU-supported health facilities, private health care facilities, other DOH attached agencies, development partners, and other relevant stakeholders…" work for the following:

a. Establish WCPUs, and where there are none, VAWC Desks in every hospital.
b. Provide training on the enhanced 4Rs for hospitals
c. Set in place a referral structure for VAWC
d. Create a PhilHealth Benefit Package for victim-survivors of VAWC
e. Craft accreditation guidelines for hospitals

4. March 14-15, 2017 – DOH held a Writeshop on the Finalization of Guidelines for the establishment of VAWC Protection Desks in all hospitals and POGS was invited to give our story of how we incorporated GBV in our residency training curriculum. Thus, the partnership was realized – POGS, with UNFPA & CPN working together with DOH to bring GBV care to all women and children in all hospitals.

5. The second quarter of 2017 saw the start of the Training of Trainors for POGS-accredited hospitals, continuing on to 2019:

a.	Committee April 20-21, 2017	NCR Hospitals	POGS Bldg
b.	May 30-31, 2017	Visayas & Mindanao	Cebu City
c.	July 12 & 13, 2017	S. Luzon & N. Luzon	BCG, Taguig City
d.	March 22-23, 2018	Regions 1,2,3	Baguio City
e.	June 16-17, 2018	Regions 6&7	Dumaguete City
f.	March 23-24, 2019	Region 2 & 3	Angeles City
g.	July 13-14, 2019	Region 11	Koronadal City
h.	Oct. 12-13, 2019	Region 5	Legaspi City

With the Covid 19 Pandemic lockdown in March 2020, all travel ceased but the advocacy continued:

1. July 9, 2020 Webinar: "GBV in the Pandemic, A Closer Look Inside the Lockdown"
2. Nov. 19, 2020 Webinar: "Nanay Na Si Nene…giving attention to the rising epidemic of teenage pregnancy during the lockdown.
3. Aug. 31, 2021 Unified Webinar with AHIP, PREPARE, & Task Force on Family Planning: "Laban Para Kay Nene – Stop the Epidemic of Teenage Pregnancy."
4. Posters were created – "Fight Back for Abused Heroes." Addressing the abuse, discrimination, & challenges that HCW faced during the early part of the pandemic.
5. Nov. 25, 2021 Webinar: "Our VAW-Free Community Starts with POGS" – Hosted by POGS Cebu Chapter & Region 7.

Now, we have a well-designed logo, created by a special committee created during the pandemic – the POGS Creative Advisory Team Committee (CATCOM).

Last to be accomplished for this year is the Handbook for GBV which you now hold in your hand.

In closing, I would like to ask the question – **"Why are we here?"**

We are here because:

In 2003, we had a dream that one day, POGS members will consider Gender-Based Violence as an important part of women's health care, and that the obstetrician-gynecologist will include abuse – physical, emotional, psychological, sexual, and institutional – as a factor that greatly affects the health of the woman, and will be able to give the appropriate response and intervention to the victim-survivor of VAW-C.

We have been granted a special professional privilege of being physicians to women by virtue of our unique knowledge of female anatomy and physiology, and our training in their medical care. We have been given the privilege of being privy to their most intimate parts.

It is now time to go beyond the biomedical, the purely obstetrical and gynecological, and deal with them as individuals with human rights, sexual and reproductive rights, as well as persons with various roles and tasks in their daily lives.

We are here because:

The International Federation of Obstetrics & Gynecology (FIGO) in 2000 mandated that all member countries uphold women's sexual and reproductive rights in all aspects of our interactions with them.

We want you to be a FRIEND and an ADVOCATE for the women who come into our spheres of influence.

"Silence in the face of evil is itself evil… Not to speak is to speak; not to act is to act." DIETRICH BONHOEFFER

"Violence toward women isn't cultural; it's criminal." HILLARY CLINTON

CHAPTER 1:

Gender-Based Violence- A Worldwide Concern

Rebecca M. Ramos, MD, MPH, FPOGS

Gender-Based Violence (GBV) continues to be one of the most notable human rights violations within all societies and a major public health problem. While it is pervasive, it can be prevented.

More specifically, violence against women (VAW) - particularly intimate partner violence (IPV) and sexual violence – is a violation of women's human rights.

The United Nations defines violence against women as "any act of Gender-Based Violence that results in or is likely to result in physical, sexual or mental harm or suffering to women, including threats of such acts, coercion or arbitrary deprivation of liberty, whether occurring in public or private life".

While both women and men experience Gender-Based Violence, majority of victims are women and girls. Hence, Gender-Based Violence (GBV) and Violence Against Women (VAW) are terms that are often used interchangeably as it has been widely acknowledged that most Gender-Based Violence is inflicted on women and girls, by men. However, using the 'gender-based' aspect is important as it highlights the fact that many forms of violence against women are rooted in power inequalities between women and men.

Magnitude of the problem:

The World Health Organization (WHO) reports that 35 percent of women worldwide have experienced either physical and/or sexual IPV or non-partner sexual violence (WHO 2013).

Almost one third (27%) of women aged 15-49 years who have been in a relationship report that they have been subjected to some form of physical and/or sexual violence by their intimate partner.

Violence studies from 86 countries across WHO regions of Africa, the Americas, Eastern Mediterranean, Europe, South-East Asia and the Western Pacific, show that up to 68 percent of women have experienced physical and/or sexual violence in their lifetime from an intimate partner. The Western Pacific Region where the Philippines belongs has a prevalence of 26.4% of women who experienced GBV.

The highest prevalence rates were found in central sub-Saharan Africa, with an estimated up to 66 percent of ever-partnered women having experienced physical and/or sexual violence by an intimate partner.

The United Nations Women 2011 reports that globally, *one out of every five* women will become a victim of rape or GBV, and will be a major cause of disability and death for women aged 15–44 years.

A 2018 analysis of prevalence data from 2000-2018 across 161 countries and areas, conducted by WHO on behalf of the UN Interagency working group on violence against women, found that worldwide, nearly *1 in 3*, or 30%, of women have been subjected to physical and/or sexual violence by an intimate partner or non-partner sexual violence.

Population-level surveys based on reports from survivors provide the most accurate estimates of the prevalence of intimate partner violence and sexual violence. Many cases of GBV have not been reported by women victims' "culture of silence" as many of them are ashamed to relate

their experience while others tend to dismiss their ordeal as a result of their lack of faith in their country's justice system or by frustrations over the lack of results in filing complaints.

Lockdowns during the COVID-19 pandemic and its social and economic impacts have increased the exposure of women to abusive partners and known risk factors, while limiting their access to services.

The Philippine Situation:

The National Demographic Survey (NDHS 2017), reporting on violence against women in the Philippines, say that more than 1 in 4 ever-married women aged 15-49 have experienced spousal violence, whether physical, sexual, or emotional. Twenty four percent (24%) of all ever-married women had experienced physical, sexual, or emotional violence by their current or most recent husband/partner, and in the 12 months preceding the survery,15% experienced such violence. Injuries due to spousal violence were 40% of this group of ever-married women who experienced spousal physical or sexual violence sustaining an injury. For help seeking, only one out of three (34%) of these women sought help.

Intergenerational effects of spousal violence are evident in the Philippines. Women who report that their fathers beat their mothers are more likely (37%) to have themselves experienced spousal physical, sexual, or emotional violence than women who report that their fathers did not beat their mothers.

Recent spousal violence by any husband/partner declined with increasing household wealth. Twenty percent of women in the lowest wealth quintile experienced spousal physical, sexual, or emotional violence by husband/partner in the 12 months preceding the survey, as compared with 8% of women in the highest wealth quintile.

While this may be an interesting finding, globally, GBV cuts across age, culture, religion social and economic status/wealth, sexual orientation, indigenous and other vulnerable groups.

Impact on children:

- Children who grow up in families where there is violence may suffer a range of behavioral and emotional disturbances. These can also be associated with perpetuating or experiencing violence later in life.
- Intimate partner violence has also been associated with higher rates of infant and child mortality and morbidity (through, for example diarrheal disease or malnutrition and lower immunization rates).

Violence against women is preventable. The health sector has an important role to play to provide comprehensive health care to women subjected to violence, and as an entry point for referring women to other support services they may need.

References

Facts and figures: Ending violence against women. (n.d.). UN Women. https://www.unwomen.org/en/what-we-do/ending-violence-against-women/facts-and-figures

Strategies for ending gender-based violence globally. (2020, October 22). Global Washington. https://globalwa.org/issue-brief/strategies-for-ending-gender-based-violence-globally/

United Nations Definition of Violence Against Women –. (2018, March 3). Center for Relationship Abuse Awareness & Action. http://stoprelationshipabuse.org/educated/definitions/united-nations-definition-of-violence-against-women/

Violence against women. (2021, March 9). World Health Organization. https://www.who.int/news-room/fact-sheets/detail/violence-against-women

World Health Organization. (2020a, April 8). *Responding to intimate partner violence and sexual violence against women*. https://www.who.int/reproductivehealth/publications/violence/9789241548595/en/

World Health Organization. (2020b, July 1). *RESPECT women: preventing violence against women*. https://www.who.int/reproductivehealth/topics/violence/respect-women-framework/en/#:%7E:text=Violence%20against%20women%20(VAW)%20has,an%20impediment%20to%20sustainable%20development.

The Cycle of Violence. (2012). Mpdc. https://mpdc.dc.gov/page/cycle-violence

Publications detail. (n.d.). World Health Organization. https://www.who.int/publications-detail-redirect/9789241564625

Heise,L., et al. (1999). Ending Violence Against Women, Population Report Series 11, Johns Hopkins University.

CHAPTER 2:

Introduction to the Dynamics of Gender-Based Violence: Understanding Gender, The “G” in GBV

Sharon Gianan-Cruz, MD, FPOGS, MAWD

Healthcare professionals, especially the obstetricians and gynecologists, are often the first point of contact for survivors of GBV. The HCPs are in a strategic position to recognize women who are survivors and/or at risk of experiencing violence. For us to be able to understand Gender-Based Violence, we have to have a basic understanding of what gender truly means.

The context of gender that we will be tackling as a function of sexuality is that it is hierarchical in patriarchal societies (societies dominated by men or societies where mostly men are in power), where male and female sexualities are socially conditioned. Masculinity is defined as sexual dominance, femininity as sexual submissiveness. This framework will help us understand the dynamics of Gender-Based Violence or GBV.

Differentiating Sex from Gender

The definition of sex is based on a physical or biological dimension. Sex is defined by characteristics that are present from conception, at birth and are largely unchangeable. It can be used as a label or identification of a human being as being male or female.

Defining Sex and Sexuality

WHO defines sex as the biological characteristics that define humans as male or female. The biological or physiological differences between male and female including both the primary sex characteristics, such as, the reproductive system (uterus or testes) and the secondary sex characteristics (breasts or beard). Biological functions are programmed genetically, XX chromosomes for female and XY chromosomes for male, and are unalterable.

Sexuality is an essential feature of being human all through life, and includes sex, sexual categories, roles and orientation, gratification, relationships, and procreation. Sexuality is influenced by a variety of factors such as, genetics, socio-cultural, economic, political, as well as, religious and spiritual factors. In short, sexuality is being human.

Dimensions of Sex

Sex Dimensions	Male	Female
1. Chromosomes	XY	XX
2. Gonads	Testes	Ovaries
3. Hormones	Androgens	Estrogens
4.External Genitalia	Penis, Scrotum	Labia, Clitoris
5.Internal Organs	Prostate, seminal vesicles, vas deferens	Vagina, uterus, tubes, ovaries
6.Secondary sex characteristics	Beard, low voice, sperm emission	Breasts, menstruation

Defining Gender

Gender, as defined by WHO refers to socially constructed characteristics of masculinity and femininity. It includes behaviors, roles, personality traits, norms that a group or society determines what is standard for its males and females. It is a concept specifying the socially and culturally suitable character that men and women are to practice. It is culturally different and changes with time and history.

"Gender and sexuality are political, it is organized into systems of power, which reward and encourage some individuals and activities, while punishing and suppressing others." Gayle Rubin, 1984

Biological Determinism of Gender

In the past, sex and gender were used interchangeably. Biological determinism theorists believe that the biological distinction between men and women automatically translate into differences in their social roles. One's biological sex usually establishes a pattern of gendered expectations.

Women are child-bearers, and are automatically ascribed connected roles such as child rearing and housekeeping. Women's traditional gender roles are to manage the household: cooking, cleaning, washing, and taking care of the husband, the children, and the elderly. It is work in the concealed domain of the home, often unpaid labor, and of no economic value.

Unfortunately, these ideas have been used particularly to deny specific rights to women, and leads to Gender-Based Violence. A woman is beaten because she did not take care of her husband's needs. In contrast, the husband, the aggressor may be perceived as acting like a normal male and receives little blame.

Gender Dimensions of VAW

In many societies, prevailing attitudes and norms subordinate women to men. Women are taught at the beginning of their lives that they are less significant to men and must be submissive to them. On the other hand, men are entitled to dominate and use violence to control women, justifying, tolerating, and condoning GBV.

All in all, including the cultural and the social norms that shape gender roles, ideologies of male sexual entitlement and objectification of women and the unequal distribution of power among men and women contribute to the social problem of GBV.

In summary, the G in GBV means:

Gender is socially constructed, it is a learned concept and it can be unlearned or changed to be better.

Gender is not biologically determined but culturally and socially constructed it changes with society and across time. Biology is not destiny. Men too can be nurturers.

Gender relations are power relations often showing male dominance in a patriarchal or male dominated society over female submissiveness.

Gender is context specific and varies with ethnicity, class, culture, and religion. It is also institutional - whoever is in power controls society and the norms that are to be followed.

I sincerely hope that I have enlightened you and given you a better understanding on the dynamics of Gender-Based Violence.

Let me end this chapter with a quote from ***Simone de Beauvoir***, a great French feminist, philosopher and novelist:

"On the day when it will be possible for woman to love, not in her weakness but in strength, not to escape herself but to find herself, not to abase herself but to assert herself – on that day love will become for her, as for man, a source of life and not of mortal danger. In the meantime, love represents in its most touching form the curse that lies heavily upon woman confined in the feminine universe, woman mutilated, insufficient unto herself."

References:

Beauvoir, Simone, "The Second Sex." New York: Vintage Books, 1973

Farrell, Kenan. Where have all the young girls gone? Preconception gender selection in India and the United States. IUPUI, 2001

MacKinnon, Catharine, Toward a Feminist Theory of the State. 1989.

Mikkola, Mari, "Feminist Perspectives on Sex and Gender. 2008. The Stanford Encyclopedia of Philosophy.

Newman, Tim. Sex and Gender: What is the difference? Medical News Today Newsletter, 2018

Rubin, Gayle. "Thinking Sex: Notes for a Radical Theory of the Politics of Sexuality." 1984

WHO Gender and Health.

CHAPTER 3:

Screening and Referral of Victim-Survivors of Gender-Based Violence

Elizabeth J. Batino, MD, FPOGS

DIAGNOSING GENDER-BASED VIOLENCE

Gender-Based Violence (GBV**)** is an umbrella term for violence that targets individuals or groups based on their gender. It cuts across all ages endangering adults and children alike. An associated form of violence is Violence Against Women and Girls (VAWG), which is directed specifically at females.

I. SCREENING APPROACHES

Screening is "asking" women and girls about experience of violence or abuse, whether or not they have any signs or symptoms. In the United States and other industrialized countries, routine screening for violence has increasingly been considered the standard of care within women's health. Without screening a great fraction of victim-survivors who need assistance for any form of abuse will be missed out resulting to additional risk of violence (UN Women,2011).

There are four basic approaches to screening (UN Women, 2011)

1. *Universal Screening* – asking all women about abuse at all first visits provided there is safety and quality of care present
2. *Selected Integration* – routine asking in specific areas like in emergency department, or areas that can improve overall health outcomes like prenatal care clinics, HIV-AIDS clinics, family planning clinics, subspecialty clinics. This is a cost-effective way to identify women, provided the staff are well-trained about potentially re-traumatizing the woman or the girl during the screening.
3. *High-risk Screening* – involves screening groups of women who have been identified as being at high risk: girls in child marriages, domestic workers, girls in households without either parent, sex workers, women and girls in emergency settings (armed conflict, natural calamities), crisis such as the COVID-19 pandemic, women with mental illness, those with disabilities, and those who are HIV-positive
4. *Selective Screening* – is done when there are signs or indications that violence may be occurring

It is prudent that the obstetrician-gynecologist, being a service provider, must understand the health consequences of VAWG to be able to detect possible health indicators of abuse.

Regardless of which type of screening is implemented, health care providers have an ethical obligation to do no harm. The challenge that GBV presents is that detection and the way in which the problem is approached is decisive, not only to avoid the victim's re-living the trauma of the violence, but most importantly to avoid a repeat of the violence that could lead to death. (WHO, 2013).

The World Health Organization's (WHO) in 2013 recommends that health-care providers should ask about exposure to Intimate Partner Violence (IPV) when assessing conditions that may be caused or complicated by IPV in order to improve diagnosis/identification and subsequent care.

SCREENING TOOLS:

A. American College of Obstetrics and Gynecology (ACOG) recommends screening all patients at gynecologic, family planning, and preconception visits, and during pregnancy during each trimester and postpartum. They developed a 3-item Screening Tool for domestic violence (DV) that the clinician can administer (ACOG, 2003):

1. "Within the past year-or since you have become pregnant-have you been hit, slapped, kicked, or otherwise physically hurt by someone?
2. "Are you in a relationship with a person who threatens or physically hurts you?
3. "Has anyone forced you to have sexual activities that made you feel uncomfortable?"

The clinician must use language that the victim-survivor understands such that the above items may be asked in the dialect of that particular region.

A Screening Tool for sexual assault developed by ACOG (ACOG 2003):

1. "Do you have someone special in your life? Someone you're going out with?"
2. "Are you now, or have you been, sexually active?"
3. "Think about your earliest sexual experience. Did you want this experience?"
4. "Has a friend, a date, or an acquaintance ever pressured or forced you into sexual activities when you did not want them? Touched you in a way that made you uncomfortable? Anyone at home? Anyone at school? Any other adult?"
5. "Although women are never responsible for rape, there are things that they can do that may reduce their risk of sexual assault. Do you know how to reduce your risk of sexual assault?"

B. SAFE Questions (Basile, 2007)

S	Stress/Safety	1. What stress do you experience in your relationship?
		2. Do you feel safe in your relationship
A	Afraid/Abused	3. People in relationships sometimes fight. What happens when you and your partner disagree?
		4. Have there been situations in your relationship where you felt afraid?
		5. Have you been physically hurt or threatened by your partner?
		6. Has your partner forced you to engage in sexual activities that you did not want?
F	Friends/Family	7. Are your friends and family aware of what is going on?
E	Emergency	8. Do you have a safe place to go in case of emergency?

The Emergency Department (ED) is a place where women with injuries as a result of violence may seek help. A positive screening for gender violence determines developing an adequate plan of care for the victim-survivor (UN Women, 2011).

C. **HITS** (Hurt-Insult-Threaten-Scream) scale is another promising domestic violence screening mnemonic (Basile 2007). This tool is a simple, brief instrument for use to identify victims of domestic violence consisting of four items, asking the client:

1. **H- "**Have you ever been physically hurt by your partner?"
2. **I-** "Have you ever been insulted?"
3. **T-** "Did he threaten or curse you?"
4. **S-** "Does he scream at you?"

Remember, **DO NOT** ask questions like:

- "Why don't you just leave? Why do you stay with someone like that?"
- "Why did you wait so long to say something? (Oftentimes, a doctor is heard saying: "Bakit ngayon ka lang, Misis?")
- "What did you do to make him hit you?"
- "If it were me, I wouldn't put up with this."
- "Have you tried marriage counselling?"
- "Let me give you something for your nerves"

II. GBV RED FLAGS in ADULTS

The practitioner should be able to **RECOGNIZE** clinical conditions which are the red flags, the warning indicators of abuse.

1. Risk factors for GBV:

- younger age
- delayed/poor response or "slow pick-up"
- female
- out of school
- lower socioeconomic status
- unemployed
- lower-level educational attainment
- past abuse (if disclosed)

2. Behavior suggestive of abuse events (Stanford Medicine, n.d.)

- Reluctant to remove clothing, partially undresses
- Avoids eye contact, fearful eye contact
- Flat affect, appears "zoned out"
- Unexplained crying
- Exaggerated startle response to touch
- Excessive distress out of proportion to the clinical situation
- Avoidance behavior- keeping knees together, withdrawal from the examiner
- Increased muscle tension during the exam
- Sexuality issues
- Exacerbation of medical conditions: asthma, DM, IBS, autoimmune, hypertension, CVD, musculoskeletal problem
- Palpitations
- Non-compliant with medical advice

- Decreased breastfeeding
- Frequent/unexplained appointment changes or no shows “hides” with heavy make- up, sunglasses, clothing which covers arms and neck, hoodies

3. Physical findings:

- The history does not fit the injury or there are inconsistencies in the story
- There is delay in seeking treatment
- There is a pattern of repeated emergency department visits

The following physical findings are “red flags”:

- Defensive injuries on forearms
- Bruises/other injuries in various stages of healing, usually on the central trunk
- Contusion-hematoma, bruise, laceration, abrasion on the face, eyes, mouth, head, neck, chest
- Unexplained, multiple or bilateral injuries
- Rectal/ genital injuries (post-coital laceration)
- Burns
- Welts
- Bite marks
- Fractures, dislocations
- Injury during pregnancy usually on abdomen and breasts
- Choking sequelae: hoarseness, dysphagia, dyspnea, subconjunctival hemorrhage, cognitive problems
- Nutritional deficiency
- New onset of seizure, unexplained stroke
- Neurologic changes- paresthesia, numbness, loss of hearing or vision

The OB-GYN practitioner encounters patients at different points in their life cycles, from infancy, childhood, teen, adulthood, to the elderly stage. In addition to the indicators of abuse mentioned above that the clinician should never miss, the following symptoms and conditions are equally important (NICE, 2016; WHO, 2013):

- Unexplained reproductive symptoms including pelvic pain, sexual dysfunction (low sexual desire, lack of response/orgasm, sexual arousal disorder, dyspareunia)
- Multiple unintended pregnancies or terminations, stillbirth
- Vaginal bleeding, bleeding during pregnancy, intrauterine hemorrhage
- Abortion
- Adolescent/Teenage pregnancy
- Delayed or no prenatal care, IUGR, premature labor, preterm birth, LBW, SG
- Unexplained genitourinary symptoms, including frequent bladder or kidney infection
- HIV and other STI
- UTI, dysuria
- Vaginal fistula, vulvar hematoma, post-coital laceration
- Chronic unexplained pelvic pain
- Traumatic injury, particularly if repeated and with vague or implausible explanations

4. VAW affects the emotional and mental state of the victim profoundly.
    - Symptoms of depression, anxiety, post-traumatic stress disorder (PTSD),

- Suicidality or self-harming
- Alcohol or other substance misuse/abuse
- Unexplained chronic gastrointestinal symptoms, other chronic pain or disability
- Repeated health consultations with no clear diagnosis (psychosomatic syndrome
- Presence of intrusive "other person" in consultations, including partner or spouse, parent, grandparent, or adult (on an elderly)
- Sleep problems
- Eating disorders
- Distrustful, angry, defensive

Reporting and Referring of Victim-Survivors of GBV

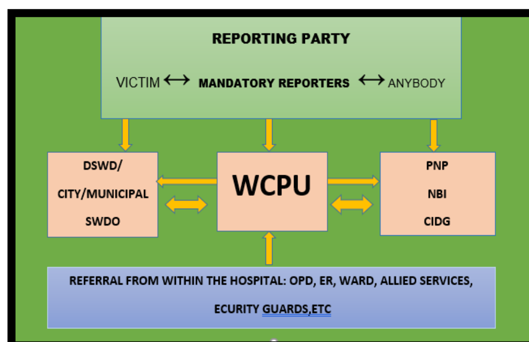
What is a referral system?

A Referral System is a cooperative scheme of duty-bearers and stakeholders working to protect and promote the human rights of VAWC survivors to ensure that necessary services are extended by a referral network composed of agencies, organizations, and institutions.

In institutions where there is a well-established facility to cater to the referrals from all sectors, victim-survivors of GBV receive holistic care.

The diagram below shows how WCPU-BGHMC handles cases of GBV in collaboration with the different network agencies to provide an efficient service.

Fig. 1: Management of Cases of Abuse (Reporting and Referring Cases)



The mandatory reporting of gender violence has become a controversial issue among health care practitioners and victims. There are complex ethical, moral, and legal issues that are not within the scope of this chapter.

The barangay has a limited role in cases of VAWC. The VAWC Desk Officer must report the case to the nearest DSWD or law enforcement agency when they receive a complaint or refer directly to the WCPU. Alleged victims of abuse from other hospitals as well as from private physicians may be reported to the DSWD or law enforcement agency or directly referred to the WCPU for medico-legal examination and other interventions.

Within the hospital, referrals come from different units, sections, and other departments. Victims may be referred directly to the E.R or the OPD where the clinician performs screening, medical legal examination following guidelines as stated above. He/she must refer to other specialty and sub-specialty if deemed necessary.

III. References

- *Anti-Violence Against Women and their Children Act.* (2004, March 8). Philippine Constitution. https://www.officialgazette.gov.ph/2004/03/08/republic-act-no-9262-s-2004/

- Basile, K.C., Hertz, M.F. & Back, S.E. (2007). *Intimate Partner Violence and Sexual Violence Victimization Assessment Instruments for Use in Healthcare Settings: Version 1* [PDF]. Centers for Disease Control and Prevention, National Center for Injury Prevention and Control: Atlanta, Georgia. https://stacks.cdc.gov.44660_DS1

- Cahn, N., Aoláin, F. N., & Haynes, D. F. (2012, May). Sexual Violence in Conflict Zones: From the Ancient World to the Era of Human Rights. Human Rights Quarterly, 34 (2), 682-688. The John Hopkins University Press. https://www.jstor.org/stable/i23254613

- California Department of Social Services: Office of Child Abuse Prevention. (n.d.). *The California Child Abuse & Neglect Reporting Law: Issues and Answers for Mandated Reporters.* https://www.rcbo.org/wp-content/uploads/CA-Child-Abuse-Laws.pdf

- Child Protection Network Foundation Inc. (CPN). (2015). *Child Maltreatment: Medico-legal Terminology and Interpretation of Medical Findings: A Consensus of Medical and Legal Child Protection Practitioners in the Philippines*, 4th ed. Manila, Philippines. https://www.childprotectionnetwork.org/wp-content/uploads/2019/06/MedicoLegalConsensus_3.10-ver-2.pdf

- Committee for the Special Protection of Children (CSPC). (2014, November 26). *Protocol for Case Management of Child Victims of Abuse, Neglect, and Exploitation*. Department of Justice. https://www.doj.gov.ph/files/transparency_seal/2016-Jan/CPN-CSPC%20Protocol%2026Nov2014.pdf

- Goldenring, J.M. & Rosen, D.S. (2004, January). Getting into adolescent heads: an essential update. *Contemporary Pediatrics*, 21 (1), 64. Intellisphere, LLC. https://go.gale.com/ps/anonymous?id=GALE%7CA112941767&sid=googleScholar&v=2.1&it=r&linkaccess=abs&issn=87500507&p=AONE&sw=w

- Gonzales, G. (2020, December 15). *Violence against women and girls: A pandemic we must end now.* United Nations Philippines. https://philippines.un.org/en/105122-violence-against-women-and-girls-pandemic-we-must-end-now

- *HEEADSSS 3.0: The psychosocial interview for adolescents updated for a new century fueled by media.* (2014, January 1). Contemporary Pediatrics. https://www.contemporarypediatrics.com/view/heeadsss-30-psychosocial-interview-adolescents-updated-new-century-fueled-media

- Hutchinson, J. W., & Stafford, E. M. (2005). Changing parental opinions about teen privacy through education. Pediatrics, 116(4), 966–971. https://doi.org/10.1542/peds.2005-0318

- Katzenellenbogen, R. (2005). HEADSS: The "Review of Systems" for Adolescents. *Virtual Mentor*, 7(3),231-233. doi: 10.1001/virtualmentor.2005.7.3.cprl1-0503.

- Kosterina, E., Horne, S.G. & Lamb, S. (2019, January 30). The role of gender-based violence, health worries, and ambivalent sexism in the development of women's gynecological symptoms. Journal of Health Psychology, 26(4), 567-579. https://doi.org/10.1177/1359105318825292

- Krug, E.G., Dahlberg, L.L., Mercy, J.A., Zwi, A.B. & Lozano, R, eds. (2002). *World report on violence and health.* World Health Organization: Geneva. https://apps.who.int/iris/bitstream/handle/10665/42495/9241545615_eng.pdf

- National Institute for Health and Care Excellence (NICE). (2016, February, 29). *Domestic violence and abuse.* NICE. https://www.nice.org.uk/guidance/qs116/resources/domestic-violence-and-abuse-pdf-75545301469381

- *Screening Questions for Routine Intake Assessment.* (n.d.). Child Abuse Reporting. https://www.dorightbykids.org/how-do-i-recognize-child-abuse-and-neglect/screening-questions-for-routine-intake-assessment/

- *Special Protection of Children Against Abuse, Exploitation and Discrimination Act.* (1992). Philippine Constitution. https://www.officialgazette.gov.ph/1992/06/17/republic-act-no-7610/

- Stanford Medicine. (n.d.). *Domestic Abuse.* Stanford Medicine. https://domesticabuse.stanford.edu/

- Suryavanshi, N., Naik, S., Waghmare, S., Gupte, S., Khan, S., Mave, V., Deluca, A., Gupta, A., Golub, J., Bollinger, R.C. & Shankar, A. (2018, January 15). Gender-based violence screening methods preferred by women visiting a public hospital in Pune, India [PDF]. *BMC Women's Health*, 18 (19). doi: 10.1186/s12905-018-0515-2

- The National Child Traumatic Stress Network (NCTSN) Child Sexual Abuse Committee. (2009). *Caring for Kids: What Parents Need to Know About Sexual Abuse.* National Center for Child Traumatic Stress: Los Angeles, California & Durham, North Carolina. https://www.nctsn.org/sites/default/files/resources/fact-sheet/caring_for_kids_what_parents_need_know_about_sexual_abuse.pdf

- United Nations (UN) Women. (2011, February 25). *Conduct Screening*. UN Women Virtual Knowledge Centre to End Violence against Women and Girls. https://www.endvawnow.org/en/articles/667-conduct-screening.html

- United Nations Convention on the Rights of the Child (CRC)

- WHO Team: Sexual and Reproductive Health and Research. (2013). *Global and regional estimates of violence against women* [PDF]. WHO. http://apps.who.int/iris/bitstream/handle/10665/85239/9789241564625_eng.pdf

- WHO. (2013, October 20). *Responding to intimate partner violence and sexual violence against women: WHO clinical and policy guidelines* [PDF]. World Health Organization. https://apps.who.int/iris/bitstream/handle/10665/85240/9789241548595_eng.pdf;jsessionid=20E03C5F85601B86A737E3DB47DC58C0?sequence=1

- World Health Organization (WHO). (2005, June 2*).* *Integrating Poverty and Gender into Health Programmes: A Sourcebook for Health Professions: Module on Gender-Based Violence* [PDF]. WHO Regional Office for the Western Pacific, Manila. https://apps.who.int/iris/bitstream/handle/10665/207485/9290611944_eng.pdf?sequence=1&isAllowed=y

Appendix A

There are 113 WOMEN AND CHILDREN PROTECTION UNITS (WCPUs) AND VAWC DESKS LOCATED IN 57 PROVINCES AND 10 CITIES

Courtesy of Child Protection Network, UP-PGH.

CHAPTER 4:

PRIVACY AND CONFIDENTIALITY

Ma. May Grace M. Doromal, MD, FPOGS

When a victim survivor of Gender-Based Violence seeks help, the health worker must realize how much courage it took them to come out and go through their harrowing experience all over again by retelling all details of that life-changing experience. Thus, giving them privacy is essential and service providers must remember that confidentiality, the right to choose and consent are crucial elements of survivor-centered skills which our resident trainees and all GBV responders must learn thoroughly. Recommendations arrived at in this chapter were based on existing protocols recommended by WHO and UNHCR.

DEFINITION OF TERMS:

PRIVACY – being away from public attention, the state of being apart from company
CONFIDENTIALITY – being trusted with secret or private information

How to ensure privacy:

- Talk to the patient alone with nobody else listening. This includes other physicians (unless they are part of the team), students, nurses, and others.
- There should be a private place where you can talk to the patient alone.

How to ensure confidentiality:

- No one should be able to access the chart and the medical records when they are not part of those giving direct care to the patient.
- No gossiping of the case to other people including other doctors not involved in the case and the patient's own family members.
- The medical certificate and medical records should not be given to just anybody including husbands, relatives, lawyers and police without the victim's written permission. If the patient is mentally-challenged, medical certificates shall be issued to the guardian or government social worker handling the case if without a guardian.
- The patient's identity and even the fact that she consulted should not be given to just anybody without the victim's written permission.

Maintaining confidentiality ensures that a survivor does not experience further threats and/or violence as a result of seeking assistance. Confidentiality is one of the essential elements that lead to an increased sense of security for survivors. When programmes maintain confidentiality, more survivors feel comfortable reporting what happened to them, and are able to pursue help. When a programme serving survivors of sexual violence breaks confidentiality, or when a health center is unable to keep their records safe and secure, information about survivors can easily get into the wrong hands. If the information gets into the hands of perpetrators, or other adversaries in the community, the consequences can be devastating. When confidentiality is broken, both survivors and caretakers are at further risk of harm.

LEGAL MANDATES ON PRIVACY & CONFIDENTIALITY:

R.A. 7610 (Special Protection of Children Against Child Abuse, Exploitation, and Discrimination Act)
Mandates that the name of offended party is kept private until the court has jurisdiction of the case. Physicians, nurses, and hospital administrators and clinics are mandatory reporters of suspected child abuse cases within 48 hours of knowledge of the case. Always report whether or not parent/guardian files a criminal case. This means that in child abuse cases, confidentiality

is still in place except that they have to report to the authorities. Confidentiality must be ensured from barangay level to court level. There must be no media during rescue operations.

Official acceptors of reports:

- DSWD or LGU Social Welfare Office
- Law Enforcement Agency
- Barangay Council for the Protection of Children

R.A. 9262 (Anti-Violence Against Women and Their Children Act of 2004**)**
Mandates confidentiality for victim survivors of GBV with corresponding penalties for violations. Any person who violates this provision shall suffer the penalty of one (1) year imprisonment and a fine of not more than Five Hundred Thousand Pesos (P500,000.00).

RA 10173 (Data Privacy Act of 2012)
Protects individuals from unauthorized processing of personal information that is (1) private, not publicly available; and (2) identifiable, where the identity of the individual is apparent either through direct attribution or when put together with other available information. It is the policy of the State to protect the fundamental human right of privacy, of communication while ensuring free flow of information to promote innovation and growth.

Consent – Release of Information
Asking for consent means asking the permission of the survivor to share information (release of information) about him/her with others (for instance, with referral services and/or monitoring organizations) or to undertake any action (for instance, organizing referral and/or starting a medical examination). Under no circumstances should the survivor be pressured to consent to any examination, conversation, assessment, interview or other intervention with which she does not feel comfortable. A survivor can also at any time decide to stop an intervention (e.g., during a medical examination). Healthcare providers, but also sometimes human rights workers, investigators and others will use a consent form. By signing this form, the survivor can formally agree (or disagree) with a physical examination, receiving medication, sharing information with other organizations. The form should clearly state how information will be used, stored, and disseminated. For proper documentation, the person who gathered the information should affix signature as well as signatures of witness/es.

If a survivor does not consent to sharing information, then only non-identifying information can be released to other organizations (e.g., general information about the number of cases of sexual violence a center supported). When obtaining informed consent**,** the survivor should fully understand what she/he is consenting to, and this should be taken prior to any examinations or tests. Before agreeing, she/he should be first informed about all the available options for support. The full range of choices should be presented to the survivor, regardless of the individual beliefs of the community worker, health care worker, or others dealing with survivors. In the case of children, informed consent is normally requested from a parent or legal guardian or government social worker if without legal guardian and the children themselves.

Elements of informed consent:

- Tell a survivor what is going to happen to him/her and what diagnostic screening tests will be performed. Tell survivor that photos/videos will be taken as part of evidences and shall only be presented in court.
- Explain to him/her the benefits and risks of an intervention (medical treatment, interview)
- Explain that she/he has the right to decline or refuse any part of an intervention.
- Explain that pressure will not be exerted in any form.
- Explain that if the survivor does not want to be interviewed about the events (to a health care worker or humanitarian worker), this will not affect access to health and other services and does not preclude participation in future proceedings related to legal justice.

- Inform the survivor about any mandatory reporting in the setting.
- Inform the survivor that information about him/her will be discussed in the team.
- Ensure that the survivor understands what you have told him/her.

Right to choose:

The right to choose is particularly important because it gives back a feeling of control and power to the survivor, which she/he lost during sexual violence. Survivors should not be forced to or pressured to undergo any treatment, examination, or other intervention against their will. Decisions for health care, counselling, legal aid and other interventions are personal and can only be made by the survivor him/herself or in the case of children, the child and their parent or legal guardian. In this context, it is essential that the survivor receives appropriate information to allow him/her to make informed choices. Survivors also have the right to decide whether by whom they want to be accompanied when they receive information, are examined, or receive other services. These choices must be respected.

Possible exceptions to breach of confidentiality:

1. **Suspicion of child abuse or neglect**
   In many countries you have the duty to report any suspicion about child abuse or neglect. The safety of the child is in this situation more important than the confidentiality.

2. **Emergency or life-threatening situations**
   In situations where the life of the survivor or of others is endangered, you have to release information and undertake action (e.g., if the person is suicidal or expresses a serious threat to harm others).

3. Health care workers and counsellors can share information about a case with colleagues, to ask for technical advice or in the context of supervision. It is not considered to be a breach in confidentiality. This must be explained to the survivor at the start of the consultation.

REFERENCES:

- UNHCR (2001), How To Guide: Sexual and Gender-based Violence Programme in Liberia. www.rhrc.org/pdf/h2g008.pdf.
- RHRC Consortium, Communication Skills Training Manual – Facilitator's Guide, p.50. http://www.rhrc.org/resources/gbv/comm_manual/comm_manual_toc.html
- UNHCR. (2003). Sexual and Gender –Based Violence against Refugees, Returnees and Internally Displaced Persons: Guidelines for Prevention and Response.
- WHO/UNHCR (2005). Clinical Management of Rape Survivors, p. 3
- Gender-Based Violence (GBV) prevention and response in humanitarian settings

CHAPTER 5:

COUNSELING SURVIVORS OF GENDER-BASED VIOLENCE

Madeline Meldrid Rita G. Amadora, MD, FPOGS

The latest Social Weather Stations survey of 2021 on domestic violence reveal that one out of four adult Filipinos have said harmful acts in various forms are among the most pressing problems of women during the present health crisis. Eleven (11%) percent of cases are physical violence considered as top-of-mind concern (from 9% in 2017), while 7% cited sexual violence and 7 % emotional violence.

Understanding the dynamics of domestic violence and child abuse victims:

Why do women stay in abusive relationships?

- The man might change for the better.
- She loves him.
- She does not want a "broken family".
- She stays for the sake of the children.
- She cannot support herself or her children.

Before the provision of a counseling, it is important for the counselor to understand the dynamic that manifests in an abusive intimate partner relationship and child abuse. In this way, the treatment could be tailor fit to the problem and it will become more effective. The utmost goal of treatment is for the client to be empowered and processed of her/his experiences.

Two theories have been proposed that would define the psychological characteristics of the victim:

1. Learned helplessness **–** When animals were placed in an aversive situation where there was no escape, they appeared to take on a sense of helplessness. Later when placed in an aversive situation which they could easily escape, they made no attempt to do so.

   In 'The Battered Woman', an abused woman will often become 'paralyzed' as a consequence of learned helplessness. The woman comes to believe she has no control over her situation and consequently becomes submissive towards punishment and violence. Nothing she does changes her situation so she thinks she is the problem and that she must change herself. She blames herself for not being able to change the situation and therefore suffers from low self-esteem and becomes anxious and depressed.

2. Traumatic Bonding- describe the strong emotional attachment that evolves between victims/survivors and their abusers. There is power imbalance in this kind of relationship. The abuser may alternate from being violent to loving and warm. As no other relationship is available to the victim/survivor, they attach more on the positive side of the abuser. In honeymoon phase in the cycle of violence, the victim/survivor comes depend to on their abuser for emotional comfort after an abusive incident as this is commonly a time when the abuser is kind and loving towards the victim/survivor.

At some point, a woman may come to you for help. This woman has been experiencing violence by an intimate partner. What do you do?

You can offer a first line of support. First-line support provides practical care and responds to a woman's emotional, physical, safety, and support needs. When providing support to a woman who has been subjected to violence, the following needs deserve attention:

- Immediate emotional/psychological health needs
- Immediate physical health needs
- Ongoing safety needs
- Ongoing support and mental health needs

What is person-centered counseling?

It is a talk therapy or counseling that allows the client to lead the conversation and does not attempt to lead the client in any way. This approach support on one vital quality: unconditional positive regard. This means that the therapist avoids from judging the client for any reason, thus, providing complete acceptance and support (Cherry, 2017).

Goals of client centered counseling:

- Facilitate personal growth and development
- Eliminate or alleviate feelings of distress
- Boost self-esteem and openness to experience
- Raise the client's understanding of him- or herself

Client-centered counseling method and techniques:

- Set clear boundaries
- Clients know best
- Act as a sounding board
- Don't be judgmental
- Don't decide for your clients
- Focus on what they are saying
- Be genuine
- Accept negative emotions
- How you speak can be more important than what you say

Providing counseling and psychological intervention to women and girl victims of violence is a specialized practice. Domestic violence, child abuse and its effects differ from tragedies, accidents, natural and man-made disasters. The dynamic of this act of maltreatment is more personal and the victim is seen as more of a target therefore the effects are also unique.

It is important to consider that although traumatized women and girls appreciate long-term and intensive psychotherapy, most of them prefer the short-term, brief, problem-oriented intervention. For some, the provision of practical resources and emotional support is already sufficient. This is because most of them do not have the time and financial resources to attend to the scheduled sessions. It is also important to know that victims' symptomatology are common reactions to an uncommon event.

Guidelines in responding to victims of domestic violence:

- Respect the woman's wishes. Her wishes should determine the care that you give.
- Respect for women's rights
- Gender equality

We respond to survivors of Gender-Based Violence by the acronym of **LIVES** (**L**isten, **I**nquire about needs and concerns**, V**alidate**, E**nhanced Safety and **S**upport).

LISTEN:

Listen to the woman with empathy, and without judging. Listening is the most important part of good communication and the basis of first-line support. It involves more than just hearing the woman's words. It means being mindful of the feelings behind her words, observe body language – both hers and yours – like eye contact, facial expressions, gestures, sitting or standing at the same level and close enough to the woman to show concern and attention but not so close as to invade her privacy.

INQUIRE ABOUT NEEDS AND CONCERNS:

Assess and acknowledge to her various needs and concerns like emotional, physical, social, and practical. As you listen to the woman's disclosure, be attentive to her needs and concerns. Some of her needs may not be articulated during your conversation so it is essential for you to be observant of her non-verbal communication and body language.

Techniques for interacting:

1. Phrase your questions as invitations to speak.
   Example: "What would you like to talk about?"

2. Ask open-ended questions to encourage her to talk instead of asking yes or no questions.
   Example: "How are you feeling today?"

3. Repeat or restate what the person says to check your understanding?
   Example: "You mentioned that you feel very disappointed?"

4. Reflect the survivor's feelings.
   Example: "You seem upset".

5. Ask for clarification if you don't understand.
   Example: "Can you explain that again, please?"

6. Help her to identify and express her needs and concerns.
   Example: "It seems that you are worried about your children?"

7. Summarize what she said.
   Example: "You seem to be saying that…"

VALIDATE:

Show her that you understand and believe her. Assure her that it is not her fault. Validating another's experience means letting the person know that you are listening attentively, that you understand what she is saying, and that you believe what she is saying without judgment or conditions.

Important things to say:

a. "It's okay, it's not your fault".
b. "No one deserves to be hit by a partner"
c. "You are not alone".

Ways to respond in helping women with negative feelings:

1. Denial - "I'm taking what you have told me seriously. I will be here if you need help in the future."

2. Guilt and self-blame - “You are not to blame for what happened to you. You are not responsible for his behavior”.
3. Shame - “Whatever happened, you are still valuable”.
4. Anger with perpetrator- Acknowledge that this is a valid feeling.

ENHANCE SAFETY:

Many women who experienced violence have fears about their safety. Other women may not think they need a safety plan since they do not expect that the violence will happen again. Assessing and planning for safety is a continuing process – it is not just a one-time conversation. You can help her by discussing her particular needs and situations and exploring her options. Some women will know when they are in immediate danger and are afraid to go home. If she is worried about her safety, take her seriously. Other women may need help thinking about their immediate risk. There are specific questions you can ask to see if it is safe for her to return to her home. It is important to find out if there is an immediate and likely risk of serious injury.

Women who answer “yes” to any of the following questions may be at high or immediate risk of violence:

- Has the physical violence happened more often or gotten worse over the past 6 months?
- Has he ever used a weapon or threatened you with a weapon?
- Has he ever tried to strangle you?
- Do you believe he could kill you?
- Has he ever beaten you when you were pregnant?
- Is he violently and always jealous of you?

Ask her if she has a safe place to go – “If you will leave your home, where could you go?
Planning for the children – “Would you go alone or take your children with you?”
Transport – “How will you get there?”
Items to take with you – “Do you need to take any documents, keys, money, clothes, or other belongings with you when you leave? What is essential? Can you put together items in a safe place or leave them with someone, just in case?”
Financial – “Do you have access to money if you need to leave? Where is it kept?”
Avoid putting her at risk by talking about the abuse to others. Remember to maintain confidentiality of your conversation or records. Discuss your plans for her and the process that she will go through.

SUPPORT

Support her by helping her connect to information, services and social support. The purpose of this is to connect a woman with other resources for her health, safety, and social support.

How to help:

- Ask her what issues are most important to her right now. You can ask her, “What would help the most if we could do it right away?”
- Help her to identify and consider her options.
- Discuss her social support. Does she have a family member, friend, or trusted person in the community whom she could talk to?

Find out what support and resources are available to the woman in the community. It can help if you have a personal contact to send her to at each place. Possible resources are protection center, support groups, crisis center, legal support, social worker and psychologists.

Some frequently asked questions:

1. Why not offer advice?

Answer: The woman may not need your advice at the time that she is in crisis. What she needs is to be listened to and to feel validated.

2. "What if she decides not to report to the police?"

   Answer: Respect her decision. Let her know that she can change her mind. But always stress safety measures.

3. "What if she starts to cry?"

   Answer: Give her time to do so.

Responding to child abuse victims:

When a child discloses that he/she has been abused: Choose your words carefully—don't be judgmental about the child or the alleged perpetrator. Avoid interrogating the child. Listen and let the child disclose his/her own story. Be calm, your response can confuse or scare the child. Assure the child that you believe his/her disclosure. Find out what the child wants and be honest about what you can do – the child may want you to promise that you won't tell others – tell the truth and do not make promises. Evaluate whether the child is in immediate danger. Tell the child that his/her feelings are okay. Assure the child that you care and that he/she is not to be blamed. Acknowledge to the child that you're glad he/she told you and that you will get help.

REFERENCES:

Judith Herman MD. (1992). Trauma and Recovery

Linda Campbell et al. (March 2020). APA Guidelines for Psychological Assessment

Inter-agency Standing Committee. (2020). Basic Psychological Skills

Nora Sveass et al. Mental Health and Gender-Based Violence, Helping Survivor of Sexual Violence

IASC. (August 2015). Guidelines for Integrating Gender-Based Violence Interventions in Humanitarian Action

Polaris. (2018) In their Shoes: Understanding Victims' Mindsets and Common Barriers to Victim Identification

CHAPTER 6:

Promoting Awareness of Gender-Based Violence in the Community

Florencia T. Miel, MD, FPOGS, FPCS, FPSGE

Gender-Based Violence (GBV) awareness is important. Promoting GBV awareness is equally important because it enhances everyone's knowledge of GBV causes. and prevention. It also provides information for people in the community about support for survivors of violence.

To raise GBV awareness, we have listed some strategies.

Strategies for Promoting Awareness of Gender-Based Violence/IPV

Be familiar with the Laws concerning GBV/VAWC in the Philippines.

Republic Act No. 9262 *The Anti-Violence against Women and their Children Act of 2004*.

Under the RA 9262, VAW refers to "any act or a series of acts committed by any person against a woman who is his wife, former wife, or against a woman with whom the person has or had a sexual or dating relationship, or with whom he has a common child, or against her child whether legitimate or illegitimate, within or without the family abode, which result in or is likely to result in physical, sexual, psychological harm or suffering, or economic abuse including threats of such acts, battery, assault, coercion, harassment, or arbitrary deprivation of liberty." (lawphil.net)

Republic Act No. 9710, the Magna Carta of Women "affirms the role of women in national building and ensures the substantive equality of women and men" in society. Pushing for the empowerment of women and for equal opportunities for both women and men, RA 9710 highlights the state's position, particularly of how the state "condemns discrimination against women in all its forms and pursues equal opportunities for women and men and ensures equal access to resources and to development results and outcome." RA 9710 was signed on August 14, 2009 by former President Gloria Macapagal-Arroyo.

(officialgazette.gov.ph)

Knowledge of these laws is important to be able to educate women and children of their rights thereby empowering them.

For women to understand the law better, the ZONTA Club of Cebu II came up with a Visayan translation of the RA 9262 and distributed these to all Barangays in Cebu City through the Gender and Development (GAD) Focal point persons after a series of fora dubbed "Dangoyngoy sa Kahilum" (Crying in Silence) explaining its provisions. The Visayan version is, "Undangon na ang Pagpanagmal sa mga Babaye". This may be translated into the local vernacular in other regions.

Provide Barangays with Barangay VAW Desk Handbooks preferably in the dialect. This may be done through an NGO with funding by the LGU Women's Commission.

Join or network with like-minded organizations with advocacy on the fight against GBV/DV. Individually, we are capable of doing something but collectively, we can do more and be better heard.

Create signages/posters on Saying No to Violence against Women and Children in public places, establishments and workplaces not only during the celebrations of the18-Day Campaign to End Violence Against Women or of Women's month, but throughout the year to make the campaign more sustainable. Visibility is important in any awareness campaign.

Use social media for GBV awareness and information dissemination. We can use this to our advantage since almost everyone has a social media app. Audio-visual media & music are avenues for changing gender power relationships...Attend public fora about topics related to GBV, policing, public safety, changes in law, sexual harassment and stalking, and similar themes. Be involved.

Seminar-workshops, webinars and follow-ups of the different stakeholders involved with GBV/VAWC such as Barangay GAD focal point persons, VAWC desk in-charge, social workers psychologists and teachers. It is not enough that we hold seminars but we should look into their impacts and outcomes.

Join the yearly Women's Month celebration in March and the 18-Day Campaign to End Violence Against Women from November 25 to December 12 of every year to promote awareness and visibility.

Worldwide, the 16 Days of Activism against Gender-Based Violence is an annual international campaign that kicks off on November 25, the International Day for the Elimination of Violence Against Women and runs until December 10, Human Rights Day. The global theme for this year's celebration is: "Orange the world: End violence against women now!" (unwomen.org).
In the Philippines, it is celebrated annually as 18-Day Campaign to End Violence Against Women which starts November 25 and ends December 12 as mandated by Proclamation 1172 s. 2006 (pcw.gov.ph)

As members of POGS, not only should we be involved in GBV advocacy, but we must also be a voice for women.

References:

Lawphil.net
WHO: Gender-Based Violence
United Nations: VAWC
UN Women/unwomen.org
GBV Awareness Campaign pdf
https://www.strath.ac.uk/media/1newwebsite/departmentsubject/socialwork/documents/eshe/Key_Messages_Report_2019_Final.pdf
Gender Matters website: Council of Europe
National Commission on the Role of Filipino Women (NCRFW)
Violence Against Women in the Philippines
https://en.wikipedia.org/wiki/
UNFPA

CHAPTER 7:

LAWS FOR THE ADVANCEMENT OF WOMEN

Atty. Irene Ann C. Caballes
Legal Alternatives for Women Center, Inc.

R.A. 9710 - Magna Carta of Women 2009:

The MCW is a comprehensive women's human rights law, ensuring equality of women and men, and equal opportunities and access for both men and women; it seeks to eliminate discrimination against women through the recognition, protection, fulfillment, and promotion of the rights of Filipino women, especially those belonging to the marginalized sectors of the society. It conveys a framework for women based directly on international law.

It establishes the Philippine government's pledge of commitment to the Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW) and to the UN Human Rights Council. It is the local translation of the provisions of the CEDAW, particularly in defining gender discrimination, state obligations, substantive equality, and temporary special measures.

Among the salient features of MCW are:

- Right of women to protection and security during incidents of armed conflict, crises, calamities, particularly against GBV like rape and other forms of sexual abuse.
- Government personnel shall undergo mandatory trainings on human rights and gender sensitivity.
- Establishment of VAW desks in every barangay to ensure that violence against women cases are fully addressed in a gender-responsive manner.
- Provision for equal access and elimination of discrimination in education, scholarships, and training. Thus, "expulsion, non-readmission, prohibiting enrollment, and other related
- Discrimination of female students and faculty due to pregnancy out of marriage shall be outlawed.
- Equal rights in all matters relating to marriage.
- In addition to guaranteeing substantive rights, the MCW establishes the responsibility of the Philippine government to take actions in order to end discrimination against women and mandates the State to take steps to review, amend, or repeal existing laws that are discriminatory towards women.

Act 3815 December 8, 1930 - Revised Penal Code of the Philippines:

Felonies which may constitute GBV:

Rape – Will be discussed separately.

Threats and Coercion –

Threats – threatening another with the infliction upon the person, honor or property of the latter or of his/her family of any wrong, amounting to a crime (grave threats) or not amounting to a crime (light threats); threatening with or drawing a weapon in a quarrel, oral threats uttered in heat of anger and threatened act is not a crime (other light threats)

Coercion - preventing another from doing something not prohibited by law, or compelling him to do something against his will, whether it be right or wrong, by means of violence and without authority of law; higher penalty if the coercion is related to a religious act.

Unjust Vexation – "unduly vexing or irritating another";

Proposed definition by Sen. Miriam Defensor Santiago: Committing a course of conduct directed at a specific person/s, that causes substantial emotional distress in such person/s and serves no legitimate purpose.

Acts of Lasciviousness – sexual behavior that is contrary to local moral or other standards of appropriate behavior. It is similar in meaning to "lewd", "lustful", "indecent", "unchaste", "licentious" or "libidinous.

R.A. 7877 - Anti-Sexual Harassment Act of 1995

Work, education or training-related sexual harassment is committed by an employee, employer, manager, supervisor, agent of the employer, teacher, instructor, professor, coach, trainor or any other person who, having authority, influence or moral ascendancy over another in a work or training or education environment, demands, requests or otherwise requires any sexual favor from the other, regardless of whether the demand, request or requirement for submission is accepted by the object of said act.

The sexual favor is made as a condition in the hiring or in the employment, re-employment or continued employment of said individual, or in granting said individual favorable compensation, terms, conditions, promotions, or privileges; or the refusal to grant the sexual favor results in limiting, segregating or classifying the employee which in a way would discriminate, deprive or diminish employment opportunities or otherwise adversely affect said employee.

When the sexual favor is made a condition to the giving of a passing grade, or the granting of honors and scholarships, or the payment of a stipend, allowance or other benefits, privileges, or considerations or when the sexual advances result in an intimidating, hostile or offensive environment for the student, trainee or apprentice.

Any person who violates the provisions of this Act shall, upon conviction, be penalized by imprisonment of not less than one (1) month nor more than six (6) months, or a fine of not less than Ten thousand pesos (P10,000) nor more than Twenty thousand pesos (P20,000), or both such fine and imprisonment at the discretion of the court.

R.A. 8353 – **Anti-Rape Law of 1997**

Rape is a now "public" crime!

2 Kinds of Rape: "Traditional" and "Rape by Sexual Assault

- **Traditional Rape**: (reclusion perpetua to death)
  A man has carnal knowledge of woman under the following circumstances:
    - Thru force, threat, or intimidation
    - When offended party is deprived of reason/unconscious
    - Thru fraudulent machination/grave abuse of authority
    - When offended party is under 12 yrs or demented
- **Rape by Sexual Assault**: (prison mayor to reclusion perpetua)

Any person who, under any of circumstances mentioned in paragraph 1, shall commit an act of sexual assault by:

- inserting his penis into another person's mouth or anal orifice or
- Inserting any instrument or object (including a finger) into the genital or anal orifice of another person

"Rape Shield" - prohibits the admission into evidence of the sexual past and reputation of a rape victim, to prevent stigmatization of the victim and victim-blaming.

R.A. 9262 – Anti-Violence Against Women and their Children Law of 2014

"Violence" is any act or a series of acts committed by any person

- against a woman who is
  - his wife
  - former wife
  - with whom the person has or had a sexual or dating relationship,
  - with whom he has a common child, or
- against her child whether legitimate of illegitimate, within or without the family abode

Dating relationship defined:

A situation wherein the parties:

Live together as husband and wife without the benefit of marriage, or

Are romantically involved over time and on a continuing basis during the course of the relationship

Note: A casual acquaintance or ordinary socialization between two individuals in a business or social context is NOT a dating relationship.

Sexual relationship defined:

A single sexual act which may or may not result in the bearing of a common child.

Children defined:

Those below 18 years of age or older but are incapable of taking care of themselves

Includes biological children of the victim and other children under her care

Criminal Acts of VAW (Section 5):

- The crime of VAWC is committed through any of the following acts
  a) Causing physical harm to the woman or her child
  b) Threatening to cause the woman or her child physical harm
  c) Attempting to cause the woman or her child physical harm
  d) Placing the woman or her child in fear of imminent physical harm
  e) Attempting to compel or compelling the woman or her child
     - to engage in conduct which the woman or her child has the right to desist from, -to desist from conduct which the woman or her child has the right to engage in, or attempting to restrict or restricting the woman's or her child's freedom of movement or conduct by
     - force or threat of force, physical or other harm or
     - threat of physical or other harm, or

- intimidation directed against any woman or her child

f) Inflicting or threatening to inflict physical harm on oneself for the purpose of controlling her actions or decisions

g) Causing or attempting to cause the woman or her child to engage in sexual activity which does not constitute rape, by force or threat of force, physical harm, or through intimidation directed against the woman or her child or his/her immediate family

h) Engaging in purposeful, knowing, or reckless conduct, personally or through another, that alarms or causes substantial emotional or psychological distress to the woman or her child

i) Causing mental or emotional anguish, public ridicule or humiliation to the woman or her child, including but not limited to, repeated verbal and emotional abuse, and denial of financial support or custody of minor children or denial of access to the woman's children

Penalty: Imprisonment

Maximum penalty:

- If acts committed while woman or child is pregnant
- Committed in the presence of her child

Additional penalties:

- Fine in the amount of 100,000 to 300,000
- Mandatory psychological counseling or psychiatric treatment and shall report compliance to the court

Protection Orders:

- An order issued under the Act for the purpose of preventing further acts of violence against a woman or her child
- The relief granted under a protection order should serve the purpose of
  - safeguarding the victim from further harm,
  - minimizing any disruption of the victim's daily life, and
  - facilitating the opportunity and ability of the victim to independently regain control of her life

Protection orders may be

Barangay protection order (BPO)
Temporary protection order (TPO)
Permanent protection order (PPO)

Provisions shall be enforced by law enforcement agencies.

Type	Where	Acts	How	Days
BPO	Punong Barangay or Barangay Kagawad	Sec. 5 (a), 5 (b)	Date of filing after exparte determination of the basis	15
TPO	Court	All	Same. Sked hearing for PPO before expiry	30
PPO	Court	All	After notice and hearing (1 day)	Until revoked

POs shall include any, some, or all of the following reliefs:

- Prohibition of respondent from threatening or committing the acts
- Prohibition of respondent from harassing, annoying, contacting with petitioner
- Removal or exclusion of respondent from residence, regardless of ownership, permanently or temporarily
- Directing respondent to stay away from petitioner and family members at specified distance, or from places frequented by petitioner
- Directing lawful possession and use by petitioner of an automobile, other essential personal effects, regardless of ownership
- Granting temporary or permanent custody of a children of petitioner
- Directing respondent to provide support to the woman and or her child if entitled to legal support, may direct appropriate percentage of income or salary to be withheld by respondent's employer and to be automatically remitted directly to the woman

NOTE: reliefs shall be granted even in the absence of decree of annulment, nullity or legal separation

Who may file for petition for PO?

- Offended party
- Parents or guardians of offended party
- Ascendants, descendants or collateral relatives within 4th civil degree of consanguinity or affinity
- Officers or social workers of DSWD or social workers of LGUs
- Police officers, preferably those in charge of women and children's desks
- Punong Barangay or Barangay Kagawad
- Lawyer, counselor, therapist or healthcare provider of the petitioner
- At least two concerned responsible citizens of the city or municipality where the VAWC occurred and who has personal knowledge

Where to apply for PO:

Type of PO	**Where to file**
BPO	
If parties reside in same barangay	Barangay of residence of both parties
If parties reside in different barangays	Barangay where respondent resides
If arising at workplace or educ. institution	Barangay where workplace or educ. Institution is located
TPO & PPO	RTC, MTC, MCTC with territorial jurisdiction over place of residence of petitioner, FC if any

Duties of Barangay Officials and Law Enforcers:

- Respond immediately to a call for help by entering the dwelling
- Confiscate deadly weapon from perpetrator
- Transport or escort victim to safe place
- Assist victim in removing personal belongings from house
- Assist barangay officials and other government officers and employees who respond
- Ensure enforcement of POs
- Arrest suspects even without warrant

- Immediately report to DSWD or SWD of LGUs or accredited NGOs

Exemption from Liability:

In every case of violence against women and their children, any person, private individual or police authority or barangay official who, acting in accordance with law, responds or intervenes without using violence or restraint greater than necessary to ensure the safety of the victim, shall not be liable for any criminal, civil or administrative liability resulting therefrom.

Battered Woman Syndrome as a Defense:

- BWS is a scientifically defined pattern of psychological and behavioral symptoms found in women living in battering relationships as a result of cumulative abuse.
- Survivors who are found by the courts to be suffering from BWS shall not have any civil or criminal liability even in the absence of any of the elements required for self-defense under the RPC.
- Experts to assist court in determining BWS.

Prohibited Defense:

- Being under the influence of alcohol, any illicit drug, or any other mind-altering substance shall not be a defense for the commission of any of the crimes constituting violence against women and children.

Entitlement to Leave:

Victims of VAWC shall be entitled to take a paid leave of absence up to 10 days.

- In addition to other paid leaves under the Labor Code and the Civil Service Rules and Regulations
- Extendible when there is a need for an extension (as specified in the Protection Order)

Custody:

- The woman victim shall be entitled to the custody and support of her child/children.
- Children below 7 or older but with mental or physical disabilities shall automatically be given to the mother, with right to support, unless the court finds compelling reasons to order otherwise.
- A woman victim with BWS shall not be disqualified from having custody of her children. In no case shall the custody of the minor children be given to the perpetrator of a woman victim with BWS.

Confidentiality:

All records pertaining to case of VAWC including those at the barangay shall be confidential and all public officers and employees and public or private clinics or hospitals shall respect the right to privacy of the victim. Whoever publishes or causes to be published in any formal the name, address, tel.no., school, business address, employer or other identifying info of a victim or an immediate family member without consent shall be liable to the contempt power of the court.

Penalty: one year imprisonment or fine of not more than P500,000

NO REFERENCES FOR THIS CHAPTER

CHAPTER 8:

TESTIFYING IN COURT

Lynnette Lu-Lasala. MD, FPOGS, FPSSTD

Reporting of abuse cases, be it among women or children, is mandated in the *Republic Act 9262* which is the ***Anti-Violence Against Women and their Children***. Medical doctors are expected to go to court and testify whenever they receive a subpoena.

The court process is very challenging, even for those who have experience in court. The court is like a theatre where lawyers and physicians meet showcasing a battle of wit and character. However, for most physicians, testifying in court could be their worst nightmare.

Some doctors choose not to report/manage cases of abuse for fear of testifying in court. Reasons may include fear of intimidation, ignorance or misunderstanding the law or fear of the "unknown". However, not going to court may mean missing out helping the victim-survivor get the justice she deserves and other outcomes which could improve her situation.

This chapter is designed in order for the medical doctor specifically the obstetrician-gynecologist to understand the court system (especially those with no or with little experience), navigate what can be a very complex process and become a competent expert witness.

THE COURTROOM

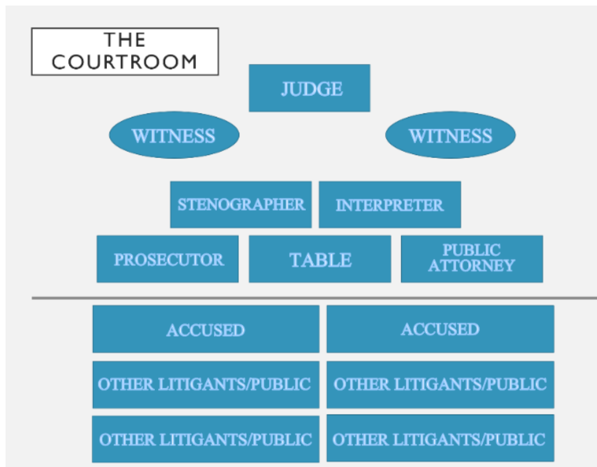


Figure 1. The Courtroom

The elevated place is occupied by the **judge**, the person who holds the highest position in the court. He is a person who is appointed to decide cases and to make sure that legal procedures are followed in the courtroom. On both sides of the judge are the witness stands. Court personnel such as the stenographer and the interpreter, as well as the prosecutor and the defense lawyer occupy the place below the judge. An interpreter may be necessary for non-English speaking countries. The litigants, accused, their relatives/family, police personnel and the general public occupy the largest part of the room. In some proceedings, a **jury** composed of people from the community, may be convened to in order to determine the guilt or non-guilt

of the defendant. The lawyers screen the members of the jury to make sure that these individuals are neutral or impartial.

The **prosecutor** is an attorney who represents the State on behalf of the victim of a crime, specifically of abuse. The **public attorney**, who is at times called the **defense lawyer**, is a practicing lawyer representing the accused. The medical doctor who is called to testify in court should understand the set-up in a court process.

THE EXPERT WITNESS

Human conflicts, especially those involving Gender-Based Violence such as sexual abuse, are usually resolved in court. However, those who are responsible to make decisions over
these conflicts lack the required knowledge in order to make sound and fair decisions. The judges need to be provided with information which interprets the evidences presented to them and that explains human behavior for them to reach appropriate resolutions. Those who are called upon to so educate these judges are called ***expert witness***.

An ordinary witness is a person who can perceive, can make known their perception to others, subject to exceptions (Rules of Court). He/she may be an observer, viewer, spectator, watcher or on-looker and will only testify according to what he has heard. Smelled, saw, tasted. He cannot testify according to how he interprets his observations.

An **expert witness** is one whose knowledge, skill or experience on the subject of which he is called to testify either by his study of the recognized authorities on the facts in issue or by the application of his practical experience is much desired to assist the trial court in solving a problem (Generoso, 2011). He is someone with specialized experience, training, or knowledge who is able to explain scientific or complicated matters in layman's term. The expert witness is an educator, an interpreter and an explainer. He provides the education for fact finders, but must educate persuasively enough to convince the judges to believe them. These expert witnesses are professionals who have enough experience in their chosen field to give a reliable and informed opinion to a court about the particular issues in a lawsuit or criminal case. He/she should smart, thorough, attentive, informed, savvy and articulate.

Dr. Keith Rix (2011), a consultant forensic pathologist at Cygnet Hospital, Wyke, West Yorkshire believes that doctors have a moral imperative to act as expert witnesses. "Any professional person in a society like ours has a duty to assist the courts in the resolution of disputes and the administration of justice where without their expert knowledge the dispute will not be resolved or there might be a miscarriage of justice", he says. "That doesn't mean that every doctor, for example, must if requested provide expert witness advice, but there's a reasonable expectation of the court that when they need medical opinion that they will be able to get it."

PREPARATION OF THE EXPERT WITNESS FOR COURT APPEARANCES

The medical doctor who examined the victim of abuse and issued a medico-legal certificate becomes an expert witness. He/she is summoned to appear in court once a subpoena is served. A ***subpoena*** is an order of the court that commands a witness to appear at a certain time and place to give a testimony about a specific matter (*subpoena ad testificandum*) or commands a person or an organization to provide specific documents (*subpoena duces tecum).*

Prompt notification of examiners should be promoted if there is a need for them to testify in court. Lawyers should regard the expert witness with respect for the knowledge and expertise they give to the court. The first time an attorney contacts the medical doctor should not be

through a subpoena. Unexpected subpoenas cause a great deal of anxiety for the medical doctor. The lawyer explains to the expert witness the case and what is expected of him as a witness.

Pre-trial preparation of the expert witness is encouraged.

- Medical records such as medical forensic report, photographs, medico-legal certificates should be successfully subpoenaed, since most of these records are confidential.
- The expert witness, ideally, meets in advance with the attorney(s) calling him/her as a witness, in order to prepare for testimony. No witness, especially an expert witness, should ever go to court to testify without meeting the lawyer who will present his/her testimony. If the expert witness is not able to meet the lawyer prior, it is advisable to come early to court and talk to the lawyer regarding the case and be briefed on the questions he might ask.
- The expert witness should review records of the exam and keep a log of the materials reviewed. It is imperative that the expert witness is thoroughly knowledgeable of the criminal process.
- The expert witness should be prepared to educate the court, particularly the judges. Terminology and descriptions used should be considered so that there most will clearly understand what he/she is presenting in court.
- He/she should be prepared to prove qualifications and be ready to discuss educational background, clinical experience, and prior experience as expert witness. A portfolio that lists education, experience and previous appearances as a witness should be kept and updated. This should be complete and 100% accurate. He or she can bring this portfolio during the court appearance, and can be presented if the lawyer is trying to establish his/her credibility as an expert witness.
- The expert witness should remember that his role in court is to present the examination findings written on the medical certificate and to educate the judge or the jury, and never to conclude that RAPE or SEXUAL ABUSE happened.

YOUR DAY IN COURT

The day has arrived for you to testify in court. In order to have a successful day in the court, here are a few pointers for you to remember.

- Arrive in court early. This will allow you to observe the courtroom and get used to the people around you, collect yourself, review your notes, and erase the “fear factor”.
- Business attire is appropriate for court appearances. Wearing the white blazer is also acceptable for easy identification. Limit excessive jewelry and other accessories which can be distracting. It is important to know that looks count.
- Be courteous to court personnel. Never be a braggart. Remember that demeanor counts. This will somehow increase the judge’s confidence in you as an expert witness.
- Be prepared. The expert witness must act with professionalism at all times in the courtroom. Tell the truth. Be impartial and objective. Testify according to what is asked of you. Use simple terminologies and descriptions. Find your own style in explaining the evidence or the examination findings. Fully answer all questions.
- Know your audience. The judge is your audience. Address the judge as “Your Honor”. When answering questions, you must look at the judge and the person who asking the question. Learn how to communicate effectively in court because you need to persuade the judge. Take note of verbal and non-verbal cues. If you see the judge is not listening or is asleep, stop talking. This is because you are educating the judge and not the lawyers.

- Be yourself. Remember that you are the expert witness and you came to court because you need to shed light on the medical records/documents requested from you and educate the decision-makers. Cite literatures which would help you expound on your findings.
- The expert witness should speak in English, if that is the language of the court. You must use simple language, as no one else in the court will understand what you are talking about. You can show and tell to get your point across, or use words to visualize a fact, draw diagrams and teach in the courtroom. Speak clearly and slowly. Listen carefully to the question, and answer only what is asked. Never answer in an unclear manner. It is okay to say "I do not know, Sir". Never answer with "I think" or "I believe". The expert witness must not answer a question that he did not understand. You must never agree with a statement that you do not agree with.
- Be the expert witness. Do not try to be the lawyer.
- Remember that during the direct examination, the expert witness is the star of the show. He knows the game plan of the lawyer. However, during cross-examination, the defense lawyer is the star of the show. The defense lawyer may intimidate you or throw questions which may distract you or confuse you. Always listen to the question first before answering. If the question is unclear, you can ask the defense lawyer to repeat it or maybe rephrase it. When the defense counsel loses his temper and maybe cause some "commotion", keep calm, and do not answer until the court requires you to answer. The expert witness can protect himself in the courtroom, and ensure that he is testifying properly, when he asks the judge for guidance in the event that he does not understand the ruling of the judge.
- The expert witness should NOT be afraid to testify in court.
- The expert witness is much respected if he is honest, impartial, professional and well-prepared.

References:

Child Protection Network. (2004). Testifying in court. *CPU-NET Medical Alert*, *2*(1).

Generoso, E. B. (2009). *Evidence for everybody* [E-book]. Evergreen Publications.

Murphy, J. L. (2018). When clinicians are summoned to testify in court: Orientation to the process and suggestions on preparation. *SAGE Open Nursing*, *4*, 237796081875709. https://doi.org/10.1177/2377960818757097

Rix, K. (2011). *Expert Psychiatric Evidence*. Royal College of Psychiatrists.

Samut, R. (2019, April 12). *Giving evidence in court - tips and traps for medical professionals who may be called on as an expert witness*. Lexology. https://www.lexology.com/library/detail.aspx?g=abb547bf-e396-4bc4-8674-b75a02a0ddb4

VanDercar, A., MD, & Resnick, P. J., MD. (2020, September 30). *Tips for Testifying in Court*. Psychiatric Times. https://www.psychiatrictimes.com/view/tips-for-testifying-in-court

CHAPTER 9

CHILD SEXUAL ABUSE VICTIM-SURVIVOR

Bernadette J. Madrid, MD, FPPS

All Obstetrician-Gynecologists should be able to:

1. Recognize cases of child sexual abuse;
2. Know how to respond to and evaluate a child who is suspected of being sexually abused;
3. Know when to refer the child to a Woman and Children Protection Unit;
4. Know when to report the case to the appropriate government agency;
5. Perform the basic management of cases of child sexual abuse.

Definition of Child Sexual Abuse (CSA). The World Health Organization (2017) defines child sexual abuse as *"the involvement of a child or an adolescent in sexual activity that he or she does not fully comprehend and is unable to give informed consent to, or for which the child or adolescent is not developmentally prepared and cannot give consent, or that violates the laws or social taboos of society. Children can be sexually abused by both adults and other children who are – by virtue of their age or stage of development – in a position of responsibility or trust or power over the victim. It includes incest which involves abuse by a family member or close relative. Sexual abuse involves the intent to gratify or satisfy the needs of the perpetrator or another third party including that of seeking power over the child. Adolescents may also experience sexual abuse at the hands of their peers, including in the context of dating or intimate relationships. Three types of child sexual abuse are often distinguished: (i) non-contact sexual abuse (e.g., threats of sexual abuse, verbal sexual harassment, sexual solicitation, indecent exposure, exposing the child to pornography); (ii) contact sexual abuse involving sexual intercourse (i.e., sexual assault or rape); and (iii) contact sexual abuse excluding sexual intercourse but involving other acts such as inappropriate touching, fondling and kissing. Child sexual abuse is often carried out without physical force, but rather with manipulation (e.g., psychological, emotional or material). It may occur on a frequent basis over weeks or even years, as repeated episodes that become more invasive over time, and it can also occur on a single occasion."*

When to suspect Child Sexual Abuse (CSA). The most common presentation is a child who discloses experiencing acts that constitute sexual abuse without any accompanying signs and symptoms. The child may also be brought to the OB-GYN for genital signs and symptoms such as a genital injury, bleeding, dysuria or a vaginal discharge. A common referral is an adolescent who is pregnant. Even if the adolescent claims that the father of her baby is her boyfriend, an age-gap of 5 years can be considered as child sexual abuse (Matthews & Collin-Vezina, 2019). No child can get married in the Philippines who is not yet 18 years of age and even then, they would need their parents' permission. The age of statutory rape is below 12 years old in Philippine law but the bill increasing it to below 16 years has been approved in the senate and congress. However, until it becomes law, the Philippines has one of the youngest age of statutory rape in the world. Infections can be spread by nonsexual as well as sexual transmission. However, most sexually transmitted infections, if perinatal transmission and rare non-sexual transmission are excluded, are usually diagnostic of child sexual abuse or at the very least suspicious and needs to be reported (Table 1.).

Table 1. Implications of commonly encountered sexually transmitted (ST) or sexually associated (SA) infections for diagnosis and reporting of sexual abuse among infants and pre-pubertal children

ST/SA CONFIRMED	EVIDENCE FOR SEXUAL ABUSE	SUGGESTED ACTION
Gonorrhea *	Diagnostic	Report
Syphilis *	Diagnostic	Report
Human immunodeficiency virus	Diagnostic	Report
Chlamydia trachomatis *	Diagnostic	Report
Trichomonas vaginalis *	Diagnostic	Report
Genital Herpes	Suspicious	Report
Condyloma acuminata (anogenital warts) *	Suspicious	Report
Bacterial vaginosis & Anogenital Molluscum Contagiosum	Inconclusive	Medical follow-up

Source: Adapted from Kellogg N, American Academy of Pediatrics Committee on Child Abuse and Neglect. The evaluation of child abuse in children. Pediatrics 2005;116(2):506–12. Updated 2013 available at http://pediatrics.aappublications.org/content/132/2/e558: MMWR Recomm Rep 2021
* If not likely to be perinatally acquired and rare nonsexual, vertical transmission is excluded.
If not likely to be acquired perinatally or through transfusion, unless there is a clear history of autoinoculation
Report if there is additional evidence to suspect abuse, including history, P.E. & other infections identified.

When is an urgent evaluation needed? Most of the cases of child sexual abuse present late; months or years after the incident. Majority of child victims do not disclose what happened to them for many reasons e.g., fear of the perpetrator, shame, stigma, fear of not being believed. There are cases that need urgent evaluation: 1. Any child with acute ano-genital bleeding and discharge, pain, or injury should be examined immediately; 2. Children with psychological or safety concerns such as suicidal ideation or presence of the perpetrator at home; 3. Children with history of sexual contact within 72 hours should be examined for evidence of sexual abuse; 4. Children exposed to HIV-positive alleged perpetrators need to begin HIV postexposure prophylaxis within 72 hours of exposure; 5. Adolescents who wish to obtain pregnancy prevention need to be evaluated within 120 hours of the incident. The algorithm of the management of possible STI and HIV exposure is in ANNEX 1.

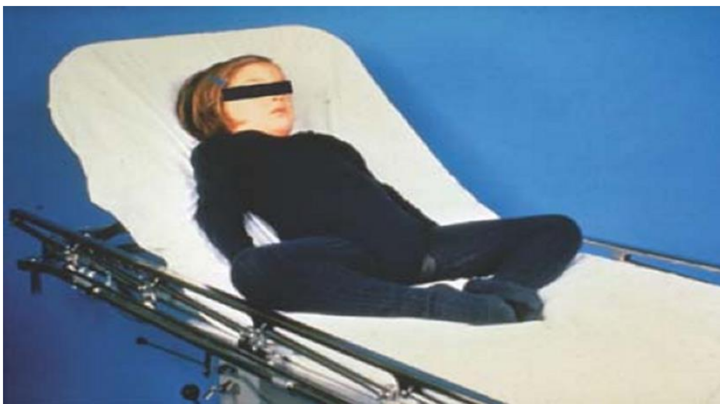
Mandatory reporting for child abuse cases. R.A. 7610, the anti-child abuse law in the Philippines makes it mandatory for the head of any public or private hospital, medical clinic and similar institution, as well as the attending physician, and nurse to report either orally or in writing, to DSWD/LGU Social Welfare Department, the examination and/or treatment of child who appears to have suffered any abuse within 48 hours from knowledge of the incident. These mandated reporters should report their suspicion and are under no obligation to prove that it happened. They are also protected from suits whether civil or administrative for reporting in good faith.

Interviewing the child. The main principle in the management of child abuse cases is to avoid re-traumatization of the child victim/survivor. The experience of the child with health providers

can determine whether they will start the path to healing or be further traumatized. Build rapport first before you do anything. Reassure the child that it is all right to tell what happened. Project a calm, understanding and supportive attitude. Do not express feelings of shock, anger or disgust even if that is how you feel. Always reassure the child that it is not her fault and do not accuse her of lying. Never promise that you will not tell anybody even if the child asks that of you. Tell the child that if you think that she is in any danger you will need to seek help from authorities who can help keep her safe. Minimize the need to tell the history repeatedly. Interview the child and the caregiver separately if possible. The child might not tell the whole story if she is afraid of the reaction of her parents. You also do not know if a parent or a close relative is the offender. There should be privacy and confidentiality when you are interviewing the child. An emergency room setting with other people nearby is not the place to do the interview. Use language that is age-appropriate and non-stigmatizing. Start with an open-ended question like "Please tell me what happened." The description of the incident and the name of the offender should come from the child and not the interviewer. Document what the child says word-for-word and place quotation marks. It should not just be a summary. If You are not a trained forensic interviewer do not go into so much detail but instead concentrate on what is needed to treat the child and to assess safety. It is very important to make an assessment of the emotional and psychological state of the child as part of the over-all evaluation. She might need emergency mental health care. This should also be recorded in the chart.

Physical Examination. Just like in the interview, maximize efforts to do only one examination. Explain what needs to be done prior to each step. Offer choice on the sex of the examiner where possible. Make sure that another adult of the same sex as the patient is present during the examination. The examination must be from head to toe and not only the genital area. Use positions that minimize physical discomfort or psychological distress. For young children the genital area can be best visualized in the supine position with her knees apart and the feet touching in the frog-leg position. The young child could also be examined sitting on the lap of her mother and her mother positioning the child in the frog-leg position. If possible, also examine the hymen with the child on the knee-chest position for better visualization of the hymen.

Figure 1. Supine position with her knees apart and feet touching in the frog-leg position.



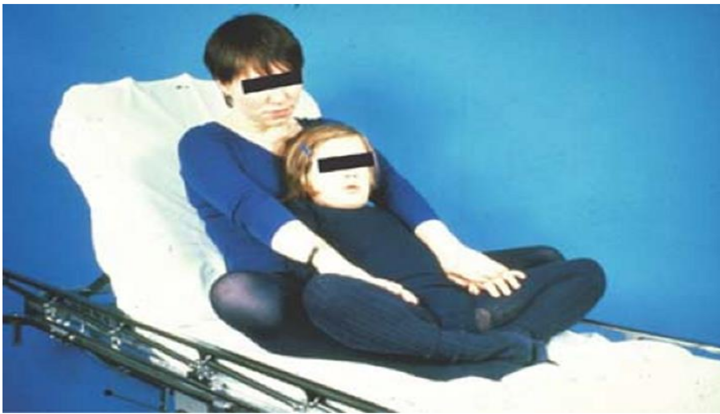


Figure 2. Positioning the child in the frog-leg position with the aid of her mother.

Speculums, anoscopies, digital and bimanual exams of the vagina and rectum are NOT routinely used in the examination of a sexually abused child unless medically indicated. Sedation or general anesthesia is used if a speculum is needed in a young child.

If the examination is done within 72 hours of the incident, ensure collection of forensic evidence based on the account of the abuse and on what evidence can be collected, stored and analysed. It should be done with the informed consent of the child and the non-offending caregiver, as appropriate. Never conduct virginity testing; it is traumatic to the child and has no scientific validity. Make a detailed description of the injuries and symptoms with diagrams. Digital pictures and the use of magnification are recommended with consent of the child and non-offending parent or legal guardian. It allows for peer review and decreases the need for multiple exams. The interview and physical examination of the sexually abused child need training and special skills.

Physical examination findings. Majority of the physical examination of sexually abused child have normal findings especially if seen non-acutely. A study showed that when sexually abused girls are examined nonacutely only 2.2% have findings whereas when examined within 72 hours of the incident, 21.4% had findings (Adams, Farst, Kellog, 2018). Another study showed that there was no association between the number of reported penile-genital penetrative events and definitive genitals findings (Anderst, Kellog, Jung 2009). There are many reasons why there are no findings:

1. The nature of the assault may not be damaging;
2. The perception of "penetration" may be in error by the child;
3. Disclosure my be delayed days to years after the assault;
4. Complete healing can occur;
5. The hymen can "grow" as puberty progresses, making prepubertal injuries. When findings are normal, just write "No evident injury at the time of examination" in the medical certificate. Do not use the words "intact hymen" or "virgin hymen" or "can insert two

fingers at the genital opening with ease". These terms do not have any meaning anymore and it gives the false impression that nothing happened.

For guidance on the interpretation of medical findings in suspected child sexual abuse, please read the article of Joyce Adams, Karen Farst and Nancy Kellog, Journal of Pediatric Adolescent Gynecology 2018 Jun; 31 (3): 225-231 and download the Child Maltreatment: Medico-legal terminology and interpretation of medical findings (2015) from www.childprotectionnetwork.org.

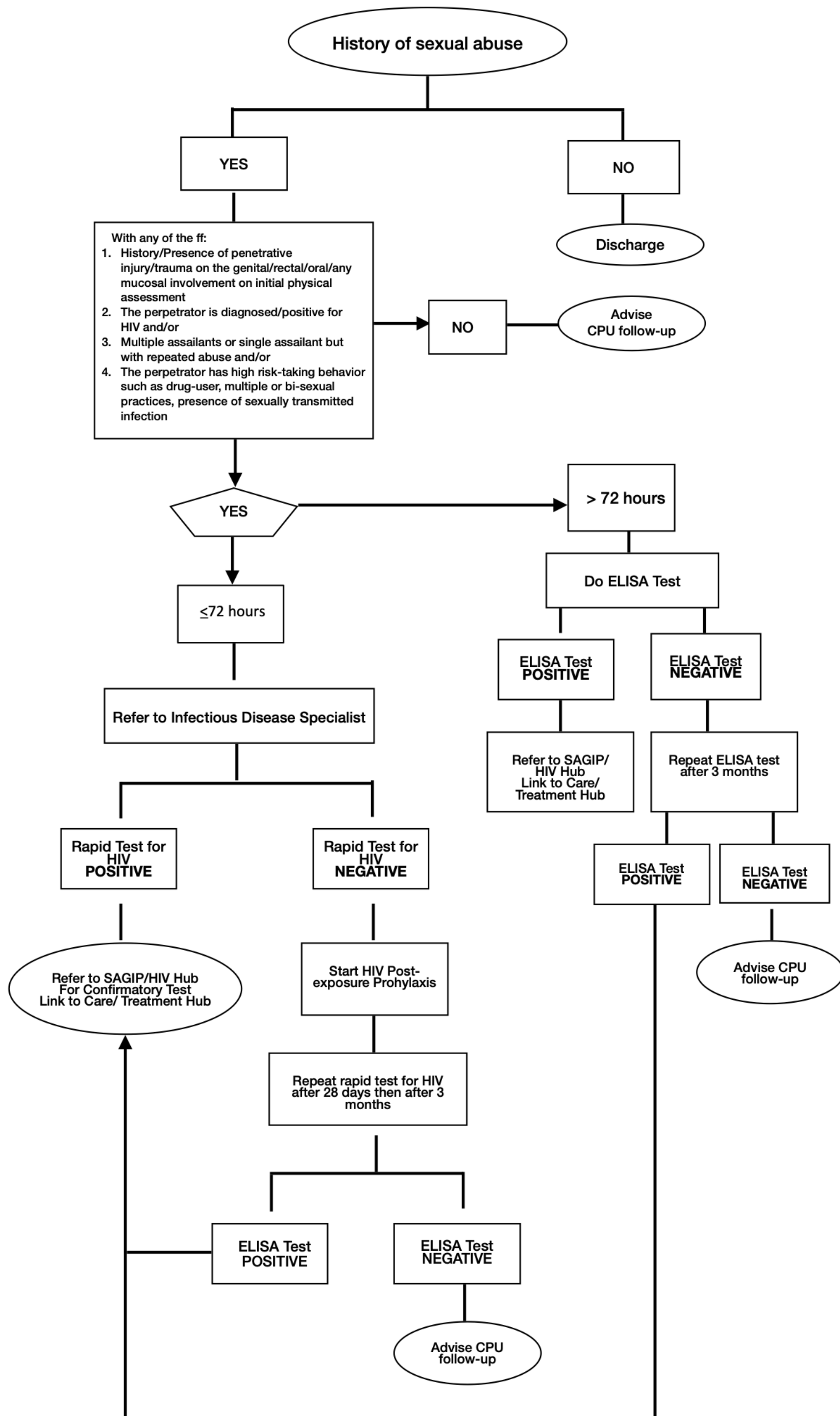
Co-occurrence of Violence Against Women (VAW) and Violence Against Children (VAC). In the evaluation of any form of child abuse and violence against women, it is important to assess the co-occurrence of the differents forms of child abuse and violence against women. Co-occurrence of VAW and VAC is the norm and not the exception (Carlson, Namy, et.al., 2020). VAW and child maltreatment share similar etiological factors. In investigating cases of VAW, one should also assess for child maltreatment and vice versa (Bidarra, Lessard, Dumont, 2016). The management of the case cannot be limited to just the chief complaint e.g. sexual abuse, for in order for the management to be successful it has to be comprehensive and include all the different types of abuse occuring in the whole family.

Role of the health care provider. The management of child sexual abuse requires a multidisciplinary team composed of the physician, the social worker, the mental health professional and the police officer. Each member of the team holds a piece of the puzzle and each has a specific role and responsibility. The primary responsibility of the physician is to prioritize the best interest of the child regarding emotional and physical health as well as a safe environment (Kotze & Brits, 2018).

REFERENCES:

1. Responding to children and adolescents who have been sexually abused: WHO clinical guidelines. Geneva: World Health Organization; 2017. License: CC BY-NC-SA 3.0 IGO.
2. Mathews B, Colin-Vezina D. Child sexual abuse: Toward a conceptual model and definition. TRAUMA, VIOLENCE, & ABUSE 2019, Vol. 20(2) 131-148.
3. Adams JA, Farst KJ, Kellog ND. Interpretation of Medical Findings in Suspected Sexual Abuse: An Update for 2018. J Pediatrc Adolescent Gynecology 2018 Jun;31(3):225-231.
4. Anderst J, Kellog N, Jung I. Reports of Repetitive Penile-Genital Penetration often Have No Definitive Evidence of Penetration. Pediatrics 2009;124; e403-e409.
5. Child Protection Network Foundation, Inc. Child Maltreatment. Medico-legal Terminology and Interpretation of Medical Findings. A consensus of medical and legal child protection practitioners in the Philippines;2015. Manila, Philippines. Downloaded from www.childprotectionnetwork.org
6. Carlson C, Namy S, Pala A, Wainberg ML, Michau L, Nakuti J, Knight L, Allen E, Ikenberg C, Naker D, and Devries K. Violence against children and intimate partner violence against women: overlap and common contributing factors among caregiver-adolescent dyads. BMC Public Health (2020) 20:124.
7. Bidarra ZS, Lessard G, Dumont A. Co-occurrence of intimate partner violence and child sexual abuse: Prevalence, risk factors and related issues. Child Abuse & Neglect 55 (2016) 10–21.
8. Kotzé JM, Brits. Child sexual abuse: The significance of the history and testifying on non-confirmatory findings. Afr J Prim Health Care Fam Med. 2019 Jun 10;11(1): e1-e7.

ALGORITHM ON HIV POST EXPOSURE PROPHYLAXIS IN SEXUALLY ABUSED CHILDREN



ALGORITHM ON HIV POST EXPOSURE PROPHYLAXIS IN SEXUALLY ABUSED CHILDREN

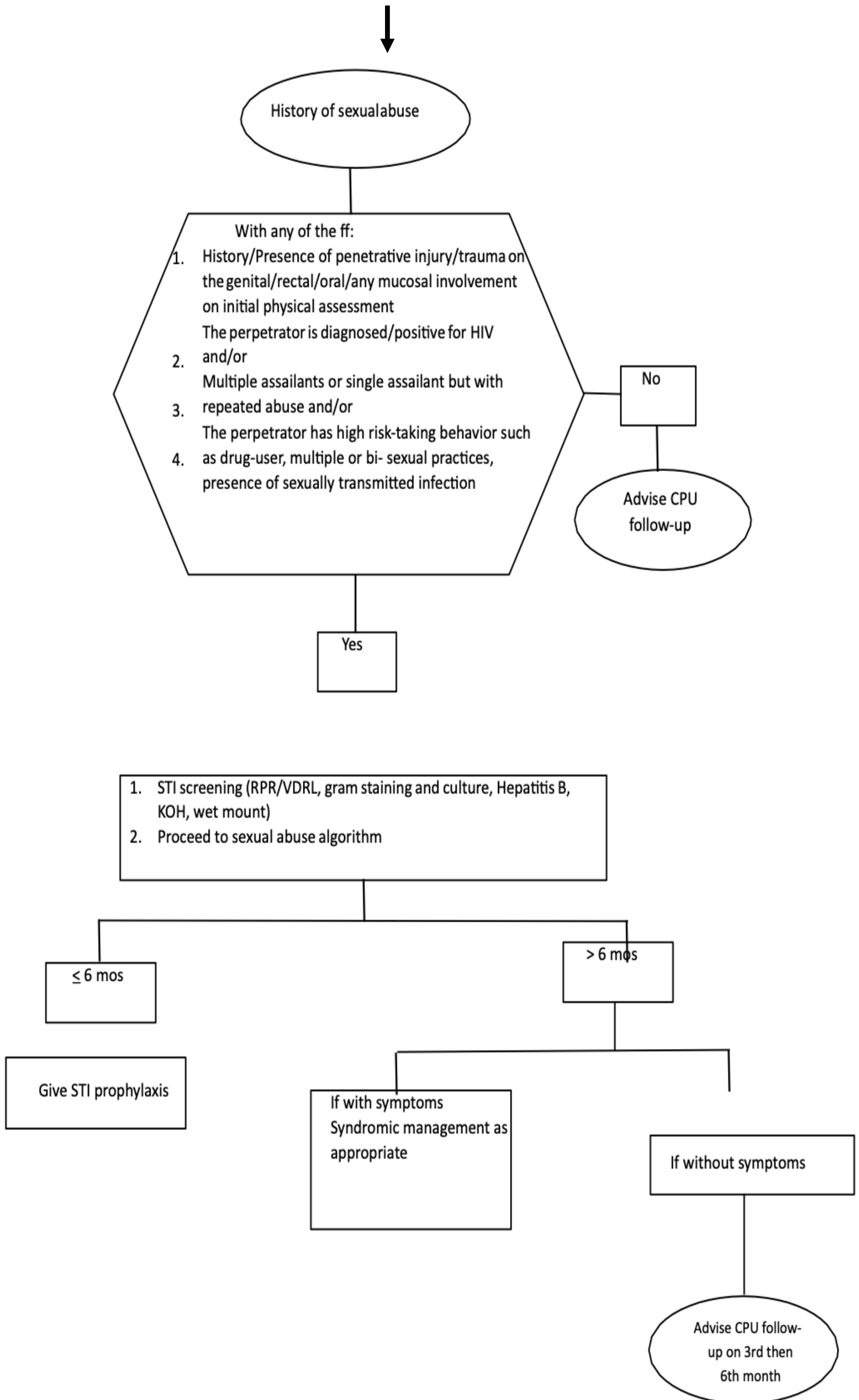
Recommended regimen for infants and children less than 3 years old)
Preferred First line regimen: 2 NRTI + boosted Protease Inhibitor (PI)
Abacavir (ABC) OR Zidovudine (AZT) + Lamivudine (3TC) + Lopinavir/ritonavir (LPv/r)
Alternative First line regimen: 2NNRTI + 1NNRTI
Abacavir (ABC) OR Zidovudine (AZT) + Lamivudine (3TC) + Nevirapine (NVP)

Prescribing frequency
A 28-day prescription of Anti-retroviral drugs should be provided for HIV post-exposure prophylaxis following initial risk assessment

LABORATORY TESTS FOR PERSONS PRESCRIBED WITH PEP	
Serum creatinine	Get Baseline and repeat after 4-6 weeks
AST, ALT	Get Baseline and repeat after 4-6 weeks
For all persons with HIV infection confirmed at any visit	
HIV Viral Load and CD4 count	Repeat after 6 months
HIV genotypic resistance and drug susceptibility testing	Repeat after 6 months

Recommended Regimen for Children (3 - < 10 years old)
First line regimen: 2 NRTI + 1 NNRTI
Preferred first line NRTI: Abacavir (ABC) + Lamivudine (3TC)
Alternative first line NRTI:
i. Zidovudine (AZT) + Lamivudine (3TC)
ii. Tenofovir (TDF) + Lamivudine (3TC)
Tenofovir is preferred over Zidovudine for children with anemia (hemoglobin levels ≤ 10g/dL)
Preferred first line NNRTI: Efavirenz (EFV)
Alternative first line NNRTI: Nevirapine (NVP)

ALGORITHM ON STI POST EXPOSURE PROPHYLAXIS IN SEXUALLY ABUSED CHILDREN



Sexually transmitted infection (STI) testing in a child when sexual abuse is suspected	
Organism / Syndrome	Specimens
Neisseria gonorrhea and Chlamydia trachomatis	Rectal, throat, urethral (male), and/or vaginal cultures
Syphilis	Darkfield examination of chancre fluid, if present; blood for serologic tests at time of abuse and 6, 12, and 24 weeks later
Human immunodeficiency virus	Serologic testing of abuser (if possible); serologic testing of child at time of abuse and 6, 12, and 24 weeks later
Hepatitis B virus	Serum hepatitis B surface antigen testing of abuser or hepatitis B surface antibody testing of child, unless the child has received 3 doses of hepatitis B vaccine
Herpes simplex virus (HSV)	Culture of lesion specimen if present; in addition, polymerase chain reaction assay of lesion specimen if lesion crusted; all virologic specimens should be typed (HSV-1 vs HSV-2)
Bacterial vaginosis	Wet mount, pH, and potassium hydroxide testing of vaginal discharge or Gram stain in pubertal and post-menarchal girls
Human papillomavirus	Clinical examination, with biopsy of lesion specimen if present, if diagnosis unclear
Trichomonas vaginalis	Wet mount and culture of vaginal discharge
Pediculosis pubis	Identification of eggs, nymphs, and lice with naked eye or using hand lens

[c] Prophylaxis After Sexual Victimization of Adolescent Children	
For Gonorrhea	≤ 45Kg Ceftriaxone, 25-50 mg/kg body weight IV or IM in a single dose, not to exceed 250 mg IM **OR** > 45 Kg Ceftriaxone 500 mg/IM in a single dose for persons weighing <150 Kg; if ≥150 Kg, give 1g/IM in a single dose *Alternative Regimens if Ceftriaxone is not available: Gentamicin 240mg IM in a single dose **PLUS** Azithromycin 2g orally in a single dose **OR** Cefixime 800 mg orally in a single dose

For C. trachomatis infection	Infants and Children < 45Kg Erythromycin base or ethyl succinate 50 mg/kg body weight/day PO divided into 4 doses daily for 14 days *Data are limited regarding the effectiveness and optimal dose of azithromycin for treating chlamydial infection among infants and children weighing <45 Kg For children weighing ≥45Kg but aged <8 years: Azithromycin 1 g orally in a single dose For children aged ≥8 years: Azithromycin 1 g orally in a single dose **OR** Doxycycline 100 mg orally, twice a day for 7 days
For Trichomoniasis	Metronidazole, 500 mg orally 2 times a day for 7 days (for Women) Metronidazole 2g orally in a single dose (for Men) *Alternative Regimen for Men and Women: Tinidazole 2g orally in a single dose
For Bacterial Vaginosis	Metronidazole, 500 mg orally 2 times a day for 7 days
For Syphilis	Infants and Children: Benzathine Penicillin G 50,000 units/Kg body weight IM up to the adult dose of 2.4 million units IM in a single dose
For Hepatitis B virus infection	Hepatitis B virus immunization at time of initial examination, if not fully immunized. Follow-up doses of vaccine should be administered 1–2 and 4–6 months after the first dose If the assailant is known HBsAg positive, unvaccinated survivors should receive both Hepatitis-B vaccine and HBIG
Human Papilloma virus	For female and MSM victims who have not received HPV vaccine or have incomplete dose, HPV vaccine should be administered at the time of the initial examination, and follow-up dose administered at 1–2 months and 6 months after the first dose.

SUGGESTED CITATION: Algorithms for the Post-Exposure Prophylaxis for STI and HIV in Sexually Abused Children. UP -PGH Department of Pediatrics Child Protection Unit and Pediatric Infectious Disease and Tropical Medicine. Project Leads: Dr. Marimel Pagcaptipunan, Dr. Bernadette Madrid and Dr. Merle Tan.

HIV/AIDS & ART REGISTRY OF THE PHILIPPINES

FACILITIES DESIGNATED AS HIV TREATMENT HUBS/PRIMARY CARE AND CERTIFIED RHIVDA CONFIRMATORY LABORATORIES

Region	Name of Facility	Address	Landline	Mobile
1	Ilocos Training and Regional Medical Center	Parian, San Fernando City, La Union	(072) 6076418 (072) 6079912	-
2	Cagayan Valley Medical Center (Haven of Hope)	Dalan na Pagayaya, Carig Sur, Tuguegarao, Cagayan	(078) 377-2420	-
3	Bataan General Hospital (Bataan HAVEN)	Manahan St., Tenejero, Balanga City, Bataan	(047) 237-1274 (047) 237-1275 loc. 103	09998844522
	Bulacan Medical Center (Luntiang Silong)	3rd Flr Pay 3 - Rm 301 Mojon, City of Malolos, Bulacan	-	09234051309 09155214322 09171397123
	Dr. Paulino J. Garcia Memorial Research and Medical Center (Sanctuario De Paulino)	Mabini St., Cabanatuan City, Nueva Ecija	(044) 463-8888 loc. 203	09190027679 09454626620
	Jose B. Lingad Memorial Regional Hospital (Bahay LInGAD)	Brgy. San Dolores, San Fernando, Pampanga	(045) 435-6801	09336215028
4A	Batangas Medical Center (BATMC Wellness Zone)	Kumintang Ibaba, Batangas City	(043) 740-8307 loc 1121	09338617592
4B	Ospital ng Palawan (Red Top Center)	220 Malvar St. Puerto Princesa City	-	09266309103 09560350568
5	Bicol Medical Center	BMC Road, Naga, Camarines Sur	-	09178317482 09175803624
6	Corazon Locsin Montelibano Memorial Regional Hospital	2nd flr. OPD Bldg. Lacson St. cor Burgos, Bacolod City	(034) 707-2280	-
	Western Visayas Medical Center	Q. Abeto St., Mandurriao, Iloilo City	(033) 321-1631	09153281269
7	Vicente Sotto Memorial Medical Center	B. Rodriguez St., Cebu City	-	09432937853 09561273994
9	Zamboanga City Medical Center	Dr. Evangelista St., Sta. Catalina, Zamboanga City	(062) 991-2934	09177718147
10	Northern Mindanao Medical Center	Provincial Capitol Compound, Cagayan de Oro City	(082) 856-4147 loc 361	09054407272
11	Southern Philippines Medical Center	J. P. Laurel St., Bajada, Davao City	(082) 227-2731 loc. 5041	09325601960 09555145191
CAR	Baguio General Hospital and Medical Center	Governor Pack Road., Baguio City	(074) 442-4216 loc. 381	09155816480
NCR	Klinika Bernardo	Ermin Garcia St., Brgy. Pinagkaisahan, Quezon City	-	09324033412
	Love Yourself - Anglo Clinic	3rd floor, Anglo Bldg. Shaw Blvd, Mandaluyong	-	09278926611
	Pasig City Treatment Hub (PATH)	CHAMP Bldg, Caruncho Ave, Pasig City	(02) 798-2572	-
	Philippine General Hospital (SAGIP - Unit)	Taft Ave., Manila	(02) 554-8400 loc. 3249	09289948380
	Marikina City Satellite Treatment Hub	Marikina Healthy City Center, Shoe Ave., Sto. Niño, Marikina City	(02) 948-8925	09175631722
	Research Institute for Tropical Medicine	Filinvest Corporate City, Alabang, Muntinlupa City	(02) 807-2628 loc. 332	09178731984

DOH Department Memorandum No. 2021-0109: Updated List of Health Facilities with Rapid HIV Diagnostic Algorithm (rHIVda) Service
DOH Department Memorandum No. 2020-0485: Directory of DOH-Designated HIV Treatment Hubs and Primary HIV Care Facilities in the Philippines

TREATMENT HUBS (OUTPATIENT AND INPATIENT CARE & TREATMENT)

Region	Name of Facility	Address	Landline	Mobile
1	Ilocos Sur Provincial Hospital - Gabriela Silang	Quirino Blvd., Tamag Vigan Ilocos Sur	-	09272957363 09175641530
	Mariano Marcos Memorial Hospital and Medical Center	Barangay 6 San Julian, Batac, Ilocos Norte	(077) 600-8000	09177790207
	Region 1 Medical Center (PINAS - Unit)	Arellano St. Dagupan City, Pangasinan 2400	(075) 515-8916	09159063375
2	Region II Trauma and Medical Center	Magsaysay, Bayombong, Nueva Vizcaya	(078) 805-3561 loc. 1098	-
3	Allied Care Experts Medical Center (EmbrACE Unit) - Baliwag	Pinagbarilan, Baliuag, Bulacan	(044) 816-1000 loc 204	09338737688
	Apalit Doctors Hospital, Incorporated (ADHope Unit)	Gonzales Ave, San Juan, Apalit, Pampanga	-	096745117380 09338263471
	Concepcion District Hospital	St. Jude Village, Alfonso Concepcion, Tarlac	(045) 923 0642 (045) 491 3664	09107080130
	Guimba Community Hospital (Balay Ti Namnama)	L. de Ocampo St. Saranay District, Guimba, Nueva Ecija	(044) 951-0485	-
	Jose C. Payumo Jr. Memorial Hospital (HEARTH Unit)	Tala St. San Ramon, Dinalupihan, Bataan 2110	-	09295852241 09156008004
	James L. Gordon Memorial Hospital (L.E.A.D. Shelter)	#1 Perimeter Rd., New Asinan, Olongapo City	(047) 602-4052	09988627015
	Maria Aurora Community Hospital	Saturno St., Brgy. 01, Maria Aurora, Aurora	-	09075948798
	Mariveles Mental Wellness and General Hospital	P.Monroe St. Bayan ng Mariveles, 2105 Bataan	-	09282764197 09239188454 09063491276
	Premiere Medical Center (TAHANAN sa Premiere)	Maharlika Highway, Daan Sarile, Cabanatuan City, Nueva Ecija	(044) 463-7845 to 49 loc 2073	09322128175 095968173441
	President Ramon Magsaysay Memorial Hospital	Ermin Garcia St., Brgy. Pinagkaisahan, Quezon City	-	09324033412
	(Balin Kalinga)	Zambales Medical Society Building (beside Eye Center Clinic) Palanginan, Iba Zambales	-	09153966014 09192442299
	San Marcelino District Hospital Shelter of Holistic and Positive Embrace (HoPE)	1st/F Admin Bldg, Ntl. Rd. Sto. Domingo, San Marcelino, Zambales	(047) 913-1244	09398630806
	Talavera General Hospital (Talevera's Hope)	Maestrang Kikay District, Talavera, Nueva Ecija	(044) 463-1166	09358124776 09218881119
	Tarlac Provincial Hospital (TPH Cares)	San Vicente, Tarlac City	(045) 491-8970 loc. 225	09289064776
4A	Calamba Doctors Hospital (Plus Life Center)	San Cristobal Bridge, Calamba, Laguna	(049) 545 2529 (049) 545 7371 loc 182	-
	General Emilio Aguinaldo Memorial Hospital	Brgy Luciano Trece Martires Cavite	(046) 6860856	09773325852
	Laguna Medical Center (LMC HACT Clinic)	J. De Leon St, Santa Cruz, Laguna	(049) 543-3351	09178465901
	Ospital ng Biñan (ONB HIV Treatment Hub)	Canlalay Bridge, Biñan, Laguna	(049) 502 8200 loc 8223	0916680029
	Quezon Medical Center (Live Positive Wellness Center)	Brgy XI, Quezon Avenue, Lucena, Quezon Province	(042) 717-6323 loc. 342	-
	San Pedro District Hospital	Bgy. San Antonio Holiday Homes San Pedro, Laguna	-	09178908767 09985500462
4B	Dr. Damian Reyes Provincial Hospital (Triple Heart Treatment Hub)	National Highway, Boac, Marinduque	-	09209721385
5	Bicol Regional Training and Teaching Hospital	Rizal St., Legazpi City	(052) 483-0017 loc. 4227	
	Masbate Provincial Hospital - St. Aloysius Gonzaga	Provincial Health Office Road, Brgy Kalipay, Masbate City	(056) 333-1590	09082061334 09193383397 09212434425
6	Angel Salazar Memorial General Hospital	Tobias A. Fornier St, San Jose de Buenavista, Antique	-	09557790824
	Dr. Rafael Tumbokon Memorial Hospital	Mabini St., Kalibo, Aklan	(036) 268-6299	09260726703 09394109160
	Rep. Pedro G. Trono Memorial Hospital (RISE Clinic)	Guimbal, Iloilo	(033) 327-0188	-
	St. Paul's Hospital—Iloilo (Mother Candle Center)	Cardinal Dougherty Annex Bldg. Ground Floor, Gen. Luna St. Iloilo City	(033) 337-2742 to 49 loc 2067	-
	The Medical City - Iloilo (i-REACT Clinic Iloilo)	Locsin St., Molo, Iloilo City	-	09053468571 09613184508
7	Cebu Provincial Hospital - Balamban	Pilapil Street, Balamban, Cebu	(033) 500-1000	09567058332
	Cebu Provincial Hospital - Carcar	Baracca St. Pob. 2 Carcar City, Cebu	(032) 333-2273	09055257363
	Chong Hua Hospital - Mandaue (ART Club 802)	Int'l Mantawi Drive. Rec. Area, Bgy. Subangdaku, Mandaue	(032) 487-8120	09276817593
	Eversley Childs Sanitarium and General Hospital	Upper Jagobiao Rd, Mandaue City, Cebu	(032) 233-8000 loc.8880	-

DOH Department Memorandum No. 2020-0485: Directory of DOH-Designated HIV Treatment Hubs and Primary HIV Care Facilities in the Philippines

HIV/AIDS & ART REGISTRY OF THE PHILIPPINES

TREATMENT HUBS (OUTPATIENT AND INPATIENT CARE & TREATMENT)

Region	Name of Facility	Address	Landline	Mobile
7	Gov. Celestino Gallares Memorial Hospital	M. Parras St., Tagbilaran City	-	09339600387 09171793069
	Negros Oriental Provincial Hospital	Real St., Dumaguete City, Negros Oriental	-	09430585721
	Talisay District Hospital	San Isidro, Dakbayan sa Talisay	(035) 226-4066	09173816617
	Visayas Community Medical Center (Balay Malingkawasnon)	Osmeña Blvd., Cebu City	-	09333252888 09954677467
8	Biliran Provincial Health Office (Reproductive Health Clinic)	Naval, Biliran	-	09223426623 09265320200
	Divine Word Hospital	Avenida Veteranos St. Tacloban City	(053) 500-9918	-
	Eastern Samar Provincial Hospital	Borongan, Eastern Samar	(053) 321-4228	-
	Eastern Visayas Regional Medical Center	Magsaysay Blvd., Tacloban City	(055) 560-9869 (055) 261-2206	09777170765
	Felipe Abrigo Memorial Hospital	Hillsview, Guiuan, Eastern Samar	-	09551031242
	Hilongos District Hospital	CV Alcuiwo St., Hilongos, Leyte	(053) 336-2102	-
	Leyte Provincial Hospital	Pawing, Palo Leyte	-	09064786313
	Northern Samar Provincial Hospital	Catarman, Northern Samar	(055) 500-9770	-
	Salvacion Oppus Yniguez Memorial Hospital	Dakbayan Maasin, Southern Leyte	-	09471515248
	Samar Provincial Hospital	Imelda Road Catbalogan City Proper Catbalogan, Samar	-	09173031276
	St. Camillus Hospital	Maharlika highway Brgy Trinidad Calbayog, Samar	(055) 209-3906	-
9	Corazon C. Aquino Memorial Hospital	Basong Dipolog, Zamboanga del Norte	-	09399247765
	Margosatubig Regional Hospital	F. Nightingale St, Margosatubig, 7035 ZDS	-	09177001500 09452954381
	Zamboanga del Sur Medical Center	Provincial Gov't Complex, Bgy. Dao, Pagadian City, Zamboanga del Sur	-	09173116880 09291384112
10	Adventist Medical Center (HAVEN)	Andres Bonficacio Ave, Sn Miguel, Iligan		09177155200
	Bukidnon Provincial Medical Center	Sayre Highway, Malaybalay, Bukidnon	-	09177198179
	Mayor Hilarion A. Ramiro Sr. Regional and Teaching Hospital	Bacolod , 7200 Ozamis City , Misamis Occidental		09278678841
11	Davao Doctors Hospital (ARTU)	118 E Quirino Avenue, Poblacion District, Davao City	(082) 222 8000 loc 7105	-
	Davao Regional Medical Center (RED STAR Clinic)	Apokon, Tagum City, Davao del Norte	-	09566921048 09239598931
	Allah Valley Medical Specialists Center	Purok Villegas, General Santos Drive, Koronadal City	-	09491631598
12	Amado B. Diaz Provincial Foundation Hospital	Roosevelt St. Poblacion 4, Midsayap North Cotabato	-	09178696865
	Cotabato Provincial Hospital	Amas, Kidapawan City	-	09302567522
	Dr. Arturo P. Pingoy Medical Center	General Santos Drive, Zone IV,Koronadal City	-	09174090537
	Dr. Jorge P. Royeca Hospital	E. Fernandez St. Bgy. Lagao, General Santos City	-	(083) 552-1357
	South Cotabato Provincial Hospital (IPHO-SCPH HACT Clinic)	Aguinaldo St., Koronadal City, South Cotabato	(083) 877-7314 (083) 310-0747	-
BARMM	Amai Pakpak Medical Center	Marawi City, Lanao del Sur	-	09178871029
	Cotabato Regional and Medical Center	RH-11, Sinsuat Ave., Cotabato City	-	09178946224
	Cotabato Sanitarium Hospital	Bgy. Ungap, Sultan Kudarat, Maguindanao	-	09054085742
CAR	Notre dame de Chartes Hospital	Assumption Rd. Baguio City	-	09177085433
Caraga	Adela Serra Ty Memorial Medical Center (SDS Wellness Ctr.)	Capitol Hills, Telaje, Tandag, Surigao del Sur	(086) 211-4306	09392318446
	Butuan Medical Center (Pallative and Wellness Care Center)	Km 5 Baan, Butuan City	-	09177098555 09126155895
	CARAGA Regional Hospital (OP Wellness Center)	Rizal St. National Road, Surigao City	(086) 826-0568	09209482130
	Democrito O. Plaza Memorial Hospital (Heart Room)	P2, Patin-ay, Prosperidad, Agusan del Sur	-	09466074119 09126875138
NCR	Asian Hospital and Medical Center (General Medicine Clinic)	2205 Civic Drive, Filinvest City, Alabang	(02) 8771 9000 loc 849	09178114388 09989641964
	Dr. Jose N. Rodriguez Memorial Hospital	St. Joseph Avenue, Tala Caloocan	-	09218775900 09253547547
	Lung Center of the Philippines	Quezon Ave., Diliman, Quezon City	-	09189158378 09267398000
	Makati Medical Center (Center for Tropical & Travel Medicine)	#2 Amorsolo St., Legaspi Village, Makati City	(02) 888-8999 loc.2134	09178014314
	Manila Doctors Hospital	667 United Nations Avenue, Ermita Manila	(02) 8558-0888 loc. 4480	09989557598
	Mary Johnston Hospital	1221 Juan Nolasco Street, Tondo Manila	(02) 245-4021 loc 385/412	-
	Quezon City General Hospital	Seminary Road, EDSA	-	091750536767 09264015339
	Rizal Medical Center (OPD Annex)	Pasig Blvd, Pasig City	-	09361944238 09616714440
	San Lazaro Hospital (H4 OPD Clinic)	Quiricada St., Sta. Cruz, Manila	(02) 310-3128	-
	San Juan de Dios Hospital (Holy Mother of Light Center)	2772 Roxas Blvd. Brgy. 76, Pasay City	-	09275811346 09298511346
	St. Luke's Medical Center - Quezon City (CHBC Room 2)	279 E. Rodriguez Sr. Ave, Quezon City	-	09498817626
	St. Luke's Medical Center - Global City (Room 1276)	Rizal Drive cor. 32nd & 5th Ave.,Taguig City	(02) 789-7700 loc 8276/5003	-
	Sta. Ana Hospital	New Panaderos St., Sta. Ana, Manila	(02) 516-6790	-
	The Medical City - Ortigas (i-REACT Clinic Pasig)	Ortigas Ave., Pasig City	(02) 988-1000 loc. 6765	-
	Tondo Manila Center (TMC Haven)	H. Lopez Blvd. Balut, Tondo, Manila	-	09989446223

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PRIMARY HIV CARE FACILITIES (OUTPATIENT CARE & TREATMENT)

Region	Name of Facility	Address	Landline	Mobile
1	Lacasandile Medical Clinic and Diagnostic Center	Bgy. Lacong National Highway, Tagudin Ilocos Sur	-	09062518009
2	Santiago City Health Office	Santiago-Tuguegarao Road, San Andres, Santiago, 3311	(078) 305 2775	-
3	Angeles City Reproductive Health and Wellness Center and Primary HIV Care Clinic (Bale Angeleño)	C. Surla St., Balibago, Angeles City	-	09260726899 09325479455
	Family Planning Organization of the Philippines - CAPUTOL CARES	39 Rizal Ave, Bgy Maimpis, San Fernando Pampanga	-	09323194911 09959720968 09209815156 09232529712
	Guiguinto RHU II Primary Care Clinic Center (Gintong Kanlungan)	2nd Flr, RHU II, Green Estate Subdivision, Guiguinto, Bulacan	(044)760-3450	09325478488 09260726900
	Lakan Community Center and Primary HIV Care Clinic	104-B Roxas St. Lakandula, Mabalacat, Pampanga	-	09325208672 09057084382
	Mabalacat RHU II (Lingap Balacat)	Brgy. Dau, Mabalacat City Pampanga	-	09991067475 09260726596
	Meycauayan City Primary HIV Care Clinic	Peso St., St. Michael Homes, Pandayan, Meycauayan, Bulacan	-	09272324119 09232982649
	Moncada Rural Health 1	Poblacion 1 Moncada, Tarlac	(045) 06061417	09088818284

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HIV/AIDS & ART REGISTRY OF THE PHILIPPINES

PRIMARY HIV CARE FACILITIES (OUTPATIENT CARE & TREATMENT)

Region	Name of Facility	Address	Landline	Mobile
3	San Jose del Monte Primary HIV Care Clinic (Villa Esperanza)	Ospital ng Lungsod ng San Jose del Monte, Bagong Buhay 1, SJDM, Bulacan	-	09230221010 09174592984
	San Jose del Monte Primary HIV Care Clinic II (Villa Esperanza II)	2nd floor Health Station, St. Peter Parish Street, Tungkong Mangga, Sta. Maria Rd, SJDM, Bulacan	-	0998840837 09171533890
	RE De Jesus Multi-Specialty Clinic and Diagnostic Center (The Green Clinic)	Brgy. Caypombo (Back of LBC Caypombo), Sta.Maria, Bulacan	(044) 815-3145	09368040043
	RHU 1 Marilao Bulacan (Kanaryong Silungan)	2nd Floor, RHU 1, Northbound NLEX Road, Marilao, Bulacan	-	09256070888
4A	Antipolo Social Hygiene Clinic	M. Santos St., Brgy. San Roque, Antipolo City	(02) 8696-4097	-
	Bacoor Social Hygiene Clinic	Floraville Subdivision, Panapaan 1, Bacoor City	-	09499940184
	Cainta Reproductive Wellness - Social Hygiene Clinic	Municipal Cmpd A. Bonifacio Ave. Brgy. Sto. Domingo, Cainta	(02) 696 2607	-
	Dasmariñas City Health Office I (SHC)	Zone 2, Manggubat St., City Health Office I, Dasmariñas, Cavite	(046) 416-0279	09171656457
	Imus Social Hygiene Clinic	Medicion 1C, Velarde Subdivision, Imus	(046) 434-4057	09267013539 09258787158
	Klinika Lipa	Lipa City Hall Maraway Lipa City	-	09567392902
	Rodriguez Municipal Health Office	J.P Rizal St. Baliote Rodriguez Rizal	-	09209215204 09228768220
	San Pablo Social Hygiene Clinic	City Governance Bldg, Apolinario Mabini Ext, Barangay 5A, San Pablo City	(049) 562 8116 (049) 562 7872	-
	Santa Rosa Social Hygiene Clinic	Riza Blvd. Building B Market Area, Santa Rosa Laguna	(049) 530-0015 loc 5309	-
	Sentrong Pangkagalingan ng Mauban	Devera St. Sadsaran Mauban Quezon	(042) 785-0925	09109749371
	Tanay Social Hygiene Clinic	MLH Del Pilar St. Municipal Compound, Plaza Aldea, Tanay Rizal	654-2609	-
6	Family Planning Organization of the Philippines - Community Health Care Birthing Center and Laboratory	Dulalia Bldg., Brgy. Maria Clara Iloilo City	-	09175170111
7	Cebu Social Hygiene Clinic	General Maxilom Avenue Extension, Carreta, Cebu City	(032) 233-0987	09255591663
	Danao City Social Hygiene Clinic (Get Well Resource Center)	Danao City Hall, F. Ralota St., Poblacion	-	09176326694 09330266694
	Mandaue City Social Hygiene Clinic	Mandaue City Health Office, F.B. Kabahog St. Centro Mandaue City	(032) 268-2489	09285077400
	Talisay City SHC	Multi Purpose Bldg, Brgy. Poblacion, Talisay City	(032) 4915567 (032)2734704	-
8	Ormoc City Health Office	CHO Aunubing Street, Barangay Cogon, Ormoc City, Leyte	-	09171126000
10	HIV/AIDS Primary Care Services Integration of Maramag	Dionisio Micayabas St. Maramag Bukidnon	-	09177025990
11	Davao Reproductive Health and Wellness Center	Emilio Jacinto St., Poblacion District, Davao City, Davao del Sur	(082) 222-4187	-
12	Kalamansig Rural Health Unit	Poblacion Kalamansig, Sultan Kudarat Province	(064) 204-6113	-
	General Santos City Social Hygiene Clinic	City Health Office, Fernandez St., Lagao, General Santos City	(083) 302-8115	-
CAR	Baguio Reproductive Health and Wellness Center	T. Alonzo St. Baguio City	(042) 442 4542	
NCR	Batasan Hills Super Health Center (SHC)	#1 IBP Road, Batasan Hills, Quezon City	-	09322959752 09232790558
	Bernardo Social Hygiene Clinic	Ermin Garcia St., Brgy. Pinagkaisahan, Quezon City	-	09193635919
	Klinika Novaliches	2/F Bautista Building, 8 Dona Isaura, Novaliches, Quezon City	-	09985734877
	Klinika Project 7	39 Bansalangin St., Veterans Village, Project 7, Quezon City	09178561158	
	Las Piñas Social Hygiene Clinic	Barrio Hall, Alabang-Zapote Road, Almansa, Las Piñas City	(02) 800-6406	-
	Malabon City Social Hygiene Clinic	PBM Cpd. Dagat-dagatan cor. Maya-maya St. Lungos Malabon	(02) 373-3431	-
	Mandaluyong Social Hygiene Clinic	20 M. Lerma St. cor. Vicencio St, Mandaluyong City	(02) 546-7799	-
	Manila Social Hygiene Clinic	208 Quiricada St., Sta. Cruz, Manila	(02) 711-6942	-
	Muntinlupa Reproductive Health and Wellness Center	2nd Flr, Putatan Health Center, Ntl. Rd, Putatan, Muntinlupa City	(02) 834-5997	-
	Parañaque City Social Hygiene Clinic	3rd Floor Paranaque City Hall, San Antonio Valley 1, San Antonio, Sucat	(02) 826-8229 (02) 826 8219	-
	Pasay City Social Hygiene Clinic	2nd Flr. Doña Elvira Lagrosa Health Center, FB Harrison Pasay	(02) 809-3671	-
	Project 7 Social Hygiene Clinic	39 Bansalangin St., Veterans Village, Project 7, Quezon City	-	09204227596 09998415060
	San Juan City Social Hygiene Clinic	2nd Floor Batis Health Center, F. Manala St. San Juan City	-	09176678163 09277645343
	Sustained Health Initiatives of the Phils. (SHIP Clinic)	565 Shaw Blvd. Highway Hills, Mandaluyong City	(02) 3491-7349	09178281278
	Taguig Social Hygiene Clinic	TND Village Corner P. Cruz, Tuktukan	(02) 642-1262	09267542917
	Valenzuela Social Hygiene Clinic	Valenzuela City Hall, Poblacion II, Malinta, Valenzuela City	(02) 352-6000 loc. 6046	-

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OTHER FACILITIES PROVIDING OUTPATIENT HIV CARE AND TREATMENT

Region	Name of Facility	Address	Landline	Mobile
6	Roxas City Health Office	Bangbang Street, Inzo Arnaldo Village Roxas City	(036) 621-0578 (036) 621-3244 (036) 621-0578 (036) 621-5686	-
NCR	Klinika Batasan (Sundown Clinic)	#1 IBP Road, Batasan Hills, Quezon City	-	09366573531 09228012958
	Taguig City Drop-in Center	Service Road, Western Bicutan	(02) 642-1262	09267542917