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Multidisciplinary models of care in the Philippines

Strengthening services for child victims and survivors of sexual abuse and exploitation in the digital age



Safe Online

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Executive summary

When children have suffered abuse, they have a right to access services that support healing, protection and justice. This requires coordinated support from practitioners from multiple specialized disciplines, including police investigators, prosecutors, social workers, medical professionals and psychologists. Bringing these disciplines together in an integrated model can result in both efficiencies in service delivery and better outcomes through adopting a child-centred approach.[1] However, evidence remains limited on how such models operate across diverse socioeconomic contexts and on their capacity to respond effectively to technology-facilitated harm.[2]

This report is part of a series of four country reports and presents findings from a global rapid literature review, a country-level document review and fieldwork conducted in the Philippines focusing on the Women and Children Protection Unit (WCPU) multidisciplinary service model. The study aimed to generate evidence for policymakers and practitioners on good practice for strengthening multidisciplinary collaboration and improving outcomes for children and families.

The WCPU model

Established as 'one-stop-shop' facilities, WCPUs co-locate physicians, social workers, mental health professionals and police investigators to deliver integrated medical, psychosocial, legal and social work services to children and women who are victims of abuse, eliminating the need for victims to navigate multiple agencies and repeat their accounts to multiple agencies. A defining feature of the model is the use of a 'joint interview', in which professionals of all disciplines are present to hear the child's account of the abuse, ensuring that the child need only give a comprehensive account in a single session and therefore reducing the potential for retraumatization. While predominantly hospital-based, the WCPU network has been extended to community settings through the establishment of centres led by local government units (LGUs) and 138 'TeleWCPU' satellite hubs that bring specialist services to remote and underserved areas. This extends the provision of specialist services to remote communities while maintaining a health-centred paradigm that prioritizes treatment regardless of whether families pursue legal action against perpetrators of sexual abuse and exploitation.

The WCPU model was established in the mid-1990s, when early pilots in Cebu (1996) and Manila (1997) created the multidisciplinary team structure that would serve as the national blueprint. The model was underpinned by a Department of Health (DOH) administrative order issued in 1997 and quality assurance partnerships formalized through the Child Protection Network (CPN) from 2002 onwards. As at December 2025, the network comprised 162 WCPUs and Violence Against Women and Children (VAWC) Desks across 70 of the Philippines' 82 provinces and 10 cities, with the government committed to eventually placing a WCPU in every public hospital in the country by 2030. This goal is being pursued through sustained and strategic advocacy and legislative efforts and has been reinforced by growing recognition that the model serves as a replicable framework for other low- and middle-income countries.

1 United Nations Children's Fund, *Multidisciplinary Models of Care: Strengthening services for child victims and survivors of sexual abuse and exploitation in the digital age*, UNICEF, New York, December 2025.

2 United Nations Children's Fund, *Multidisciplinary Models of Care for Child Victims and Survivors of Sexual Abuse and Exploitation in the Digital Age: A rapid review of the literature on child-centred services responding to in-person and technology-facilitated abuse*, UNICEF, New York, March 2025.

Opportunities and learning

The study findings provide evidence of what works within the WCPU model (e.g., co-location, joint interviews, the TeleWCPU network) and what gaps persist (e.g., human resource shortages, funding constraints, coordination challenges). Opportunities for multidisciplinary stakeholders to collaborate to further strengthen responses to child sexual abuse and exploitation in the Philippines have also been identified.

WCPU staff revealed that overwhelming caseloads, insufficient staffing and the emotionally taxing nature of work with traumatized children create severe risks of burnout, stress and vicarious trauma for providers. While some facilities have implemented stress debriefing activities and staff can often access internal mental health professionals, support remains inconsistent and often inadequate relative to demand. Critically, the reality is that, without addressing these workforce well-being issues through managing caseloads, offering permanent positions to provide job security and institutionalizing mental health support for all staff, even well-designed models are unlikely to be able to sustainably provide high-quality care. This recognition that provider well-being directly affects service quality and outcomes for children demonstrates the need to prioritize 'care for the carers' and ensure that it is an essential, rather than optional, element of any multidisciplinary service model.

The findings also reveal that current services, designed primarily for 'offline' abuse, are inadequate for addressing the scale and complexity of technology-facilitated sexual abuse and exploitation in the Philippines. Front-line workers currently lack specialized training, assessment tools and therapeutic interventions for technology-facilitated cases, instead relying on general trauma-informed care skills. As digital harm becomes increasingly prevalent, this capacity gap will widen unless systematic investment is made in developing and disseminating specialized protocols. It is vital that emerging initiatives, such as remote-counselling protocols, training modules on technology-enabled sexual abuse and partnerships with organizations providing specialized support in communities particularly affected by technology-facilitated abuse, are expanded to create comprehensive capacity-building programmes that ensure that all WCPU staff can effectively respond to all forms of abuse and exploitation.

Progress towards sustainability and scale

Development partners have provided crucial funding for TeleWCPU expansion (United Nations Children's Fund), LGU-led centre development (Consuelo Foundation), and mental health provision in technology-facilitated sexual abuse hotspots (International Justice Mission or IJM). While these investments have generated important innovations, outcomes still vary greatly depending on geographical location. Therefore, rather than fragmented, project-based support, strategic investment in core infrastructure and capacity, which would have multiplier effects across the entire system, is crucial.

The challenges identified, including the reluctance of medical professionals to accept medico-legal cases, constant police rotation that disrupts continuity, Department of Education (DepEd) bureaucratic obstacles, and turnover of *barangay* (village) officials breaking community connections, also indicate that

strengthening the multidisciplinary response requires policy interventions beyond the health sector. Opportunities exist for developing interdepartmental coordination mechanisms, including introducing appropriate compensation for court testimony, ensuring stability in terms of the police investigators involved in specialized assignments and streamlining DepEd referral processes and systems to maintain continuity despite electoral cycles. The Revised Protocol for the Case Management of Child Victims of Abuse, Neglect, Exploitation and Discrimination (2025) provides a foundation for this, but implementation will require a high level of commitment across multiple government agencies.

As at December 2025, WCPUs had been established in 70 of the Philippines' 82 provinces. During the first Global Ministerial Conference to End Violence Against Children, the Philippines made a commitment that all public hospitals in the country would eventually have a WCPU. Successful LGU-led WCPUs like the Valenzuela City Child Protection Center will serve as replicable models for other LGUs. The DOH recognizes, however, the need to standardize LGU-led WCPUs, which operate outside hospital settings, as the official DOH policy only applies to hospital-based WCPUs.

However, the creation of fully functional units remains uneven, largely owing to limited dedicated funding and staff being hesitant to assume additional workloads. In response, bills filed under the 20th Congress seek to institutionalize WCPUs across all government hospitals.[3] These proposed measures are designed to secure permanent funding, standardize staffing requirements and ensure nationwide coverage, thereby supporting the scale-up and long-term sustainability of WCPUs.

Critical factors for successful replication of the model include securing high-level commitment and political will from local chief executives, establishing formal memorandums of agreement that make LGU commitments legally binding, ensuring staff undergo standardized multidisciplinary training provided by CPN, establishing sustainable funding that is integrated into hospitals' or LGUs' main budgets, and building strong interagency collaboration mechanisms with clear referral pathways.

With the successful expansion of WCPUs from 1 pilot site to 162 units nationwide, DOH and CPN now also face the ongoing challenge of maintaining quality standards across a geographically dispersed network with varying resource levels. Continued growth must be accompanied by robust quality assurance mechanisms such as accreditation systems, on-site mentoring and regular monitoring to ensure that expansion does not dilute service quality. Findings point to the value of systematically documenting and disseminating good practices from high-performing units, fostering peer learning networks and introducing tiered technical assistance calibrated to facility capacity.

3 See Senate Bill 165 (https://legacy.senate.gov.ph/lisdata/4664242647!.pdf) and House Bill 2036 (https://docs.congress.hrep.online/legisdocs/basic_20/HB02036.pdf).



The way forward

The study identified the following critical success factors for strengthening the WCPU model and multidisciplinary service provision for child victims and survivors of sexual abuse and exploitation in the Philippines. Detailed recommendations are presented in Annex I.



INTEGRATION:

Design and implement integrated networks in which community-based centres, VAWC Desks in district hospitals, TeleWCPU satellite sites and tertiary hospital WCPUs function as complementary components of a coordinated system rather than as parallel structures.



STAFF CAPACITY AND SUPPORT:

Institutionalize regular mental health support and stress management programmes for all WCPU staff, including mandatory quarterly debriefing sessions and access to counselling services, while addressing the root causes of burnout through reducing caseloads, maintaining adequate staffing levels and creating permanent positions for all multidisciplinary team members.



SYSTEMS AND COORDINATION MECHANISMS:

Develop and enforce formal interagency agreements with clear referral protocols, particularly for technology-facilitated cases; mechanisms to provide appropriate compensation and support for professionals engaged in medico-legal work; and systems that maintain continuity despite personnel rotations and political transitions.



INNOVATION AND ADAPTATION TO THE DIGITAL AGE:

Develop and roll out specialized therapeutic interventions and training modules specifically addressing technology-facilitated sexual abuse and exploitation, including standardized case management protocols that incorporate routine screening for digital harm indicators during all intake assessments.



SUSTAINABILITY AND SCALE:

Anchor the model in national systems by securing its legal mandate and dedicated public financing, extending national service standards to LGU-led and community-based units, and embedding training within government workforce development and continuing professional development systems.



ACCESSIBILITY AND INCLUSION:

Expand the TeleWCPU infrastructure to reach underserved remote communities and provide systematic financial assistance for transport costs and lost wages to reduce access barriers for indigent families, while developing specialized protocols and training on serving children with disabilities, refugee and migrant children, and LGBTQI+ youth.

The factors identified in the Philippines as being critical to success closely align with those identified in the other countries examined in this global study, namely Bulgaria, Nigeria and South Africa (see *Box 1*).

Box 1:

Key learnings from the global study on multidisciplinary models of care

1 **Integrate services through more than co-location:** Success depends on strong cross-sectoral relationships, clear legal mandates, joint protocols and regular coordination mechanisms, not just physical proximity.

2 **Address technology-facilitated abuse systematically:** Services need tailored protocols, staff training and better pathways in law enforcement to support children experiencing technology-enabled sexual abuse and exploitation.

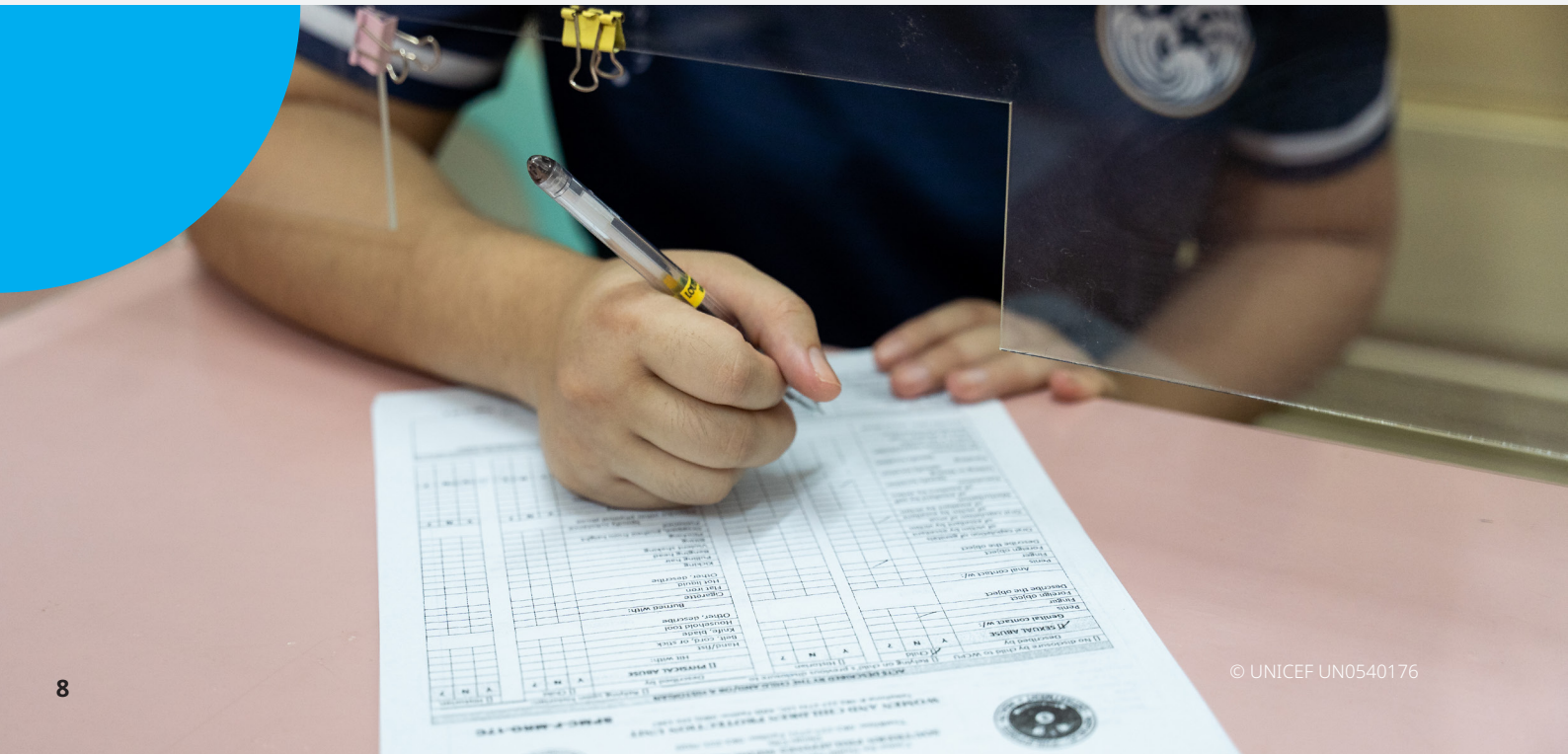
3 **Embed models in national systems:** Effective models should be legally mandated, publicly funded and scaled equitably nationwide through planned government transitions with clear financial strategies.

4 **Centre children and community voices:** Children, families and communities should be involved in service design and improvement to ensure cultural relevance, accessibility and trust. Services must reach the most vulnerable.

5 **Support staff well-being:** Psychological supervision, peer support, realistic caseloads and stress management should be built into models to prevent burnout and sustain high-quality care, especially for psychosocial service providers.

6 **Monitor for learning and improvement:** Monitoring systems should be designed that capture child-centred outcomes, service quality feedback and emerging trends to continuously strengthen practice.

Source: Adapted from United Nations Children's Fund, *Multidisciplinary Models of Care: Strengthening services for child victims and survivors of sexual abuse and exploitation in the digital age*, UNICEF, New York, December 2025.



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1 Background

While using multidisciplinary service models is promoted as being good practice for supporting child victims and survivors of sexual abuse and exploitation,[4] evidence and information are generally lacking on service models' capacity to address the needs of children in low- and middle-income countries and to support children affected by sexual violence facilitated by technology.[5] The aim of this study was to generate evidence for policymakers and practitioners on good practice, to strengthen multidisciplinary working and offer improved care and outcomes for children and their families.

This report draws on findings from a rapid global literature review,[6] a country-level document review and fieldwork data collection in the Philippines. It is one of a series of four country reports and focuses on the Philippines' Women and Children Protection Unit (WCPU) multidisciplinary service model.

The study found that it is important to distinguish between the **form** of multidisciplinary models and their **function** in practice. While interagency collaboration is widely endorsed, effective coordination remains challenging. Drawing on the experiences of child protection actors working within these models, the study examined both the opportunities and the constraints of multidisciplinary approaches.

Methodology

Following the rapid global literature review, the research team developed a research methodology for the country visits, informed by the guidance of an expert reference group.[7] The methodology underwent ethical review by the Health Media Lab Institutional Review Board and received approval in April 2025.

Table 1:
Data collection tools and respondents

Country	Key informant interviews	Survey responses	Focus group discussions	Documents reviewed
Philippines	11	72	2	30

4 Radford, Lorraine, et al., *Action to End Child Sexual Abuse and Exploitation: A review of the evidence*, United Nations Children's Fund, New York, 2020, pp. 111–118.

5 *Multidisciplinary Models of Care for Child Victims and Survivors.*

6 Ibid.

7 The reference group, composed of external strategic partners within the child online safety ecosystem, was tasked with providing feedback on the implementation of the research at critical stages, including reviewing and providing feedback on the deliverables.

Key informant interviews and focus group discussions were conducted by an experienced team of international and national researchers with purposively selected key informants whose work directly relates to the WCPU model (see *Table 1*). These included informants from state organizations and non-governmental organizations (NGOs). A desk review of relevant documents shared by UNICEF Philippines and national stakeholders also contributed to the analysis. An online quantitative survey was administered to front-line service providers involved in implementing the WCPU model to elicit perspectives from a broader range of stakeholders. The principles of informed consent, subject safety and confidentiality were adhered to in relation to all data collection. Information obtained through field data collection was triangulated and analysed alongside findings from the document review, which involved reviewing 30 sources (see *Annex II*).

For quality purposes, data collected by the national research team on the WCPU model were cross-checked iteratively and analysed in several stages. The country-level data were initially reviewed and consolidated by the research team and validated by selected stakeholders, followed by further analysis by Child Frontiers to consolidate key findings. These findings were further reviewed and synthesized for this report to gain an understanding of the model and map the lessons learned, including opportunities for and challenges in supporting victims and survivors of child sexual abuse.

Gaps and limitations

Study scope: The study had a relatively limited scope, with primary data collection having been undertaken at only two sites in the Philippines. The global and national literature reviews were not intended to be exhaustive, and the level of detail was constrained by the study's time frame and scope and the existing evidence base. Despite these limitations, the study generated a solid body of evidence. Primary data were triangulated with literature reviews and quantitative surveys, and findings were reviewed by the research team for accuracy. The strong consistency observed across data sources strengthens confidence in the overall conclusions.

Perspectives of children and their families: The limited information gathered on children's and caregivers' perspectives was identified as a gap. The study drew on secondary sources, including findings of an examination of how service providers gather children's views on the relevance and effectiveness of services. Forthcoming research, including from the Disrupting Harm project[8] and the Barnahus Network,[9] will provide important insights into children's and families' perspectives.



8 More information can be found on the project web page (https://www.unicef.org/innocenti/projects/disrupting-harm).

9 More information can be found on the project website (https://barnahus.eu/).

2 Overview of the WCPU multidisciplinary service model in the Philippines

Overview: **WCPU model**

Core team: doctors, social workers, police investigators and mental health professionals.

Formal coordination mechanism: mandatory involvement of local social welfare and development offices and the Department of Social Welfare and Development in cases of child sexual abuse and exploitation.

External partners:

- Philippine National Police (PNP) (Women and Children Protection Desk, Women and Children Cybercrime Protection Unit);
- National Bureau of Investigation;
- Department of Education;
- Department of Justice.

Location: majority of WCPUs based in hospitals or medical centres, with some based in other locations such as community-based centres.

The WCPU multidisciplinary service model aims to provide comprehensive and integrated care for children and women who are victims of abuse and neglect, most commonly in cases of sexual abuse, in the Philippines.[10] Established as 'one-stop-shop' facilities, WCPUs deliver medical, psychological, social and legal services through co-located teams of trained physicians, social workers, mental health professionals and police investigators. The model is based on WCPUs being primarily located in hospitals but has been adapted to expand the WCPU network to local government unit (LGU)-led community-based centres, with services extending to remote areas through 'TeleWCPU' satellite hubs located in *barangays* (villages) and municipal social welfare offices.

10 Child Protection Network, *2023 Annual Report: Protecting the child from the many faces of abuse*, CPN, Manila, 2023.

The WCPU model was developed in response to widespread child abuse and a fragmented, retraumatizing service delivery system. Early studies by the Advisory Board Foundation (now CityBridge Foundation) in 1997 revealed that most street children in Manila had experienced physical or sexual abuse, highlighting an urgent unmet need.[11] At the time, the existing system required victims to navigate multiple offices – hospitals, social welfare departments, police stations – and repeatedly recount traumatic experiences to different professionals at each location, causing many to abandon the reporting process. The foundational policy for the creation of a WCPU network emerged in 1997, when the Department of Health (DOH) issued Administrative Order No. 1-B mandating that WCPUs be established in all DOH-retained hospitals; this mandate was later amended through DOH Administrative Order No. 2013-0011 (Revised Policy on the Establishment of Women and their Children Protection Units in All Government Hospitals). Locating WCPUs within the hospitals provided a natural and 'non-threatening' access point for victims of violence and capitalized on existing medical and psychosocial staff, supporting the sustainability of the model. While the model's founding mandate is a health-sector one, WCPUs are increasingly defined in national instruments as service points within the wider child protection system (such as in the 2025 Revised Protocol for the Case Management of Child Victims of Abuse, Neglect and Discrimination and Executive Order 79 Establishing the MAKABATA program).

The Vicente Sotto Memorial Medical Center (VSMMC) WCPU in Cebu province began as a pilot in 1996, initially operating as a desk in the emergency department before moving to its own dedicated room, known as the 'Pink Room'. The Philippine General Hospital Child Protection Unit (PGH-CPU) in Manila, formally established in January 1997 through a partnership between the University of the Philippines Manila and the Advisory Board Foundation, pioneered the multidisciplinary team approach and became the model for nationwide replication. The Child Protection Network (CPN), a stand-alone NGO, was established in 2002 to scale up and standardize the model and advocate for its implementation nationwide.

Co-ownership and the partnership between government entities, including the DOH and LGUs, and CPN function as strategic arrangements that combine governmental authority and resources with specialized NGO expertise in the prevention and treatment of child abuse, as well as operational support. Formalized in 2013 through the DOH designating CPN as its primary partner for establishing the WCPU network, mentoring WCPU staff and assessing the quality of service provision,[12] this NGO–government partnership has helped to ensure the sustainability and system-wide reach of WCPUs while embedding child- and gender-sensitive protection. This shared responsibility helps to mitigate potential disruptions associated with changing priorities and the frequent turnover of government officials. In addition, the DOH formally recognizing the WCPU model as a programme, rather than as solely an advocacy initiative, has resulted in a larger budget allocation and stronger policy support.

"So, without an NGO doing this [providing support in the establishment, standardization and management of WCPUs], this will never have happened. And it's not because of our ego. It's just the way how our government works."

– CPN Executive Director

11 Cited in Herrera, Victoria L.M., David G. Bradley and Bernadette J. Madrid, 'Qualitative Analysis of Operational Deliverables of the PGH-Child Protection Unit and Child Protection Network in Advancing the Care Continuum for Child Maltreatment: A roadmap for setup and evaluation', *Acta Medica Philippina*, vol. 56, no. 15, 2022, https://doi.org/10.47895/amp.v56i15.1885.

12 See DOH Administrative Order No. 2013-0011 (Revised Policy).

The WCPU model's combined focus on women and children reflects the interconnected nature of violence, recognizing that often "children who are abused have mothers who were either domestic violence victims or were abused as a child or both".[13] A distinctive feature of the WCPU model is its success in maintaining specialized child-centred services despite serving both women and children, a challenge that many combined models struggle with. Through mechanisms such as child participation in creating intervention contracts, age-appropriate communication protocols tailored to children's developmental stages, specialized programmes (like personal safety lessons and the Kids in Court programme designed specifically for children) and dedicated child psychology services, the model ensures children's unique developmental and emotional needs are prioritized rather overshadowed by adult-focused services.

One of the core services of this model is the 'joint interview', where police investigators, doctors and social workers are present to hear the child's account of the abuse, eliminating the potential for retraumatization from repeated interviews. Medical services include comprehensive medico-legal examinations, forensic evidence collection (within 72 hours for acute cases), treatments such as emergency contraception and sexually transmitted infection (STI) prophylaxis, and specialist referrals. Psychosocial services comprise mental health evaluation, psychological first aid, trauma-informed psychosocial processing services, individual psychotherapy education and specialized programmes. Legal support includes legal counselling, coordination with prosecutors and family courts, and accompanying children to hearings. Social workers conduct safety and risk assessments, undertake case management processes, create individualized intervention contracts with the child's participation, facilitate court preparation programmes (e.g., Kids and Teens Court Awareness Program) and coordinate shelter placements when needed.

At the family level, the model provides trauma-informed counselling and psychotherapy education sessions for both children and their guardians, and family-strengthening programmes addressing dysfunctional dynamics and encouraging positive discipline. Legal guidance is available to families throughout the duration of criminal proceedings, with social workers explaining the process from the initial complaint filing to court decisions being made. Case management includes coordinating with LGU social workers for home visits, financial assistance and livelihood support on a case-by-case basis. TeleWCPU services, first offered in 2021, enable remote follow-up consultations through secure video connections, significantly reducing travel costs and time burdens for families in remote areas.

At the community level, the model has established Violence Against Women and Children (VAWC) Desks in district and provincial hospitals to provide basic case management and decentralize services. TeleWCPU centres, strategically located in *barangays* and municipal social welfare offices, extend specialist access to underserved communities. Community partners include Barangay Council for the Protection of Children (BCPC) and VAWC Desk officers, who serve as first responders, receiving initial reports of abuse and facilitating referrals.

At the local government level, the Local Council for the Protection of Children (LCPC) provides an important coordination mechanism for child protection. The LCPC brings together relevant local government and community stakeholders to support the planning, coordination and monitoring of programmes and services for children. Linking WCPUs and other multidisciplinary services with the LCPC can help strengthen referral pathways, local planning and follow-up, and ensure that the response to individual cases is connected to broader local child protection systems.

Through its partnership with the Department of Education (DepEd), the model has developed screening tools, to enable school guidance counsellors and guidance advocates to detect potential cases of abuse, and prevention programmes for the classroom aimed at teaching children about personal safety. The model also supports training for professionals, including police investigators, social workers and teachers, in trauma-informed approaches and multidisciplinary case management.

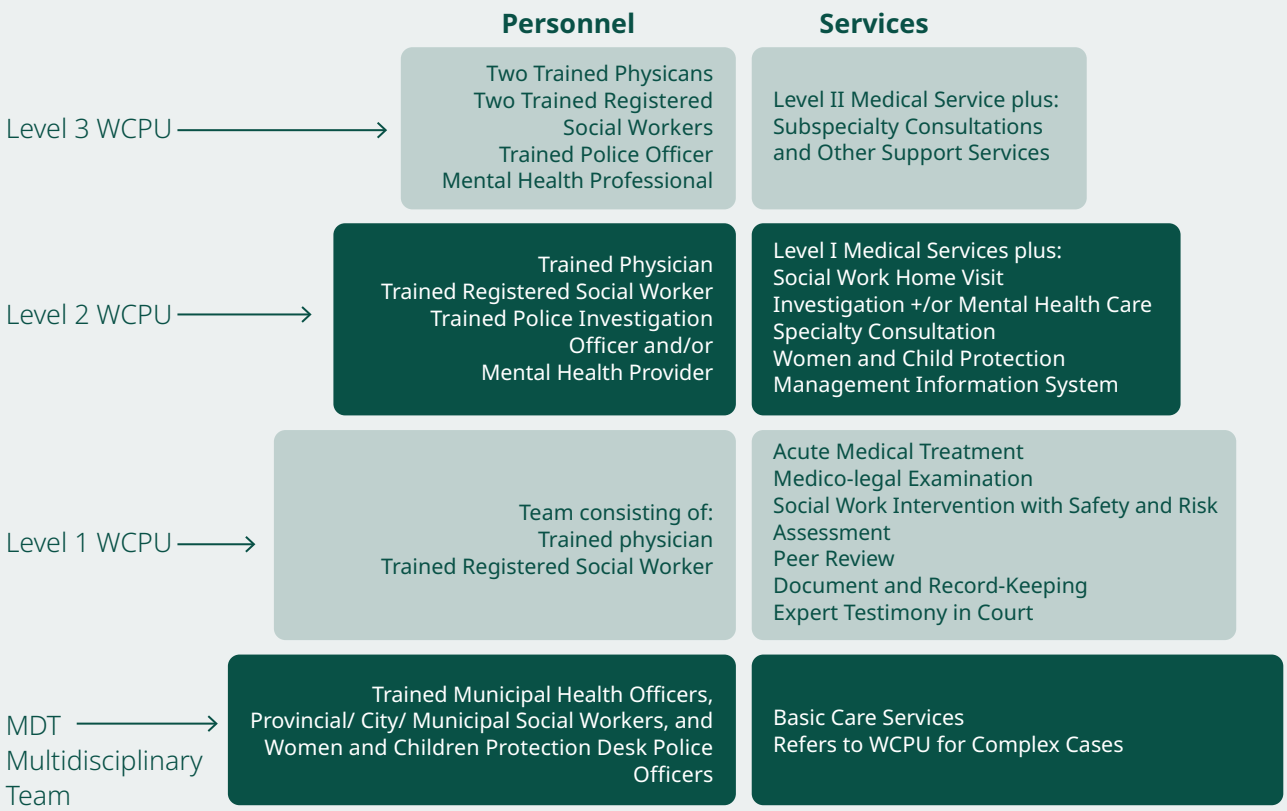
13 Child Protection Network, *2022 Annual Report: Celebrating 25 years of protecting the child from the many faces of abuse*, CPN, Manila, 2022.

Under the model, a network of 162 WCPUs, including VAWC Desks, has been established,[14] covering 70 provinces and 10 cities, along with 138 TeleWCPU centres nationwide. Units are categorized into the following tiered levels based on personnel capacity and service scope (see *Figure 1*):

- basic multidisciplinary teams, each comprising a trained municipal health officer, a social worker and a police desk officer;
- Level 1 WCPUs, each comprising a trained physician and a social worker who provide acute medical treatment and medico-legal examinations;
- Level 2 WCPUs, each comprising the same personnel as a Level 1 WCPU but with the addition of a police investigator and/or mental health provider;
- Level 3 WCPUs (the highest level), each comprising a team of at least two trained physicians and two social workers, a mental health professional and a police investigator, with the aim of providing enhanced, subspecialty consultations.

Team members are required to complete standard online training conducted by CPN, culminating in Women and Children Protection Specialty Certification, which ensures consistent training quality nationwide.

Figure 1:
WCPU categories



Source: Child Protection Network, *2023 Annual Report: Protecting the child from the many faces of abuse*, CPN, Manila, 2023.

14 According to CPN, this figure covers both WCPUs and hospital-based VAWC Desks (see https://www.childprotectionnetwork.org/wcpu-directory/).

Resources and funding

The model relies on hybrid funding, combining government and external resources. The DOH suballocates funds to regional centres for health development and directly to DOH-retained hospitals for operational support, training and hiring contract-based staff. Provincial hospitals receive funding from LGU budgets, formalized through memorandums of agreement requiring LGUs to provide physical space, salaried personnel (permanent positions) and operational budgets. LGU-led centres like the Valenzuela City Child Protection Center (CPC) are fully funded and institutionalized through local ordinances. External funding comes from the United Nations Children's Fund (UNICEF) (particularly for TeleWCPU establishment and expansion), the Consuelo Foundation (supporting LGU-led centre development), IJM (funding mental health providers in technology-facilitated sexual abuse hotspots) and other development partners. CPN secures funding for nationwide training delivery and manages the Women and Children Protection Management Information System (WCP MIS), which serves as the official national VAWC database for policy development and monitoring. Significant funding gaps remain in funding for personnel, client transport assistance and comprehensive family support, funding for which is currently provided on only a case-by-case basis rather than systematically.

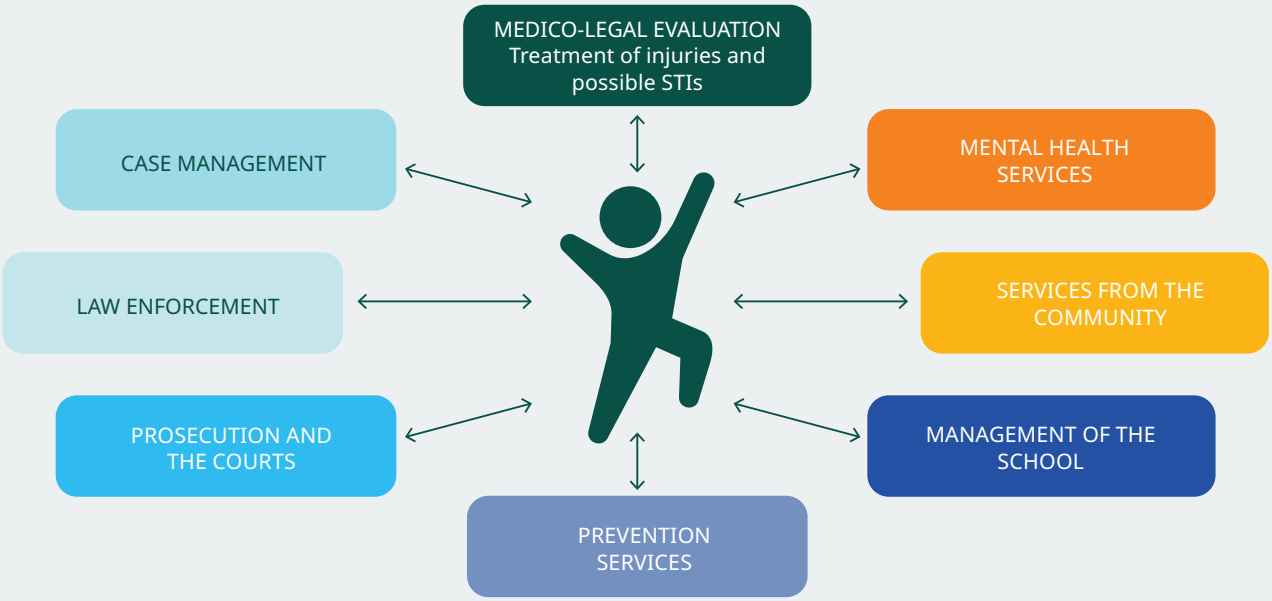


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3 Integration of service delivery

The effective integration of service delivery relies on multiple structures that vary by location and service type. Factors identified in the global literature review as being key to successful service delivery include the physical co-location of services, formal information-sharing protocols, and legal frameworks or interagency agreements that authorize collaboration across sectors.[15] The WCPU model demonstrates strong integration of services across multiple professional disciplines through its one-stop-shop design and co-located multidisciplinary team structure (see *Figure 2*). Respondents consistently identified the integration of services as a core strength of the model, highlighting the effectiveness of co-location and the joint interview process.

Figure 2:
Multidisciplinary response to a case of reported abuse under the WCPU model



Source: Child Protection Network, *2022 Annual Report: Celebrating 25 years of protecting the child from the many faces of abuse*, CPN, Manila, 2022.

15 *Multidisciplinary Models of Care for Child Victims and Survivors*, p. 21.

Services are integrated into each unit through multidisciplinary teams composed of doctors, social workers, mental health professionals and police investigators, who often work together within a shared physical space. This avoids the *pasa-pasahan* (passing from one office to another) that characterizes traditional siloed systems where victims must navigate multiple agencies separately. Daily meetings ensure that all team members are aware of each case and its management plan, fostering shared understanding and coordinated approaches. According to one CPN project staff, at the Philippine General Hospital Level 3 WCPU, "the doctors work together with the mental health professionals and the social workers. They meet, they have audits and conferences, and we talk with each other, especially when cases are difficult. We ask each other how we can provide the best treatment."

The joint interview process exemplifies the model's integrated approach and is consistently cited by respondents as its most effective component. During this process, the police investigator, doctor and social worker are present to hear the child's initial account of the abuse, eliminating the need for the child to repeat their account for different agencies. This allows team members to suggest follow-up questions in real time, resulting in more complete interviews while significantly reducing retraumatization. Practitioners of each discipline maintain distinct but highly interconnected roles, from nurses conducting initial triage to social workers serving as primary case managers and coordinating all aspects from intake to long-term follow-up, LGU coordination, shelter placements and court assistance.

While the model aims for holistic integration, respondents indicated that some disciplines are more prominent than others, often reflecting the model's public health foundations. Health care and social services are strongly emphasized, given that the model is fundamentally rooted in treatment and healing regardless of whether any legal case is filed. Front-line service providers indicate that the services most frequently delivered by WCPUs are social work and case management interventions (82 per cent), followed by medical care (71 per cent).[16] Law enforcement and justice systems maintain an integrated but secondary focus, with police investigators' active involvement being concentrated at the beginning of the process during the joint interview and evidence-gathering stages. Integration with mental health services and the education sector is a component of the model, but, in practice, this integration is challenging, as access to these services is often delayed because of personnel shortages and a lack of in-house psychiatrists or psychologists, which in turn necessitates external referral.

The WCPU model operates within a comprehensive legal and policy framework. At the national level, DOH Administrative Order No. 2013-0011 mandates the establishment of WCPUs in all government hospitals and sets uniform service standards. CPN has also developed standardized protocols and training curricula. At the local level, LGU-led centres are institutionalized through local ordinances, as exemplified by the Valenzuela City CPC.

Analysis across multidisciplinary models in different countries indicates that the location of model implementation directly influences the types of services offered, as well as the nature of collaborative work across services. Hospital and medical centre-based models such as WCPUs in the Philippines, Sexual Assault Referral Centres in Nigeria and Thuthuzela Care Centres in South Africa primarily provide health care and medical forensic services but may face challenges in addressing legal, psychosocial and other dimensions of care. Models that are not based in health facilities, such as the Zona ZaKrila model in Bulgaria, have difficulties coordinating with medical services but are able to effectively provide counselling and legal assistance.

16 Source: WCPU front-line staff survey, 2025.

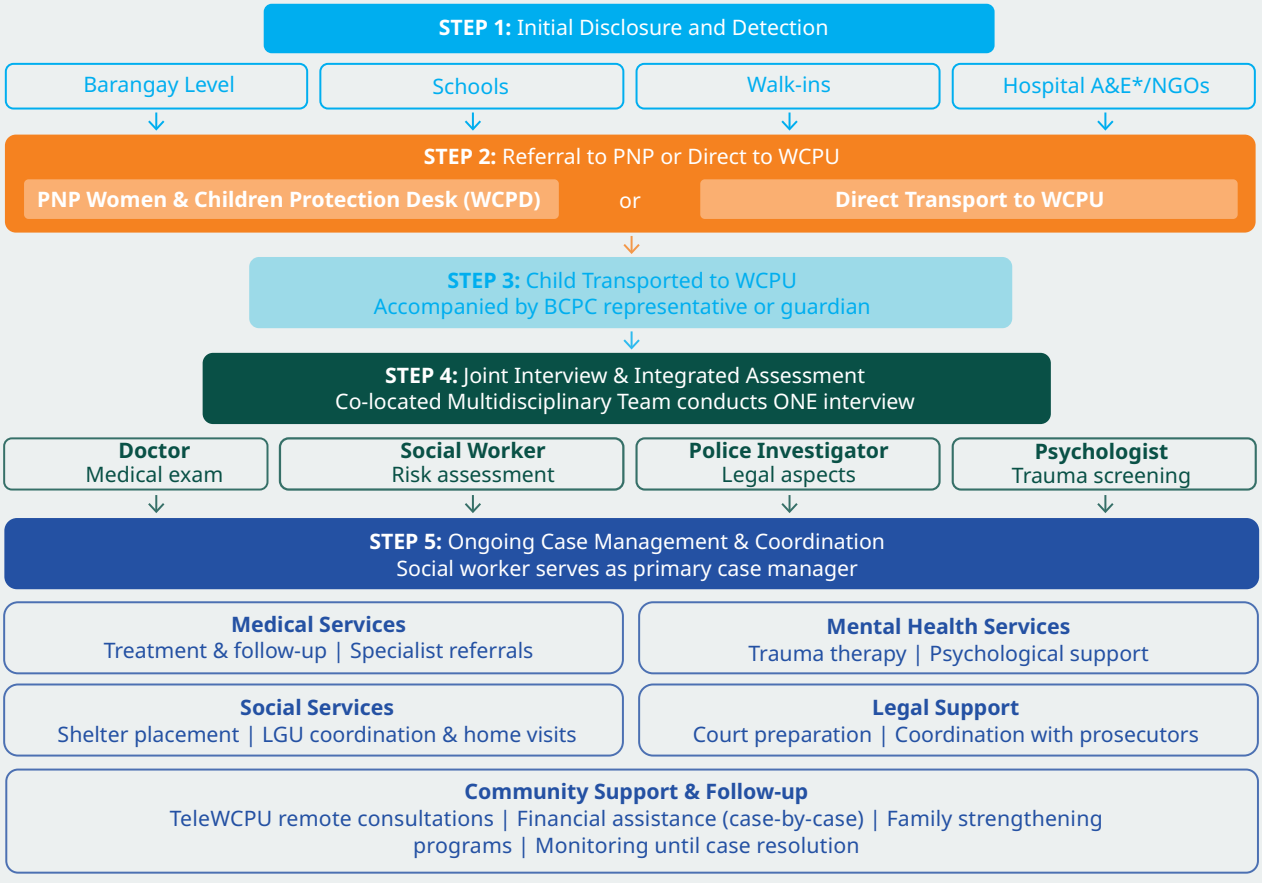
Referral pathway

The adoption of the Revised Protocol for the Case Management of Child Victims of Abuse, Neglect, Exploitation and Discrimination (CANE+D) in 2025 represents a significant milestone for multidisciplinary working in the Philippines. First issued by the Committee for the Special Protection of Children in 2013, the Protocol was substantially revised to further institutionalise multidisciplinary case management; to provide clearer cross-sector responsibility lines; and to cover various cases of child harm, including cases of technology-facilitated sexual abuse and exploitation. The revised Protocol is the instrument that defines the formal referral pathway within which WCPUs operate, and its application is mandatory in all CANE+D cases. This pathway is reinforced by the Implementing Guidelines of Executive Order No. 79 or the Mahalin at Kalingain Ating Mga Bata (MAKABATA) Program (2024), which apply a "No-Wrong-Door" policy requiring any agency, local government unit or private partner receiving a report to act on and endorse it rather than turn the child away.

> *"In the hospital, the WCPU can be well integrated among the doctors – among ourselves. But another step is the integration of the LGU, because the LGU itself is also supposed to be integrated. Then, the WCPU and the LGU should also be integrated with each other."*
>
> – CPN staff member

On the ground, the referral pathway typically follows the process described in Figure 3. Challenges arise in coordinating with external

Figure 3:
WCPU referral pathway



*A&E: Accident and emergency department

systems, particularly in relation to ensuring timely access to mental health services and navigating DepEd bureaucracy for school-based referrals.

Additional gaps in service delivery were identified by WCPU staff and experts and through the literature review. Although prevention programmes exist through DepEd partnerships, these are not yet systematically implemented across all regions. Response services for children harmed by technology-facilitated sexual abuse and exploitation are an emerging focus area, with remote-counselling protocols having been recently developed and piloted, but they remain underdeveloped compared with services for survivors of 'offline' abuse.[17]

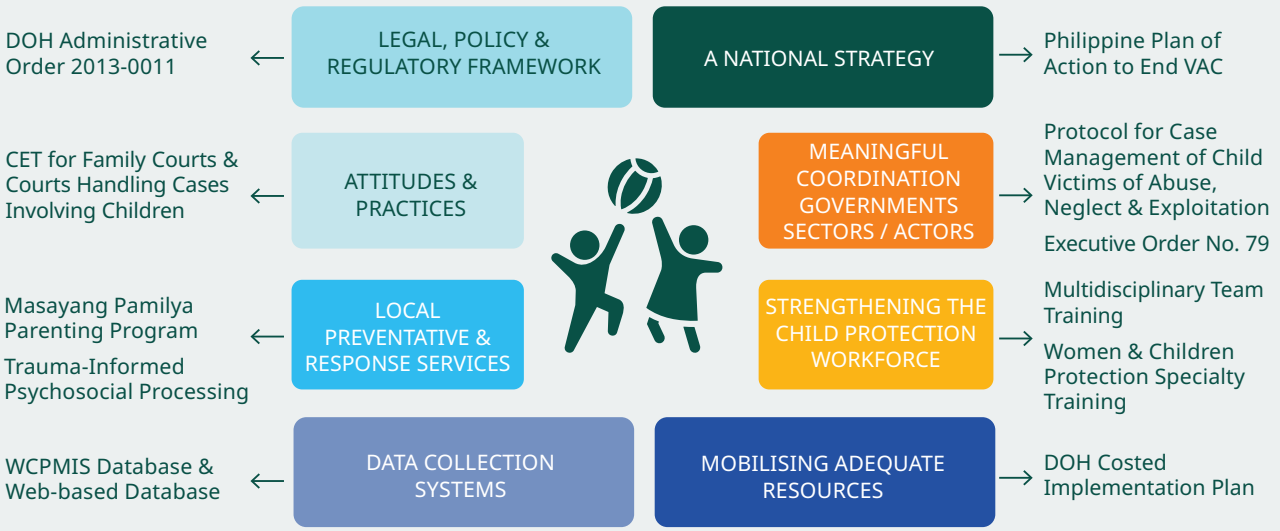
Gender-based violence services for women have been integrated with child protection services through the combined WCPU model. The global literature review on multidisciplinary models of care conducted for this study found that many combined models encounter challenges in maintaining specialized services for children. Integration can sometimes lead to resource competition, with the specific needs of child victims being overshadowed by adult cases in units with high caseloads. However, this was not found to be true in the Philippines, where, based on nationwide WCPU data, child cases significantly outnumber adult cases and both groups are reportedly able to access crucial services through the integrated model. To address the potential challenges inherent in a joint service approach, the DOH and CPN have collaborated to establish frameworks, policies, principles and protocols that prioritize child protection.

A key component of the model's joint service approach is the Costed Implementation Plan for the Women and Children Protection Program (2021–2025), which outlines evidence-based strategies, estimates implementation costs and positions WCPU functionality as a core programmatic priority. This, along with other approaches and interventions (see *Figure 4*), demonstrates that WCPUs function within a coordinated, rights-based and trauma-informed system oriented towards the protection, recovery and best interests of the child.

Notwithstanding these strengths, stakeholders raised concerns about potential conflicts of interest within the integrated model, particularly in cases where an adult woman is both a victim of domestic violence and suspected of abusing a child. In such situations, the dual roles of victim and alleged perpetrator may complicate service provision, a tension that has led some countries to maintain separate service structures for women and children.[18]

Figure 4:

WCPU contributing to strengthening the child protection system in the Philippines (CET, child exploitation team; MOA, memorandum of agreement; VAC, violence against children)



Adapted from: Child Protection Network, *2022 Annual Report: Celebrating 25 years of protecting the child from the many faces of abuse*, CPN, Manila, 2022.

17 Tarroja, Maria Caridad H., et al., *Development and Pilot-Testing of Remote Counseling Treatment Manual and Protocol for 15-Year-Old and Above OSAEC Survivors: Final report*, SaferKidsPH, 2023.

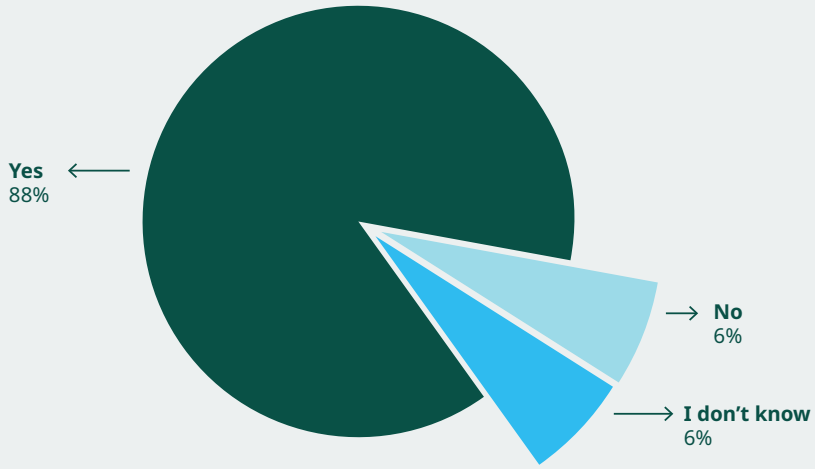
18 Dr Bernadette J. Madrid, founding Executive Director of the Child Protection Network, personal communication, 23 April 2025.

4 Adaptability to the digital age

The global literature review found that, while multidisciplinary models increasingly encounter cases of technology-facilitated abuse, the capacity to identify and respond to such cases remains limited.[19] Professional awareness and specialized training are inadequate, and appropriate therapeutic interventions are scarce. The various ways in which technology is used to facilitate abuse, including how the digital and physical contexts can overlap, are also not yet well understood by many service providers.

Respondents explicitly mentioned the technology-facilitated sexual abuse and exploitation of children as a significant concern in the Philippines, which is a globally recognized hotspot for these crimes.[20] Cases reported to WCPUs include online grooming resulting in offline abuse, livestreaming of sexual acts and the production of child sexual abuse and exploitation materials. Survey respondents confirmed that WCPUs are currently providing services to child victims of technology-facilitated sexual exploitation and abuse (see *Figure 5*).

Figure 5:
Responses to the survey question "Does the WCPU model provide services to child victims of technology-facilitated sexual exploitation and abuse?" (n = 72)



Source: WCPU front-line staff survey, 2025.

19 *Multidisciplinary Models of Care for Child Victims and Survivors*, pp. 24–28.

20 International Justice Mission, et al., *Online Sexual Exploitation of Children in the Philippines: Analysis and recommendations for governments, industry and civil society*, IJM, 2020.

Multiple stakeholders working within the WCPU model respond to cases of technology-facilitated sexual abuse through mechanisms that were originally designed to address offline abuse but have been adapted to address technology-facilitated abuse. Schools are an important location for detecting technology-facilitated sexual abuse, particularly cases involving grooming by teachers. Local WCPUs provide direct victim services to children harmed by technology-facilitated abuse through the same integrated multidisciplinary team approach. The PNP Women and Children Cybercrime Protection Unit at Camp Crame leads investigations on technology-facilitated sexual abuse and exploitation, with local police being required to forward such cases to this specialized national unit. In some regions, the National Bureau of Investigation (NBI) and the Inter-Agency Council Against Trafficking (IACAT) handle these cases first, before referring victims to WCPUs for medical or psychological services. LGU social workers are responsible for community-level case management. Prosecutors and courts handle legal proceedings, with WCPUs providing support.

CPN, together with partners like UNICEF and IJM, provides training for WCPU professionals on various forms of abuse, including technology-facilitated sexual violence, through their standardized training programme. A significant emerging initiative is the development of an intervention involving remote counselling for patients affected by technology-facilitated sexual abuse, which is currently being studied at PGH-CPU and is designed for survivors aged 15 years or above with plans to roll out the intervention for younger children. However, respondents noted that service providers' capacity and skills remain limited. No tailored case management process for technology-facilitated sexual violence has yet been created, with staff instead relying on basic trauma-informed care skills applicable to all abuse forms. Local police generally lack the training and capacity needed to investigate technology-facilitated sexual abuse cases, necessitating referrals to national-level units. The specialized forensic expertise needed to handle digital evidence is lacking, particularly outside major cities.

It is important to note that, despite the scale of the problem nationally, WCPUs handle relatively few cases of technology-facilitated sexual abuse. This discrepancy highlights the significant challenges in bringing these cases into the formal child protection system, particularly for cases involving livestreaming, as victims and their families and law enforcement officials may not perceive the activity as abuse if no physical contact has occurred or financial rewards have been involved. Previous studies have similarly noted that technology-facilitated sexual abuse is often not disclosed, reported or formally identified as sexual exploitation or abuse.[21] As a result, such cases are difficult to track and identify, and many children affected remain outside the reach of health and protection services altogether.

21 Child Frontiers, Psychosocial Support and Children's Rights Resource Center and UNICEF Philippines, *Study on Intervention Strategies for the Rehabilitation and Reintegration of Child Victims/Survivors of Online Sexual Abuse and Exploitation in the Philippines*, UNICEF Philippines, Mandaluyong City, November 2023.

"But for some reason, they [law enforcement/ police] usually don't bring those kids to us. We don't know where they take them. We don't even know if they receive therapy."

– CPN staff member



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"Actually, OSAEC [online sexual abuse and exploitation of children] cases are increasing. Our problem is that they're just not being reported. We see, we hear, we know that there are many cases, and we also know which places have widespread OSAEC."

– WCPU staff member

"They [data on technology-facilitated child sexual exploitation and abuse] are not really captured by the health facilities but by other agencies."

– WCPU staff member

When cases do come to light, they are frequently addressed by government agencies or civil society organizations that are not involved in the multidisciplinary model (e.g., IACAT, NBI, IJM) and victims are not always referred to WCPUs for medical or psychological intervention, leading to potential gaps in holistic care. Respondents raised concerns that many victims in cases initiated by foreign law enforcement alerts, in particular, are not referred to WCPUs for therapy and support, suggesting that there are systemic barriers to connecting the victims identified with services. The focus on medico-legal assessment can, at times, mean that cases in which no physical injury can be observed may be overlooked or diverted.



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"Some of them, we don't see them for examination, and I don't understand why. They really do need to be examined, because you never know – even if it seems to be 'just online', it might turn out that they were also sexually abused offline, but we don't get to see them. I think some police officers are learning to think, 'Oh, it's just online – the child was undressed in front of the camera or did certain acts on their own, so there's no need for a medical examination.' What they don't understand is that when we interview these children, we don't only ask about what happened in front of the camera. We also ask about other incidents of abuse. We may be able to detect neglect. We may be able to identify physical abuse. We may uncover traditional sexual abuse. We may even identify date rape. All of these also need to be addressed; otherwise, these children will remain victims if these issues are not addressed by the other agencies."

– WCPU service provider

Despite the gaps described above, the capacity to identify and provide services for children affected by digital forms of harm is improving. Progress made includes the implementation of youth-led prevention initiatives like Valenzuela City's DigiChamps programme, supported by UNICEF, which teaches young people about responsible digital citizenship. Some practitioners incorporate questions about technology use and grooming indicators into assessments, with doctors at facilities like the Valenzuela City CPC explicitly screening victims for risky sexual behaviours and signs of grooming.

Despite these advancements, adaptation remains inconsistent and incomplete across regions. Routine questioning and diagnostic processes do not consistently identify online dimensions of abuse, and technology-facilitated sexual abuse cases are often recorded simply as 'sexual abuse' rather than being specifically classified as being facilitated by technology. While the Women and Children Protection Management Information System (WCP MIS) is currently being updated to better capture data related to technology-enabled abuse and exploitation, earlier system limitations have most likely constrained accurate documentation and reporting. A key assessment challenge is recognizing that not all victims of technology-facilitated sexual abuse exhibit clear signs of trauma. This is particularly evident among victims involved in livestreaming activities for monetary gain, some of whom may not perceive their experiences as abuse, especially when financial rewards have been received.

Capacity is also insufficient to offer long-term psychological support specifically tailored to victims of online grooming, livestreaming or sextortion. The significant gap between the known prevalence of technology-facilitated sexual violence in the Philippines and the small number of cases reaching WCPUs suggests that detection, reporting and referral pathways for technology-facilitated sexual abuse must be substantially strengthened to ensure that the model is as effective in addressing abuse facilitated by technology as it is in addressing offline sexual exploitation and abuse.

"We analysed the database, and the problem lies in how the questions in the database are structured. For example, the database asks for the primary diagnosis. When the case is online sexual abuse, it gets reported in the database as sexual abuse, but it is not tagged as online-related. That's the gap. So when you look at the numbers, they appear small, but in actual cases, the numbers are already high."

– CPN staff member

A common pattern across all countries is that technology-facilitated abuse cases come to services' attention primarily when they result in 'offline' harm or are linked to physical violence. Technology-facilitated abuse and exploitation alone (particularly livestreaming, sexual extortion or image-based abuse without physical contact) often goes undetected or unreported within these multidisciplinary models, representing a critical blind spot.

5 Child-centred approach and community linkages

The global literature review found that, although gender and age are important considerations in ensuring a child-centred approach, multidisciplinary services are not always equipped to adequately address specific forms of sexual violence or to effectively integrate a gendered and life-course perspective.[22] Within the WCPU model, there is a general effort to individualize services according to each child's specific needs, age and vulnerabilities, ensuring a survivor-centred approach. Services are tailored to each case, with the multidisciplinary team adapting psychological, medical and social interventions to each child's experiences and needs for healing and recovery.

Forensic interviews and psychological support are adapted to each child's age, developmental stage and ability to express themself. For example, staff members adjust their communication style to match the age of the child. Respondents emphasized awareness of gender-specific risks and dynamics, with staff trained to recognize boys' reluctance to discuss abuse owing to stigma while also understanding the specific vulnerabilities that girls face. For children with physical disabilities, such as deafness, staff use writing or drawing or seek external interpreters, although finding qualified interpreters remains a significant challenge. Initial steps have been taken to provide basic sign-language training, although standardized guidelines and comprehensive training programmes are lacking.

While the model primarily focuses on child victims of violence or exploitation, it also responds to cases involving children displaying harmful behaviours – particularly self-harm, suicidal ideation and risky sexual behaviours – through psychological and social interventions, screening, psychological first aid and referrals to psychiatric care when needed.

The model also does not encompass specialized, institutionalized approaches for refugee, migrant, minority or LGBTQI+ children; instead, these children receive the same core services as other children, although staff are sensitive to each child's needs and provide services without bias. Male victims, especially boys, are explicitly accepted and provided with services despite the units being named 'Women and Children Protection Units'. Child trafficking cases are handled following the same multidisciplinary approach as other cases, although specialized referral pathways involving IACAT and the PNP Anti-Trafficking in Persons Division are followed for investigation and coordination.

Community linkages are a strength of the WCPU model, with BCPC and VAWC Desk officers serving as crucial first responders, receiving initial reports of abuse and facilitating referrals. In Valenzuela City, permanent city-funded child welfare assistants provide community-level services, and children are organized into Barangay Children's Associations

22 *Multidisciplinary Models of Care for Child Victims and Survivors*, pp. 29–32.

that advocate for children and facilitate peer support. Schools constitute another vital link to the community, with screening tools for detecting abuse, developed under the WCPU model, being provided to guidance counsellors/advocates in schools; however, coordination with the education sector is challenging because of bureaucratic hurdles and a reluctance among teachers to report cases due to fear of getting involved in legal proceedings and concerns about their own safety.

An innovative intervention for strengthening community linkages is the TeleWCPU network, comprising 138 satellite centres strategically located in *barangays* and municipal social welfare offices. TeleWCPUs connect children and families in remote areas to hospital-based specialists via secure video connections. Respondents highlighted the importance of this service, which enables families to attend follow-up counselling, and even court hearings, close to their homes, saving them significant travel and meal costs and avoiding the need for them to miss multiple days of work. Because TeleWCPUs are embedded within formal community structures such as barangays and local social welfare offices, they can also serve as platforms for community-based child protection advocacy. Their local presence can be used to raise awareness of children's rights, available services and reporting mechanisms; normalize help-seeking; and encourage the early reporting and referral of child abuse, exploitation and violence. Local provision of space, connectivity, electricity and equipment maintenance can also contribute to the sustainability of these service hubs.

The model demonstrates how technology can enhance rather than replace face-to-face services, which is particularly relevant for addressing geographical challenges in an archipelagic nation. Despite these strengths, structured links to the community remain inconsistent across regions, particularly in rural areas where awareness of WCPU services is limited.

"We saw the importance of having available equipment and technology in the barangay because most of our patients are living below the poverty line. What we wanted was for them not to have problems with resources when accessing tele[services]."

– CPN staff member

"Another thing our service providers have observed is that sometimes, at home, they only have one room. Everything is there; the parents are there. There is no private space for the child to do telemedicine. They cannot speak up or share what they want. And sometimes, since the parents really want to know everything about their child and the management, even if we tell them to use headsets. Like in one instance, the headset had two earpieces – the right side was with the child, while the left was with the mother. So there are privacy issues and space issues. Having the sessions in a teleCPU [TeleWCPU] center is really justifiable because we want to make sure that the patient has a safe space and all the equipment they need to continue the sessions, especially the mental health sessions."

– CPN staff member

Children and families are involved in the planning and management of their own cases to some extent, as exemplified by the intervention contract process employed at the Valenzuela City CPC. Children actively help to create their own contracts, having a say in what kind of interventions they are willing to engage with, empowering them and ensuring that intervention plans address what they identify as their own needs. Respondents noted, however, that the voices of children in certain groups are often underrepresented, especially younger children who are often not given structured platforms through which they can express their wishes and views.

While case-level participation exists to some extent, users' formal involvement in service design and improvement remains limited. For instance, to obtain detailed feedback from children who use the TeleWCPU service, social workers distribute a questionnaire to their parents, guardians or caregivers, who then administer it to their children. Respondents explained that, although feedback is collected through satisfaction surveys, focus group discussions and anecdotal observations, there is no formal channel through which children or their families can shape how services are evaluated or improved at the system level. Service planning is highly institutional and expert-driven, with new programmes often developed in response to gaps identified by staff rather than as a result of direct consultation with children who use the services. The DOH is considering developing a standardized customer satisfaction survey tool, but comprehensive mechanisms for child-friendly consultation processes and participatory approaches to improving services remain underdeveloped.



6 Evaluating effectiveness and ongoing systems of monitoring

Globally, there remains a need for more systematic data collection, analysis and use, to support evidence-based policymaking and multidisciplinary service improvement.[23] The quality and effectiveness of the services offered by WCPUs are monitored through a combination of internal case management processes, data collection systems and external reviews, although a standardized system-wide evaluation framework is under development. Even with the WCP MIS in place, the model continues to face challenges in collecting data and monitoring impact, especially in directly collecting information from children and their families and systematically disaggregating these data.

Several mechanisms are in place to monitor service quality and effectiveness. At the operational level, multidisciplinary teams hold daily endorsement meetings each morning to discuss all cases handled the previous day, ensuring the entire team is aware of each case, its progress and any concerns. In specific cases, multidisciplinary teams conduct case conferences, sometimes involving external partners such as LGU social workers, to plan and review interventions. Social workers use tools such as progress reports and journal notes to monitor progress over the typical six-month intervention period, assessing compliance with co-created intervention contracts to determine whether cases can be terminated or require further action.

External and systems-level monitoring mechanisms are also in place, though implementation remains uneven. The Valenzuela City CPC conducts a programme implementation review and assessment twice annually to track progress, identify constraints and recommend innovations, as required for Department of Social Welfare and Development accreditation. VSMMC WCPU conducts annual on-site visits to VAWC Desks at which it has trained staff in district and provincial hospitals across Cebu, evaluating progress and providing mentoring. The DOH is mandated to oversee the monitoring of WCPUs; while progress in this area had been identified as a gap, the DOH is now working to implement a monitoring system and has developed a monitoring tool, with regional DOH counterparts tasked with monitoring WCPUs in their jurisdictions. Institutionalizing this monitoring function through a standardized national framework with defined indicators and a routine reporting cycle owned and resourced by the DOH and its regional offices would shift quality assurance from periodic external evaluation to a permanent government responsibility.

Data collected through various means, especially through the WCP MIS developed by CPN, are used for multiple purposes. For planning and operational purposes, the primary use of WCP MIS data is for case management, tracking patients' journeys from intake to follow-up and case closure. WCPUs maintain daily and monthly records to track

23 *Multidisciplinary Models of Care for Child Victims and Survivors*, p. 37. For example, of the 28 countries studied with Barnahus or Barnahus-type services in place, only 6 (Denmark, Finland, Norway, Poland, Spain and Sweden) reported evaluating services (see Greijer, Susanna, and Daja Wenke, *Barnahus: A European journey – Findings of a mapping study on multidisciplinary and interagency child-friendly justice models responding to violence against children*, Council of Europe, Strasbourg, 2023, pp. 85–88).

the number of patients and the types of abuse cases reported, helping them to identify trends. For example, a PNP representative in Valenzuela City reported using these data to analyse rape cases and identified that in 60 per cent of cases perpetrators lived in the same residence as their victim, which helped to inform the design of family-focused prevention programmes. Data can be used to justify requests for budget and resource increases to the hospital administration.

Data generated from the WCP MIS have been crucial for national-level advocacy in relation to supporting the passage of laws on statutory rape and child marriage during legislative hearings. The DOH has signed a memorandum of agreement with CPN recognizing the WCP MIS as being the official source of data on violence against women and violence against children for informing national policy and planning. WCPUs are not universally required to use these data, and therefore their use depends on CPN convincing individual units to do so. For research purposes, WCP MIS data are used by academics to study trends and outcomes in child abuse cases.

The involvement of children and non-offending caregivers in the formal monitoring and evaluation of the overall WCPU model is limited, but their feedback on the services they receive is actively collected. Some units, particularly PGH-CPU, use online satisfaction surveys, administered via Google Forms, after TeleWCPU consultations, and some WCPUs have started implementing standardized satisfaction survey tools. The Valenzuela City CPC has conducted focus group discussions with child clients to gather feedback. Staff also gather feedback informally through conversations and by observing client behaviour, with children's willingness to return for follow-up appointments and positive changes in demeanour seen as indicators of satisfaction.

However, limitations exist in relation to the involvement of children and their families in general monitoring and evaluation. A key reason for this limited involvement in systemic evaluation is that, when asked for feedback on improving the system, children and families tend to focus on their immediate personal needs, such as scholarships or continued therapy, rather than providing suggestions for programmatic changes. There is currently no standardized, system-wide mechanism for formally consulting children and families on the general design and improvement of services across all WCPUs, though the planned DOH evaluation may address this by developing a customer satisfaction survey tool that could be used more broadly. Overall, gaps remain in evidence-based planning, with the DOH currently lacking concrete data on the quality and effectiveness of WCPU services and relying on anecdotal reports from meetings rather than systematic outcome measurements.

7 Service provider support and capacity-building

Emerging support structures

Greater supervision and support for professionals working with children affected by violence are needed.[24] There are programmes and services in place to support the mental health and well-being of staff working in WCPUs, but the availability and formality of these services vary significantly between units. Respondents highlight that staff burnout and vicarious trauma are major challenges, making these support systems crucial for maintaining service quality.

Formal institutionalized programmes exist in some facilities. The VSMMC WCPU and the Valenzuela City CPC conduct stress debriefing activities, or 'care for the carers' activities, twice a year, during which staff focus on unwinding and relaxing. CPN includes a 'care for the carers' session as part of its standardized specialty training, ensuring that staff are equipped with foundational knowledge on self-care. CPN also offers free online training on trauma-informed care. At PGH-CPU, staff have access to the unit's own psychologists and psychiatrists for consultation, while at VSMMC WCPU staff can also go to their 'friendly psychologists' for debriefing when needed.

Beyond formal programmes, individual units have developed informal coping mechanisms. Social workers are encouraged to share and discuss complex cases with colleagues before leaving for the day. The PGH-CPU team conducts monthly peer reviews, which also serve as debriefings. To manage stress, VSMMC WCPU has set limits on the number of patients a member of staff can see in a day – doctors see a maximum of five to six patients per day, while psychologists are limited to two or three patients per day, down from the previous six. Staff make a point of eating lunch together without talking about work and celebrating birthdays monthly, fostering healthy team dynamics.

Despite these efforts, significant challenges still exist. Overwhelming caseloads and a lack of human resources are cited as the main problems, with high caseloads driving staff burnout, especially among social workers. The Valenzuela City CPC has only six social workers, who rotate to handle a high volume of diverse and complex cases. While laws like the Mental Health Act mandate workplace support, respondents feel that they are not fully implemented, particularly at the LGU level. The prevailing workplace culture prioritizes work over well-being, with staff continuing to work even when sick and 'mental health breaks' not being common practice. While larger centres like PGH-CPU and VSMMC WCPU have internal resources, this is not the case for all WCPUs. Sustaining service quality across an expanding network depends on treating capacity-building as a routine, institutionally funded function rather than a periodic activity.

24 *Multidisciplinary Models of Care for Child Victims and Survivors*, p. 42.

Training and capacity-building

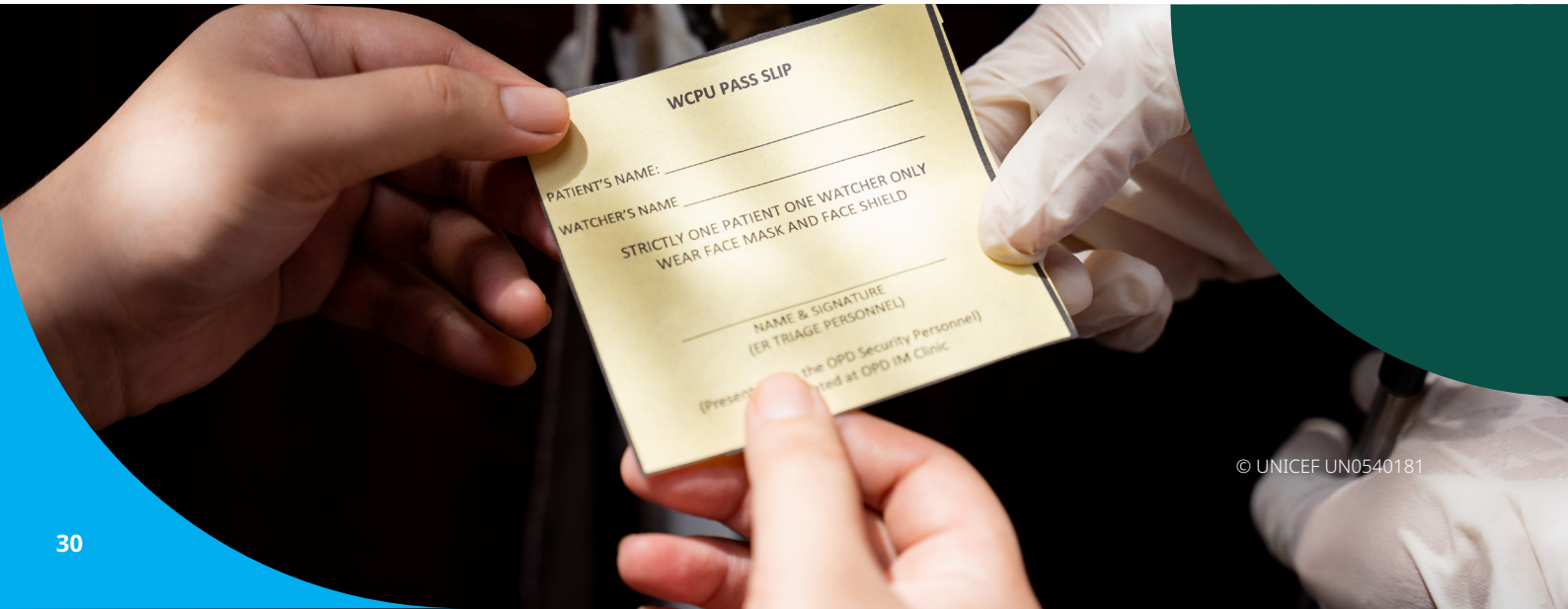
Extensive and standardized capacity-building and skills development training are requirements for WCPU staff. CPN provides a standardized training curriculum, ensuring that all personnel have the necessary skills regardless of location. The training is structured into three phases: Phase 1 involves free asynchronous online training covering the basics of recognition, recording, reporting and referring (the '4Rs'); Phase 2 (multidisciplinary team training) requires at least one doctor and one social worker to enrol together; and Phase 3 (specialty training) includes a two-week face-to-face practicum at an accredited training centre. Training is designed for the entire multidisciplinary team, to foster collaborative approaches.

Continuing education is supported through the annual CPN Ako Para Sa Bata conference, and training is provided by partner NGOs. However, gaps identified include the practice of *sabak agad* ('trial by fire'), where new social workers are deployed immediately without prior training. Staff have also identified a need for specialized training in addressing the needs of children with disabilities, with the basic sign-language training currently provided being considered insufficient.

Specific training on handling cases involving children affected by technology-enabled sexual abuse and exploitation has not yet been standardized and is not widely implemented. While the definition of technology-facilitated sexual abuse has now been introduced to newer training modules, a tailored case management process has not yet been created. However, emerging initiatives are developing. For example,

- a remote-counselling intervention has been developed for victims of technology-enabled abuse;
- the main theme of the Ako Para Sa Bata conference held in November 2025 was addressing technology-facilitated sexual abuse and exploitation of children; and
- social workers in Valenzuela City have received training (supported by IJM, which funds the work of mental health providers in technology-facilitated abuse hotspots) in unique therapy interventions for use in cases involving technology-facilitated sexual abuse.

Although these emerging initiatives indicate growing recognition of the need for specialized training on technology-facilitated sexual abuse and exploitation, comprehensive, systematic capacity-building strategies in this area remain underdeveloped across the model.



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8 The way forward

The achievements of implementing the WCPU model over nearly three decades in the Philippines demonstrate how sustained commitment can transform a country's response to child sexual abuse and exploitation. Evolving from the pioneering initiatives of the 1990s, the model has expanded into a nationwide network of 162 units across 70 provinces and 10 cities, supported by 138 TeleWCPU satellite centres, and this has contributed towards strengthening the country's child protection infrastructure.

Recent policy further strengthens WCPUs within the national child protection system rather than alongside it. Executive Order 79 (2024) and the 2025 Revised Protocol distribute responsibility across DOH, DILG, DSWD and CWC, and establish Child Protection Officer roles from national agencies down to barangays, while the Child Protection Network holds national functions in training, certification and management of the WCP MIS.

The strategic partnership between government agencies and CPN has been instrumental in achieving both the scale and quality of the services now available, combining governmental authority and resources with specialized NGO expertise in child protection. This formal collaboration, consolidated by the DOH's designation of CPN as its core partner in establishing and assuring the quality of WCPUs, has helped to advance sustainability and system-wide reach while integrating child- and gender-sensitive standards.

However, systemic challenges persist in translating the model's design into consistent, high-quality implementation across all contexts. The most critical barrier relates to human resource constraints: nationwide shortages of psychologists, psychiatrists, developmental paediatricians and social workers, combined with a lack of permanent positions and overwhelming caseloads, drive severe staff burnout and vicarious trauma while limiting the number of children who can be served. Financial limitations create access barriers for vulnerable families despite services being nominally free. Interagency coordination remains inconsistent, particularly in connecting children affected by technology-facilitated exploitation with therapeutic services, with victims in many cases being handled by agencies outside the multidisciplinary model and never being referred to WCPUs for medical or psychosocial support.

Perhaps most concerning is the dramatic gap between the known prevalence of technology-facilitated sexual abuse in the Philippines, and the number of such cases reaching WCPUs. While the model is known for responding to 'offline' sexual abuse, a substantial level of adaptation will be required to ensure its suitability and effectiveness in addressing technology-facilitated abuse. Cultural misperceptions that livestreaming and other forms of technology-facilitated abuse without physical contact are not 'real abuse', particularly when financial rewards are involved, mean that many affected children never receive formal services.

The way forward for the WCPU model lies in building on its demonstrated strengths while systematically addressing the persistent gaps. Multilevel action will be required to address policy frameworks, institutional capacity, operational practice and cultural norms. The WCPU model's successes demonstrate what is possible with sustained commitment and strategic partnerships, while the remaining challenges highlight that realizing the full promise of multidisciplinary approaches will require continued investment, innovation and adaptation to the evolving forms of violence against children.

Annex I:

Recommendations

Strengthening internal capacity and infrastructure

Strengthen human resources and staffing

- Create dedicated WCPU plantilla items within approved hospital and LGU staffing patterns, covering medical officers, social workers and mental health professionals, so that multidisciplinary teams are staffed through routine personnel systems rather than through secondment from other units.
- Establish a national child protection workforce plan setting staffing benchmarks against caseload, projecting supply requirements for the multidisciplinary team members, and identifying measures to address shortages at source, including expanded training places and scholarships with return-service agreements.
- Offer adequate compensation to attract and retain specialists, including allowances for court appearances.

Enhance staff capacity and training

- Ensure that all multidisciplinary team members receive practical training in child-friendly, age-appropriate and non-retraumatizing participatory methodologies for case management, including how to support children to express their views safely and meaningfully during assessment, intervention planning, case review and closure.
- Provide in-depth specialized training, particularly on handling cases involving children with specific vulnerabilities, to overcome communication and legal barriers.
- Encourage staff to specialize in key areas (e.g., victims of abuse, children in conflict with the law) to help them manage diverse and complex caseloads effectively.
- Institutionalize a standing induction and refresher cycle delivered through government-accredited training centres and recognized for continuing professional development credit, with completion of induction a condition of assignment to a WCPU and tracked through unit licensing and accreditation.
- Develop and institutionalize continuous training and refresher courses for partners with frequently rotating personnel, such as PNP investigators and BCPC workers, to ensure consistent adherence to standardized protocols.
- Train municipal health officers and rural health unit staff in handling medico-legal cases to improve access to services in remote areas.

Improve infrastructure and logistical support

- Ensure that dedicated 'child-friendly' vehicles are available to facilitate the safe, timely and non-threatening transport of child victims and survivors for medical assessments and rescue operations.
- Ensure that WCPUs are located in dedicated physical spaces with child-friendly, soundproof interview rooms and observation facilities to protect confidentiality and prevent retraumatization during interviews or case discussions.

Strengthen mental health and well-being support for staff

- Require and adequately fund mental health and wellness programmes, including stress debriefings and mindfulness activities, for all WCPU staff at least twice a year.
- Fully implement systemic support mandated by laws like the Mental Health Act.

System-level recommendations

Strengthen the legal and policy framework for WCPUs

- Pursue enactment of pending legislation institutionalizing WCPUs and, in parallel, prepare the implementing instruments (such as staffing standards, budget structure and accreditation criteria) required for the law to take effect without delay upon passage.
- Strengthen LGU accountability by passing specific laws or mandates that strengthen the referral system.

Improve interagency coordination and protocols

- Enforce policies or agreements (like memorandums of agreement) to ensure that trained police investigators assigned to WCPUs are guaranteed a minimum deployment period of at least two years.
- Strictly enforce DOH regulations prohibiting hospitals from refusing to treat people who are involved in medico-legal cases.
- Improve collaboration between and integration of local health services (rural health unit officers/municipal health officers) and local social services (local social welfare and development officers/BCPC officers) to ensure that child abuse identification and referral can occur at the primary care level and are not solely done by on social workers.

Ensure sustainable funding and resources

- Issue a joint circular directing LGUs to institutionalize WCPU or community-based centre functions through local ordinance with a dedicated annual appropriation, and incorporate compliance into existing local governance assessment and child-friendly local governance recognition systems.
- Provide systematic financial assistance for families to cover transport costs and lost wages.
- Expand funding for long-term therapy and follow-up care.

Enhance monitoring, evaluation and data systems

- Adopt a standardized national monitoring and evaluation framework with defined quality and outcome indicators, a fixed reporting cycle and a named unit accountable for consolidation and publication, building on the monitoring tool already developed.
- Establish a dedicated and recurring budget line for WCPU monitoring and evaluation within relevant DOH and LGU annual plans and budgets. This should cover routine data collection and analysis, child-friendly feedback mechanisms, periodic independent evaluations, and the dissemination and use of findings for service improvement.
- Create formal mechanisms for collecting feedback from children and families on service satisfaction.

Enhance access and inclusion

- Proactively conduct regular community outreach and information dissemination campaigns in schools and *barangays* to increase awareness of WCPU services and ensure that communities know where to refer victims.
- Expand TeleWCPU coverage in geographically isolated and underserved communities, particularly in provinces without a Level 2 or Level 3 WCPU.
- Establish predictable financial assistance mechanisms (e.g., a locally-funded victim assistance scheme) covering transport, meals, and caregiver income loss to remove the indirect costs that cause families to disengage from follow-up care.
- Develop inclusive service protocols for children with disabilities, LGBTQI+ children, migrant children, and other groups who may face additional barriers in accessing care.

Address technology-facilitated sexual abuse and exploitation

- Prioritize the development and widespread roll-out of specialized therapeutic approaches (such as the remote-counselling approach for victims of technology-enabled abuse) and tailored training modules to address the unique psychological trauma and complexities inherent in technology-facilitated sexual abuse cases.
- Update routine assessment and intake procedures to incorporate questions related to technology use and online interactions to support children effectively, even in cases where this is not initially reported. This must be done carefully to avoid inadvertent victim-blaming.
- Accelerate the migration of the WCP MIS to its new web-based platform with offline modality, ensuring dedicated fields are used to accurately capture and track the incidence and specific nature of technology-facilitated sexual abuse.
- Build on existing curriculum coverage of technology-facilitated sexual abuse and exploitation by developing a standardized case management protocol defining the responsibilities of each discipline from intake through to long-term follow-up, and embed it as a required component of multidisciplinary team and training, supported by mentored case consultation through the TeleWCPU network so that all team members, not only specialist providers, can apply it in practice.
- Strengthen detection, reporting and referral pathways to address the significant gap between the known prevalence of technology-facilitated sexual abuse and the number of such cases reaching WCPUs.

Annex II:

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