

# **Impact Evaluation of Luxembourg Government- Funded Programme**

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## Table of Contents

Abbreviations and acronyms.....	vi
List of Figures.....	ix
1. Background and objectives of the impact assessment study.....	1
1.1. Rationale and significance of CAI programs.....	1
1.2. Objectives of the impact assessment study.....	3
2. Services rendered by CAI.....	4
2.1. In-house program.....	4
2.2. After care program.....	6
2.3. Advocacy and education and development program.....	7
2.4. Total expenditure on the CAI programs.....	7
3. Review of academic literature.....	9
3.1 Child sexual abuse.....	9
3.2 Interventions and challenges on CSA.....	9
3.3 Social welfare programs for CSA survivors in the Philippines.....	11
3.4 Impact assessment.....	12
3.5 Depression and post- traumatic stress disorder among CSA survivors.....	14
3.6. Theories, perspectives, and issues on recovery programs for survivors of CSA.....	15
3.7. Summary.....	17
4. Methodology.....	19
4.1. Methodological framework for impact assessment.....	19
4.2. Mixed method approach to impact assessment.....	21
4.3. Description of the study population.....	21
4.4. General sampling procedures.....	22
4.5. Assessing IH and AC programs.....	26
4.6. Assessing advocacy program.....	26
4.7. Research instruments, informed consent and assent.....	27
4.7.1. Survey instrument.....	27
4.7.2. Guide questions for key informant interview (KII) and focus group discussion (FGD).....	29
4.7.3. Informed consent and assent.....	29
4.7.4. Recruitment of participants.....	29
4.8. Data analysis.....	30

4.9.	Ethical review and considerations .....	31
4.9.1.	Research ethics review.....	31
4.9.1.1.	Data handling.....	31
4.9.1.2.	Possible harms to participants .....	31
5.	Outputs of CAI programs and their analyses .....	33
5.1.	The In-house program.....	33
5.1.	1. Education support.....	34
5.1.2.	Legal services.....	35
5.1.3.	Arts and sports activities .....	36
5.1.4.	Output from other activities that was funded by the Government of Luxembourg under the In-house program .....	38
5.2.	After-care program.....	39
5.2.1.	Education.....	40
5.2.2.	Legal assistance .....	41
5.2.3.	Other support services extended .....	41
5.3.	The Advocacy and education and development program .....	42
5.3.1.	Scholarship and training programs .....	42
5.3.2.	Sports and circus program.....	43
5.3.3.	Health advocacy program.....	44
5.3.4.	Livelihood and skills development training.....	45
5.3.5.	Advocacy and education and development program (AP) .....	46
6.	Outcomes of CAI programs and their analyses.....	48
6.1.	Socio - demographic profile of respondents .....	48
6.2.	Improvement on health and well-being.....	51
6.3.	Improvement on family, social and economic status .....	60
6.3.1.	On education of the direct beneficiary and family members.....	60
6.3.2.	On the employment of the members of the beneficiary household .....	62
6.3.3.	On the household income of the family.....	63
6.3.4.	On community participation by the direct beneficiary .....	64
6.4.	Advocacy programs .....	65
7.	Impacts of CAI programs.....	67
7.1.	Healing, stabilization and resilience of girls.....	67
7.2.	Advocacy program .....	71
9.	Recommendations .....	76
9.1.	In-house and after-care programs.....	76

9.2.	Advocacy .....	77
9.3.	Other related recommendations.....	78
10.	References.....	80
11.	Annexes .....	85
	Annex A.1 National Stressful Events Survey PTSD Short Scale (NSESSS)	
	English Version.....	85
	Annex A.2 National Stressful Events Survey PTSD Short Scale (NSESSS)	
	Local Dialect Version .....	88
	Annex B.1 HAM-D Rating Scale English Version .....	90
	Annex B.2 HAM-D Rating Scale Local Dialect Version .....	94
	Annex C.1 Child PTSD Symptom Scale English Version .....	97
	Annex C.2 Child PTSD Symptom Scale Local Dialect Version .....	99
	Annex D.1 Socio- Economic Information Sheet (English) .....	107
	Annex D.2 Socio- Economic Information Sheet (Local Dialect) .....	110
	Annex E. Focus group discussion questionnaire .....	113
	Annex F. Key informant interview questionnaire .....	116
	Annex G.1 Participant Information and Informed Consent English Version .	118
	Annex G. Participant Information and Informed Consent Local Dialect	
	Version .....	125
	Annex H.1. Participant information, informed consent form and assent	
	agreement English Version .....	133
	Annex H.2. Participant information, informed consent form and assent	
	agreement Local Dialect Version .....	140
	Annex I. Translation of scale for research .....	148
	Annex J. Operational definition .....	149

## **Abbreviations and acronyms**

AC	After-care Program
AP	Advocacy Program
CAI	CAMELEON Association Incorporated
CBT	Cognitive Behavior Therapy
CCS	Caring for Child Survivors
CDRS-R	Child Depression Rating Scale – Revised
CM	Case Management
CPSS	Child PTSD Symptom Scale
CSA	Child sexual abuse
CYHA	CAMELEON Youth Health Advocates
DepEd	Department of Education
DSWD	Department of Social Welfare and Development
FGD	Focus group discussion
HAM-D	Hamilton Depression Rating Scale
ICF	Informed Consent Form
IH	In-house Program
IRC	International Rescue Committee
KII	Key informant interview
LGU	Local Government Unit
MSWD	Municipal Social Welfare and Development
NSESSS	National Stressful Events Survey PTSD Short Scale
NCR	National Capital Region
NGO	Non-government organization

PNP	Philippine National Police
PTSD	Posttraumatic Stress Disorder
SPED	Special Education Program
TF-CBT	Trauma-focused Cognitive Behavior Therapy
UBRERC	Unified Biomedical Research Ethics Review Committee
UNICEF	United Nations Children's Fund
VCC	Voice of the CAMELEON Children
WHO	World Health Organization

## List of Tables

No.	Title	Page
1	CAI Program Budgets, in €,.	8
2	Distribution of survey respondents by sample categories, 2018	23
3	Date conducted, Venue, CAI programs discussed, number of participants, descriptions/position of participants of the five FGDs conducted	24
4	Respondents, the venue, CAI descriptions/position of participants of KII conducted during the KII, CAI, 2018	25
5	The Beneficiaries of CAMELEON Inc. In-House Program, 2013 to 2017	33
6	Educational levels of girls under the IH program funded by the Government of Luxembourg, 2013 to 2017	34
7	Status of legal support to girls under the In-house program funded under the Government of Luxembourg Funding	36
8	Participation in circus and other sports and outdoor activities that was funded under the Government of Luxembourg, 2013 to 2017	37
9	Number of Government of Luxembourg-sponsored girls enrolled in AC program.	39
10	Number of girls that were suspended, terminated and graduated in the AC Program from 2013 to 2017	40
11	Distribution of girls under the AC Program by level of education	40
12	Number of girls given legal assistance by CAI from 2013 to 2017	41
13	Number of beneficiaries of CAI's Scholarship and Training Programs from 2013 to 2017	43
14	Number of beneficiaries of various sports, recreation, and circus activities of CAI from 2013 to 2017	44
15	Number of beneficiaries of various health advocacy activities of CAI from 2013 to 2017	45
16	Number of beneficiaries of various skills trainings sponsored by CAI from 2012 to 2016	46
17	Number of audience reached by the various activities under the Advocacy Program of CAI from 2013 to 2017	47
18	Age and educational attainment before and after CAI intervention of respondents, 2018	49
19	Age and educational attainment of household head of respondents, 2018	50
20	Household size, percentage of household members who are male, percentage of household members who are educated and percentage of household members who are employed, 2018	51
21	Comparison of PTSD scores between new entrants, IH girls, AC girls, and alumni	52
22	Comparison of PTSD degree across groups of respondents, CAI, 2018.	54
23	<b>Comparison of PTSD symptoms across groups of respondents, CAI,</b>	55

<b>2018</b>		
<b>24</b>	Comparison of HAM-D scores between new entrants, IH girls, AC girls, and alumni	57
<b>25</b>	Distribution of respondents by level of depression hinged on HAMD Score, CAI, 2018	58
<b>26</b>	<b>HAM-D symptoms experienced by different groups of girls, CAI, 2018</b>	59
<b>27</b>	Comparison of the mean level of education of beneficiaries and other household members	62
<b>28</b>	Comparison of household members 18 years old and older who are employed before and after the intervention	62
<b>29</b>	Comparison of the household income before and after CAI's intervention	63
<b>30</b>	Comparison of the participation to socio-civic organization by the direct beneficiaries before and after CAI intervention, 2018	64
<b>31</b>	Crime statistics committed against women and children in Western Visayas, Iloilo Province, Passi City and the municipalities of Bingawan and San Enrique, 2012 to 2017	73

### List of Figures

<b>No.</b>	<b>Title</b>	<b>Page</b>
1	CAMELEON Programs in the Philippines (CAI internal documents, n. d.)	2
2	Impact assessment conceptual framework for CAMELEON Association, Inc. Programs from 2012 to 2017	20

## Executive Summary

The Government of Luxembourg funded from 2012-2017 several programs of the CAMELEON Association Incorporated (CAI) in the Philippines, which were designed to protect and promote children's rights, as well as the empowerment and development of children and their families through education, advocacy, and psychosocial interventions. Specifically, the Philippines continues to face serious cases and concerns about child sexual abuse (CSA), especially in rural and poor areas. Despite their own constraints, non-government organizations (NGOs) particularly CAI have been supporting the recovery and improvement of the lives of children survivors of CSA and their families. The core programs of CAI funded by the Government of Luxembourg are the In-house (IH), After-care (AC), and Advocacy (AP) programs, which intend to (1) heal and stabilize girls who are survivors of CSA and other related violence, (2) improve the wider communities' knowledge of children's rights and related issues (e.g. health, sexual health), and (3) increase reporting of sexual abuses especially CSA, and related crimes in the community. Analysis of qualitative and quantitative results for all programs shows that the overall well-being of girls who graduated from CAI has improved. The positive change in their well-being is consistently observed both during their recovery, healing and reintegration to the wider community. In particular, the impacts of CAI's programs on the overall well-being of the beneficiaries and their families are evidenced in the following aspects:

*a. Good health and recovery from traumatic experiences.* The positive general health and recovery from traumatic experiences of the beneficiaries could be seen in the "transitions" that these girls go through from one program to the other until they are deemed ready to be re-integrated into the wider community. In the first 2 years of stay of a beneficiary in CAI's IH program, data suggest decreasing negative effects of a traumatic incident. Less medications (for mental illnesses), overall good quality of sleeping patterns, normal body mass indices, as well as positive feelings of safety and security are manifestations of the positive impacts of the program on the girls. As significant, a beneficiary's transition from IH to the AC program is a positive direction because the beneficiaries are assessed and these assessments show continued recovery so much so that they are deemed ready to face the wider world. Finally, data

on alumni of CAI's programs reveal emotionally stable survivors of CSA, who are independent and well-functioning members of society.

*b. Educational, financial and legal support.* Education of the beneficiaries affects positively the well-being of the beneficiaries because it is not only a means to alleviate the poverty of families, but it is also a means for CSA survivors to cope up with traumatic experiences. The education provided also led to employment of the alumni. Legal support of CAI has led to prosecution of perpetrators but due to the problems in the legal system, filing of legal charges and prosecution remain as key concerns. Financial assistance to families of CAI beneficiaries has a positive impact on these families because they are provided with a means to earn a living. This support has been extended by CAI to the families of the beneficiaries affected by natural calamities like Typhoon Haiyan (Yolanda) by rebuilding houses.

*c. Advocacy on Children's Rights and Health.* The welfare of poor but deserving youths and their families in towns where CAI operates is positively impacted by CAI's Advocacy program (AP). AP offered educational scholarships (i.e., particularly for non-CSA individuals) and livelihoods to families. AP has also provided information on children's rights and health, and free (though limited) health campaigns and services (e.g., lectures, symposia on health, circus as awareness campaign for children's rights, and medical campaigns such as comprehensive health services for the beneficiaries of IH and AC programs, as well as free though limited dental and optometry services). In terms of the information campaign for children's rights and health of young people, limited evidence suggests that the message of CAI regarding protecting and enhancing children's rights is well received by local communities. Moreover, a number of beneficiaries of CAI who serve as campaigners for children's rights and health of young people are positively impacted in these civic activities where they gain self-confidence, skills in public communication, and personal satisfaction.

In spite of the wide-ranging and commendable programs and services offered by CAI, there are normal challenges and constraints for the organization. In this report, we present only three examples of these challenges and constraints. Firstly, the Philippine legal system is a difficult challenge to navigate especially for survivors of CSA, their families and for CAI who support them. Secondly, limited funding of CAI is

a constraint to provide additional support for more survivors of CSA including boys and homosexual children who are survivors of CSA. At present, CAI is limited to 50 female beneficiaries in its IH program. It has plans to open up a new center in Negros Island, which is a welcome news to help more CSA survivors outside of the island of Panay. Thirdly, for the advocacy program, this research was limited to examine police statistics for crimes against women and children. Findings suggest that the overall reporting of these crimes is inconclusive to attribute to CAI's AP.

# **Impact Evaluation of Luxembourg Government-Funded Programme**

## **1. Background and objectives of the impact assessment study**

### **1.1. Rationale and significance of CAI programs**

CAMELEON Association Incorporated (hereafter referred to as CAI) has been providing protection, healing and reformation to Filipino girls who are victims/survivors of sexual abuse for a little over 20 years. Founded and established in the Philippines in 1997 by French national Laurence Ligier, CAI is a haven, where abused children can rebuild their lives. It is a non-profit organization, with no political or religious affiliation with financial support from various institutions. The CAI Center is located in Brgy. Sablogon in Passi City. It can house 50 beneficiaries at a given time. On the other hand, the Iloilo City facility includes administrative offices and the CAI dormitory. Passi City has 90,000 residents and an area of 251 square kilometers and is 60 kilometers from Iloilo City, the capital of the Western Visayas Region.

CAI's envisions "a society where families and communities are self-reliant, child-friendly, and free from all forms of abuse and violence." Consistently, CAI mission is to stand and act as a model institution that promotes the empowerment and development of children and their families through education, advocacy, and psychosocial interventions. Among others, it has these three objectives:

- Protect, rehabilitate and reintegrate children, who are survivors child of sexual abuse (hereafter referred to as CSA), as well as provide social support and education to their families;
- Provide education, health, professional instruction, and independence to disadvantaged youths and their families; and
- Raise awareness among the general public and the media about child sexual abuse, and to advocate and to lobby to decision-makers and politicians the enforcement of laws protecting children's rights.

CAI has remained steadfast to the mission of its founder of taking action and fighting CSA in the Philippines (CAI Annual Report, 2011 – 2012). Its programs include personal rebuilding; reintegration and independence; and education, development, and advocacy. Beneficiaries are not limited to children victims of sexual abuse but also various members of the society.

In 2012, the Ministry of Foreign Affairs – Luxembourg financed CAI’s three major programs: the In-house program, the After-care program, and the Advocacy program (Figure 1). Personal rebuilding is addressed by the In-house Program (IH), while reintegration and independence for girls is being addressed by the After-care program (AC). The CAI’s education and development, and advocacy program is initiated to address the needs of the various sectors of society. This impact assessment study attempts to measure the impacts of these programs.

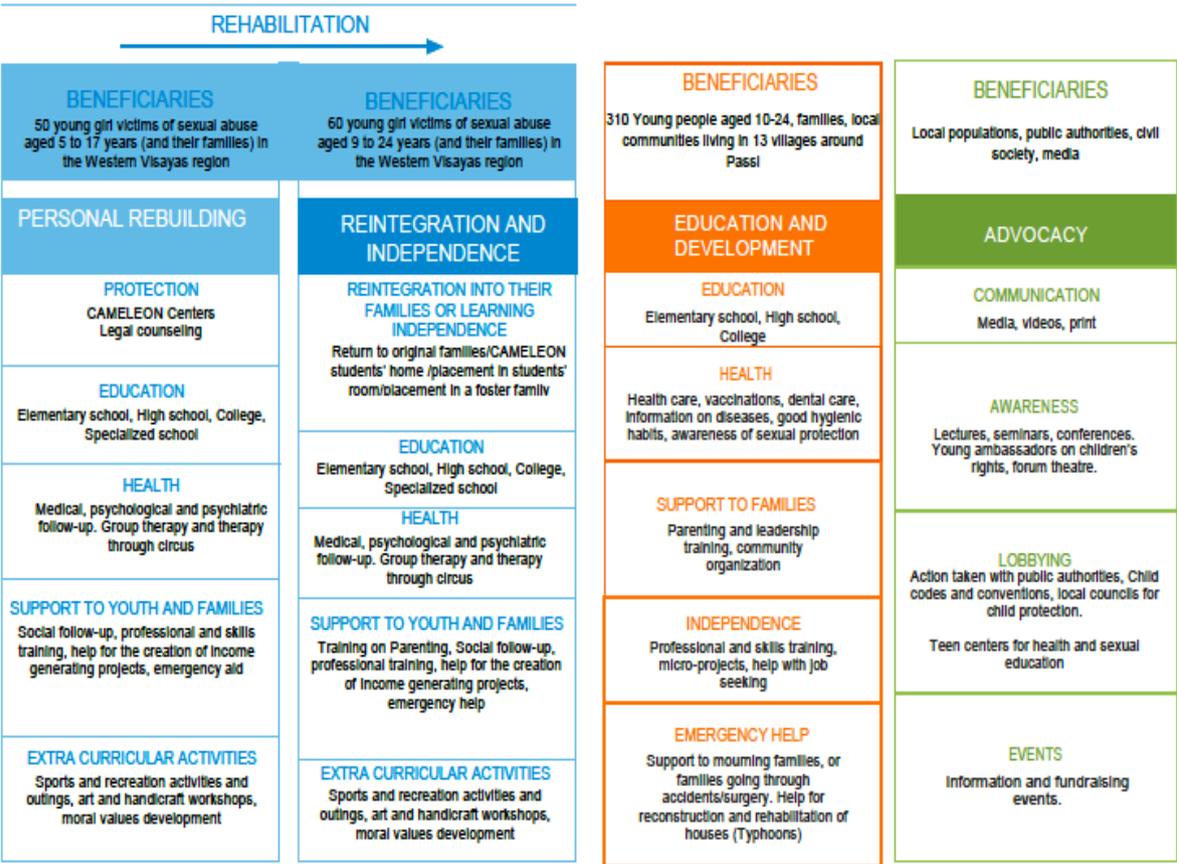


Figure 1. CAMELEON Programs in the Philippines (CAI internal documents, n. d.)

Measuring and understanding the project impacts must be one of the key priorities of any organization or institution. Its assessment is crucial as it measures the

effectiveness of various activities of the organization. Through this report, CAI and its donor agencies will be able to understand the significance of their rehabilitation and advocacy programs so as to help them with finding out what gaps exist and what future interventions can be developed. Thus, this will assist them in (re)setting their priorities and in learning lessons and challenges of their past projects.

## **1.2. Objectives of the impact assessment study**

This study evaluated the 5-year program of CAI that was funded by the Ministry of Foreign Affairs of Luxembourg from September 2012 to August 2017. It examined the impacts of these three associated programs: (1) the IH, (2) the AC, and, (3) the AP. Two of the three programs were designed to rehabilitate the young girls who had experienced CSA, and one program was implemented to educate and train local communities to protect and promote children's rights as well as to prevent and report CSA. Specifically, the project aimed to:

1. Assess the impact of the rehabilitation program on the healing and stabilization process, the resilience of girls who are victims of sexual violence; *and*,
2. Assess whether there has been a change in mentality, a better knowledge of the issues, resulting in a change in behavior (prevention of abuse), an increase in reports and an improvement of the protection practices.

This document has eleven (11) sections. **Section 1** (this section) introduces the rationale for impact assessment of CAI programs funded by the Government of Luxembourg. **Section 2** describes the three funded programs while **Section 3** discusses relevant studies on CSA and well-being of CSA. The mixed method approach to this impact assessment, including ethical process and approval, are presented in **Section 4**. What follow are discussions on the outputs (**Section 5**), outcomes, (**Section 6**), and impacts (**Section 7**) of CAI programs. A summary of the impact assessment findings and their corresponding lesson are presented in **Section 8**; followed by recommendations in **Section 9**. Bibliography and Annexes are shown in **Sections 10 and 11**, respectively.

## 2. Services rendered by CAI

This section presents three programs that were supported, namely the IH, the AC and the AP.

### 2.1. In-house program

The IH or the Residential Care Program aims to rehabilitate young girls who are survivors of CSA, and to safeguard a positive reintegration to their families (when possible) and to their respective communities. It provides a “family environment” to CSA survivors by making them feel safe, secure, normal, and balanced.

There are two major facilities for girls in CAI: the Center 1 and the Center 2. These centers when combined can accommodate 50 girls coming from various locations in Western Visayas (e.g., Iloilo Province, Negros Occidental, Capiz, Guimaras). Center 1 caters to newly admitted girls, while Center 2 shelters girls who are evaluated to have progressed well in their rehabilitation. In 2013, for example, the center admitted girls having cases falling under any of these three CSA categories: rape (50%), incest (46%), and sexually molested (4%).

The various activities in the IH program are classified into six sub-groups: (1) home-life services; (2) educational assistance; (3) legal assistance; (4) psycho-social intervention; (5) practical and life skills training; and (6) sports and circus.

**Home-life services** of CAI entail the provision of basic needs to the beneficiaries, including but not limited to shelter, food and clothing. Girls were provided with individual beds and cabinets, but there were also shared facilities like bathrooms and living area. Balanced and nutritious meals were also provided (breakfast, lunch, dinner, and snacks in the morning and in the afternoon). Additional health supplements such as vitamins and hair lice treatment are also afforded while other medical expenses are provided such as vaccination for flu, pneumonia, hepatitis B, and hospitalization. Clothing and other personal hygiene needs are also given for the girls, such as school uniforms, personal clothes, toiletries, towels, linens, and the likes. As in a normal household, the values of responsibility, discipline and cooperation were also

highlighted. A 24/7 security guards are provided at the facilities.

**Education assistance** is given to all beneficiaries at various educational levels: elementary, special education program (SPED), high school, vocational/college, and postgraduate studies. The assistance aimed not only to enhance the literacy of the girls but also to improve their educational status, self-esteem, self-worth and real potential to gain employment upon their graduation. Aside from the usual tuition fee support, the housemothers, social workers, volunteers, or CAI staff also provided schoolwork-related assistance such as but not limited to tutorials and progress monitoring.

**Provision of legal assistance** to the beneficiaries is an integral component of the program. It covers facilitation and assistance in the processing of court cases. The support is vital to ensure that girls are safe with minimal apprehensions during the court hearings, eventually giving them courage and hope. Six lawyers volunteered to defend CAI beneficiaries in their cases in 2017. In 2014, a seminar/workshop on “Empowering abused through knowledge of court procedures” was conducted by the Women Law Advocate Philippines with all 50 girls participating.

**Psychosocial intervention** is another core service that is provided to the beneficiaries. This involves an individualized treatment for each girl that covers psychiatric and psychological evaluations and counseling. Group activities for self-expression like verbal communication, drawing, writing of poems and stories, are also encouraged. Mental health of girls was improved through daily group prayers, reflection/meditation, catechism, and spiritual retreat. All these activities are supervised and monitored by social workers, housemothers, and external psychologist/psychiatrist.

**Practical and life skills trainings** were also afforded to the beneficiaries that will enhance their skills, competencies, hobbies and interests thus preparing them to become economically independent and resilient individuals. Examples of trainings are cooking, sewing and other crafts, table etiquette, landscaping, among many others.

**Sports and/or circus** were introduced to the girls during their free time forming part of their rehabilitation process. These activities provided avenues for self-expression and tension release due to trauma, hostility and/or depression. Examples of sports activities were basketball, taekwondo, taebo, badminton, biking, swimming, dancing,

wall climbing and many more.

## **2.2. After care program**

The AC Program was developed in order to sustain the recovery of the girls from the IH program. In this program, the girls are reintegrated either with their biological family, foster family, or stay in the dormitory/boarding house. While in their independent living, the girls are provided with the following: (1) educational support, (2) psycho-social support, (3) capability building trainings, (4) legal support, and (5) monitoring and follow ups. This package of intervention will enhance their ability to cope with life's realities.

CAI continues to support the girls in their **formal education** when they are elevated to the AC program. The support covers expenses such as school fees, school projects/supplies, transportation, boarding house rentals, food allowance, and many more. The CAI staff and local social workers manage these provisions.

**Psychological support** is also provided to the girls. Psychological sessions were given to the girls on a regular basis for those taking maintenance medications. Other related provisions were also offered, such as sports and recreational activities, group sessions/fellowships, and other psychosocial activities.

Girls continue their **capacity building trainings** under the AC program. Aside from the usual skills trainings (e.g., beauty culture, cooking, computer literacy, etc.), girls are also encouraged to join educational exposure trips and on-the-job trainings. In addition, seminars on effective parenthood were also conducted to the parents of the beneficiaries that will help address conflicts and misunderstandings in the family.

**Legal support** provided by CAI involves briefing and debriefing of the girls before, during and after court hearings. Moreover, local social workers give legal updates to the girls and their families.

**Monitoring and evaluations** are done through school and/or home visits of social workers and/or families. In instances where the place of residence is remotely located, the social workers follow-up the girls and their respective family/guardian via telephone or other means of communication.

### **2.3. Advocacy and education and development program**

The AP aims to raise awareness on children's rights and to promote respect of these rights and laws. The various activities under the AP are nutrition and personal hygiene campaign, adolescent reproductive health and sexuality, and emergency response training. Workshops, lectures, and facilitation were key activities under this program, wherein several stakeholders were involved. For example, lectures on proper health and nutrition (including sanitation) practices were delivered to the beneficiaries of CAI; while workshops on issues on adolescent reproductive health and sexuality were delivered to youths in the community. Moreover, movies on child's rights were shown to elementary, high school, and college students. Two youth organizations, the Voice of CAMELEON Children (VCC) and the CAMELEON Youth Health Advocates (CYHA), are active in CAI's AP. AP also includes scholarships for poor but deserving elementary, high and college students, livelihood support to their families, health assistance to the scholars and their respective families, skills training towards independence, and emergency assistance in times of calamities.

### **2.4 Total expenditure on the CAI programs**

In 2012, the Government of Luxembourg co-funded the amount of €1,009,016, roughly equivalent to Php5,606,871.76.<sup>1</sup> This covered the expenditure for the period covering 2012 to 2017. In addition, the Luxembourg Government also extended its help after the Typhoon Yolanda by giving extra funding to help rebuild the houses of 320 families including 9 staff in 2013. Moreover, all the expenditures of the two Luxembourg lawyers who helped CAI in its advocacy program (technical assistance for database and to study the files of the girls) was also co-funded. Finally, the Government of Luxembourg also approved to co-fund the construction and operation of CAI's new center in Negros Occidental.

CAI's annual expenditure and source of funds to finance its programs are shown in Table 1. The percentage contribution of the Government of Luxembourg varies annually with the highest of 39.51% in 2016 – 2017 and lowest at 32.48% in 2013-2014. Overall, the Government of Luxembourg contributed 36.42% of CAI's operational

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<sup>1</sup>Based on December 2012 exchange rate of 1€ = Php 55.11)

expenses and CAI- Philippines raised the remaining 63.58% from 2012 -2017. The funds generated in a given fiscal year were 100% expended during the entire year's operation.

Table 1: CAI Program Budgets, in €.

		Period Cover							
Year	Period Covered	Fund Sources						Fund Uses*	Net Funds Available
		LUX /CHL		CameleonPhils		Total			
		Amount	%	Amount	%	Amount	%		
1	2012-2013	€ 308,701.39	37.82	€ 507,438.73	62.18	€ 816,140.12	100.00	€ 816,240.12	€ (100.00)
2	2013-2014	€ 264,815.92	32.48	€ 550,475.92	67.52	€ 815,291.84	100.00	€ 815,391.84	€ (100.00)
3	2014-2015	€ 254,081.57	37.84	€ 417,420.45	62.16	€ 671,502.02	100.00	€ 671,602.02	€ (100.00)
4	2015-2016	€ 265,617.55	34.97	€ 494,044.01	65.03	€ 759,661.56	100.00	€ 759,761.56	€ (100.00)
5	2016-2017	€ 284,975.64	39.51	€ 436,207.94	60.49	€ 721,183.58	100.00	€ 721,283.58	€ (100.00)
		€							
	<i>Total</i>	1,378,192.07	36.42	2405587.05	63.58	€ 3,783,779.12	100.00		
	<i>Mean</i>	€ 275,638.41	36.51	481,117.41	63.49	€ 1,261,259.71	100.00		

### **3. Review of academic literature**

#### **3.1 Child sexual abuse**

Childhood sexual abuse (CSA) is recognized as an important social and global problem that has devastating consequences for the psychological adjustment of the survivors (Browne & Finkelhor, 1990; Spaccarelli, 1994; Trickett & Putnam, 1993). Emotional and physical well-being of survivors has been well documented to have been adversely affected both in short and long term (Young & Widom, 2014; Gould et al., 2012; Bonnona et al., 2002; Beitchmann et al., 1992).

The World Health Organization's (WHO) defines CSA as " the involvement of the child in sexual activity that he or she does not fully comprehend, is unable to give informed consent to, or for which the child is not developmentally prepared and cannot give consent, or that violates the laws or social taboos of society. Child sexual abuse is evidenced by this activity between a child and an adult or another child who by age or development is in a relationship of responsibility, trust or power, the activity being intended to gratify or satisfy the needs of the other person. This may include but not limited to: inducement or coercion of a child to engage in unlawful sexual activity; the exploitative use of a child in prostitution or other unlawful sexual practices; and the exploitative use of children in pornographic performance and materials" (WHO, 2003).

Dubowitz (2017) argues that CSA is dependent on the laws, cultural context, and local thresholds. The author reports that definitions of CSA and child neglect vary across world regions and country income categories, but is notably concerned with the status of child protection programs and services that even in high income countries need improvement (Dubowitz, 2017).

#### **3.2 Interventions and challenges on CSA**

In the Philippines, the academic literature on CSA is reflected in the growing efforts of diverse academics such as in the pages of the Philippine Journal of Child Sexual Abuse (PJCSA). PJCSA is a journal of the Center for the Prevention and Treatment of Child Sexual Abuse, which is a Philippine non-government organization (NGO). Since 2011, papers in this journal covered different research interests such as the use of clay

therapy amongst survivors of CSA (Lanes & Decatoria, 2011); traumagenic dynamics framework with Filipino clients of CSA (Rabanillo, 2011), and the like. In the same vein, Yacat, Rosales and Rabanillo (2018) examined the practices, beliefs of Filipino counsellors of children survivors of CSA. On the other hand, Rabanillo (2011) analyzed CSA cases of Filipina girls using the traumagenic framework of Finkelhor and Browne (1988), a framework that was developed in a western context. This particular framework is a comprehensive model that examines the trauma of sexual abuse including its short- and long-term effects on the victims. For Rabanillo (2011), the framework is appropriate in evaluating 25 CSA cases of Filipina girls, such as cases of rape, incest and sexual molestation. Her study suggested that these cases demonstrated the problem of stigmatization, which is the highest traumagenic dynamics among the CSA victims, followed by betrayal, powerlessness and sexual traumatization (Rabanillo, 2011). However, Stoltenborgh et al. (2011) argue that CSA is problem of significant extent but methodological issues such as self-reported cases of CSA influence the extent of actual cases.

Legal concerns on CSA in the Philippines have been raised in academic and grey literatures. Sague-Castillo (2009) probed on the legal outcomes and factors associated with CSA cases filed in the courts from 1997-2000 in one Manila-based public hospital. The joint report (UPR: Universal Period Report) of the Apprentisd'Auteuil Foundation, CAI, Center for the Prevention and Treatment of Child Sexual Abuse, and the Action Against Violence and Exploitation, Inc. points out to the poor enforcement record of the Philippines in relation to laws and international standards for the protection of children's rights (see AAF, 2016). In the same report, cases of CSA in the Philippines are observed to be increasing and the victims are getting younger (AAF, 2016). Where cases reached the courts, the same report highlights the very low percentage (2% in the provinces of Iloilo and Capiz, Philippines) of perpetrators being sentenced (AAF, 2016).

In the United States, Estes and Weiner (2001) report that there is a long tradition of upholding and enforcing children's rights, child protection, as well as the prevention of the sexual exploitation of children. This US tradition allowed non-government organizations (NGOs) to play a significant part in protecting children's rights as well as the prevention of exploitation of children in any form. The same can be said in the

Philippines where NGOs are taking the fight, as it were, to the core societal issues (e.g., poverty, culture of silence and blaming the victims, inefficient courts, problematic laws) that are seriously damaging the enforcements of the legal rights of children not to be abused, neglected and violated (see AAF, 2016).

Both in the US and in the Philippines, public and private organizations have a longstanding participation and collaboration relating to child protection, and prevention of the sexual exploitation of children. Among the NGOs, there are sharp ideological disagreements as to the appropriate actions that should be taken by these organizations to address sexual exploitation (Estes & Weiner, 2001). Furthermore, Estes & Weiner (2001) observe that NGOs are small and severely under-funded, and they compete among themselves for the limited available funding. Similar academic reports on NGOs in the Philippines seem absent in the academic literature, though the grey literature is providing information of the work of NGOs (see AAF, 2016; CAI website). These papers are rich sources of information for the operations of NGOs dedicated to rehabilitate and protect survivors of CSA in less developed countries.

The academic findings of Dubowitz (2017) and Estes and Weiner (2001) do not seem to bode well for NGO programs dedicated to the protection and rehabilitation of sexually abused children in less developed countries particularly the Philippines. This means that there are a number of challenges for NGOs in the Philippines such as funding, integrating their rehabilitation programs into the local culture and politics on top of the very demanding efforts and requirements of actually rehabilitating survivors of CSA. However, there is no doubt that the work of NGOs in helping survivors of CSA is an invaluable social work.

### **3.3 Social welfare programs for CSA survivors in the Philippines**

The Department of Social Welfare and Development (DSWD) is the executive department responsible for the protection of the social welfare rights of the Filipinos and for the promotion of social development. DSWD regulates and monitors service providers (e.g., NGOs providing programs for CSA). In Western Visayas, the DSWD runs a CSA-related program, the Home for Girls. It is a temporary residential facility in Central Iloilo, which was designed as an alternative form of family care. The facility

provides a 24-hour group living on a temporary basis to girls below 18 years old, with special needs, where needs cannot be met by their own families and relatives over a period of time. Its goal is to enable girls with special needs and in especially difficult circumstances to resolve their problems and to restore their normal functioning eventually leading to regaining their self-worth and dignity as a person through provisions of protective and rehabilitative programs and services, thus, making them ready towards family reunification (whenever possible) and community reintegration. The target clientele are girls below 18 years old and who are: 1) victims of involuntary/ forced prostitution; 2) victims of illegal recruitment; 3) physically abused children; and, 4) victims of sexual abuse. Victims of sexual abuse may be in the following form: 1) incest; 2) rape; and, 3) acts of lasciviousness.

To actualize its goals, DSWD's Home for Girls offers the following services: 1) social services; 2) homelife services; 3) educational services; 4) psychological/ psychiatric services; 5) health services; 6) economic productivity/ skills training; 7) recreational sports and other socio-cultural activities; 8) development services; and finally, 9) spiritual services. Funding for the Center is provided mainly by the government, but strategic alliances are formed with the academe, the hospitals, religious groups, and professional organizations, e.g., the Women Lawyers Association of the Philippines.

### **3.4 Impact assessment**

One perspective of impact assessment/evaluation that focuses on welfare sees impact assessment as an effort to understand whether the changes in the well-being of those who received an intervention are indeed due to the program, project or intervention introduced (Khandar et al., 2010). Specifically, impact evaluation tries to determine whether it is possible to identify the effects, outcomes and/or impacts of a program, and to what extent the measured effect can be attributed to the program and not to the other causes. Contrasting it with an operational evaluation, the impact evaluation relates to ensuring effective implementation of a program in accordance with the program's initial objectives.

In the academic literature, there are very few works that examined the social welfare programs in the Philippines dedicated to helping and supporting children survivors of

CSA. The work of Yacat, Rosales and Rabanillo (2018) surveyed empirically the educational background, professional training, practices, beliefs and activities of counsellors in the Philippines who support survivors of CSA. Their data suggest that they have a total of 55 respondents who came mostly from the National Capital Region (NCR) (n=24 or 43.6% of their respondents), but very few from Visayas (n=18 or 32.7%) and Mindanao (n=11 or 20%). 52 of the respondents are females (or 94.5%). The majority of their respondents work for different NGOs (62.1%), and the rest work for the DSWD (37.9%) (Yacat, Rosales & Rabanillo, 2018). They conclude that counselling interventions for survivors of CSA are mostly from a social work academic and training background. For the same authors, counselling is the most commonly used method of intervention for CSA survivors though the social workers are mostly relatively new to the profession with an average of 4.5 years as counsellors.

The work of Yacat, Rosales and Rabanillo (2018) depicted a commonly used process in the Philippines when providing interventions to survivors of CSA. This process involves more or less the following steps: firstly, initial contact with a victim of CSA followed by an intake procedure (of the DSWD or NGOs); secondly, a referral system is in place that involves a team whose members are coming from different fields of expertise (e.g., child psychiatry, social work, legal, child education, et al.); thirdly, the introduction of interventions such as a pre-assessment step including a diagnosis of potential posttraumatic stress disorder (PTSD), psychotic and affective disorders, followed by a treatment plan and the application of this treatment plan to the client. However, Yacat, Rosales and Rabanillo (2018) did not examine the potential impacts of these interventions in relation to the different aspects of CSA programs, for example, effectivity of the interventions, costs, healing or resiliency of clients, and the like.

A number of gaps were identified by Yacat, Rosales and Rabanillo (2018) including lack of programs for sexually abused boys and sexually abused gay children, the self-reported poor capability of counsellors to manage cases of sexually abused boys and sexually abused gays, and very low percentage of counsellors utilizing good documentation practices of their caseloads, to name a few.

### **3.5 Depression and post- traumatic stress disorder among CSA survivors**

Trauma and abuse have the potential to generate serious emotional consequences for its victims, with several studies in the past revealing that Post Traumatic Stress Disorder (PTSD) and Depression being among the most common outcomes. This contention can be confirmed by recent studies.

A prospective cohort study on the mental and sexual health outcomes following sexual assault in adolescent done in Greater London, United Kingdom found that anxiety, post-traumatic stress, and major depressive disorders were the common diagnoses. (Khadr, 2018; Sinanan, 2015). In a systematic review of health outcomes of sexual violence on civilians in conflict zones between 1981 and 2014, mental health outcomes were reported in 14 studies, the most frequent being PTSD (range 3.1-75.9%), anxiety (range 6.9-75%), and depression (range 8.8-76.5%) (Ba, 2017). A study on the consequences of domestic violence to the mental health of abused women in Greece revealed that 60% of the victims presented symptoms of PTSD. More than half of those presented with PTSD have chronic symptoms: 73% of the victims presented with reduction in functionalism and 56% have symptoms of depression (Polychronopoulou, 2016). Similarly, cross-sectional survey with female survivors of rape was carried out in 3 provinces of South Africa 6 months after the rape. Eighty seven per cent reported high levels of PTSD and 51% moderate to severe depression post rape. One of the major risk factor for PTSD and depression were the unmarried survivors of rape (Mgoqi-Mbalo, 2017 May).

The severity and timing of abuse are important predictors for the development of adult depression and post-traumatic symptoms (Capretto, 2017). Compared with other developmental periods, early childhood sexual maltreatment experiences (5 years of age and below) and late childhood physical maltreatment experiences (13 years of age and above) were stronger predictors of adult depression and post-traumatic stress symptoms (Capretto, 2017).

In terms of resiliency, coping and self-efficacy, it was also found out that the violence of the sexual abuse was negatively related to self-efficacy, and consequently, self-efficacy

was positively related to active coping and negatively related to symptomatology. Equally important, perception of family support was positively related to self-efficacy and negatively related to symptomatology (Guerra, 2018). Sexual abuse experienced in childhood and adolescence is associated with severity of PTSD, depressive symptoms, and emotion regulation difficulties. Greater emotion regulation difficulties were associated with greater severity of PTSD and depressive symptoms. In addition, the relationship between emotion regulation difficulties and PTSD severity was mediated by depressive symptoms. However, the reverse was also true: the relationship between emotion regulation difficulties and depressive symptoms was mediated by PTSD symptoms (Chang, 2018).

Tocker et al. (2017) found a correlation between sexual abuse and higher levels of the clinical measures (depression, anxiety, dissociation, and PTSD, attachment patterns, self-esteem, self-disclosure, and family environment characteristics). In addition, a correlation was found between sexual abuse and level of avoidant attachment, self-esteem, and family environment characteristics (Tocker, 2017). Shame also was found to partially mediate the relationship between self-blame and PTSD. Shame and depressive symptoms were also found to partially mediate the relationship between self-blame and suicidal ideation (Alix, 2017). Further the capacity of survivors to become effective mothers is also hampered by PTSD symptoms. Stevens et al. (2017) found that PTSD Symptoms are associated with increased risk of obstetric complications among pregnant survivors of trauma, abuse and interpersonal violence. Women most at risk for experiencing distress during their obstetric visits and/or undergoing potentially distressing procedures may also be the least likely to communicate their distress to obstetricians (Stevens, 2017).

### **3.6. Theories, perspectives, and issues on recovery programs for survivors of CSA**

This section reviews the pertinent literatures on theories and perspectives of programs focused on supporting the recovery and healing of CSA survivors. The International Rescue Committee (IRC) formulated a resource package or set of guidelines called Caring for Child Survivors (CCS) of CSA that is a comprehensive and practical approach to help survivors of CSA and their families recover and heal, especially in humanitarian

crises situations (IRC, 2010). CCS is based on a “theory of change that posits children can be supported in their recovery and healing from sexual abuse, with child-specific, compassionate, and appropriate care and treatment” (IRC, 2010: 5). CCS adapts an individual “case work” (or case study) management where a team of health and psychosocial service providers coordinate their expertise, knowledge and skills in implementing coordinated health and psycho-social interventions, including treatment when necessary (IRC, 2010). In other words, CCS advocates a child-centered case management approach with a multi-disciplinary team of service providers for programs focused on the recovery and health of survivors of CSA and their families.

Case management (CM) is a commonly used framework for an effective response for any child survivor of traumatic experiences. CM is understood as a set or series of actions provided by individuals or organizations to support and help a child or adult survivor of gender-based violence including CSA (IRC & UNICEF, 2011). CM’s core elements or functions include but are not limited to: case identification, client and family assessment, case planning, planning implementation, case monitoring, client advocacy, and case termination. CM may also cover system advocacy (i.e., intervening with organizations or institutions) and resource development (i.e., addition of services and resources to meet client’s needs) (IRC & UNICEF, 2011). These core elements of CM are relevant in this study because these elements or functions of CM appear to be applied or used by the organization under study.

However, the obvious caveat regarding CCS of IRC is that it is a set of guidelines for service providers in crisis and humanitarian situations. This study is not contextualized in such a situation but the fundamental concepts for a theory of changing the negative and traumatic experiences of CSA survivors in the CCS is pertinent to this study. The organization under study in this research has set as its goal of “changing lives” after a traumatic experience. Thus, the “theory of change” that informs IRC’s CCS is a relevant theory that is applicable to this research. Moreover, the case work-based approach of CCS resonates with the programs and practices of supporting CSA survivors in the Philippines. This means that individual case management is used with a multi-disciplinary team of service providers for programs and activities focused on assisting survivors of CSA and their families. This is best gleaned from the program of the

Department of Social Welfare and Development (DSWD) for CSA survivors (discussed above, Section 3.3).

In terms of therapy, psychotherapy is commonly used to treat survivors of CSA. This treatment offers a model of a healing and nurturing relationship, where the survivor can (re-)discover trusting other people (Sinanan, 2015). Where a survivor suffers from posttraumatic stress disorder (PTSD), Cognitive Behavior Therapy (CBT) is one of the treatment tools employed by healthcare professionals. CBT assists survivors of CSA identify, evaluate and reframe dysfunctional cognitions associated to a specific trauma and its sequelae (Sinanan, 2015). Cohen, Mannarino and Deblinger developed “Trauma-focused cognitive behavior therapy” (TF-CBT) as a psychosocial treatment model intended to treat PTSD and related stress, emotional and behavioral problems in children and adolescents. TF-CBT was originally designed for PTSD due to CSA (Sinanan, 2015). There are other forms of therapy in the literature. The three mentioned here is meant to present potential treatments that could be used by individuals and programs who help CSA survivors in the Philippines. However, we (authors) argue that programs who help CSA survivors in the Philippines, especially those developed and implemented by NGOs must follow the minimum standards set by the government through DSWD. These local standards, arguably, follow a case management approach. Any additions to a program for CSA survivors must be carefully studied and should be informed by best practices models (see for example IRC & UNICEF, 2011; IRC, 2010).

### **3.7. Summary**

From the literatures reviewed, it is apparent that child sexual abuse is an important social and global problem that has devastating consequences for the psychological adjustment of the survivor. The literatures both local and international are rich on studies pertaining to CSA and that these studies however are constrained by methodological issues. Especially for less-developed countries, existing literature is skewed towards the problems faced by NGOs in the protection and rehabilitation of sexually abused children. Of particular importance is the practice of collaboration as an effective solution in addressing the many issues. There is a dearth of existing literature on the evaluation of impacts of the services rendered particularly in the rehabilitation

of the victims of CSA such that the effectiveness of protocols/ procedures in rehabilitation is still wanting. This literature review also explored depression and PTSD among CSA survivors. It was evident that the severity and timing of abuse are important predictors of adult-depression and post-traumatic symptoms. Finally, this literature review examined the different theories, perspectives, and issues on recovery programs for survivors of CSA. Potent therapy options were presented notable of which is the use of psychotherapy.

## **4. Methodology**

This section summarizes the detailed methodology used to evaluate the programs supported by the Government of Luxembourg. The first section presents the framework for evaluation of impacts of program. To unpack the different elements of the aforementioned framework, the following sections discuss the description of the study population, the mix method approach, assessment of IH, AC and AP, the research instruments and the ethical review and considerations.

### **4.1. Methodological framework for impact assessment**

Figure 2 is the study's methodological framework and that it shows the relationships between the immediate outputs associated with the programs of CAI, the outcomes that are expected from each of the implemented activities of CAI, and the impacts of these to the beneficiaries of the programs. Constructing an effective conceptual framework to examine the impacts of programs is necessary in order to identify, assess and communicate the individual programs (i.e., inputs and projects). Ideally, an organization should possess a clear understanding (e.g., conceptual structure) of describing how intended impacts (and outcomes) are reached. Having presented these fundamental issues in impact evaluation research, the conceptual framework presented in Figure 2 aims to address these core conceptual and practical concerns.

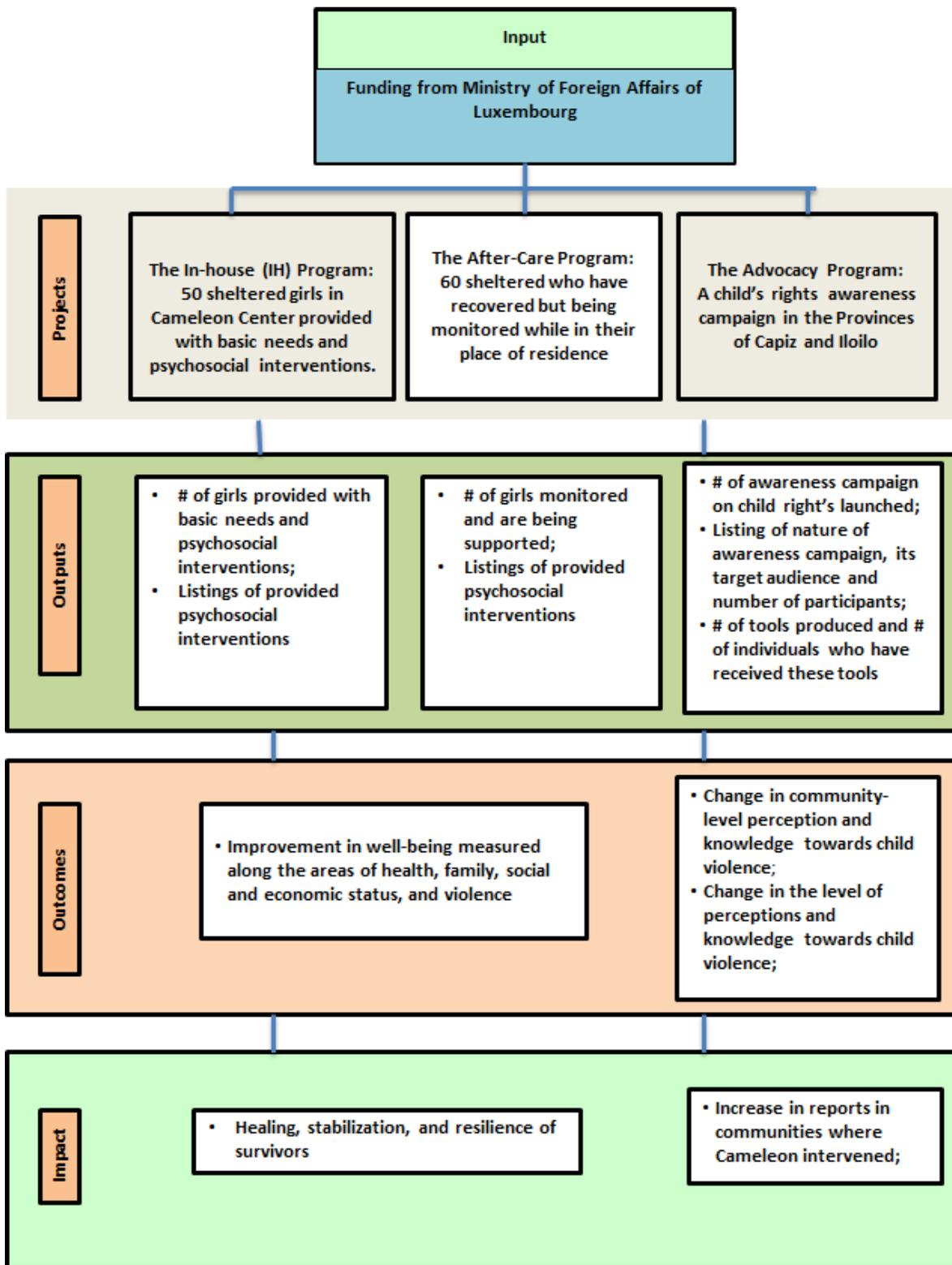


Figure 2. Impact assessment conceptual framework for CAMELEON Association, Inc. Programs from 2012 to 2017.

## **4.2. Mixed method approach to impact assessment**

This research employed a mixed method approach using both quantitative and qualitative data collection tools and analyses. Both secondary and primary data were collected. Quantitative data were collected using survey questionnaires (details are discussed below). Qualitative data were generated from in-depth interviews through key informant interviews and focus group discussions as well as from documents provided by CAI. Data collection was administered in the facilities of CAI in Iloilo City and Passi City. This ensured privacy of the respondents. The objectivity, impartiality and confidentiality of data generation were maintained by the researchers considering its survey and interview instruments.

## **4.3. Description of the study population**

The study population is a mix group who are directly and indirectly involved in CAI's programs. The primary targeted participants for the assessment of the IH and the AC programs were girls/young ladies who are survivors of CSA. The study design was to compare the "with and without" CAI interventions. Thus, the targeted study populations were girls who benefited from CAI programs and those who did not receive support from any CAI. However, complexities in the recruitment of girls who have not benefited from CAI hindered the researchers in pursuing the original plan.

As alternative, four sampling population have been used in order to compare the data on the physical and psychological/mental health status of CSA survivors at the time of this research. These are the new entrants (8), the IH (8), the AC girls (17) and the alumni (8) (i.e. those girls who completed their program from 2012 to 2016 i.e. years covered in the Luxembourg funding). There is a total of 23 alumni from 2012 to 2016.

The population for the assessment of the AP was taken from samples of towns, barangays and schools who were recipients of the advocacy campaigns, education and development programs and events that were conducted by CAI from 2012 to 2017. Respondents include representatives from government agencies including the Philippine National Police, the Department of Education, and the Department of Social Welfare and Development as well as secondary school students.

#### 4.4. General sampling procedures

The impacts assessment employed a combination of sampling approaches for survey, KII and FGD.

##### a. Survey

Originally, the sample size for the survey to compare CSA girls “with or without” CAI intervention was obtained using the following formula:

$$\text{Sample size } n = \frac{NZ^2s^2}{Nd^2 + Z^2s^2}$$

where N = total number of sampling units in a population,  $s = \delta^2$ , Z = normal variable and d = maximum error deemed acceptable (Israel, 1992). Sampling frame was developed from the list of girls that were provided by CAI. Appropriate sample size per target population was determined based on 90% level of confidence, 5% margin of error, population size of 125 and 50% response distribution. Total number of respondents based on the above formula is 46. Thirteen (13) CAI-beneficiaries (in-house and after care girls) were selected randomly through computer generated random numbers from the list given by CAI. This sample has to be matched with 13 girls who did not receive any form of intervention/s from CAI (non-CAI assisted girls).

However, due to the complexities in obtaining respondents for “without” CAI interventions, the sampling design was revised. Non-purposive sampling was employed. The 8 new entrants were considered as proxy for “without” CAI intervention. This number represents the total newly admitted girls in 2018. A matching of 8 in-house girls was sampled based on the profile of the new entrants in terms of age and the number of respondents for the in-house girls was pegged at eight to match the number of new entrants.

A total population of 23 alumni was considered however only 8 were available and willing to be interviewed. In order to satisfy the rule of thumb in statistics of minimum of 30 samples, 17 available girls from the after-care program were considered. The

computed sample was 46 but was reduced to 41 due to availability of respondents particularly the alumni.

Respondents include newly admitted girls, beneficiaries currently under the IH and AC programs, and the alumni. About 41% of the beneficiaries are currently under the AC program and that the newly-admitted beneficiaries, beneficiaries under the IH program, and the CAI alumni have an equal share with respect to the total number of respondents at 19.51% (Table 2).

Table 2. Distribution of survey respondents by sample categories, 2018.

<b>Particulars</b>	<b>Frequency</b>	<b>Percentage</b>
Newly admitted girls	8	19.51
In-house girls	8	19.51
Girls from the after-care program	17	41.46
Alumni	8	19.51
Total	41	100

b. Focus group discussion (FGD)

FGD participants were representatives of students of various educational levels who have been beneficiaries of CAI's programs particularly the advocacy as well as education and development programs. Representation from the elementary, high school and college levels was ensured. Additional data has been gathered from the parents of the beneficiaries through an FGD that was gathered during one of CAI's regular monitoring sessions in the second quarter of 2018.

Primary qualification for each of these respondents was their direct attendance and participation to advocacy campaigns and events of such nature that were sponsored by CAI from 2013 to 2017. In addition, children who participated in CAI advocacy and education and development programs were recruited for the discussions (e.g., public school students). FGD participants were purposively chosen from each of the three municipalities who are beneficiaries of CAI to ensure representation of CAI stakeholders.

The adult participants included the following respondents: parents, teachers, barangay and LGU Officials, as well as a policy maker mainly in the municipalities of Bingawan, San Enrique, and Passi City (Table 3).

Table 3. Date conducted, Venue, CAI programs discussed, number of participants, descriptions/position of participants of the five FGDs conducted.

<b>FGD</b>	<b>Date conducted</b>	<b>Venue</b>	<b>CAI Programs Discussed</b>	<b>Number of Participants</b>	<b>Description/position of Participants</b>
1	26 May 2018	St. Clement's Church, Lap Paz, Iloilo City	Follow-up on the status of girls under the After-Care program, Issues and challenges of girls under the program	13	Parents and close relatives of After-Care participants (sister, aunt)
2	19 June 2018	Computer Laboratory of Bingawan National High School	Scholarship, Training Programs, Livelihood Programs,	13	Junior high school, senior high school and college students who have attended CAI Advocacy Activities
3	23 June 2018	Brgy. Quinolpan, San Enrique, Iloilo	Lectures on Child's Rights and Child Abuse	14	Elementary students who attended CAI Advocacy Activities
4	23 June 2018	CAMELEON Center, Passi City	Youth health Advocacy and CAMELEON Youth	12	Ambassadors of Voice of CAMELEON Children and Committee of Youth Health Advocates
5	7 July 2018	CAMELEON Dorm- Jaro	Experiences as former beneficiaries of In-house and After-Care programs	11	Current After-Care beneficiaries

c. Key informant interview (KII)

For KII, data was sourced from the Foundress and Executive Director of CAI, representatives from the Regional Office of the Department of Social Welfare and Development, a local teacher who has a direct involvement in dealing with some girls housed in the Center, the in-house psychiatrist of CAI, and one representative from the LGU where CAI is currently operating.

Table 4. Respondents, the venue, CAI descriptions/position of participants of KII conducted during the KII, CAI, 2018.

<b>KII</b>	<b>Respondent/ Organization</b>	<b>Venue</b>	<b>Position of Key Informant</b>
1	Ms. Laurence Ligier	CAI, Passi City	Foundress, CAI
2	Dr. Valerie Heena Andora-Quilaton	CAI, Passi City	In-house Psychiatrist, CAI
3	PO Nacional	Camp Delgado, Iloilo City	Staff, RCWPD-VI
4	Joy Lemos-Quiba	Municipal Hall, Bingawan, Iloilo	Sangguniang Bayan Member, Bingawan
5	Stanley Lazalita	DepEd- Passi City	Department of Education- Passi City Staff
6	Aquilina Gaitan	DSWD-RFO VI, Iloilo City	DSWD-RFO VI Staff
7	Roqueta Aquio	DSWD Home for Girls, Cabatuan, Iloilo	House Manager, DSWD Home for Girls

#### **4.5. Assessing IH and AC programs**

##### **a. Survey of new entrants, IH and AC beneficiaries**

In order to assess the mental well-being of the participants, a clinical assessment using rating scales was conducted by psychiatrists, Dr. Diosdado Amargo, Jr. for adult participants, and Dr. Valerie Andora-Quilaton for child and adolescent participants. Dr. Quilaton is the resident psychiatrist of CAI. This study utilized the Hamilton Rating Scale (HAM-D) for Depressive Symptoms and the Severity of Posttraumatic Stress Symptoms – Adult (National Stressful Events Survey PTSD Short Scale (NSESSS) for Post-Traumatic Stress Symptoms. Mindful that these scales are used most in adults, Dr. Quilaton has guided the child and adolescent participants in accomplishing the questionnaires.

Any clinical symptoms manifested by the participants during the survey which may have needed immediate attention or follow up therapy has been referred to the in-house psychiatrist, Dr. Valerie Andora-Quilaton for management.

##### **b. Focus group discussion of CAI: Current beneficiaries**

An FGD was conducted among AC beneficiaries to examine their perceptions and experiences as recipients. It also explored the perspective of the beneficiaries in all CAI programs. To selected AC beneficiaries, their roles as well as their benefits in participating to the advocacy program were also probed.

#### **4.6. Assessing advocacy program**

##### **a. Focus group discussion of beneficiaries of CAI's AP**

To determine the impact of CAI's Advocacy Program, five FGDs were conducted. The following were the information gathered:

1. Information about their role in the community, including their role with children who are survivors of child sexual abuse (CSA);

2. Perspectives on survivors of CSA
3. Their role in addressing violence toward children who are survivors of CSA
4. Perspectives of the CAMELEON Rehabilitation, After Care and Advocacy Programs
5. Recommendations for future interventions

b. Key Informant Interviews of various stakeholders

During KII, the respondents were asked about their work in an organization regarding child's rights and on children who are survivors of child sexual abuse (CSA); perspectives on CAMELEON programs and projects; current issues and challenges in child's rights especially concerning abuse and neglect of children; and recommendations for future interventions.

#### **4.7. Research instruments, informed consent and assent**

Research instruments for KII, FGD, and surveys are discussed in this section.

##### **4.7.1. Survey instrument**

The overall aim of the survey is to assess the self-reported effects of the programs to the well-being of the respondents. This study utilized Post Traumatic Stress Disorder symptoms and Depressive Symptoms to measure the most common psychiatric sequelae associated with traumatic experiences (Steel et al., 2011) such as CSA. Two (2) rating scales were used to measure the symptoms of the participants, particularly the CSA survivors who are the direct beneficiaries of CAI's programs, namely the National Stressful Events Survey PTSD Short Scale (NSESSS) (Annex A.1 English Version and Annex A.2 Local Dialect Version) and the Hamilton Depression Rating Scale (HAM-D) (Annex B.1. English Version; Annex B.2. Local Dialect Version). The NSESSS measured the Post Traumatic Stress symptoms and HAM-D measured the Depressive symptoms.

The Hamilton Rating Scale for Depression (often abbreviated to HRSD, HDRS or Ham-D) was written in the late 1950s by Max Hamilton, a psychiatrist at Leeds University. The scale is still widely used to measure depression. The questionnaire is designed to

be used by a healthcare professional during a clinical interview with an already identified depressed patient. Hamilton suggested that no specific questions needed to be asked during an unstructured interview in a health care setting. He indicated that the value of the questionnaire 'depends entirely on the skill of the interviewer'. The interview should typically take between 15 and 20 minutes and in practice this time taken may well limit its use outside a psychiatric clinical setting.

The National Stressful Events Survey PTSD Short Scale (NSESSS) is a 9-item measure that assesses the severity of post-traumatic stress disorder in individuals age 18 and older following an extremely stressful event or experience. The measure was designed to be completed by an individual upon receiving a diagnosis of post-traumatic stress disorder (or clinically significant post-traumatic stress disorder symptoms) and thereafter, prior to follow-up visits with the clinician. Each item asks the individual receiving care to rate the severity of his or her posttraumatic stress disorder during the past 7 days. Each item on the measure is rated on a 5-point scale (0=Not at all; 1=A little bit; 2=Moderately; 3=Quite a bit, and 4=Extremely). The total score can range from 0 to 36 with higher scores indicating greater severity of posttraumatic stress disorder. The clinician is asked to review the score on each item of the measure during the clinical interview and indicate the raw score for each item in the section provided for "Clinician Use." The raw scores on the 9 items should be summed to obtain a total raw score. In addition, the clinician is asked to calculate and use the average total score. The average total score reduces the overall score to a 5-point scale, which allows the clinician to think of the severity of the individual's posttraumatic stress disorder in terms of none (0), mild (1), moderate (2), severe (3), or extreme (4). The use of the average total score was found to be reliable, easy to use, and clinically useful to the clinicians in the DSM-5 Field Trials. The average total score is calculated by dividing the raw total score by number of items in the measure (i.e., 9).

A socio-economic questionnaire was administered prior to the assessment of the Post-Traumatic Stress Disorder symptoms and Depressive Symptoms (Annex D.1. English Version; D.2. Local Dialect Version).

#### **4.7.2. Guide questions for key informant interview (KII) and focus group discussion (FGD)**

FGD guide questions (Annex E) and KII Guide Questions (Annex F) were used during the FGD and KII, respectively.

#### **4.7.3. Informed consent and assent**

All respondents gave their informed consent and assent (for minors). We used both a written document and oral form for informed consent and assent for minors. For the informed consent forms see Annex EG1. English Version; Annex G.2. Local Dialect Version, and for the assent forms see Annex H.1. English Version; H.2. Local Dialect Version. These forms explained the purpose and interests of the research team, and provided the contact information of the lead proponent and Chair of the Unified Biomedical Research Ethics Review Committee (UBRERC), West Visayas State University (WVSU).

#### **4.7.4. Recruitment of participants**

CAI has provided the following information that has aided the researchers in recruiting the samples for the research:

- Contact information of new entrants, in-house, and aftercare beneficiaries as well as alumni of CAMELEON.
- Contact information of possible FGD and KII participants;
- Annual statistics on the audience reached for the period covering 2012-2017 and list of municipalities targeted;
- Information about the nature of advocacies (child rights and reproductive health) and their corresponding interventions for the period covering 2012-2017; and,
- Other relevant information from the in house documents.

For FGD and KII, the potential participants were formally invited by a letter of invitation that includes the research participant information and informed consent/assent form(s). If the potential participant is a minor, the assent and consent

forms were ensured that they are consistent with the policies of recruiting vulnerable minor research participants of the Philippine National Health Research System (2011) (Annex G.1. English Version of ICF; Annex G.2. Local Dialect Version of ICF) or assent (Annex H.1. English Version; Annex H.2. Local Dialect Version).

#### *Inclusion criteria*

Supposed to be, the study should have included the girls/young ladies who are survivors of CSA: one group the direct beneficiaries of CAI's programs, and the other not receiving support of CAI's program. However, as mentioned earlier, there are circumstances that hinder the participation of the latter. Thus, the new entrants were chosen as proxy for those who did not benefit from the intervention. In the assessment of the advocacy program, the participants are those who attended and participated in the CAMELEON sponsored advocacy campaigns and events from 2012 to 2017.

#### *Exclusion criteria*

Girls/young ladies who were physically but not sexually abused, and those who have not participated in any activities sponsored by CAI were excluded as research subjects. Mentally incapacitated CSA survivors were also excluded because of their highly vulnerable status. Finally, young boys who are survivors of CSA are also excluded from this study because they are not CAMELEON beneficiaries.

### **4.8. Data analysis**

For quantitative analyses, normality of the data was first tested using Shapiro-Wilk test. Results showed that distribution for most data is not normal. Henceforth, non-parametric statistical tools such as Chi square, Wilcoxon Signed-Rank test and Wilcoxon Ranked test were employed. For qualitative analyses, thematic and document analyses were applied.

## **4.9. Ethical review and considerations**

### **4.9.1. Research ethics review**

The Unified Biomedical Research Ethics Review Committee (UBRERC) of the West Visayas State University reviewed the ethical considerations of this research, and it granted ethical approval on the 8th June 2018. The benefits of the ethics review approval are many such as the guarantee that sensitive, private and confidential data, the means of collecting these through our research, as well as the management of these data are ethically responsible. The approval is also a requirement of international journals should the researchers and CAI decides to publish academically the findings of this research.

#### ***4.9.1.1. Data handling***

To maintain confidentiality of the identity of the respondents, the survey instrument was structured in such a manner that personal identification information was separated from the other parts of the instrument. Further, this information was electronically inputted separately from the rest of the survey section during the data encoding.

For FGDs and KIIs, aliases were used in the transcription of interviews as well as in this final report. Real names and their corresponding aliases have been kept separately in password encrypted computers.

#### ***4.9.1.2. Possible harms to participants***

One common reaction to traumatic events is an enduring negative emotional reaction to reminders of the event. Reminders of the event can trigger distress including anxiety and general upset. The survey asks participants about their experiences, therefore, there is the potential for this research to trigger emotional distress in reactive participants. A layered system of protection was set up in order to mitigate potential distress.

The initial layer was the voluntary mechanism of recruitment. Participants were asked to take the affirmative step of agreeing to participate in the research before the actual data collection. Second, participants were made to understand and sign the informed consent which contained the process and consequences in participating in the research. Dr. Diosdado Amargo, the research team psychiatrist, managed the survey. Any clinical symptoms manifested by the participants during the survey which require immediate attention or follow up therapy was referred to the in-house psychiatrist of CAI, Dr. Valerie Heena Andora-Quilaton, for appropriate management.

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## 5. Outputs of CAI programs and their analyses

This section presents the outputs of the three programs of CAI: the In-house (Residential) Care Program, the After-Care (AC) Program, and Advocacy and Education and Development Program (AP). We present the outputs per program, highlighting the basic needs provided (e.g., food, health, shelter, safety, security, and education) and psycho-social interventions in the IH and AC; number of girls who were supported in the two programs; and the number of awareness campaign on child's rights launched, listing of nature of awareness campaign, its target audience and number of participants as well as the number of tools produced and number of individuals who have received these tools in CAI's advocacy program. The names of research participants quoted in this final report were anonymized in order to respect and protect their privacy.

### 5.1. The In-house program

From 2012 to 2017, around 50 girls were supported by CAI, which is the maximum capacity of Centers 1 and 2. Table 5 below presents the number of girls admitted from 2013 to 2017 and their classification (i.e, newly admitted, those who were reintegrated by the end of the year, and the corresponding to the number of girls who were terminated for that year).

Table 5. The Beneficiaries of CAMELEON Inc. In-House Program, 2013 to 2017.

Year	Total number of girls staying in Centers 1 and 2	# of new girls admitted	# of girls reintegrated to the community	# of girls terminated in the program
2013	50	11	9	3
2014	50	16	12	2
2015	50	13	14	1
2016	50	14	14	0
2017	53	22	15	4
<b>Average</b>	<b>50</b>	<b>15</b>	<b>13</b>	<b>2</b>

Source: Internal Documents and Reports of CAI

The above statistics indicate that CAI maximizes its resources by catering to the maximum capacity of its facility by accepting 50 beneficiaries. At the average, about

one third (15/50) of these girls were admitted for the last 5 years while average of 13 girls were reintegrated to the community in the same period. Notably, only 2 girls on the average were terminated in the program during the 2013-2017, with none in 2016.

General reasons for termination were either violations of CAI policies or pregnancy. Termination of beneficiaries does not necessarily mean a negative action because there are some cases that a parent or a legal guardian requested that their daughter or ward be allowed to leave CAI's facility in order to be reintegrated to their families. In these cases, CAI ensures that the place to which the beneficiary will be reintegrated is safe and secure. In appropriate cases, the financial capacity of the family to support the beneficiary is also being assessed before a beneficiary is re-integrated to her family.

### **5.1. 1. Education support**

Educational support of CAI is one of its basic and core functions. Though not supported by the Luxembourg Government, CAI has supported the **formal education** of their beneficiaries in the IH Program (Table 6), Majority of the girls were enrolled in elementary and high school (91%). There were also a few who were enrolled in special education (2.4%) and some who were enrolled in colleges (6.8%).

During the FGD with young ladies (n=11) who once were under the IH program, free education is a dominant and significant theme that the beneficiaries identified. The importance and impacts of the educational support to the beneficiaries will be discussed more in subsequent sections. For now, we have presented some statistics on the educational support of CAI, as well as a brief note on what beneficiaries say about it. For example, there were three sets of sisters who participated in the FGD, one of the sets claimed that,

*“Without the educational support of CAI, we could not go to senior high school and college because our family could not afford our education” (Fides, pers. com 2018).*

The message in the quote above is a common theme among beneficiaries (CSA cases and non-CSA cases under the Advocacy Program of CAI) and their parents. This report will discuss the significance of the educational support of CAI and what it means to the beneficiaries and their families (see Section 6.9 below).

Table 6. Educational levels of girls under the IH program funded by the Government of Luxembourg, 2013 to 2017.

Year	Distribution of girls under the in-house program by level of education								Total	
	SPED	%	Elementary	%	High school	%	College	%	N	%
2013	1	2.00	29	58.00	17	34.00	3	6.00	50	100
2014	3	6.00	17	34.00	24	48.00	6	12.00	50	100
2015	1	2.00	25	50.00	19	38.00	5	10.00	50	100
2016	0	-	21	42.00	27	54.00	2	4.00	50	100
2017	1	1.96	21	41.18	28	54.90	1	1.96	51	100
<b>Average</b>	<b>1</b>	<b>2.39</b>	<b>23</b>	<b>45.04</b>	<b>23</b>	<b>45.78</b>	<b>3</b>	<b>6.80</b>	<b>50</b>	<b>100</b>

Source: CAMELEON Internal Documents and Annual Reports (2013-2017).

### 5.1.2. Legal services

**Legal support** is one of the services offered by CAI's IH Program as it reflects CAI's assistance in the prosecution of perpetrators of CSA. Table 7 summarizes the yearly legal status of cases of IH beneficiaries. Out of 50 girls, around 34 to 44 cases were filed. Reasons for not filing cases included the unwillingness of some of the beneficiaries to file a formal complaint because the perpetrator is a member of their family (i.e., incest cases are numerous among CAI beneficiaries), the perceived costs of the legal process and the length/duration of the same process. Despite the legal support of CAI and of DSWD, cases were very slow to progress. It takes 5-7 years with a public prosecutor to reach a trial (AFA, 2016, p. 5) This may be attributed to the broader culture of the Philippine legal system where cases are generally processed very slowly (see AFA et al., 2016).

During the FGD, parents or legal guardians of beneficiaries shared their frustrations of the progress of the cases. For example, Hope, a legal guardian of one of the beneficiaries, claimed that,

*“The fiscal of our town showed very little interest in the rape case of my niece. The perpetrator is known and he has moved to another town not far from our town in Negros Island” (pers.com2018).*

In another case, Fe, a mother of one of the beneficiaries who was raped, said that the

trial is very slow.

*“It takes 3-4 months before a hearing takes place in Iloilo City. We live outside of the city but our town’s MSWDO gives me money to travel for the hearing. It is just time-consuming and without the support we receive, we would not afford this legal procedure,”*  
 according to Fe (pers. com 2018).

Clearly, these are claims about the problems that victims of CSA and their families face when litigating cases. Table 6 below presents the number of cases filed and not filed from 2013 to 2017 as well as their corresponding status. Though some information are not available from CAI documents.

Table 7. Status of legal support to girls under the In-house program funded under the Government of Luxembourg Funding

Year	Number of Cases			Status of Legal Cases									
	Cases Filed	Case Not filed	Total	On-filing process	On-trial	%	Pending	%	Litigated/Promulgated	%	Case closed (death of perpetrator)	%	Total
2013	44	6	50	n.a.	17	38.64	18	40.91	7	15.91	2	4.55	44
2014	44	6	50	n.a	n.a	n.a	n.a	n.a	n.a	n.a	n.a	n.a	n.a
2015	42	8	50	9	21	n.a	10	n.a.	2	n.a.	n.a.	n.a.	n.a.
2016	37	13	50	0	21	n.a	13	n.a.	3	n.a.	n.a.	n.a.	n.a.
2017	34	14	n.a.	n.a.	14	n.a	19	n.a.	1	n.a.	n.a.	n.a.	n.a.
<b>Ave</b>	<b>40</b>	<b>9</b>	<b>50</b>	<b>4.5</b>	<b>18</b>		<b>12</b>		<b>3</b>		<b>2</b>		

Sources: CAMELEON Annual Accomplishment Reports, 2013-2017.  
 n.a.= not available

### 5.1.3. Arts and sports activities

Another important service under the IH was their immersion to **arts, circus, sports, and other outdoor activities**. In the academic literature, it is well-documented that arts and sports therapy have big potentials in helping develop resilience and other coping mechanisms among children survivors of traumatic experiences including CSA (D’andrea et al., 2013; Gil, 2012; Goodyear-Brown, 2012; Malchiodi, 2012; Lanes &Decatoria, 2011). In the Philippines, the use of clay for artsy purposes was reported to develop the resilience of Filipina survivors of CSA (Lanes &Decatoria, 2011). In

CAI’s program, the use of art such as drawings and sketches have been integrated into the activities of the beneficiaries to help them express their feelings, thoughts, emotions and aspirations.

Drawings, sketches and personal diaries abound the portfolios of the beneficiaries when the research team reviewed the individual documents. Some of the drawings and sketches that were noted portray diverse images that illustrated a spectrum of emotions such as happiness, thankfulness, safety, joy, anger, confusion, sadness, hope, among many others. Malchiodi argued that many children survivors of sexual abuse “use art expression to create visual symbols and metaphors to describe what happened” to them (Malchiodi, 2012: 341).

Circus has evolved into a popular activity among CAI’s beneficiaries. It can be seen from Table 8 that all girls have undergone circus training, with 34% in 2013, 20% in 2014 and 18% in 2017 of these girls becoming circus trainers and performers. Circus has evolved into one of the sports-related and group activities in CAI where all girls are encouraged to participate in various sports and outdoor activities. What follows is an illustration (Table 8) of the participation of CAI beneficiaries in circus, sports and outdoor activities.

Table 8. Participation in circus and other sports and outdoor activities that was funded under the Government of Luxembourg, 2013 to 2017.

Year	# of girls who have undergone circus training	# of girls identified as circus trainers and performers		# of girls who has participated to sports and other outdoor activities
2013	50	17	34%	50
2014	50	10	20%	50
2015	50			50
2016	50	15		50
2017	53	17	18%	50

Source: CAMELEON Annual Accomplishment Reports, 2013-2017.

#### **5.1.4. Output from other activities that was funded by the Government of Luxembourg under the In-house program**

Equally important are outputs from **other activities in the IH such as the psycho-social intervention, health assessment, as well as practical and life skills trainings**. The psycho-social intervention is provided to girls based on the findings, assessment, and diagnosis hinged on case-specific observations and treatment plan of each girl. This is reminiscent of the case management approach presented in the literature review. That is, the literature suggests that individual case management approach is considered as one of the most common and effective approach in the recovery and healing of CSA survivors. In the case of CAI, the interventions are facilitated through the collaborative efforts of social workers, house mothers, external psychologists and/or psychiatrists. Through its psycho-social interventions, all the girls have undergone individualized treatment on the basis of their psychological evaluation. All the girls also participated in group/ individual counseling sessions that will address their individual issues, problems and concerns. One remarkable output of the psycho-social intervention is the overcoming of some girls their borderline psychotic disorders. Case conferences are regularly conducted with a local social worker, families and child if need arises for behavioral modification of the girl and to strengthen the support of the family.

Regular **health assessments** were conducted to all IH girls especially those who have regular treatment and maintenance medication by CAI nurse in close coordination with the housemothers. During this reporting period, the common illnesses encountered by the girls in the center and were given immediate response are cough, fever, skin allergies, body pains, hyperacidity, urinary tract infections and tonsillitis. Moreover, availability of basic medicines for the common illnesses and first aid treatments are being ensured in the Center through regular monitoring and inventory. Likewise, CAI continuously works with the local health providers that provide support to the health needs of the beneficiaries.

**Practical and life skills training** is being instituted to prepare the girls for future economic independence necessary for their eventual reintegration. All the IH girls are

enjoined to participate in these sessions as they are conducted during the girl's free time either on a weekend or during holidays. This program was regularly implemented to foster positive values and skills to improve the competencies in practical life and for personality development.

## 5.2. After-care program

Once the girls are ready for reintegration to the wider community, they are moved to the AC Program. Over the 5-year period, the average number of girls enrolled in the AC is 59. At the average, 21 of these girls are reunited with their biological parents while 16 were staying in the boarding houses, 10 were staying in the CAI facility, 6 with friends and 4 with foster parents (Table 9). The safety and security of those who are not reunited with their families as well as legal issues are the main reasons why some of these beneficiaries are not entrusted to their biological families.

Table 9. Number of Government of Luxembourg-sponsored girls enrolled in AC program.

Year	Total # of girls enrolled in the program	% of new girls in the program	# of girls placed under foster/parents	# of families placed with friends	# of girls accommodated under CAMELEON facility	# of girls reunited with biological parents	# of girls in boarding houses
2013	53	n.a	5	n.a.	14	20	14
2014	64					14	
2015	57	14	6		10	23	18
2016	60		5	6	11	22	16
2017	61		5		15	28	
<b>Average</b>	<b>59</b>	<b>14</b>	<b>4</b>	<b>6</b>	<b>10</b>	<b>21</b>	<b>16</b>

Source: CAMELEON Annual Accomplishment Reports, 2013-2017.

Meanwhile, during the 5-year study period, 29 girls successfully concluded the program. Those who did not complete the program were either due to suspension (9)

or were terminated (6) (Table 10). Grounds for termination may include pregnancy, transgression with major rules, living with boyfriend/girlfriend, getting married, preferring to work and moving out of the service area.

Table 10. Number of girls that were suspended, terminated and graduated in the AC Program from 2013 to 2017

Year	# of girls under suspension	# of girls terminated from the program	# of girls successfully concluding the program
2013	5	2	2
2014	4	4	7
2015			6
2016			14
2017		6	
<b>Average</b>	<b>9</b>	<b>12</b>	<b>29</b>

Source: CAMELEON Annual Accomplishment Reports, 2013-2017.

### 5.2.1. Education

The AC program supports girls across a wide range of educational levels. During the 5 years study period, about half of the girls are enrolled in college or vocational courses (Table 11). In close second are girls enrolled in the secondary level. It is worth noting that CAI supports one girl who is taking her post graduate degree and that it also supports the education of differently-abled beneficiaries.

Table 11. Distribution of girls under the AC Program by level of education

Year	Distribution of girls under the After-Care Program by level of education					Total
	Special Education	Elementary	Secondary	College/Vocational	Post-graduate	
2013	3	2	20	27	1	53
2014	3	2	18	28	1	52
2015	2	2	19	33	1	57
2016		3	27	24		54
2017		3	41	16		60
<b>Average</b>	<b>3</b>	<b>2</b>	<b>25</b>	<b>26</b>	<b>1</b>	<b>55</b>

Source: CAMELEON Annual Accomplishment Reports, 2013-2017.

### 5.2.2. Legal assistance

Just like the IH program, legal assistance is provided to girls under the AC program (Table 12). In 2017, there are 13 on going cases likewise, 13 girls opted not to file a case. Remarkably, a case was successfully concluded in 2013 while 18 cases were pending in 2015. Some cases were not successful because some beneficiaries opted for an out of court settlement and others for a plea-bargaining agreement. The primary reason why cases do not prosper is that the survivors opt not to file a formal charge because perpetrators happen to be an immediate family member who stands as the family’s breadwinner. For example, in 2017 of the 27 cases under the guidance of CAI, 13 were not continued because the 13 girls opted not to file complaints or charges. These legal concerns are not lost to the foundress of CAI, Laurence Ligier, when she shared that:

*“For us and to the girls, it’s a big challenge because it takes 6 years to 10 years per case to be processed. Postponement, other strategies to delay the case such as to reduce the case of rape to acts of lasciviousness, or strategies to pay the family and, a lot of things. are some of the reasons why cases are lengthy processes”*

*(Laurence, pers.com, May 2018)*

Table 12. Number of girls given legal assistance by CAI from 2013 to 2017.

Year	Legal status of cases					
	On-going cases	Pending	Out-of-court settlement	Girls opting not to file a cases	Plea bargaining agreement	Successfully concluded
2013	7	1				1
2014	5					
2015	8	18				
2016	7				3	
2017	13		1	13		

Source: CAMELEON Annual Accomplishment Reports, 2013-2017.

### 5.2.3. Other support services extended

Psycho-social services to beneficiaries under the AC Program may be in the form of sessions with the psychologists/ psychiatrists or engagement in sports and

recreational activities. In 2013, five girls were having regular sessions with the psychiatrist and one of the five was provided with maintenance medication. It is worth noting that with the support extended to the beneficiaries in enhancing their skills in sports, one AC girls was able to participate in an international bowling competition and bringing home a silver medal.

All girls under the AC program undergo annual medical checkup. Regular treatment and maintenance medication were provided by CAI nurse in close coordination with the housemothers or social workers. CAI continuously works with the local health providers that could provide support to the health needs of the AC program beneficiaries.

Just like the girls in the IH Program, capability buildings were also provided to girls in the AC Program. Some graduates in 2013 were able to acquire the skills and eventually getting a full-time job.

### **5.3. The Advocacy and education and development program**

#### **5.3.1. Scholarship and training programs**

Educational support of CAI is one of its basic and core functions. Under this program, CAI also provides scholarships to local, poor but deserving youths in Passi City, and the municipalities of San Enrique, and Bingawan.

In 2013, CAI sponsored 300 school-children (Table 13). The number of beneficiaries has increased to 310 per year from 2014 to 2017. Out of these scholars, 100% were promoted to the next level every school year from 2013 to 2015. Promotion rate to the next level has dropped to 95% in 2016 and 2017. Pregnancy of the beneficiaries is the major reason cited. The beneficiaries were not only promoted to the next level but a number (45 beneficiaries) of them received academic and other awards. One commendable output is that 86% of the scholars are immediately getting employed.

CAI's assistance transcends the youth. It has also provided training programs to the parents of the scholars benefitting 57 to 285 parents annually.

Table 13. Number of beneficiaries of CAI’s Scholarship and Training Programs from 2013 to 2017.

Year	# of sponsored children	Educational Support												# of beneficiaries receiving academic and other awards	% age of beneficiaries who have finished tertiary education and who are employed	# of parent leaders who have attended various training workshops
		Elementary				High School				College						
		Non-graduating	Graduating	Graduated	% age of graduating scholars that has graduated	Non-graduating	Graduating	Graduated	% age of graduating scholars that has graduated	Non-graduating	Graduating	Graduated	% age of graduating scholars that has graduated			
2013	300	2	3	3	100%	49	32	33	100%	194	20	19	95%	43	91%	285
2014	310	1	3	3	100%	38	39	39	100%	154	75	74	98.60%	47	88%	52
2015	310	N/A	1	1	100%	32	54	54	100%	167	57	56	98.24%	61	85%	104
2016	310	N/A	N/A	N/A	N/A	90	30	30	100%	154	36	34	94.44%	36	84%	156
2017	310	N/A	N/A	N/A	N/A	118	0	0	-	159	33	31	93.94%	36	84%	57
Ave	308													45	86%	149

Source: CAMELEON Annual Accomplishment Reports, 2013-2017.

### 5.3.2. Sports and circus program

As part of the AP, CAI is also into sports and circus. They were able to present a total of 37 circus shows for the last 5 years reaching 26,880 individuals (Table 14). On an annual basis, the average number of beneficiaries of the sports program is 389 while the beneficiaries of the recreation program is 365. The circus show is an example of an avenue where girls from CAI interact with the public.

Table 14. Number of beneficiaries of various sports, recreation, and circus activities of CAI from 2013 to 2017.

Year	# of beneficiaries of the sports program	# of beneficiaries to the recreation program	Circus	
			# of shows conducted	# of individuals reached
2013	403	352	7	5100
2014	400	356	6	6880
2015	400	346	12	6000
2016	339	382	7	4300
2017	401	390	5	4600
<b>Total</b>	<b>1,943</b>		<b>37</b>	<b>26,880</b>
<b>Average</b>	<b>389</b>	<b>365</b>		

Source: CAMELEON Annual Accomplishment Reports, 2013-2017.

### 5.3.3. Health advocacy program

CAI's Advocacy and Education and Development Program (AP) promotes the health of its beneficiaries. This is achieved through lectures and symposia, as well as medical, dental and optical missions. These interventions were efficiently translated to the overall state of health of all the beneficiaries, especially under the IH and AC programs. On the average, 96.4% of CAI's beneficiaries are categorized as healthy (Table 15).

Table 15. Number of beneficiaries of various health advocacy activities of CAI from 2013 to 2017.

Year	%age of the direct beneficiaries who are healthy	Lecture/ symposia			Medical/dental mission		
		# of members of CYHA	# of lectures/ symposia conducted	# of participants	# of beneficiaries in the medical mission	# of beneficiaries in the dental mission	# of beneficiaries availing of the services of an optometrist
2013	98%	-	-	-	326	34	27
2014	96%	-	-	-	53	44	45
2015	95%	19	7	310	251	83	129
2016	97%	24	11	1300	356	356	356
2017	96%	26	16	1491	380	76	30
<b>Total</b>		<b>69</b>	<b>34</b>	<b>3,101</b>	<b>1,366</b>	<b>593</b>	<b>587</b>
<b>Average</b>	<b>96.4%</b>						

Source: CAMELEON Annual Accomplishment Reports, 2013-2017.

Two youth organizations were established that help strengthen CAI's AP: (1) Voice of CAMELEON Children (VCC); and (2) CAMELEON Youth Health Advocates (CYHA). The VCC was awarded the Presidential TAYO award (Ten Accomplished Youth Organization) in its advocacy in indigenous communities in San Enrique on February 2017. CYHA is a group of youth advocates as peer educators advocating sex education, sexuality, and pregnancies.

#### 5.3.4. Livelihood and skills development training

CAI provides livelihood opportunities to families of their scholars/beneficiaries that will supplement their family income. During the 5-year period (i.e., 2013-2017), a wide range of skills training were available. Examples include garments production, baking, vegetable production, native chicken, massage, sewing, beauty culture and hair styling, table skirting and many others. The number of beneficiaries for each of this special skills training are presented in Table 16. A sense of community among the beneficiaries was also promoted by CAI. In 2016, three community-based projects were established, which are a bakery in Bingawan, a farm in Gines, San Enrique, and a group of women who are into sewing.

Table 16.Number of beneficiaries of various skills trainings sponsored by CAI from 2012 to 2016.

Skills training conducted and number of beneficiaries													
Year	# of families benefiting of differed livelihood and skills trainings	Garment production (mother)	Bakery/ Commercial baking (mothers)	Vegetable production (families)	Native Chicken production (families)	Massage	Sewing	Food processing and preservation	Computer literacy	Beauty culture and hairstyling	Table skirting and flower arrangement	Others	Community based Project Established
2013		15	20				15		10	20		15	
2014									10	25	25		
2015	150		43		31	22	17	19	20*	50	25*		
2016	113	13		12	24				20				2
2017	123	13	10	17	34	8							

Source: CAI Annual Accomplishment Reports, 2013-2017.

\*with girls

\*\*TESDA certified

### 5.3.5. Advocacy and education and development program (AP)

This program aims at raising social awareness on the issue of Child Protection and Children’s Rights Promotion. CAI hopes to minimize the cases of child abuse and exploitation and improve the treatment of these situations.

The following table shows the number of individuals which in CAI advocacy program. For the last five years, CAI has reached a total of 30, 459 composed of students, community leaders, parents and teachers. In addition, VCC has reached 2,400 students and 927 parents in their advocacy activities. *Breaking the Silence Conference*, an annual gathering of youth leaders has brought together a total of 200-270 youth leaders all over Western Visayas since 2015. Moreover, the Circus and theater of CAI reached a total of 15,380 audiences. CAI’s advocacy was also aired in both TV and radio (Table 17).

Table 17. Number of audiences reached by the various activities under the Advocacy Program of CAI from 2013 to 2017 (Source: CAMELEON Annual Accomplishment Reports, 2013-2017).

Year	Audience reached and their distribution					Voices of Cameleon Children		# of attendees to the Breaking the Silence Conference	Circus and Theater Audience	TV appearances	Radio Guestings
	# of students reached	# of community leaders reached	# of parents reached	# of teachers reached	Others (unclassified)	# of student-beneficiaries	# of parents reached				
2013	540									1	3
2014	2744				1417				6880		14
2015		918	201	2054		2400	927	270			
2016	6873		2580	822				200	2500		
2017	7415	507	3593	795					6000		

## **6. Outcomes of CAI programs and their analyses**

### **6.1. Socio - demographic profile of respondents**

In retrospect, survey was conducted to measure the quantitative outcomes and impacts of CAI to its direct beneficiaries.

As discussed in the literature, the socio-demographic status of the participants is an important explanatory variable in trying to explain one's overall well-being. Looking back at the study framework, the improvement in the beneficiaries' well-being is the key result area especially for both the IH and AC Programs. The socio-demographic indicators included in this study are: age, highest educational attainment of the beneficiaries before the CAI intervention, current educational status of the beneficiaries at the time of the survey, the age of the household head, the highest educational attainment of the head of household, the household size, % of male in the household, % of female in the household, and the % of household 18 years old and older who are currently employed.

#### **6.1.1. Respondents' age and educational attainment before and after CAI intervention**

Table 18 summarizes the age and the level of education before and after CAI intervention. The above-mentioned socio-demographic variables are also compared across the different groups of respondents. The average age of a respondent is 19 years and 3 months old, and in Grade 8 or 2nd year in high school at the time of admission to CAI. Prior to the intervention, these girls have an average of 7.48 years of schooling. The average years in school after the intervention particularly for the new entrants and the in-house girls is not determined because duration of CAI's intervention is contingent upon each of the girls progress and hence cannot be ascertained.

Table 18. Age and educational attainment before and after CAI intervention of respondents, 2018

Variable	New-entrants	In-house	After care	Alumni	All
Age (years)					
Maximum	17	18	29	27	29
Minimum	10	13	18	23	10
Mean	13.14	16.13	20.53	25	19.25
Std. dev.	2.73	2.03	2.87	1.31	4.67
No, of years in school before CAI intervention					
Maximum	10	13	11	12	13
Minimum	5	5	0	3	0
Mean	7.29	10.25	6.29	7.38	7.48
Std. dev.	2.06	3.06	3.42	3.25	3.35
No, of years in school after CAI intervention					
Maximum	n.a.	n.a.	16	18	18
Minimum	n.a.	n.a.	9	5	5
Mean	n.a.	n.a.	12.71	12.88	7.78
Std. dev.	n.a.	n.a.	1.72	4.45	6.66

### 6.1.2. Age and educational attainment of household head of respondents

Equally important in analyzing the impact of CAI's intervention, as the individual personal profile of the girls is the knowledge of the background of the households these girls came from. Table 19 summarizes the age and the level of education of the household heads these girls came from. The table also summarizes the profile for each group of respondents. Generally, the average age of head households is 41.16 years old and having spent 8.26 years in school (about second year high school).

Table 19. Age and educational attainment of household head of respondents, 2018.

<b>Variable</b>	<b>New-entrants</b>	<b>In-house</b>	<b>After care</b>	<b>Alumni</b>	<b>All</b>
Age (years)					
Maximum	52	48	65	66	66
Minimum	32	n.a.	n.a	29	-
Mean	44.43	33.14	42.13	43.71	41.16
Std. dev.	6.53	15.91	18.58	15.88	15.86
No, of years in school					
Maximum	13	14	13	12	14
Minimum	2	n.a.	2	10	2
Mean	7	9.13	7.38	10.25	8.26
Std. dev.	4.12	4.76	4.27	0.71	3.97

### **6.1.3. Household size and percentage of male HH members, percentage of educated HH members, and percentage of employed HH members**

Table 20 shows the comparative household size, percentage of household members that are male, percentage of households that are educated and the percentage of household members who are employed across respondent groups. On the average, average size of households where the respondents came from is 6 of which about 43% is composed of male household members. Prior to CAI's intervention, 71.6% of the household member 10 years old and above are educated. Generally, 36.83% of the household members where these girls came from are unemployed prior to CAI's intervention.

Table 20. Household size, percentage of household members who are male, percentage of household members who are educated and percentage of household members who are employed, 2018.

Variable	New-entrants	In-house	After care	Alumni	All
Household size					
Maximum	9	8	12	8	12
Minimum	5	n.a.	2	2	-
Mean	7.57	5.63	5.82	5	5.93
Std. dev.	1.62	2.56	3.07	1.93	2.61
% of male HH members					
Maximum	57.14%	62.5%	66%	75%	75%
Minimum	20%	28.57%	20%	33.33%	20%
Mean	38.8%	46.13%	41.89%	48.65%	43.5%
Std. dev.	12.5%	11.2%	12.17%	16.81%	13.16%
% of educated HH members					
Maximum	100%	83.33%	100%	100%	100%
Minimum	55.56%	50%	20%	50%	20%
Mean	73.5%	64.97%	64.78%	88.54%	71.6%
Std. dev.	16.39%	12.56%	23.03%	42.94%	26.99%
% of employed HH members					
Maximum	50%	100%	66.67%	100%	100%
Minimum	0	n.a.	0	0	0
Mean	31.43%	47.22%	28.3%	51.88%	36.83%
Std. dev.	18.64%	32.35%	23.28%	46.08%	30.65%

## 6.2. Improvement on health and well-being

One of the outcomes of CAI intervention is improvement of the general well-being of the beneficiaries. This will be quantitatively measured by PTSD and HAM-D.

Post-Traumatic Stress Symptoms (PTSD Scores) and Depression Symptoms (HAM-D Scores) were used to determine the well-being of the beneficiaries as these are the two (2) most common consequences of abuse or traumatic experiences. Higher the PTSD and depression scores would equate to reduction in functionalism (Polychronopoulou, 2016). Functionality refers to how well one is meeting the various problems of day to day living in terms of social, occupational and psychological functioning. Higher PTSD and Depression Scores would mean that these beneficiaries

have obstacles in doing their daily activities owing to the depth of their depressive and post-traumatic stress symptoms. These high scores would also correlate to poor coping strategies and self-efficacy (Guerra, 2018) and greater emotion regulation difficulties (Chang, 2018). Coping skills help the beneficiaries deal with problems and life's stresses. When they have poor coping skills, they may manifest with becoming upset and emotional too quickly even over trivial things and they may resort to alcohol or substance use, sexual promiscuity, self-blaming and self-harm such as suicide or suicidal tendencies/attempts. They may also become withdrawn which may further aggravate their depressive symptoms. Emotional self-regulation or regulation of emotions refers to the capacity of the beneficiary to respond to the on-going demands of their experience in a manner that is socially acceptable and sufficiently flexible. This will also account for their capacity to delay gratification of their needs. Reduced PTSD Symptoms would equate to better functionality, better coping, and better emotional regulation. This would mean that beneficiaries have attained stability and resiliency and possibly healing of their traumatic experience.

**a. PTSD scores**

Comparing the PTSD mean scores of the four (4) group of beneficiaries namely, the new entrants, the IH, the AC and the alumni, the impact of the CAI's program in terms of reducing the Post Traumatic Stress symptoms of the beneficiaries can be appreciated. Table 21 shows the comparison of PTSD scores between new entrants, IH girls, AC girls, and Alumni.

Table 21. Comparison of PTSD scores between new entrants, IH girls, AC girls, and alumni

Particulars	Count	Mean	Std.dev.	Min	Max	
New entrants	8	1.88	0.81	0.56	3.11	$\chi^2= 19.266^{***}$ p=0.0025 S
In-house	8	0.53	0.41	-	1.33	
After care	17	1.01	0.53	0.11	2.11	
Alumni	8	0.32	0.26	-	0.78	
Total	41	0.95	0.74	-	3.11	

A Kruskal-Wallis H test was conducted to determine if the PTSD score among respondents was different for the four groups: (1) newly-admitted girls (n=8); (2) in-house girls (n=8); (3) girls in the after-care program (n=17); and, (4) alumni (n=8). A Kruskal-Wallis H test showed that there is a statistically significant difference between the four groups,  $\chi^2(3) = 19.266, p = 0.0002$ .

As expected, symptoms of PTS are high with the new entrants with mean score of 16.875. This is consistent with the findings of Ba (2017) in the systematic review of health outcomes of sexual violence where post-traumatic stress symptoms range from 3.1 to 75.9% among survivors. However, with psychosocial interventions of the IH girls, the mean score was lowered to 4.750. This means that the PTS symptoms were successfully muted because of the combination of interventions implemented and referral to a psychiatrist while they are living in the center. As the girls were reintegrated with their biological or foster families, boarding houses, and similar environments during their AC program, they were again exposed to the community. These girls might have encountered stimuli in the community that may have reminded them of the trauma (which is often the case in PTSD), hence the increase in the mean PTSD score of 9.12. The mean score of Alumni who successfully graduated from the CAI program, significantly decrease to 2.875. This would mean that the healing of the PTSD symptoms was eventually reached.

The severity of the post traumatic symptoms of the participants was accounted by using their average scores in the National Stressful Events Survey for PTSD-Short Scale (NSESSS-PTSD). Following the interpretation of the NSESSS-PTSD, the means of scale used were as follows:

Average Score	Classification
0 - 0.5	None
1.6 - 2.5	Moderate
2.6 - 3.5	Severe
3.6 - 4	Extreme

The New Entrants had the most number of participants suffering from PTSD symptoms with 62.5% having moderate symptoms, 12.5% each for severe and mild

symptoms (Table 22). This was followed by the After Care group where 70.6% of the participants have mild PTSD symptoms and 5.9% for moderate symptoms. The In-house participants only demonstrated mild symptoms of anxiety for 3.75% of the group. This is true as well with the Alumni where only 12.5% of the group has mild symptoms of PTSD and the rest have no symptoms.

Table 22. Comparison of PTSD degree across groups of respondents, CAI, 2018.

PTSD Degree	Type								Total	
	New entrants		In-house		Aftercare		Alumni			
	Freq	%	Freq	%	Freq	%	Freq	%	Freq	%
None (0 to 0.5)	1	12.5	5	62.5	4	23.5	7	87.5	17	41.46
Mild (0.6 to 1.5)	1	12.5	3	37.5	12	70.6	1	12.5	17	41.46
Moderate (1.6 to 2.5)	5	62.5	0	0	1	5.9	0	0	6	14.63
Severe (2.6 to 3.5)	1	12.5	0	0	0	-	0	0	1	2.44
Extreme ( 3.6 to 4)	0	0	0	0	0	-	0	0	0	-
<b>Total</b>	<b>8</b>	<b>100</b>	<b>8</b>	<b>100</b>	<b>17</b>	<b>100</b>	<b>8</b>	<b>100</b>	<b>41</b>	<b>100.00</b>

Regardless of severity, the following symptoms of post-traumatic stress were observed among the participants (Table 23). Intrusions (100%) is universal among New Entrants. This is closely followed by dysphoria, avoidance and anhedonia (88%). Negative emotions, hypervigilance, hyperarousal and irritability were highly present among them as well (75%).

Among the In House group, avoidance and negative emotions were present in more than half of the participants (63%). Half of the group has hyperarousal and irritability (50%), while more than a third has intrusions and dysphoria (38%). A few has symptoms blaming, anhedonia and hyper vigilance (13%).

Dysphoria and negative emotions (82%) were predominant among the After Care group manifesting in more than three quarters of the population. This was followed closely by avoidance (76%). Blaming, hyperarousal and Irritability (59%) were also seen in more than half of the group as well as intrusions and hypervigilance (53%). Anhedonia was present in a just a little more than a quarter of the population.

Hypervigilance was present among half of the Alumni population and followed by hyperarousal (38%). A quarter of them have both Intrusions and Blaming and the rest have dysphoria, avoidance, negative emotions and irritability (13%). Anhedonia was absent among the Alumni group.

(The operational definition of the post traumatic stress disorder symptoms used in this study can be found in the Annex J)

Table 23. Comparison of PTSD symptoms across groups of respondents, CAI, 2018.

PTSD Symptoms	New Entrants		In House		After Care		Alumni		Total	
	Freq	%	Freq	%	Freq	%	Freq	%	Freq	%
Intrusions	8	100.00	3	37.50	9	52.94	2	25.00	22	53.66
Dysphoria	7	87.50	3	37.50	14	82.35	1	12.50	25	60.98
Avoidance	7	87.50	5	62.50	13	76.47	1	12.50	26	63.41
Blaming	6	75.00	1	12.50	10	58.82	2	25.00	19	46.34
Negative Emotions	6	75.00	5	62.50	14	82.35	1	12.50	26	63.41
Anhedonia	7	87.50	1	12.50	5	29.41	0	-	13	31.71
Hypervigilance	6	75.00	1	12.50	9	52.94	4	50.00	20	48.78
Hyperarousal	6	75.00	4	50.00	10	58.82	3	37.50	23	56.10
Irritability	6	75.00	4	50.00	10	58.82	1	12.50	21	51.22

The seeming healing of PTSD symptoms is reported by CAI alumni as follows:

*“Everything happens for a purpose. I still felt blessed and lucky to have been given support and care by CAMELEON” (Rita, pers. com, 2018);*

*“There are far more people who are in worst situation than I am, hence, it is useless to dwell in the past” (Sol, pers. com, 2018);*

*"I have already forgiven my father" (Megan, pers. com, 2018);*

*"I have accepted the incident. I saw the abuser and I no longer felt afraid" (Tina, pers. com, 2018).*

These positive statements from CAI alumni clearly illustrate how they associate their recovery from traumatic experiences with CAI and the support it gave. Statements alluding to forgiveness, acceptance, moving on, moving forward, being blessed and the like suggest a positive view of their present well-being. These positive statements could be associated with good coping strategies and positive self-efficacy. As mentioned previously, coping strategies and self-efficacy have been shown in studies to be correlated with PTSD and depression (Guerra, 2018). Thus, if beneficiaries report that they cope with their traumatic past (and correlated with their PTSD and depression scores), these information clearly indicate their recovery and healing are heading in positive directions. Indeed, coping skills help the beneficiaries deal with life's challenges, problems and stresses.

#### **b. HAM-D scores**

A Kruskal-Wallis H test was conducted to determine if the HAM-D score among respondents was different for the four groups: (1) newly-admitted girls (n=8); (2) in-house girls (n=8); (3) girls in the after-care program (n=8); and, (4) alumni (n=8). A Kruskal-Wallis H test showed that there is a statistically significant difference between the four groups,  $\chi^2(3) = 14.279, p = 0.0025$ . Refer to Table 24.

Like in the PTSD scale, the depression mean score of the new entrants were high at 17.625. This is also consistent with the findings of Ba (2017) in the review of health outcomes of sexual violence where depressive symptoms range from 8.8 to 76.5%. However, these mean scores of the girls during IH program lowered to 3.875 because of the intervention of CAI and became high again during the AC as the girls were exposed again to the stresses and complexities of life in the wider community. The depressive symptoms finally became almost negligible at 3.125 when they become alumni.

Table 24. Comparison of HAM-D scores between new entrants, IH girls, AC girls, and alumni, CAI, 2018.

Particulars	Count	Mean	Std.dev.	Min	Max	
New entrants	8	17.63	7.42	2.00	26.00	<b>X<sup>2</sup>= 14.279*** p=0.0025 S</b>
In-house	8	3.88	2.23	-	6.00	
After care	17	7.18	5.08	-	18.00	
Alumni	8	3.13	2.53	-	6.00	
Total	41	7.78	6.99	-	26.00	

Source: Authors calculations.

The total HAM-D Scores of the participants were group and following the directions of the authors, they were classified as follows:

Total HAM-D Score	Classification
0 - 7	Normal
8-13	Mild Depression
14-18	Moderate Depression
19-22	Severe Depression
23 and up	Very Severe Depression

Half of the New Entrants showed symptoms of Severe Depression, a quarter of them have Moderate Depression, and 12.5% displayed symptoms of Very Severe Depression (Table 25). Mild and Moderate Depression were present both in 17.65% of the participants in the After Care group. The In house and the Alumni group did have participants who were clinically depressed.

Table 25. Distribution of respondents by level of depression hinged on HAMD Score, CAI, 2018.

Level of depression	Type								Total	
	New entrants		In house girls		After-care		4	Alumni		
	Freq	%	Freq	%	Freq	%	Freq	%	Freq	%
Normal (0 to 7)	1	12.50	8	100.00	11	64.71	8	100.00	28	68.29
Mild depression (8 to 13)	0	-	0	-	3	17.65	0	-	3	7.32
Moderate depression (14 to 18)	2	25.00	0	-	3	17.65	0	-	5	12.20
Severe depression (19 to 22)	4	50.00	0	-	-	-	0	-	4	9.76
Very severe depression (23 up)	1	12.50	0	-	-	-	0	-	1	2.44
Total	8	100.00	8	100.00	17	100.00	8	100.00	41	100.00

When individual symptoms of Depression were accounted for regardless of their severity, depressed mood, feelings of guilt and somatic anxiety were noted in 87.5% of the New Entrants group (Table 26). Work and Interests (Anhedonia), and Psychic Anxiety followed at 75%, psychomotor retardation at 62.5% and Initial insomnia, psychomotor agitation, general somatic symptoms, and poor insight at 50%. Suicidal Ideation, middle phase insomnia, gastrointestinal somatic symptoms and weight loss were displayed in 37.5 % of population. Genital symptoms were noted in 25% of the population and terminal insomnia at 12.5%. Hypochondriasis was not noted among the New Entrants.

The prominent symptoms among the In-house group were work and interests (anhedonia) at 62.5% which was followed closely by depressed mood in half of the population. Feelings of guilt, psychomotor retardation, general somatic symptoms, and poor insight were noted in 37.5% of the group. A quarter of the population has initial insomnia, while suicidal ideation, terminal insomnia, psychomotor agitation, psychic anxiety and genital symptoms were noted in 12.5 % of the population. The following symptoms were absent among the In-house group - middle phase insomnia, somatic anxiety, gastrointestinal somatic symptoms, hypochondriasis and weight loss.

In the After Care group, the leading symptoms were depressed mood at 64.71%. Suicidal ideation and psychic anxiety followed at 47.06%. Feelings of guilt, somatic

anxiety, weight loss were noted at 41.18% while psychomotor retardation, general somatic symptoms, genital symptoms were exhibited by 35.29%. Gastrointestinal somatic symptoms and hypochondriasis were present at 29.41% of the group. Insomnia, both middle and initial, and work and interests (anhedonia) were noted in 23.53% of the group; psychomotor agitation at 17.65% and delayed insomnia and poor insight at 11.76%.

Agitation (50%) was the main symptom noted among the Alumni group. This was followed by depressed mood, psychomotor retardation, and genital symptoms at 37.5%. A quarter of the population of the Alumni group have initial insomnia and anhedonia (work and interests). Feelings of guilt, delayed insomnia, somatic anxiety, general somatic symptoms and weight loss were noted in 12.5% of the group. The rest of the depressive symptoms were absent among the Alumni group.

The operational definition of the symptoms of depression used in this study can be found in the Annex J.

Table 26. HAM-D symptoms experienced by different groups of girls, CAI, 2018.

Depression symptoms	New Entrants (n=8)		In House (n=8)		After Care (n=17)		Alumni (n=8)		Total (n=41)	
	Freq	%	Freq	%	Freq	%	Freq	%	Freq	%
Depressed Mood	7	87.50	4	50.00	11	64.71	3	37.5	25	60.98
Feelings of Guilt	7	87.50	3	37.50	7	41.18	1	12.5	18	43.90
Suicide	3	37.50	1	12.50	8	47.06	0	0	12	29.27
Insomnia - Initial	4	50.00	2	25.00	4	23.53	2	25	12	29.27
Insomnia - Middle	3	37.50	0	-	4	23.53	0	0	7	17.07
Insomnia - Delayed	1	12.50	1	12.50	2	11.76	1	12.5	5	12.20
Work and Interests	6	75.00	5	62.50	4	23.53	2	25	17	41.46
Retardation	5	62.50	3	37.50	6	35.29	3	37.5	17	41.46
Agitation	4	50.00	1	12.50	3	17.65	4	50	12	29.27
Anxiety- Psychic	6	75.00	1	12.50	8	47.06	0	0	15	36.59
Anxiety - Somatic	7	87.50	0	-	7	41.18	1	12.5	15	36.59
Somatic Symptoms - Gastrointestinal	3	37.50	0	-	5	29.41	0	0	8	19.51
Somatic Symptoms - General	4	50.00	3	37.50	6	35.29	1	12.5	14	34.15
Genital Symptoms	2	25.00	1	12.50	6	35.29	3	37.5	12	29.27
Hypochondriasis	0	-	0	-	5	29.41	0	0	5	12.20
Weight loss	3	37.50	0	-	7	41.18	1	12.5	11	26.83
Poor Insight	4	50.00	3	37.50	2	11.76	0	0	9	21.95

### 6.3. Improvement on family, social and economic status

#### 6.3.1. On education of the direct beneficiary and family members

The Wilcoxon Signed-Rank test is useful in comparing two dependent samples (i.e. education levels before and after CAI programs). The relevant question here is: Does the before-after level of education of the beneficiary and other household members differ between the time they have not received and received assistance from CAI? Findings show that the educational attainment of direct beneficiaries and family members has significantly improved after they received assistance from CAI.

The direct beneficiaries of CAI (CSA and non-CSA beneficiaries) and their parents have expressed consistently that the educational support for the beneficiaries and other family members is invaluable.

*“Kay damo na sang nabuligan ang CAMELEON, kay kung wala sila (referring to CAMELEON), diin kami puluton? Kung wala ang CAMELEON, nakaeskwela kami ayhan?”*

*(“CAMELEON has helped a lot of people, and if they are not here, where would we be? If not for CAMELEON, have we gone to school?”) (Dina, pers. com 2018).*

*“We are sisters and both our education has been funded by CAMELEON for more than 10 years now. Just like us, there are other sisters who are beneficiaries of CAI’s educational program.” (Flora, pers.com 2018)*

*“For sure, without CAMELEON my daughter could have not finished her course related to agriculture. (Juan, pers.com 2018)*

*My husband died young and I am sickly. Without CAMELEON, I would not have a ‘partner’ in educating and funding the education not only of my daughter who is a CAI beneficiary but also of my other children” (Kate, pers.com, 2018)*

These are but a few examples of what the beneficiaries and their parents or guardians claim that the educational program of CAI is very important to them. For some of these beneficiaries, their parents or guardians, education is one way of coping and potentially overcoming their poverty and trauma. Moreover, the in-house psychiatrist of CAI argued that:

*“When you think of these children, they have already several “strikes” or disadvantages against them. Firstly, they are mostly raised in very poor families. Secondly, they are abuse. Thirdly, they have limited or poor nutrition because of their family’s poverty. So if you think of these conditions as starting points, we try not to expect too much from them. We have to set different goals or objectives for them... In fact, for cases of severe abuse coupled with dysfunctional family life, I would be very happy if they manage to continue or finish their high school. For less severe cases, some are doing well, finishing college and some even go to graduate school for their master’s degrees. (CAI in-house psychiatrist, pers. com, 2018)*

For us (researchers), this lengthy quote means that the educational program of CAI serves not only as avenue to support the education of the beneficiaries, it is considered also as a measure to understand the recovery of the traumatized children. By setting individual educational goals for each beneficiary, the CAI psychiatrist suggests that the CAI program intends to convey the message that society should set different “life goals or expectations” for survivors of CSA. To achieve these life goals, we (society) should support these survivors including those who come from very poor families. These life goals are important because these help survivors of CSA cope up and recover from trauma. Moreover, the qualitative data presented above is supported by quantitative results (see Table 27 below).

However, the attribution of the quantitative results has to be interpreted with caution considering that other factors such as government assistance (e.g. 4Ps and other programs) may have had contributed to the highly significant quantitative result (see Table 27, below). Nevertheless, education and its perceived social value (e.g., means of finding jobs later on, means for social mobility) are invaluable resources for those who cannot afford education. Global and local human rights-based standards (e.g., UNESCO) posit that education is an inviolable human right that everyone should have access to.

Table 27. Comparison of the mean level of education of beneficiaries and other household members

	<b>Obs</b>	<b>Mean</b>	<b>Std. Dev.</b>	<b>Wilcoxon Signed-rank test result</b>
Education level before CAI programs	40	7.475	3.351	
Education level after CAI programs	41	7.780	6.662	z=-3.820 p=0.0001 S

\*\*\*S- significant

### 6.3.2. On the employment of the members of the beneficiary household

Similar to the impact on education, we also used the Wilcoxon Signed-Rank test to determine the impact of CAI's intervention to employment of family members of their direct beneficiaries. It can be seen that there were more family members who are employed after CAI's assistance to households of their direct beneficiaries.

This implies that CAI's intervention has significantly improved the employment rate of household members. This may be attributed to the skills training, capacity building intervention, livelihood, and other support as provided by CAI (Table 28).

The record shows that some alumni members are gainfully employed as social workers, teachers, hotel and restaurant managers, office workers and caregivers.

Table 28. Comparison of household members 18 years old and older who are employed before and after the intervention

<b>Percentage age of household members 18 years and older employed</b>	<b>Obs</b>	<b>Mean</b>	<b>Std. Dev.</b>	<b>Wilcoxon Signed-rank test result</b>
before the intervention	28	47.003	27.767	
after the intervention	17	65.798	55.465	z=4.199 p=0.0000 S

\*\*\*S- significant

### 6.3.3. On the household income of the family

A Wilcoxon signed rank test was conducted to determine if there is a difference in the monthly household income before and after CAI's assistance. The average monthly income after CAI intervention increased to Php9, 918.18 compared to Php5, 417.39 before the intervention. This difference is statistically significant which implies that the CAI's interventions greatly results to the increase in the household income of the beneficiaries.

Table 29. Comparison of the household income before and after CAI's intervention

Household income	Mean	Std. Dev.	Wilcoxon signed-ranked test
before intervention	5,417.39	7142.17	z= 3.043
after intervention	9,918.18	11943.5	p=0.0023 S

Employment is correlated with income, thus one potential explanation in the increase of the household income would be the increase in employment. The increase in the household income after the intervention apparently can be attributed to the capability building and trainings by CAI increasing the skills sets subsequently increasing the employment capacity of households. The statistical data above is complemented with interview data where the beneficiaries and their families attribute their employment opportunities to the educational support they received from CAI. For example, Glenda, who is an alumna of CAI claims that:

*“Because of CAMELEON’s assistance, I was able to finish my studies get a decent job and earn an income to help support my family” (Glenda, pers.com, 2018)*

Whilst, Juan who is a father of a current beneficiary shared that:

*“My daughter is about to finish her course related to agriculture. This achievement is*

*made possible by CAMELEON. We are now looking forward for my daughter to find a job” (Juan, pers. com, 2018).*

#### 6.3.4. On community participation by the direct beneficiary

A Wilcoxon two-sided sign test was conducted to determine if there is a difference participation of CAI’s direct beneficiaries before and after CAI’s assistance. The participation of the direct beneficiaries to socio-civic organization increase to 36% after the CAI intervention from 16% before intervention. However, this increase is not statistically significant.

Table 30. Comparison of the participation to socio-civic organization by the direct beneficiaries before and after CAI intervention, 2018.

Participation to socio-civic organizations	Before		After		Sign test
	Freq	%	Freq	%	
Not participating	33	84.62	16	64	pr= 0.3877 NS
Participating	6	15.38	9	36	

For those who started participating in socio-civic organizations, they reported that their psycho-social skills have improved especially in managing their own affairs, dealing with or managing people (i.e. social skills), managing social expectations, and gaining self-confidence. These claims can be gleaned from the thoughts of 2 of CAI’s beneficiaries.

*“Over all, nag improve gid, example saakon. Naga trust naakosamga feelings ko kag before ako mag obra sang isaka decision, gaistorya ako anay sa guardian ko. Kag ang akon social anxiety, subong kabalo na ako mag control kag naka gain pagdako self-confidence.”*

*(“Overall, there is improvement, for example in my case. I now trust my feelings, and before I make important decisions I first talk to my guardian. And my social anxiety, right now I know how to manage or control it, and this is on top of gaining self-confidence.”) (Sonia, pers. com, 2018).*

*“Sa amon, daw nag tuto kami mag tindog sa amon kaugalingon nga kami lang; kami lang mag matu-mato mag bugtaw aga, mag agto sa eskwelahan.”*  
*(For us, we learned to stand on our own. That is, we started to rise up early and go to school.)* (Janice, pers. com, 2018).

#### **6.4. Advocacy programs**

Advocacy programs of CAI reached different types of audiences. All of these beneficiaries remembered CAI’s activities. However, awareness of CAI varied from municipality to municipality where it operates. The mention of CAI is associated with scholarships, livelihood programs for the parents of the scholars, financial assistance in the aftermath of typhoon Yolanda, circus, Voice of the CAMELEON Children (VCC), and CAMELEON Youth Health Advocates (CYHA). It is worth noticing that communities, i.e. Bingawan, are privy to the accomplishment of the CAI scholars as well as those scholars who were taken out of the roll.

In the light of various advocacy programs reaching numerous audiences, the findings from FGDs showed that the target audiences’ level of knowledge and self-awareness were enhanced.

*“I learned about child’s rights, how to protect myself, how to differentiate a ‘bad touch from a good touch’ during one of the fora conducted by the Voice of the CAMELEON Children”* (Reina, pers. com, , 2018)

Equally important is the perception of a local policy maker that CAI’s work is effective in promoting various women and child’s rights and activities associated with these.

*“My knowledge about CAI’s program is that they are effective in promoting child’s rights through the institutionalization of their annual children’s congress. With our local government’s intervention limited only to GAD plan, children’s month activities, and regular maintenance of Women’s desk, CAI’s advocacy programs supplements our limited local initiatives”* (SB Member, LGU Bingawan, pers. com, 2018)

In some areas it was reported during the FGD that the parents appreciated the information drive of CAI especially to the elementary school children. However, they

noted that it should be done on regular basis. Retention of the information shared among school kids is limited given that the irregularity in schedule of CAI's campaigns.

*“Kami nga mga ginikanan Sir, total kami nga mga ginikanan diri man kami naga Atubang kag nagapamati kung anu gintudlo nila sa mga kabataan namon. Madugang kolang Sir, mas manami kung sige-sigehon nanda nga tudlo sa mga kabataan namon siguro diyan naton makit-an kung ano ang pagplastar nanda sa mga bata namon kag makadugang kung ano man mga kinahanglanon sang mga kabataan”*

*(“As the parents, sir, we are present whenever CAI comes here to teach our children. We are also attending these events, so, we hear what is being taught. I wanted to add, sir, that it would be better if CAI continues these lessons to our children because only through these continues lessons, we could evaluate these lessons as well as see what these children really need.”) (Rene, San Enrique, pers. com, 2018)*

## **7. Impacts of CAI programs**

### **7.1. Healing, stabilization and resilience of girls**

The In-House (IH) or residential care program is a vital and core program of CAI. In the IH program, positive health and general well-being outcomes can be observed in two stages. Firstly, there are manifest impacts in relation to mental health, overall health and general well-being (e.g., performance in school, positive social interaction) of the beneficiaries as they progress from Center 1 to Center 2 of CAI's IH program. In retrospect, Center 1 is the first stage in CAI's IH program where the survivors of CSA are initially enrolled in. In Center 1, the average stay of the beneficiary is two (2) years where the beneficiary receives the core services of CAI.

One of the clear impact of the IH program in the first 2 years of stay of a beneficiary is the decreasing negative effects of a traumatic incident (e.g., rape or incest). Less medications (for mental illnesses), overall good quality of sleeping patterns and/or normal body mass indices and observance of good personal hygiene practices are some of the manifestations of the positive impacts of the IH program on the girls.

It was observed during visits in the facilities that the beneficiaries are generally positive, healthy-looking and outwardly joyful. For example, during the FGD with 11 AC beneficiaries, it was observed that the girls have positive general well-being, as if that these young ladies have not been scarred by traumatic experiences.

In-house documents and interview with the staff including the in-house psychiatrist suggest that there is progress of each beneficiary in Center 1. The assessment was based on the progress of each beneficiary in the following areas: psycho-social evaluation (e.g., counseling notes, quarterly evaluation for residential rehabilitation, incident notes and reports); health assessment (i.e., psychiatric and psychological check-ups and other medical examinations); and educational performance.

Secondly, the "graduation" of a beneficiary from Center 2 (from the IH program) to the AC program is a manifestation of the overall impact of the IH program because the beneficiaries are assessed to be recovering from their traumatic experiences so much

so that they are functioning normally in relation to their education as well as in their social relations and activities.

Finally, the positive correlation between PTSD and the depressive symptoms connotes healing, recovery, stabilization and resiliency among the girls. This shows consistency with the works of Chang (2018) that PTSD severity was mediated by depressive symptoms. The decrease in PTSD score and validated by HAM-D score shows the degree of improvement or recovery through the introduction and progression of CAI interventions.

These findings confirm that CAI's programs have positively impacted the well-being of its beneficiaries. Interestingly however, reintegration to community had adversely affected their well-being, but the impact is immediate but short-lived.

During the discussions with the CAI beneficiaries, many shared how these artsy and sports activities have positively impacted their overall well-being through stress release, confidence building, and self-esteem improvement. For one beneficiary,

*“Ang circus nagabulig sa amon nga malipatan ang past kag ma express ang feelings or nabatyagan namon”*

*(“The circus helps us forget the past, and we could express our feelings through circus”)*  
*(Rose, pers. com, 2018).*

Through sports such as the athletic performances of a circus, some of the beneficiaries could develop healthy forms of self-expression and stress release, as well as a mechanism of acknowledging, accepting and hopefully managing well their feelings and emotions as they grow into young ladies.

Another young lady believes that the circus helped her develop self-confidence, Ana claims that,

*“Sa pagjoin ko sa circus na discover ko ang akon talent sa juggling kag aerials kag naka buliggid boost sang akon self-confidence”*

*(“When I joined the circus, I discovered that I have a talent for juggling and aerial acrobatics, and these help boost my confidence”)* *(Ana, pers. com, 2018).*

Sports-based interventions that are designed with trauma-informed principles have been reported to be part of treatment programs for adolescent girls, similar to CAI's beneficiaries, who have been traumatized (D'andrea *et al.*, 2013). In the literature, these sports-based interventions have been shown to have had a significant positive impact on the behavior and mental health in a diverse sample of adolescent girls in residential care (D'andrea *et al.*, 2013). D'andrea and associates (2013) refer to these as "therapeutic sports programs" which are adjunctive or complementary treatment tools based on emphasizing the role of physiological and behavioral strategies of regulation in treatment process. This means that CAI's adoption of circus (and other sports-related activities) can be seen as a complementary treatment strategy for traumatized girls where the rigorous and physically-challenging routines of a circus act could have a positive impact on the girls' behaviors and mental health.

The same can be said of arts as a therapeutic activity. Consistent with Malchiodi's work on trauma-informed art therapy, drawings and depictions are mechanisms where the beneficiaries can tell their stories, or at least parts of their respective stories (Malchiodi, 2012). The author argued that many children survivors of sexual abuse "use art expression to create visual symbols and metaphors to describe what happened" to them and it has shown to improve or maintain mental health and well-being of survivors of CSA (Malchiodi, 2012: 341). As mentioned previously, we have seen how drawings, sketches, and personal diaries are used in CAI's IH and AC programs to help in the recovery and healing of the survivors of CSA. We have seen illustrations and depictions of young girls in CAI that express the conflicting narratives of sadness, hope, joy, fear, anger, gratefulness, anxiety, trust, friendships, family and love.

Some girls shared that there are more challenges in AC than in IH.

*"Kag daw kahaladlukan kung sa After Care ka, kay sa sulod ka (referring to in-house), ang imo palibot kilala mo na tanan. Tapos kung mag guwa kaw, lain-lain naman makilala mo kag pwede kalagaw bisan diin. Indi man mapunggan ang temptation"*

*(It is worrisome if you are in the After Care because when you are in the IH program*

*you know everyone around you. But when you are out of the IH program (and in AC) you will meet different persons and you can go wherever you want. It's hard to resist the temptation (to go wherever)."* (Dia, pers. com 2018)

*"Kung sa in house ya 24 hours may naga monitor sa imo example, Manang mo, friend mo sa eskwelahan, imo Tita, social worker, house mother pero kung nag gwa ka nasa After Care, ikaw nalang mismo. Kung sang una may nagabulig pa, subong ikaw nalang isa mag tindog sa kaugalingon mo"*

*(In the in-house program, there is always someone monitoring you 24 hours, for example your 'big sister', your friend in school, your Tita, a social worker, the house mother but when you are out and in the After Care, you are on your own. If in the past there is someone who is helping or assisting you, now you have to care of things on your own).*

(Melanie, pers. com 2018)

Other challenges under the AC program are the lack of safe and secure (temporary) foster homes especially during holidays when it is not safe for the beneficiaries to spend holidays in their familial homes, and adjustments from a highly monitored and routinized environment in the IH program to a less monitored environment in the AC program. For example, one beneficiary reported her difficulty of finding a place to spend for her holidays when the staff of AC program are all away.

*"Kung December, wala puli-an kay holiday wala mga staff diri especially kung Christmas kag New Year, need gid mangita sang puli-an, mabudlay sa akon kay indi man ako safe sa balay. Ang akon social worker wala man siya abi naga text or inform kanday Tita, so, wala kabalo si Tita kung diin ko ibutang nga mas comfortable kag mas safe man ako.*

*Amu lang na."*

*("Every December, I have no home to go to and the staffs in the AC program are not here because of holidays, Christmas and New Year, and I feel the need to look for a place to spend the holidays because I am not safe in our family's home. The local social worker assigned to me does not send a message via SMS, or she does not inform Tita (CAI social worker), as a consequence, Tita does not know where to house me where it is comfortable and safe for me. That's the challenge). (Olive, pers. com 2018)*

This quote suggests that safety and security of the beneficiaries continue to be

concerns for the survivors of CSA, in spite of the support of programs and organizations like CAI.

Some of the girls shared minor challenges upon their re-integration in the wider community. For example, they shared their difficulty in commuting and getting around new places, managing their finances especially at the beginning of their re-integration.

*“Sa akon, mag travel kami. Kay sang sa in-house mag travel kami with social worker or family pero sang nag gwa na kami, nagamatu-matu kami nga duha kag kulbaan ako kay ma travel kami nga kami lang.”*

*(“For me, I found it challenging when I travel. When we were in the in-house program when we travelled we were accompanied by a social worker or family, but when we were out of the IH program, we travel on our own and I am anxious because my sister and I travel on our own.”). (Mona, pers. com, 2018)*

The transition from IH to AC posed challenges to newly reintegrated girls, such as the issue of self-independence and the general feeling of safety as exemplified in the following quote.

*“Ako kay Mama’s girl gid ko ya, nabudlayan ko mag adjust especially kay ariko di sa city, kaysa center siyempre dul-ong sugat pay diri gina kulbaan pa ko kay ako nalang isa ma agto sa eskwelahan, ma matu-matu kana lang bala haw.”*

*(“I am really a mama’s girl, (so) I really find it hard to adjust because I am here in the city. In the (IH) center, we were regularly driven to-and-from the center and our school but here (in the AC) I am anxious because I travel on my own when I go to school. That is, I am left on my own devices.”) (Rita, pers. com, 2018)*

## **7.2. Advocacy program**

The trend of reported cases can be used as a measure of the advocacy intervention on CSA.

*“Reported cases normally increase after the conduct of CSA advocacy program in schools and communities” (PO Nathalie, RCWPD RO VI, 2018)*

Table 31 compares the crime statistics committed towards women and children in Western Visayas, in the province of Iloilo and in the three municipalities where CAI's education, development, and advocacy campaigns are operating. Overall the reported crime rates of the areas we examined towards women and children are fluctuating from 2012 – 2017. Generally, it is apparent that reported crimes against women and children are lower in Passi and San Enrique when compared to the regional and provincial averages. Reported crime committed against women and children are however higher in the municipality of Bingawan when compared to the provincial and regional averages.

Reported crime rates can be a function of reduced crime rate or vigilance among the population such that crimes are immediately reported as they are committed. Cultural nuances prevent crime against morality from being reported, and an increased reporting may signal empowered and/or well-informed citizenry.

Table 31. Crime statistics committed against women and children in Western Visayas, Iloilo Province, Passi City and the municipalities of Bingawan and San Enrique. 2012 to 2017

Particulars	2012					2013					2014					2015					2016					2017					
	Region VI	Iloilo	Bingawan	Passi	San Enrique	Region VI	Iloilo	Bingawan	Passi	San Enrique	Region VI	Iloilo	Bingawan	Passi	San Enrique	Region VI	Iloilo	Bingawan	Passi	San Enrique	Region VI	Iloilo	Bingawan	Passi	San Enrique	Region VI	Iloilo	Bingawan	Passi	San Enrique	
Population	7,295,448	1,854,656	13,797	81,828	33,303	7,293,897	1,879,693	13,983	82,833	33,753	7,493,806	1,905,019	14,172	84,053	34,209	7,538,383	1,938,423	15,199	80,544	33,911	7,622,246	1,958,498	15,372	81,462	34,298	7,709,192	1,990,625	15,548	82,391	34,689	
Rape	597	105	1	5	1	491	125	2	10	3	654	140	1	5	3	705	142	2	7	533	122	1	7	1	533	122	1	7	1		
Attempted Rape	7	7				17	16			2	16	12				8	4	2		1	10	3			10	3					
Acts of																															
Lasciviousness	89	37	1	1	1	124	61			105	52				132	73	3		1	132	67				132	67					
RA 7877 (Sexual Harassment)	3	3				6	4			0					0					0	0	1	1	3	2	0	1	1	3	2	
RA 3775 (Child Pornography)	0					1	1			0					0					0	0					0					
Seduction	6	6				9	4			19	18				14	10				22	10				22	10					
TOTAL	702	158	2	5	3	648	211	2	10	5	794	222	1	5	3	859	229	7	7	2	697	203	2	10	3	697	203	2	10	3	
Rape per 10,000 population (municipalities treated independently)	0.96	0.85	145	0.61	0.9	0.88	112	143	121	148	106	117	0.71	0.59	0.88	114	118	4.61	0.87	0.59	0.91	104	13	1.23	0.87	0.9	1.02	1.29	1.21	0.86	
Rape per 10,000 population (municipalities with CAI intervened)																															
grouped as one)	0.96	0.85	0.99			0.88	112	137	137	106	117	0.73	0.73	2.02	114	118	2.02	0.91	0.91	1.04	1.13	1.02	1.13	0.9	1.02	1.12	1.12	1.12	1.12	1.12	

Source: PNP region VI, 2018

## **8. Conclusion and lessons**

The interventions of CAI are holistic and warrant sustainability. The IH program provided the basic needs and psycho-social interventions which cushioned the impact of traumatic experiences. As shown by evidence, the new entrants had high levels of depressive symptoms. If this data is compared to the beneficiaries of the IH program, depressive symptoms were significantly reduced in the IH group. This means for us that if the new entrants are well responsive to the interventions of CAI, their depressive symptoms could be addressed effectively.

Moreover, our data shows that the rise in depressive symptoms is observed among the beneficiaries currently in the AC group. But these symptoms decreased in the CAI alumni group. This could be interpreted that the AC group are adapting to their new environment outside of the secure walls of the IH facility and personages. In Section 7.1, we presented the concerns and challenges raised by the AC beneficiaries. Concerns regarding safety (including safe place to stay during holidays), security, managing their finances, adjusting to new schools and a general anxiety about the wider community have been identified by the AC girls. Potentially, these concerns are sources of stressors that may have contributed to the rise of depressive symptoms.

However, the depressive symptoms among CAI alumni are observed to have decreased relative to other groups of beneficiaries. We surmise that these ladies have adjusted well to the wider community, including managing well their emotions.

As with the PTSD mean scores, the rise of the mean scores in the AC group is believed to have been caused by the change of the environment and the initial re-exposure of the beneficiaries to the realities in the wider community (and the concerns raised above). We argue that the AC girls are in a transitory phase, and with continued support and guidance from CAI, they would manage to regulate and keep in check potential sources of stressors.

When the beneficiaries completed the AC program, depressive symptoms (i.e., the mean score for depression scale) notably dropped. Again, it is presumed that a real re-integration to the community happens. It is also supposed that at this time the beneficiaries have learned to cope effectively with their symptoms and have the capacity to manage and regulate their emotions. The data showed that both PTSD and

depressive symptoms were both effectively addressed and are negligible at the time when the beneficiaries finally leave CAI.

CAI is, therefore, effective in addressing both the PTSD and depressive symptoms bringing healing, recovery and restoring a positive well-being to the beneficiaries, notably among the alumni. It is prudent to assume that CAI has achieved its objective of developing the capacity of the beneficiaries to cope effectively, manage and regulate their emotions successfully, develop resilience and stability, and finally bring recovery and healing.

CAI is very active in its advocacy program reaching its various targeted audience. The individual and group testimonies can attest to the scope and depth of the said interventions. However, due to the multi-factor and complexity of CSA cases, the impact of CAI advocacy program measured in terms of reporting of cases is non-conclusive. Passi City and San Enrique had reported crime rates lower than the provincial and regional averages, while in Bingawan the average reported crime rates is higher. Change in behavior as a result of these advocacy campaigns cannot be attributed solely to the presence or absence of advocacy campaigns but rather influenced by many other factors such as knowledge of crimes and how to report these, perceptions about the state's police, cultural beliefs, as well as the strong influence of religion particularly Catholicism.

## 9. Recommendations

This section discusses key recommendations, in the light of the aforementioned findings, in order to help future decision making on investments on CAI programs.

### 9.1. In-house and after-care programs

The following are recommended to improve the general well-being of girls in the IH and AC programs.

In order to maximize positive mental improvements provided by CAI's IH program, it is recommended that opportunities be extended to other eligible CSA around Western Visayas Region.

**Develop/adapt screening tool/s** to be given to all new entrants to detect symptoms of anxiety, depression and PTSD. This might be a battery of rating scales for anxiety, depression and PTSD. The result of the screening tool/s should be the basis for referral to a psychiatrist for evaluation and possible therapy.

- Sessions with the psychiatrists/therapy must include rating of the beneficiaries using the same tool/s used in screening, which will indicate possible improvement or deterioration in the well-being of the beneficiaries.
- When the beneficiaries are transitioned to the next program (i.e. from new-entrant -IH to AC and finally as alumni), they must be tested with the same tool/s (rating scales) used.
- The results of the screening tool/s should be properly labeled as to the date and time of examination and be included in the girls' individual folders. As such, each beneficiary will have at a minimum a score during entrance, during IH, during AC and right before the beneficiary leave CAI.
- This mechanism can facilitate the objective assessment of the program based on the changes in the scores of the individual beneficiary from the time of entry until they leave CAI.

To stabilize their mental well-being, **review practice guidelines** in managing girls

who reside in CAI dormitory, especially during Christmas or holiday seasons as well as guidelines for social workers in monitoring legal cases of the girls.

**Documentation of current processes, systems and procedures** is essential in the light of CAI's effectiveness in the healing, stabilization process and the healing of girls who are victims of existing violence. This addresses the current dearth of existing literature on effective protocols in managing CSA. Its documentation will warrant replication with the same effective results in some other areas. There is also a necessity to benchmark in-house protocols and commonly used protocols in the Philippines when providing interventions.

**Maximizing existing capacities through individualized case management with multi-disciplinary perspective.** With periodic testing and rating, individual cases can be appropriately monitored such that a faster turn-over from Center 1 to Center 2 and from IH to AC will be achieved. In the long run, more girls can be accommodated and rehabilitated.

**Change in one core concept: "recovery" in lieu of "rehabilitation".** The concept of 'rehabilitation' within the IH and AC programs should be reviewed because in the academic literature on CSA and programs addressing CSA, the alternative concepts of 'recovery and healing' are often used. Rehabilitation appears to be associated with programs where the program recipients have knowledge and control of their (culpable) actions and its consequences (e.g., drug addicts and drug rehabilitation centers, and prisons in general as rehabilitation centers for felons). Survivors of CSA are children who do not have the knowledge and control of their (unfortunate) plights, unlike adult drug addicts who are arguably in control of their actions and have knowledge of its consequences. In the CSA literature, the statement of objective(s) of programs tend to use the term 'recovery' from traumatic experiences. Thus, we recommend a change of terminology.

## **9.2. Advocacy**

The following are recommended to improve the level of knowledge of the community (e.g., elementary students, high school students, college students, local and regional

policy makers, parents, etc.) regarding children's rights and health of young people.

**Review and update training/skills development/information dissemination programs** and their corresponding activities, in order to achieve greater consistency/relevance and to provide more positive impact on target audience. This is crucial as some target audiences of CAI are from multi-faith sectors, ethnically diverse communities, and from different age and educational groups. Redundancy and repetition of key messages of these activities will also be avoided once reviewed and updated.

**Strengthen partnerships** with other agencies serving CSA but also to institutions that may not focus on CSA (e.g., human rights organizations, business enterprises, etc.), as well as to socio-disadvantaged sectors (e.g. disabilities). It is oftentimes mentioned in discussions the importance of faith and spirituality in advocacy activities, so collaboration with faith organizations will make sure. It can help but it is not a condition to successful program) that these activities are relevant.

**Update guidelines relating to conduct of multi-agency training** (e.g. DepEd, DSWD, etc.) in order to further increase audience and/or to possible sharing of training costs. For example, training activities must be planned ahead to adhere government budget process. This will also develop shared perspectives across institutions.

### **9.3. Other related recommendations**

Lastly, the following are recommended to assist CAI's management of the three programs.

A **review of standardized outcomes** for impact assessment of programs, which will be implemented by an expert committee consisting of case managers, CSA practitioners, academics, and other related experts. The current outcomes, 'stability', for example, is dependent on PTSD or HAM-D scores. To the non-academics, this would be insufficient or lacking. Thus, standardized outcomes will guide future impact

assessments.

A **database or information system** should be established and maintained, in which information on current IH-AC girls, alumni, and other beneficiaries should be stored or managed. This will enhanced the collection, sorting, and retrieval of relevant information for multiple purposes.

CAI should consider to be accredited to **Level II accreditation from DSWD**, in order to pave way for more opportunities to widen the coverage of its programs, especially on its advocacy activities.

A stable and sustainable income may be achieved by all beneficiaries if trainings relating to hobbies of girls or livelihoods to immediate family of girls are **market-driven** (i.e. what is needed by customers) and should be **in-line** with the level of skills/interests/work experience/credentials of beneficiaries.

## 10. References

Alix S, C. L. (2017 Feb-Mar). Posttraumatic Stress Disorder and Suicidal Ideation Among Sexually Abused Adolescent Girls: The Mediating Role of Shame. *Journal of Child Sexual Abuse*, 158-174.

Apprentis d' Auteuil Foundation (AAF), CAMELEON Association, Inc., Center for the Prevention and Treatment of Child Sexual Abuse, and Action Against Violence and Exploitation, Inc. (2016). Universal Periodic Report 2017, 27th Session Human Rights Council. Geneva, Switzerland.

Ba I, B. R. (2017 Jan). Physical, mental and social consequences in civilians who have experienced war-related sexual violence: a systematic review (1981-2014). *Public Health*, 121-135.

Beitchman, J. H., Sucker, K. J., Hood, J. E., daCosta, G. A., Akman, D., & Cassavia, E. (1992). A review of the long-term effects of child sexual abuse. *Child Abuse and Neglect*, 16, 101-118.

Bonnona, G., Keltner, D., Noll, J., Putnam, F., Trickett, P., LeJune, J. & Anderson, C. (2002). 'When the Face Reveals What Words Do Not: Facial Expressions Emotion, Smiling and the Willingness to Disclose Childhood Sexual Abuse.' *Journal of Personality and Social Psychology*, 83 (1): 94-110.

Browne, A., & Finkelhor, D. (1986). Impact of childhood sexual abuse: A review of the research. *Psychological Bulletin*, 99, 66-77.

Chang C, K. A. (2018 May ). Emotion regulation is associated with PTSD and depression among female adolescent survivors of childhood sexual abuse. *Psychological Trauma: Theory, Research, Practice & Policy*, 319-326.

D'andrea, W., Bergholz, L., Fortunato, A., and Spinazzola, J. (2013). "Play to the Whistle: A Pilot Investigation of a Sports-Based Intervention for Traumatized Girls in

Residential Treatment,” *Journal of Family Violence*, 28 (7): 739-749. DOI: 10.1007/s10896-013-9533-x

Dubowitz, H. (2017). ‘Child sexual abuse and neglect – A global glimpse.’ *Child Abuse & Neglect*, 66: 2-8.

Estes, R. and Weiner, N. (2001). *The Commercial Exploitation of Children In the U.S., Canada and Mexico. Full Report*, University of Pennsylvania, Philadelphia, USA.

Finkelhor, D. (1990). Early and long-term effects of child sexual abuse: An update. *Professional Psychology: Research and Practice*, 21, 325–330.

Gil, E. (2012). Trauma-focused Integrated Play Therapy (TF-IPT). In: Goodyear-Brown, P. (Ed.), *Handbook of child sexual abuse: Identification, Assessment and Treatment*. John Wiley & Sons, New Jersey, pages 251-278.

Goodyear-Brown, P. (Ed.) (2012). *Handbook of child sexual abuse: Identification, Assessment and Treatment*. John Wiley & Sons, New Jersey.

Gould, F., Clarke, J., Heim, C., Harvey, P., Majer, M. & Nemeroff, C. (2012). ‘The effects of child abuse and neglect on cognitive functioning in childhood.’ *Journal of Psychiatric Research*, 46 (4): 500-506.

Guerra C, F. C. (2018 Feb ). Depression, anxiety and PTSD in sexually abused adolescents: Association with self-efficacy, coping and family support. *Child Abuse and Neglect*, 310-320.

International Rescue Committee (IRC). (2010). *Caring for Child Survivors of Sexual Abuse: Guidelines for health and psychosocial service providers in humanitarian settings*. United Nations Children’s Fund (UNICEF).

International Rescue Committee (IRC) and United Nations Children’s Fund (UNICEF). (2011). *Advancing the Field: Caring for Child Survivors of Sexual Abuse in Humanitarian Settings*.

Israel, G. D. (1992). Determining sample size (pp. 1-5). Gainesville: University of Florida Cooperative Extension Service, Institute of Food and Agriculture Sciences, EDIS.

Khadr S, C. V. (2018 Sep 2). Mental and sexual health outcomes following sexual assault in adolescents: a prospective cohort study. *Lancet Child Adolescent Health*, 654-665.

Lanes, R. and Decatoria, J. (2011). The Innovative Potential of Clay and Play (Clay Therapy, Resilience and Trauma Symptoms of Sexually Abused Girls. *Philippine Journal of Child Sexual Abuse*, 1 (1), 3-18.

Malchiodi, C. (2012). Trauma Informed Art Therapy and Sexual Abuse in Children. In: Goodyear-Brown, P. (Ed.), *Handbook of child sexual abuse: Identification, Assessment and Treatment*. John Wiley & Sons, New Jersey, pages 341-354.

Mgoqi-Mbalo N, Z. M. (2017 May ). Risk factors for PTSD and depression in female survivors of rape. *Psychological Trauma: Theory, Research, Practice and Policy*, 301-308.

Polychronopoulou M, D. A. (2016 Apr-Jun). The psychosocial repercussions of domestic violence in battered women. *Psychiatriki*, 148-149.

Rabanillo, R. (2011). Traumagenic Dynamics Framework with Filipino Clients. *Philippine Journal of Child Sexual Abuse*, 1 (1): 19-31.

Regina A. Shih, P. T. (2010 December). Prevalence of PTSD and Major Depression Following Trauma- Center Hospitalization. *J Trauma*, 1560-1566.

Richter, L., Dawes, A., and Higson-Smith, C. (Editors). (2004). *Sexual Abuse of Young Children in Southern Africa*.

Shahidur, K.R., Gayatri, K.B., and Samad, H.A. (2010). Handbook on Impact Evaluation: Quantitative Methods and Practices. The World Bank, Washington, D.C.

Sinanan, J. (2015). "Trauma and Treatment of Child Sexual Abuse," *Journal of Trauma & Treatment*, S4:024.

Spaccarelli, S. (1994). Stress, appraisal, and coping in child sexual abuse: A theoretical and empirical review. *Psychological Bulletin*, 116, 340–362.

Stevens NR, T. V.-M. (2017 Jun). Posttraumatic stress and depression may undermine abuse survivors' self-efficacy in the obstetric care setting. *Journal of Psychosomatic Obstetric and Gynaecology*, 103-110.

Stoltenborgh, M., van Ijzendoorn, M., Euser, E. & Bakermans-Kranenburg, M. (2011). 'A Global Perspective of Child Sexual Abuse: Meta-Analysis of Prevalence Around the World.' 16 (2): 79-101.

Sugue-Castillo, M. (2009). Legal outcomes of sexually abused children evaluated at the Philippine General Hospital Child Protection Unit. *Child Abuse & Neglect*, 33(3): 193-202.

Talbot, N. L. (1996). Women sexually abused as children: The centrality of shame issue and treatment implications. *Psychotherapy*, 33, 11–18.

Trickett, P. K., & Putman, F. W. (1993). Impact of child sexual abuse on females: Toward a developmental, psychobiological integration. *Psychological Science*, 4, 81–87.

Tocker L, B.-A. G.-R. (2017 May-Jun ). Predictors of Clinical Outcomes in Sexually Abused Adolescents. *Journal of Child Sexual Abuse*, 487-505.

World Health Organization (WHO). (2003). Guidelines for medico-legal care for victims of sexual abuse. Chapter 7: Child Abuse. Available at:

[http://www.who.int/violence\\_injury\\_prevention/resources/publications/en/guidelines\\_chap7.pdf](http://www.who.int/violence_injury_prevention/resources/publications/en/guidelines_chap7.pdf) (Last access August 27, 2018).

Yacat, J., Rosales, Z. & Rabanillo, R. (2018). Counselling sexually abused children in the Philippines: A Survey of Practices, Beliefs and Activities. Available at: [https://www.researchgate.net/publication/265115804 Counseling Sexually Abused Children in the Philippines A Survey of Practices Beliefs and Activities](https://www.researchgate.net/publication/265115804_Counseling_Sexually_Abused_Children_in_the_Philippines_A_Survey_of_Practices_Beliefs_and_Activities) (Last accessed 6 August 2018)

Young, J. & Widom, C. (2014). 'Long-term effects of child abuse and neglect on emotion processing in adulthood.' *Child Abuse & Neglect*, 38 (8): 1369-1381.

## 11. Annexes

### Annex A.1 Severity of Posttraumatic Stress Symptoms—Adult\*

#### \*National Stressful Events Survey PTSD Short Scale (NSESSS)

#### English Version

The APA is offering a number of “emerging measures” for further research and clinical evaluation. These patient assessment measures were developed to be administered at the initial patient interview and to monitor treatment progress. They should be used in research and evaluation as potentially useful tools to enhance clinical decision-making and not as the sole basis for making a clinical diagnosis. Instructions, scoring information, and interpretation guidelines are provided; further background information can be found in DSM-5. The APA requests that clinicians and researchers provide further data on the instruments’ usefulness in characterizing patient status and improving patient care at <http://www.dsm5.org/Pages/Feedback-Form.aspx>.

**Measure:** Severity of Posttraumatic Stress Symptoms—Adult (National Stressful Events Survey PTSD Short Scale [NSESSS])

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## Severity of Posttraumatic Stress Symptoms—Adult<sup>\*</sup>

### \* National Stressful Events Survey PTSD Short Scale (NSESSS)

Name: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: Male  Female  Date: \_\_\_\_\_

Please list the traumatic event that you experienced: \_\_\_\_\_

Date of the traumatic event: \_\_\_\_\_

**Instructions:** People sometimes have problems after extremely stressful events or experiences. How much have you been bothered during the PAST SEVEN (7) DAYS by each of the following problems that occurred or became worse after an extremely stressful event/experience? Please respond to each item by marking (  or x ) one box per row.

							Clinician Use
		Not at all	A little bit	Moderately	Quite a bit	Extremely	Item score
1.	Having “flashbacks,” that is, you suddenly acted or felt as if a stressful experience from the past was happening all over again (for example, you reexperienced parts of a stressful experience by seeing, hearing, smelling, or physically feeling parts of the experience)?	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	
2.	Feeling very emotionally upset when something reminded you of a stressful experience?	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	
3.	Trying to avoid thoughts, feelings, or physical sensations that reminded you of a stressful experience?	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	
4.	Thinking that a stressful event happened because you or someone else (who didn’t directly harm you) did something wrong or didn’t do everything possible to prevent it, or because of something about you?	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	
5.	Having a very negative emotional state (for example, you were experiencing lots of fear, anger, guilt, shame, or horror) after a stressful experience?	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	
6.	Losing interest in activities you used to enjoy before having a stressful experience?	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	
7.	Being “super alert,” on guard, or constantly on the lookout for danger?	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	
8.	Feeling jumpy or easily startled when you hear an unexpected noise?	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	
9.	Being extremely irritable or angry to the point where you yelled at other people, got into fights, or destroyed things?	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	
<b>Total/Partial Raw Score:</b>							
<b>Prorated Total Raw Score: (if 1-2 items left unanswered)</b>							
<b>Average Total Score:</b>							

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### Instructions to Clinicians

The National Stressful Events Survey PTSD Short Scale (NSESSS) is a 9-item measure that assesses the severity of posttraumatic stress disorder in individuals age 18 and older following an extremely stressful event or experience. The measure was designed to be completed by an individual upon receiving a diagnosis of posttraumatic stress disorder (or clinically significant posttraumatic stress disorder symptoms) and thereafter, prior to follow-up visits with the clinician. Each item asks the individual receiving care to rate the severity of his or her posttraumatic stress disorder **during the past 7 days**.

### Scoring and Interpretation

Each item on the measure is rated on a 5-point scale (0=Not at all; 1=A little bit; 2=Moderately; 3=Quite a bit, and 4=Extremely). The total score can range from 0 to 36 with higher scores indicating greater severity of posttraumatic stress disorder. The clinician is asked to review the score on each item of the measure during the clinical interview and indicate the raw score for each item in the section provided for "Clinician Use." The raw scores on the 9 items should be summed to obtain a total raw score. In addition, the clinician is asked to calculate and use the **average total score**. The **average total score** reduces the overall score to a 5-point scale, which allows the clinician to think of the severity of the individual's posttraumatic stress disorder in terms of none (0), mild (1), moderate (2), severe (3), or extreme (4). The use of the average total score was found to be reliable, easy to use, and clinically useful to the clinicians in the DSM-5 Field Trials. The **average total score** is calculated by dividing the raw total score by number of items in the measure (i.e., 9).

**Note:** If 3 or more items are left unanswered, the total score on the measure should not be calculated. Therefore, the individual receiving care should be encouraged to complete all of the items on the measure. If 1 or 2 items are left unanswered, you are asked to calculate a prorated score. The prorated score is calculated by summing the scores of items that were answered to get a partial raw score. Multiply the partial raw score by the total number of items on the NSESSS—PTSD (i.e., 9) and divide the value by the number of items that were actually answered (i.e., 7 or 8). The formula to prorate the partial raw score to Total Raw Score is:

$$\frac{\text{(Raw sum x 9)}}{\text{Number of items that were actually answered}}$$

If the result is a fraction, round to the nearest whole number.

### Frequency of Use

To track changes in the severity of the individual's posttraumatic stress disorder over time, the measure may be completed at regular intervals as clinically indicated, depending on the stability of the individual's symptoms and treatment status. Consistently high scores on a particular domain may indicate significant and problematic areas for the individual that might warrant further assessment, treatment, and follow-up. Your clinical judgment should guide your decision.

**Annex A.2. Severity of Posttraumatic Stress Symptoms—Adult\***

**\*National Stressful Events Survey PTSD Short Scale (NSESSS)**

**Local Dialect Version**

**PAGKALALA SANG SIMTOMAS SANG POST-TRAUMATIC STRESS (ADULT)  
National Stressful Events Survey PTSD Short Scale (NSESSS)**

Ngalan/Code: \_\_\_\_\_ Edad: \_\_\_\_\_ Kinatawo : \_\_Lalake \_\_\_\_ Babaye: Petsa : \_\_\_\_\_

Palihog lista sang mga makakulugmat nga hitabo nga imo na nagan:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Petsa sang traumatic event:

Instructions: Kung kaisa ang tawo naga problema matapos maka agi sang tam-an ka stressful nga mga hitabo or experiensya. Ano ka tuman ikaw gina tublag sa sulod sang NAGLIGAD NGA PITO (7) KA ADLAW sang mga masunod nga mga problema nga naga abot ukon naga lala matapos maka agi sang madalom nga mga hitabo/experiensya. Palihog sabat sang kada item paging sang pag check or ekis ( or X) sang box per row.

							Para lamang sa Doktor/Clinician
		Wala gid (0)	Gamay (1)	Kasarangan (2)	Daw masami (3)	Pirmi (4)	Iskor
1	May ara nga “flashbacks”, inang gulpi ka lang mag hulag or mag batyag nga ang nag agi na nga ang makakulugmat nga hitabo daw ma tabo man liwa (halimbawa, na experiensyahan mo liwat ang bahin sang nahitabo paagi sa pagkakita, pagkabati, pagpa nimaho, or physical nga na batayagan ang mga bahin sang nahitabo?)						
2	Naga lain sang tuman ang imo buot kung may nagapahanumdom sa imo sang makakulugmat nga hitabo?						
3	Pilit mo nga gina likawan ang mga pamensaron,						

							Para lamang sa Doktor/Clinician
		Wala gid (0)	Gamay (1)	Kasarangan (2)	Daw masami (3)	Pirmi (4)	Iskor
	balatyagon or mga pisikal nga nabatyagan maka pahanumdum sa imo sang makakulugmat nga hitabo?						
4	Pag panumdum nga ang makakulugmat nga hitabo ang abot bangod nga ikaw ukon ang iban nga tawo (nga wala nag himo sang malain sa imo) naka him sang malain ukon wala sang may nahimo para ma pungan ini, ukon bangon sang ano man nga tungod sa imo?						
5	May ara sang tuman ka negatibo nga pamalatyagon (halimbawa, naka batyag sang tuman nga kahadlok, akig, paghinakit, kahuyanan ukon pagkakugmat) matapos ang makakulugmat nga hitabo?						
6	Pag dula sang interest sa mga buluhaton nga imo nagustuhan antes ma agyan ang makakulugmat nga hitabo?						
7	Pagka "Super Alert", pag bantay o pirmi naga pang-aman sa katalagman.						
8	Pag ka kugmat or madali makulba-an kung makabati sang mga wala ma pa abot nga mga gahod?						
9	Todo nga pag ka iritable o pag akig asta nga maka pang yaw yaw sa mga tawo, or pag pang away, or pag pamuka sang mga bagay?						
<b>Total/Partial nga Raw Score:</b>							
<b>"Prorated" nga Total Raw Score: (kung ang isa or duha ka item wala nasabtan)</b>							
<b>Average Total Score:</b>							

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**Annex B.1 HAM-D Rating Scale**

**English Version**

**HAMILTON DEPRESSION RATING SCALE (HAM-D)**

(To be administered by a health care professional)

**Patient Name** \_\_\_\_\_ **Today's Date**  
\_\_\_\_\_

The HAM-D is designed to rate the severity of depression in patients. Although it contains 21 areas, calculate the patient's score on the first 17 answers.

### **1. DEPRESSED MOOD**

(Gloomy attitude, pessimism about the future, feeling of sadness, tendency to weep)

- 0 = Absent
- 1 = Sadness, etc.
- 2 = Occasional weeping
- 3 = Frequent weeping
- 4 = Extreme symptoms

### **2. FEELINGS OF GUILT**

- 0 = Absent
- 1 = Self-reproach, feels he/she has let people down
- 2 = Ideas of guilt
- 3 = Present illness is a punishment; delusions of guilt
- 4 = Hallucinations of guilt

### **3. SUICIDE**

- 5 = Absent
- 6 = Feels life is not worth living
- 7 = Wishes he/she were dead
- 8 = Suicidal ideas or gestures
- 9 = Attempts at suicide

### **4. INSOMNIA**

**Initial**(Difficulty in falling asleep)

- 0 = Absent
- 1 = Occasional
- 2 = Frequent

#### **■ 5. INSOMNIA - Middle**

(Complains of being restless and disturbed during the night. Waking during the night.)

- 0 = Absent
- 1 = Occasional
- 2 = Frequent

#### **■ 6. INSOMNIA - Delayed**

(Waking in early hours of the morning and unable to fall asleep again)

- 0 = Absent
- 1 = Occasional
- 2 = Frequent

#### **■ 7. WORK AND**

**INTERESTS** 0 = No difficulty

- 1 = Feelings of incapacity, listlessness, indecision and vacillation
- 2 = Loss of interest in hobbies, decreased social activities
- 3 = Productivity decreased
- 4 = Unable to work. Stopped working because of present illness only. (Absence from work after treatment or recovery may rate a lower score).

#### **■ 8. RETARDATION**

(Slowness of thought, speech, and activity; apathy; stupor.)

- 0 = Absent
- 1 = Slight retardation at interview
- 2 = Obvious retardation at interview
- 3 = Interview difficult
- 4 = Complete stupor

#### **■ 9. AGITATION**

(Restlessness associated with anxiety.)

- 0 = Absent
- 1 = Occasional
- 2 = Frequent

#### **■ 10. ANXIETY - PSYCHIC**

- 0 = No difficulty
- 1 = Tension and irritability
- 2 = Worrying about minor matters
- 3 = Apprehensive attitude
- 4 = Fears

## HAMILTON DEPRESSION RATING SCALE (HAM-D)

(To be administered by a health care professional)

### ■ 11. ANXIETY - SOMATIC

Gastrointestinal, indigestion  
Cardiovascular, palpitation,  
Headaches Respiratory,  
Genito-urinary, etc.

0 = Absent

1 = Mild

2 = Moderate

3 = Severe

4 = Incapacitating

### ■ 12. SOMATIC SYMPTOMS - GASTROINTESTINAL

(Loss of appetite , heavy feeling  
in abdomen; constipation)

0 = Absent

1 = Mild

2 = Severe

### ■ 13. SOMATIC SYMPTOMS - GENERAL

(Heaviness in  
limbs, back or head; diffuse  
backache; loss of energy and  
fatiguability)

0 = Absent

1 = Mild

2 = Severe

### ■ 14. GENITAL SYMPTOMS

(Loss of libido, menstrual  
disturbances)

0 = Absent

1 = Mild

2 = Severe

### ■ 15.

#### HYPOCHONDRIASIS

0 = Not present

1 = Self-absorption (bodily)

2 = Preoccupation with health

3 = Querulous attitude

4 = Hypochondriacal delusions

### ■ 16. WEIGHT LOSS

0 = No weight loss

1 = Slight

2 = Obvious or severe

### ■ 17. INSIGHT

(Insight must be  
interpreted in terms  
of patient's  
understanding and  
background.)

0 = No loss

1 = Partial or  
doubtful loss

2 = Loss of insight

### TOTAL ITEMS 1 TO 17: \_\_\_\_\_

0 - 7 = Normal

8 - 13 = Mild

Depression

14-18 = Moderate

Depression

19 - 22 = Severe

Depression

≥ 23 = Very Severe

Depression

### ■ 18. DIURNAL VARIATION

(Symptoms worse in morning or  
evening.

Note which it is.)

0 = No variation

= Mild variation;

1 AM ( ) PM ( )

= Severe variation; ) PM

2 AM ( ( ) )

### ■ 19.

#### DEPERSONALIZATION AND DEREALIZATION

(feelings of  
unreality,  
nihilistic  
ideas)

0 =

Absent

1 = Mild

2 = Moderate

3 = Severe

4 = Incapacitating

■ **20. PARANOID SYMPTOMS** (Notwithadepressivequality)

- 0 = None
- 1 = Suspicious
- 2 = Ideas of reference
- 3 = Delusions of reference and persecution
- 4 = Hallucinations, persecutory

(Obsessive thoughts and compulsions against which the patient struggles)

0 = Absent

1 = Mild

2 = Severe

\* Adapted from Hamilton, M. *Journal of Neurology, Neurosurgery, and Psychiatry*. 23:56-62, 196

■ **21. OBSESSIVE SYMPTOMS**

## Annex B.2. HAM-D Rating Scale

### Local Dialect Version

# HAMILTON DEPRESSION RATING SCALE (HAM-D)

(Himuon sang isa ka health care professional)

Ngalan/Code sang Pasyente \_\_\_\_\_ Petsa: \_\_\_\_\_

Ang HAM-D gin himo para iskoran ang pag ka lala sang depresyon sang mga pasyente. Bisan ini may 21 ka bahin, gina kalkular lamang ang iskor sang pasyente sa una nga 17 nga sabat.

#### 1. MASUBO NGA PAMALATYAGON

(Masubo nga mga panimuot, negatibo nga panan-aw sang pala-abuton, pagka subo, daw pirmi lang mahibi)

- 0 = Wala
- 1 = Nasubuan
- 2 = Naga hibi kung kaisa
- 3 = Pirmi lang ga hibi
- 4 = Tuman ka dalom nga simptomang

#### 2. PAGHINAKIT NGA PAMALATYAGON

- 0 = Wala
- 1 = Gina basol ang lawas, may pamatyag nga na dismayang ang iban nga tawo
- 2 = Pamensaron sang paghinakit
- 3 = Ang sakit subong isa ka silot; delusyon sang paghinakit.
- 4 = Halusinasyon sang paghinakit

#### 3. SUICIDE

- 0 = Wala
- 1 = Pamatyag nga ang kabuhi wala na pulos.
- 2 = Gusto nga mapatay
- 3 = Ideya sang suicide or may gina himo para mag suicide
- 4 = Nagbukong mag pakamatay

#### 4. INSOMNIA - Inisyal

(Nabudlayan mag tulog)

- 0 = Wala
- 1 = Kung kaisa
- 2 = Pirmi

#### 5. INSOMNIA – Sa Tunga

(Naga reklamo nga indi mapahamtang kag ginatublag sa gabi. Naga lakat kung gabi)

- 0 = Wala
- 1 = Kung kaisa
- 2 = Pirmi

#### 6. INSOMNIA – Atrasado

(Waking in early hours of the morning and unable to fall asleep again)

(Naga lakat sa ka-agahon kag indi na maka balik tulog)

- 0 = Wala
- 1 = Kung kaisa
- 2 = Pirmi

#### 7. OBRA KAG INTERES

- 0 = Wala sang kabudlay
- 1 = Pamatyag nga wala sang kapasidad, indi mapahamtang, indi maka pag desisyon sang maayo.

- 2 = Pag dula sang interes sa mga gusto obrahon kag pag buhin sang mga social nga aktibidades.
- 3 = Pag buhin nga pagka produktibo.
- 4 = Indi maka obra. Nag untat sang obra bangod sang sakit. ( Ang indi pag obra pag ka tapos sang pagpamulong ukon sa pag ayo pahimo nga maka panubo sang iskor)

#### 8. PAGKAHINA

(Mahinay ang pamensaron, ang paghambal, ang pag giho; wala sang labot, kag pagka tulala)

- 0 = Wala
- 1 = Gamay nga pagkahina sa interbyu
- 2 = Ma kita gid ang pagkahi sa interbyu
- 3 = Mabudlay mag interbyu.
- 4 = Naga tulala

#### 9. INDI PAG PAHAMTAL

(Indi mapahamtang bangod sa nerbyos)

- 0 = Wala
- 1 = Kung kaisa
- 2 = Pirmi

#### 10. NERBYOS - PAMENSARON

- 0 = Wala
- 1 = Tensyon kag pag ka irritable
- 2 = Pagka bakala sa mga gagmay nga bagay
- 3 = Pirmi lang naga kabalaka
- 4 = Pagkahadlok

#### 11. NERBYOS – SIMTOMA SA KALAWASAN

(Gastrointestinal, indi matunwan, Cardiovascular, pag kuba kuba sang dughan, sakit sang ulo, Respiratory, Genito-urinary, etc.)

- 0 = Wala
- 1 = Gamay
- 2 = Kasarangan
- 3 = Malala
- 4 = Indi na maka obra

#### 12. SIMTOMA SA KALAWASAN - GASTROINTESTINAL

(Pag dula sang gana sa kaon, Butod ang tyan, gina tubol)

- 0 = Wala
- 1 = Gamay
- 2 = Malala

#### 13. SIMTOMA SA KALAWASAN - GENERAL

( Mabug-at ang mga kamot kag tiil, likod ukon ulo; Masakit nga likod, wala sang puwersa kag masami lang makapoy)

- 0 = Wala
- 1 = Gamay
- 2 = Malala

#### 14. SIMTOMA SA KINATAWO

(Dula ang gana sa seks, pag distorto sa menstruation)

- 0 = Wala
- 1 = Gamay
- 2 = Malala

#### 15. HYPOCHONDRIASIS

- 0 = Wala
- 1 = Pagkabalaka sa kaugalingon
- 2 = Pagkabalaka sa ika-ayong lawas
- 3 = masami lang naga reklamo

4 = Hypochondriacal delusions

#### 16. PAGNIWANG

0 = Wala

1 = Gamay

2 = Malala

#### 17. INSIGHT

(Ang insight paga intrepretaron suno sa pag intiende sang pasyente kag sa iya ginhalinan)

0 = Wala sang pag kadula

1 = Gamay or kaduluda nga pagka dula

2 = Pagkadula sang insight

TOTAL ITEMS 1 TO 17: \_\_\_\_\_

0 - 7 = Normal

8 - 13 = Gamay nga Depression

14-18 = Kasarangan nga Depression

19 - 22 = Malala nga Depression

> 23 = Tuman ka lala Depression

#### 18. DIURNAL VARIATION

(Ang simtomang malala sa aga or sa gabi. Hibaluan kung sa diin)

0 = Wala sang deperensya

1 = Gamay nga deperensya; AM ( ) PM ( )

2 = Malala nga deperensya; AM ( ) PM ( )

#### 19. DEPERSONALIZATION AND DEREALIZATION

(Pag batyang nga indi tuod ang palibot, pagpati nga dali na maguba ang kalibutan)

0 = Wala

1 = Gamay

2 = Kasarangan

3 = Malala

4 = Indi na maka obra

#### 20. PARANOID NGA SIMTOMAS

(Wala sang pagkasubo nga klase)

0 = Wala

1 = Pagduda

2 = Ideas of reference

3 = Delusions of reference kag persecution

4 = Hallucinations, persecutory

#### 21. OBSESSIONAL NGA SIMTOMAS

(Obsessive nga paghunahuna kag kumpulsyon nga gina batu-an sang pasyente)

0 = Wala

1 = Gamay

2 = Malala

---

\* Adapted from Hamilton, M. Journal of Neurology, Neurosurgery, and Psychiatry. 23:56-62, 1960.

## Annex C.1. Child PTSD Symptom Scale

### English Version

#### The Child PTSD Symptom Scale (CPSS) – Part I

Below is a list of problems that kids sometimes have after experiencing an upsetting event. Read each one carefully and circle the number (0-3) that best describes how often that problem has bothered you IN THE LAST 2 WEEKS.

Please write down your most distressing event:

---

Length of time since the event:

---

	0		1		2		3	
	Not at all or only at one time		Once a week or less/ once in a while		2 to 4 times a week/ half the time		5 or more times a week/almost always	
1.	0	1	2	3	Having upsetting thoughts or images about the event that came into your head when you didn't want them to			
2.	0	1	2	3	Having bad dreams or nightmares			
3.	0	1	2	3	Acting or feeling as if the event was happening again (hearing something or seeing a picture about it and feeling as if I am there again)			
4.	0	1	2	3	Feeling upset when you think about it or hear about the event (for example, feeling scared, angry, sad, guilty, etc)			
5.	0	1	2	3	Having feelings in your body when you think about or hear about the event (for example, breaking out into a sweat, heart beating fast)			
6.	0	1	2	3	Trying not to think about, talk about, or have feelings about the event			
7.	0	1	2	3	Trying to avoid activities, people, or places that remind you of the traumatic event			
8.	0	1	2	3	Not being able to remember an important part of the upsetting event			
9.	0	1	2	3	Having much less interest or doing things you used to do			
10.	0	1	2	3	Not feeling close to people around you			
11.	0	1	2	3	Not being able to have strong feelings (for example, being unable to cry or unable to feel happy)			

- |     |   |   |   |   |  |
|-----|---|---|---|---|--|
| 12. | 0 | 1 | 2 | 3 | Feeling as if your future plans or hopes will not come true (for example, you will not have a job or getting married or having kids)           |
| 13. | 0 | 1 | 2 | 3 | Having trouble falling or staying asleep   |
| 14. | 0 | 1 | 2 | 3 | Feeling irritable or having fits of anger  |
| 15. | 0 | 1 | 2 | 3 | Having trouble concentrating (for example, losing track of a story on the television, forgetting what you read, not paying attention in class) |
| 16. | 0 | 1 | 2 | 3 | Being overly careful (for example, checking to see who is around you and what is around you)   |
| 17. | 0 | 1 | 2 | 3 | Being jumpy or easily startled (for example, when someone walks up behind you)   |

### **The Child PTSD Symptom Scale (CPSS) – Part 2**

Indicate below if the problems you rated in Part 1 have gotten in the way with any of the following areas of your life DURING THE PAST 2 WEEKS.

- |     | Yes | No |                                  |
|-----|-----|----|----------------------------------|
| 18. | Y   | N  | Doing your prayers               |
| 19. | Y   | N  | Chores and duties at home        |
| 20. | Y   | N  | Relationships with friends       |
| 21. | Y   | N  | Fun and hobby activities         |
| 22. | Y   | N  | Schoolwork                       |
| 23. | Y   | N  | Relationships with your family   |
| 24. | Y   | N  | General happiness with your life |

## Annex C.2. Local Dialect Version

### Child PTSD Symptom Scale

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Ang magasunod listahan sg mga problema nga gina-atubang sang mga kabataan pagkatapos sg isa ka malain, mabudlay kag mabug-at nga eksperyensya. Palihog basahon maayo ang tagsa ka numero kag pili-a ang sabat nga nagakaigo. Butangi sg bilog ang numero (0-3) nga pinakamalapit nga nagalarawan o nagapabutyag kung pila ka bes gakatabo sa imo ang problema SA NAGLIKAD NGA DUHA KA SEMANA.

---

Palihog sulat sg imo pinakamalain/pinakasubo nga na-agan:

---

Pila na ka adlaw/semana/bulan/tuig ang naglipas sg ini natabo:

---

Talamdan sg imo sabat para sa Una nga Parte:

*0 = Wala guid/ Kaisa lang guid sa sulod sg nagligad nga duha ka semana*

*1 = Kaisa ka bes taga-semana/ kis-a lang taga-semana/malaka*

*2 = Kaduha ka bes asta ka-apat ka bes taga semana/ daw pirmi gid*

*3 = Kalima ka bes ukon sobra pa taga-semana/ pirmi gid*

#### Nauna nga parte (Part 1)

1. May mga nagasulod nga malain nga huna-huna o paminsaron o mga laragway parte sa natabo bisan pa wala ko ini ginahungod nga paminsaron.

*0 = Wala guid/ Kaisa lang guid sa sulod sg nagligad nga duha ka semana*

*1 = Kaisa ka bes taga-semana/ kis-a lang taga-semana/malaka*

*2 = Kaduha ka bes asta ka-apat ka bes taga semana/ daw pirmi gid*

*3 = Kalima ka bes ukon sobra pa taga-semana/ pirmi gid*

2. May mga malain ako nga damgu.

*0 = Wala guid/ Kaisa lang guid sa sulod sg nagligad nga duha ka semana*

*1 = Kaisa ka bes taga-semana/ kis-a lang taga-semana/malaka*

*2 = Kaduha ka bes asta ka-apat ka bes taga semana/ daw pirmi gid*

*3 = Kalima ka bes ukon sobra pa taga-semana/ pirmi gid*

3. Nagakatabu liwat sa akon ang malain ko nga eksperyensya. (Pareho nga may mga nabatian ako ukon may mga nakita ako nga larawan (pictures) parte sa natabo kag napamatyagan ko nga daw gakatabo liwat.)

*0 = Wala guid/ Kaisa lang guid sa sulod sg nagligad nga duha ka semana*

*1 = Kaisa ka bes taga-semana/ kis-a lang taga-semana/malaka*

*2 = Kaduha ka bes asta ka-apat ka bes taga semana/ daw pirmi gid*

*3 = Kalima ka bes ukon sobra pa taga-semana/ pirmi gid*

4. Nagalain gid buot kag pamatyag ko kung panumdumon ko ang natabo ukon mabatian ko ang natabo sa akon. (Isa o sobra isa sa magasunod gakatabo sa akon: nagakulbaan ako, akig ako, nasubuan ako, nakonsyensya ako, kag iban pa nga negatibo nga pamatyagon pareho sg \_\_\_\_\_).

*0 = Wala guid/ Kaisa lang guid sa sulod sg nagligad nga duha ka semana*

*1 = Kaisa ka bes taga-semana/ kis-a lang taga-semana/malaka*

*2 = Kaduha ka bes asta ka-apat ka bes taga semana/ daw pirmi gid*

*3 = Kalima ka bes ukon sobra pa taga-semana/ pirmi gid*

5. May nabatyagan ako nga nagakatabo sa akon lawas kung panumdumon ko o mabatian ko ang natabo (Pareho sg isa o sobra isa sg mga nagasunod: nagapamalhas ukon nagakudog-kudog akon dughan kun madumduman o panumdumon ko ang natabo).

*0 = Wala guid/ Kaisa lang guid sa sulod sg nagligad nga duha ka semana*

*1 = Kaisa ka bes taga-semana/ kis-a lang taga-semana/malaka*

*2 = Kaduha ka bes asta ka-apat ka bes taga semana/ daw pirmi gid*

*3 = Kalima ka bes ukon sobra pa taga-semana/ pirmi gid*

6. Ginahungod ko (o hungod sa buot ko) nga indi pagpanumdumon, istoryahan, ukon batyagon ang malain nga natabo. (Alternatively: wala ko ginapanumdum, gina-istoryahan, ukon gina-batyag ang malain nga natabo.)

*0 = Wala guid/ Kaisa lang guid sa sulod sg nagligad nga duha ka semana*

*1 = Kaisa ka bes taga-semana/ kis-a lang taga-semana/malaka*

*2 = Kaduha ka bes asta ka-apat ka bes taga semana/ daw pirmi gid*

*3 = Kalima ka bes ukon sobra pa taga-semana/ pirmi gid*

7. Ginahungod ko nga indi mag-ugyon, mag-upod o magpartisipar sa mga buluhaton o actividades, mag-upod sa mga tawo, o magkadto sa mga lugar nga nagapadumdum sa akon sg malain nga natabo.

*0 = Wala guid/ Kaisa lang guid sa sulod sg nagligad nga duha ka semana*

*1 = Kaisa ka bes taga-semana/ kis-a lang taga-semana/malaka*

*2 = Kaduha ka bes asta ka-apat ka bes taga semana/ daw pirmi gid*

*3 = Kalima ka bes ukon sobra pa taga-semana/ pirmi gid*

8. Indi ko madumduman mga importante nga detalye o parte sg mga malain nga natabo.

*0 = Wala guid/ Kaisa lang guid sa sulod sg nagligad nga duha ka semana*

*1 = Kaisa ka bes taga-semana/ kis-a lang taga-semana/malaka*

*2 = Kaduha ka bes asta ka-apat ka bes taga semana/ daw pirmi gid*

*3 = Kalima ka bes ukon sobra pa taga-semana/ pirmi gid*

9. Wala ko gana o gakadulaan ko gana sa mga buluhaton nga naandan ko himuon o obrahon sa adlaw-adlaw.

*0 = Wala guid/ Kaisa lang guid sa sulod sg nagligad nga duha ka semana*

*1 = Kaisa ka bes taga-semana/ kis-a lang taga-semana/malaka*

*2 = Kaduha ka bes asta ka-apat ka bes taga semana/ daw pirmi gid*

*3 = Kalima ka bes ukon sobra pa taga-semana/ pirmi gid*

10. Indi ko mabatyagan nga malapit ako sa mga tawo nga kaupod ko.

*0 = Wala guid/ Kaisa lang guid sa sulod sg nagligad nga duha ka semana*

*1 = Kaisa ka bes taga-semana/ kis-a lang taga-semana/malaka*

*2 = Kaduha ka bes asta ka-apat ka bes taga semana/ daw pirmi gid*

*3 = Kalima ka bes ukon sobra pa taga-semana/ pirmi gid*

11. Indi o wala ko kabatyag sang kalipay, kasubo ukon iban ba nga mabaskog nga balatyagon pareho sang kaakig, kahadlok ukon iban pa nga pareho nga balatyagon.

*0 = Wala guid/ Kaisa lang guid sa sulod sg nagligad nga duha ka semana*

*1 = Kaisa ka bes taga-semana/ kis-a lang taga-semana/malaka*

*2 = Kaduha ka bes asta ka-apat ka bes taga semana/ daw pirmi gid*

*3 = Kalima ka bes ukon sobra pa taga-semana/ pirmi gid*

12. May balatyagon ako nga ang akon mga plano, handum, kag mga ginapa-abot daw indi matabo. (Pareho sg balatyagon nga indi ako makaobra, makapamana/makapangasawa, ukon makabata.)

*0 = Wala guid/ Kaisa lang guid sa sulod sg nagligad nga duha ka semana*

*1 = Kaisa ka bes taga-semana/ kis-a lang taga-semana/malaka*

*2 = Kaduha ka bes asta ka-apat ka bes taga semana/ daw pirmi gid*

*3 = Kalima ka bes ukon sobra pa taga-semana/ pirmi gid*

13. Indi ko katulog ukon nabudlayan ako magtulog.

*0 = Wala guid/ Kaisa lang guid sa sulod sg nagligad nga duha ka semana*

*1 = Kaisa ka bes taga-semana/ kis-a lang taga-semana/malaka*

*2 = Kaduha ka bes asta ka-apat ka bes taga semana/ daw pirmi gid*

*3 = Kalima ka bes ukon sobra pa taga-semana/ pirmi gid*

14. Pirmi lang ko akig, ukon dali maaakig, ukon iritable sa mga tawo.

*0 = Wala guid/ Kaisa lang guid sa sulod sg nagligad nga duha ka semana*

*1 = Kaisa ka bes taga-semana/ kis-a lang taga-semana/malaka*

*2 = Kaduha ka bes asta ka-apat ka bes taga semana/ daw pirmi gid*

*3 = Kalima ka bes ukon sobra pa taga-semana/ pirmi gid*

15. Dali gakadula ang akon atensyon (Pareho sang dali ako madula sa pagsunod sg istorya sg akon ginalantaw sa telebisyon, ukon gakalipat ako sa akon ginabasa, ukon wala ako nagapamati sa klase).

*0 = Wala guid/ Kaisa lang guid sa sulod sg nagligad nga duha ka semana*

*1 = Kaisa ka bes taga-semana/ kis-a lang taga-semana/malaka*

*2 = Kaduha ka bes asta ka-apat ka bes taga semana/ daw pirmi gid*

*3 = Kalima ka bes ukon sobra pa taga-semana/ pirmi gid*

16. Sobra-sobra ang akon pagkamainamdamon ukon sobra-sobra nga pagkabalaka (Pareho sg sobra nga pangusisa kung sin-o ang mga tawo sa palibot ko ukon sobra nga pangusisa kung ano nga mga bagay-bagay ang ara sa palibot ko.)

*0 = Wala guid/ Kaisa lang guid sa sulod sg nagligad nga duha ka semana*

*1 = Kaisa ka bes taga-semana/ kis-a lang taga-semana/malaka*

*2 = Kaduha ka bes asta ka-apat ka bes taga semana/ daw pirmi gid*

*3 = Kalima ka bes ukon sobra pa taga-semana/ pirmi gid*

17. Dali ako makibot o manerbios.

*0 = Wala guid/ Kaisa lang guid sa sulod sg nagligad nga duha ka semana*

*1 = Kaisa ka bes taga-semana/ kis-a lang taga-semana/malaka*

*2 = Kaduha ka bes asta ka-apat ka bes taga semana/ daw pirmi gid*

*3 = Kalima ka bes ukon sobra pa taga-semana/ pirmi gid*

## **Ika-duha nga parte (Part 2)**

Palihog sabat sa sini nga parte (Part 2) kon ang mga problema nga ginsabtan mo sa una nga parte naging sagabal sa magamasunod nga mga parte sang imo kabuhi SA SULOD SANG NAGLIKAD NGA DUHA KA SEMANA.

### **Huo ukon Wala** (Palihog pili isa sa imo sabat)

18. Sa akon pagpangamuyo

Huo                  Wala

19. Sa akon mga pang-adlaw-adlaw nga buluhatonsa panimalay

Huo                  Wala

20. Relasyon sa akon mga abyan/amiga/amigo

Huo                  Wala

21. Kalingawan ko sa pang-adlaw-adlaw kag 'hobbies'

Huo                  Wala

22. Mga ulobrahon sa eskwelahan

Huo                  Wala

23. Relasyon ukon pakigbagay sa imo pamilya

Huo                  Wala

24. Kabug-usan nga pagkakontento ukon pagkalipay sa imo kabuhi.

Huo                  Wala

This scale is from Foa, E. B., Treadwell, K., Johnson, K., and Feeny, N. (2001). Child PTSD symptom scale (CPSS): Validation of a measure for children with PTSD. *Journal of Clinical Psychology*, 30, 376-384.

Translated to Hiligaynon by Sanley S. Abila, PhD, and Diosdado Amargo, MD. We are grateful to Reynold Tan, PhD for his comments.

**Annex D.1. Socio- Economic Information Sheet**  
**English Version**

1.0 Personal data information

1.1 Name (optional) : \_\_\_\_\_

1.2 Home Address: \_\_\_\_\_

1.3 Age (years): \_\_\_\_\_

1.4 Highest educational attainment before the intervention: \_\_\_\_\_

1.5 Highest educational level after the intervention: \_\_\_\_\_

1.6 Name of household head (optional): \_\_\_\_\_

1.7 Age of household head (years old): \_\_\_\_\_

1.8 Relationship to respondent: \_\_\_\_\_

1.9 Highest educational level of the household head: \_\_\_\_\_

2.0 Household information

2.1 Household Size (including self): \_\_\_\_\_

Name of family members (optional)	Age, in years	Sex (please tick appropriate box)	Currently employed
		<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Yes <input type="checkbox"/> No
		<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Yes <input type="checkbox"/> No
		<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Yes <input type="checkbox"/> No
		<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Yes <input type="checkbox"/> No
		<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Yes <input type="checkbox"/> No
		<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Yes <input type="checkbox"/> No
		<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Yes <input type="checkbox"/> No

3.0 Assistance received

3.1 Have you received any assistance from Cameleon Inc.?

Yes                      No

If answer is YES, proceed to item 3.3. Otherwise, proceed to item 3.2.

3.2 Have you received any assistance from any individual/organization after the abuse?

Yes  No

3.2.1 If answer is YES, what are the organizations/individual which have extended any assistance? Specify also the nature of assistance which were extended.

Assistance from organization/institution	Assistance received (please list all)

3.2.2 Did any member of your family receive any assistance relating to:

		Specify assistance
Education (e.g. scholarships)	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Employment (e.g. livelihood assistance)	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Community participation (e.g. religious or civic organizations)	<input type="checkbox"/> Yes <input type="checkbox"/> No	

3.3 Other socio-demographic indicators

Indicator	Before Intervention (Year: _____)	After intervention (Year: _____)
<i>Employment</i>		
# of household members 18 years old and above who are working		
<i>Education</i>		
# of household members 10		

years and above who can read and write		
<i>Income</i> *		
Source of primary family income		
Amount, in pesos /month		
Sources of secondary family income		
Amount, in pesos /month		
Do you participate in local civic or social organization?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Role/s played in any civic or social organization (e.g. officer, member)		

**Annex D.2. Socio- Economic Information Sheet  
Local Dialect Version**

1.0 Personal nga mga impormasyon:

1.1 Ngalan (optional) :

---

1.2 Home Address:

---

1.3 Edad (tuig): \_\_\_\_\_

1.4 Pinakataas nga libel sang edukasyon antis sang interbensyon:

---

1.5 Pinakataas nga libel sang edukasyon pagkatapos san interbensyon:

---

1.6 Ngalan sang ulo sang panimalay (optional):

---

1.7 Edad sang ulo sa panimalay (tuig): \_\_\_\_\_

1.8 Relasyon sa natungdan/partisipante:

---

1.9 Pinakamataas nga libel sang edukasyon sang ulo sa panimalay:

---

2.0 Impormasyon nahanungod sa panimalay:

2.1 Kadamuon sang Miyembro sang Panimalay (upod na ang partisapante):

---

Ngalan sang Miyembro sang Pamilya (optional)	Edad, tinuig	Kinatawo (palihod tsek sa natungdan nga kahon)	Nagaubra/Gapangimpleyo
		<input type="checkbox"/> Lalake <input type="checkbox"/> Babaye	<input type="checkbox"/> Huo <input type="checkbox"/> Wala
		<input type="checkbox"/> Lalake <input type="checkbox"/> Babaye	<input type="checkbox"/> Huo <input type="checkbox"/> Wala
		<input type="checkbox"/> Lalake <input type="checkbox"/> Babaye	<input type="checkbox"/> Huo <input type="checkbox"/> Wala
		<input type="checkbox"/> Lalake <input type="checkbox"/> Babaye	<input type="checkbox"/> Huo <input type="checkbox"/> Wala
		<input type="checkbox"/> Lalake <input type="checkbox"/> Babaye	<input type="checkbox"/> Huo <input type="checkbox"/> Wala
		<input type="checkbox"/> Lalake <input type="checkbox"/> Babaye	<input type="checkbox"/> Huo <input type="checkbox"/> Wala
		<input type="checkbox"/> Lalake <input type="checkbox"/> Babaye	<input type="checkbox"/> Huo <input type="checkbox"/> Wala

### 3.0 Mga Nabaton nga Bulig

3.1 May mga nabaton bala kamo nga bulig gikan sa Cameleon Inc.?

Huo Wala

Kung ang sabat HUU, diretso sa numero 3.3. Kung Wala, diretso sa numero 3.2.

3.2 May mga nabaton nbala kamo nga bulig gikan sa indibidwal ukon organisasyon pagkatapos sang pag-abuso?

Huo Wala

3.2.1 Kung ang sabat HUU, ano nga mga organisasyon o sin-o nga mga indibidwal ang naghatag sang ila bulig? Pakibutang sang sahi/klase sang bulig nga ila nahatag.

Bulig nga nabaton gikan sa indibidwal/organisasyon	Sahi o Klase sang Bulid (palihog lista tanan)

3.2.2 May ara bala miyembro sang inyo pamilya nga nakabaton bulig nahanungod sa:

		Klase/Sahi sang Bulig
Edukayon (e.g. “scholarship”)	<input type="checkbox"/> Huo <input type="checkbox"/> Wala	
Ubra/Palangitana-an (e.g. bulig para sa palangabuhian)	<input type="checkbox"/> Huo <input type="checkbox"/> Wala	
Pagpartisipar sa Komunidad (e.g. nahanungod sa reliyon ukon banwahanon nga organisasyon)	<input type="checkbox"/> Huo <input type="checkbox"/> Wala	

### 3.3 Mga iban pa nga “socio-demographic indicators”

Mga Tanda o “Indicators”	Antis sang Interbensyon (Tuig: _____)	Pagkatapos sang Interbensyon (Tuig: _____)
<i>Ubra/Palangabuhian</i>		
Kadamuon sang miyembro sang panimalay nga naga-edad 18 pataas nga naga-ubra		
<i>Edukasyon</i>		
Kadamuon sang miyembro sang panimalay nga naga-edad 10 pataas nga kabalo magbasa kag magsulat		
<i>Palangabuhian*</i>		
Ginakuhaan sang mayor nga palangabuhian sang pamilya		
Pila ka pesos sa isa ka bulan		
Iban pa nga ginhalinan sang palangabuhian sang pamilya		
Pila ka pesos sa isa ka bulan		
Naga-partisipar ka bala sa mga lokal nga makibanwahanon (o makitawo) nga mga organisasyon?	<input type="checkbox"/> Huo <input type="checkbox"/> Wala	<input type="checkbox"/> Huo <input type="checkbox"/> Wala
Ano ang imo nga parte o bahin sa mga makibanwahanon (o makitawo) nga mga organisasyon nga ini (e.eg. opisyal,miyembro)?		

## **Annex E**

### **Focus Group Discussion Guide Questions**

#### **Target participants**

1. Adults who received at least one workshop/seminar/other related activities under the programs of Cameleon – examples are teachers, community leaders, and employees from LGU (2 GROUPS)
2. Students (preferably senior high school students) who received at least one workshop/seminar/other related activities under the programs of Cameleon (1 GROUP)

#### **Topics**

1. Information about their role in the community, including their role with children who are survivors of child sexual abuse (CSA)
2. Perspectives on survivors of CSA
3. Their role in addressing violence toward children who are survivors of CSA
4. Perspectives of the Cameleon Rehabilitation, After Care and Advocacy Programs
5. Recommendations for future interventions

#### **Questions**

##### **1. Information about their role in the community, including their role with children who were survivors of CSA**

- 1.1. What is your role in the community? How long have you been in this role?
- 1.2. (If working in an organization) What services and/or programs do you organization offer to children who were survivors of CSA? Please describe these services and/or programs.
- 1.3. (If not part of organization, such a priest/pastor, community leader) Tell us how were you involved with children who were survivors of CSA.

##### **2. Perspectives on the children who are survivors of CSA**

- 2.1. What are your views or opinions on young persons who are survivors of CSA? (Probe for follow up questions such as do they express claims such as CSA is a crime, or survivors have to be rehabilitated or assisted, or they feel strongly to report if they hear or observe highly suspicious cases of CSA in their community, and so forth. Ask follow up questions from the key claims of the respondent.
- 2.2. For you, what are challenges of children who are survivors of CSA in your community?

2.3. (GROUP ACTIVITY) Draw a map of your community- highlight individuals, institutions and services where children who are survivors of CSA can get support.

### **3. Their role in addressing violence toward children who are survivors of CSA**

3.1. Is your organization currently involved with any activity/program/project relating to children who are survivors of CSA? Please tell us about them.

3.1.1. Who are the beneficiaries/targets of the activity/program/project?

3.1.2. What does the activity/program/project involve (i.e. components or specific area or focus, if applicable)?

3.1.3. Where is the activity/program/project being implemented?

3.1.4. What organizations/individuals support the activity/program/project?

3.1.5. What are the successes of the activity/program/project?

3.1.6. What are the constraints of the activity/program/project?

3.1.7. What changes to the activity/program/project you want to see in the future?

### **4. Perspectives of the Cameleon Rehabilitation, After Care and Advocacy Programs**

4.1. At what point were you involved in the any programs from Cameleon? Were you involved in an establishment of a specific activity/project? (probe if during conceptualization, consultations, needs assessment, prioritization of needs, relevance of needs, usefulness, timeliness of project, planning implementation, evaluation?)

4.2. If not directly involved, what activity/ies have you participated in? When was this? (probe if rehabilitation, after care, and advocacy program)

4.3. What extent has the Cameleon Advocacy Program created a supporting and supportive environment for children who are survivors of CSA (i.e. those who been rehabilitated in Cameleon). In what way/s?

4.4. Do you think the Cameleon has improved the well-being of these girls? In what way/s?

4.5. Are there people in this community whose lives have been changed as a result of benefitting from any program of Cameleon? What changes have you seen as a result of this program?

4.6. Is there a success story that you can share with us that is the result of your participation in any Cameleon projects?

4.7. In what way/s do Cameleon programs different from other projects/programs relating to children who are survivors of CSA?

4.8. What recommendations can share in improving these programs of Cameleon ? (probe to give insights for rehabilitation, after care, and advocacy programs)

**5. Recommendations for future interventions**

5.1. What recommendations for future services or programs can you think of? (probe for details of each suggestion – including the target population of the services/programs, how the service/program can be implemented)

5.2. What recommendations for future services can you think of to assist children who are survivors of CSA?

**6. This is the end of the focus group discussion, anything else to add?**

-END-

## Annex F

### Key informant interview questionnaire

#### Topics

1. Your organization and its work on children who are survivors of child sexual abuse (CSA)
2. Perspectives on Cameleon projects
3. Current issues and challenges
4. Recommendations for future interventions

#### Questions

- 1. Your organization and its work on children who are survivors of child sexual abuse (CSA)**
  - 1.1. What is your current role in your organization and what is the nature of your work?
  - 1.2. Is your organization currently involved with any activity/program/project relating to children who are survivors of CSA? Please tell us about these.
    - 1.2.1. Aims/objectives
    - 1.2.2. Expected outcomes
  - 1.3. What is your association / experience with Cameleon Projects? How do you know about it and what is the extent of your contact with or involvement in the project?
  - 1.4. Do your organization fund programmes or projects intended to help, rehabilitate or support children who are survivors of CSA? Where do the funding come from?
  - 1.5. (If the organization is private) Does your organization work with or collaborate with any government department, particularly collaborative projects or programmes intended to help, rehabilitate or support children who are survivors of CSA? Ask them to describe these programmes.
  - 1.6. (If the organization is public) Does your organization work with or collaborate with any private organization including NGOs, particularly collaborative projects or programmes intended to help, rehabilitate or support children who are survivors of CSA? Ask them to describe these programmes.
- 2. Perspectives on Cameleon projects**
  - 2.1. In your opinion, do the Cameleon Rehabilitation and After-Care Project improved the well-being of children who are survivors of CSA? In what way/s.
  - 2.2. Are communities more knowledgeable on children's rights and violence? Please tell us in what way/s.

- 2.3. Are communities more understanding and socially sensitive towards children who were victims of rape and to their families? Please tell us in way/s.
- 2.4. Is there an increase in report of violations in the community? Can you attribute this from the programs from Cameleon? Please tell us in way/s.
- 2.5. Are children who are survivors of CSA supported by their parents, social/community workers, church leaders in the
  - 2.5.1. Reporting violation
  - 2.5.2. Access to support services
  - 2.5.3. Please tell us in what way/s.
- 2.6. Are there any unique strategies that have been implemented in Cameleon projects that have significantly contributed to their successes? Please describe (see if there are differences/similarities between these strategies across communities/municipalities)

### **3. Current issues and challenges**

- 3.1. Please describe the current challenges of
  - 3.1.1. Children who are survivors of CSA in the region/municipality/community
  - 3.1.2. Public institutions who are involved with children who are survivors of CSA
  - 3.1.3. Non-government institutions who are involved with children who are survivors of CSA

### **4. Recommendations for future interventions**

- 4.1. What recommendations for future services or programs can you think of? (probe for details of each suggestion – including the target population of the services/programs, how the service/program can be implemented)
  - 4.1.1. What organizations/institutions do you think should be involved?
  - 4.1.2. Where do you think funding for these activities come from?
  - 4.1.3. What challenges do you foresee for these recommendations? What are the possible solutions for these challenges?
- 4.2. What recommendations for future services can you think of to assist children who are survivors of CSA?
  - 4.2.1. What organizations/institutions do you think should be involved?
  - 4.2.2. Where do you think funding for these activities come from?
  - 4.2.3. What challenges do you foresee for these recommendations? What are the possible solutions for these challenges?

### **5. This is the end of the interview, anything else to add?**

-END-

**Annex G.1. Participant Information and Informed Consent**  
**English Version**

**PARTICIPANT INFORMATION AND INFORMED CONSENT**

RESEARCH TITLE: *Impact Evaluation of Luxemburg Government Funded Program*

Dear \_\_\_\_\_,

Greetings!

We are researchers from the University of the Philippines Visayas (UPV) and the College of Medicine, West Visayas State University (WVSU) who are studying the impacts of programs implemented by Cameleon Association Incorporated (hereafter referred to as CAI), and funded by the Government of Luxemburg. This research is funded and supported by CAI.

We would like to invite you to participate as respondent/key informant for this study. Please read this research participant information and consent document before you decide to participate in this study. This research has undergone a technical review under Ida Siason, PhD, who is a psychologist and a member of the board of trustees of CAI. For ethical concerns, the Unified Biomedical Research Ethics Review Committee of WVSU has reviewed this study. We are appreciative and grateful for your cooperation to take part in this study. The following sections will guide you understand the nature of this research and the procedures that we are implementing to protect the privacy and trust of our research participants.

**Purpose of the research study:**

This research will evaluate the 5-year program of CAI that was funded by the Ministry of Foreign Affairs of Luxembourg from September 2012 to August 2017. It will examine the impacts of the three associated programs of CAI: (1) the in house program, (2) after care program, and (3) advocacy program. All these programs were designed to address serious problems and concerns in relation to child sexual abuse (CSA) in Western Visayas, particularly rehabilitating female survivors of CSA. Specifically, our research aims to

1. Assess the impact of the rehabilitation program on the healing and stabilization process, the resilience of girls who are victims of sexual violence; and
2. Assess whether there has been a change in mentality, a better knowledge of the issues, resulting in a change in behaviour (prevention of abuse), an increase in reports and an improvement of the protection practices.

## **Procedures**

Data will be generated through surveys, focus group discussion (FGD) and key informant interview (KII).

A survey will be conducted to assess the impact of CAI's Rehabilitation Program to girls/young ladies who are survivors of child sexual abuse (CSA). We intend to survey 33 participants who are direct beneficiaries of CAI's programs, and no less than 13 participants for the non-Cameleon beneficiaries. That is, non-Cameleon participants mean survivors of CSA who are referred to government agencies such as the Department of Social Welfare and Development (DSWD) and PNP Women and Children Protection Desk (WCPD). In order to assess the mental well-being of the participants at the time of this research, clinical assessment using clinical rating scales will be conducted by our psychiatrist-researchers, Dr. Diosdado Amargo, Jr for adult participants, and Child and Adolescent Psychiatrist, Dr. Japhet Fernandez de Leon for child and adolescent participants. In addition, one FGD will be conducted with Cameleon beneficiaries.

To determine the impact of CAI's Advocacy Program, interviews will be conducted either individually (i.e., KII) or by groups (i.e., FGD). We intend to conduct at least 3 FGDs, for the adult participants (e.g., parents or guardians of beneficiaries) and school children who attended the Cameleon initiated advocacy campaigns. We will also conduct KIIs for key stakeholders such as the founder of CAI, beneficiaries, and government representatives involved in CSA.

Prior to data gathering, participants who are 18 years old and above will be requested to read and understand the *Informed Consent Form* or ICF (below) before giving your consent. For adolescent or child participants (i.e., those who are 17 years and 364 days to 7 years old), the parent or legal guardian will be asked to read, understand and sign the ICF below. Following the guidelines of the *Philippine National Health Research System (PNRS)* (2011) regarding the appropriate assent forms for adolescent and child participants, the adolescent participants are those aged between 12-15 years old, a simplified assent form is prepared separately. For child participants aged 7-12 years old a verbal assent form is provided. For child participants aged 5 years old and below, the parents or legal guardian are required to sign the ICF in behalf of the child. We will be happy to respond to any queries about the research and the ICF.

On this regard, we would like to invite you to be one of the participants in either one of the following:

- Survey
- Focus group discussion (FGD)
- Key informant interview (KII).

**As there are several key groups and individuals who will either be interviewed or complete a survey for this study, participation in this study means either:**

- a) Answering questions about your experiences, views and opinions on the rehabilitation program of CAI designed to heal and support young persons traumatized by sexual abuse and violence; and/or**
- b) Answering questions pertaining to your experiences, views, opinions and/or efforts**

**associated with the advocacy programs of CAI's programs in relation to sexual abuse and violence to young persons.**

**Time required and the language used:**

a. Survey

There are two types of surveys, clinical/medical survey and socio-economic survey. The clinical survey will use two clinical scales (Adult/Child PTSD scale and Child/Adult depression scale). These are standard scales used worldwide that could be conducted only by trained experts (i.e., child and adult psychiatrists). Each scale could be completed between 20-30 minutes. The socio-economic survey is a self-reported assessment that can be administered in 30 to 45 minutes.

b. Focus Group Discussion (FGD)

To determine the impact of CAI's programs particularly its advocacy programs, four FGDs will be conducted: two for the adult participants and one for the girls. Parents of the female beneficiaries currently availing of the assistance will also be interviewed. The FGD will take at least an hour but not more than 2 hours.

c. Key informant interview (KII)

For KII, it will take between 60-90 minutes.

**The interview (i.e., KIIs and FGDs) will be conducted primarily using the native language of the interviewee, particularly Hiligaynon. Tagalog and English are widely spoken in the Philippines, thus, these languages will also be used if the interviewee(s) is comfortable and fluent with either of these, and as the need arises.**

**The survey instruments (i.e., clinical scales and socio-economic survey) are originally in American English language but these have been translated in Hiligaynon/Ilonggo.**

**Benefits:**

Measuring and understanding the project impacts are key priorities of any organization. Assessment is important as it measures effectiveness of various activities of the organization. Through this research, CAI and its donor agencies will understand the significance of their rehabilitation and advocacy programs so as to help them with finding out what gaps exist and what future interventions can be developed. Thus, this research will assist them in (re)setting their priorities and in learning lessons and challenges of their past projects. We do not anticipate that you will benefit directly by participating in this study, however indirectly you will be benefited through improved services of CAI.

**Risks:**

One common reaction to traumatic events is an enduring negative emotional reaction to reminders of the event. Reminders of the event can trigger distress including anxiety and general upset. Because the survey asks participants about their experiences, there is the potential for this research to trigger emotional distress in reactive participants. In order to mitigate this potential distress, a layered system of protections is being put in place. The initial layer is the voluntary mechanism of recruitment. Because participants will be asked to take the affirmative step of agreeing to participate in the research before the actual data collection is scheduled, participants who are more reactive are likely to drop out at this

stage. Participants who have negative responses to reminders of traumatic events tend to avoid triggers and reminders of the event. As such, they are less likely to choose to participate in the research, and the structure of consent is such that they will be able to choose not to participate without social pressure to complete the survey.

### **Provision for medical/psychosocial support**

For those adults who will decide to participate, Dr. Diosdado Amargo, a Psychiatrist will manage the survey. He has a vast experience in handling research on individuals with traumatic experiences. Any clinical symptoms manifested by the female participants during the survey who may need immediate attention or follow up therapy will be referred to the in-house psychiatrist, Dr. Valerie Andora-Quilaton for management. This means that we assure that vulnerable participants are already under the care of CAI or DSWD.

During the survey, the transportation and food expenses of the non-Cameleon beneficiaries as well as FGD and KII participants who will be travelling to Passi City or Iloilo City will be shouldered by the research project.

### **Confidentiality, Privacy and Management of Data:**

**The objectivity, impartiality and confidentiality of data generation will be maintained by the researchers considering its survey and interview instruments. Interviews will take place in a room that has been booked specifically for this purpose and where privacy and confidentiality are guaranteed. CAI has private function rooms for interviews and/or surveys both in their Iloilo City office and Passi City rehabilitation centers that we have been given permission to use.**

**Informed consent and assent forms are essential procedures of our research so as to assure you that your responses will remain completely confidential and any personal details that you give us about you or anyone else will be made anonymous, private and confidential.**

**All the information will be stored securely in a password-encrypted file on the researchers' computers and in a locked cabinet. Your information will not be seen by anyone other than the researchers. Your identity will be kept confidential to the extent provided by law. Your information will be assigned a code number. The list connecting your name to this number, filled up questionnaires and other documents will be kept in a locked file in the researcher's office. When the study is completed and the data have been analyzed, the list will be destroyed. Your name will not be used in any report or publication.**

**The survey is structured so that personally identifying information is segregated to the first page, which is intended to be separated from the remainder of the survey before the participant completes it. Personally identifying information will be stored separately from the survey copies, and when the data are entered into electronic format only categorical data (such as age, gender, and religion) will be maintained. Names, addresses, and other contact information will not be retained.**

**For FGDs and KIIs, we will use aliases in the transcribed interviews. Real names and their corresponding aliases will be kept separately in password encrypted computers. This is to ensure the privacy of our participants as well as the confidentiality of our data.**

**Voluntary participation, Right to withdraw from the study and Compensation:**

**Your participation in this study is completely voluntary. Should you elect to discontinue participation, any information already collected will be discarded. There is no penalty or loss of benefit for choosing not to participate. You have the right to withdraw from the study at any time without consequence or penalty.**

**There are no monetary benefits that will be given to participants but only tokens of appreciation. This is to ensure that participants are not induced financially to participate.**

**Use of Data Collected from Participants:**

**All the data collected will be owned by the funder, Cameleon Association Inc (CAI). Access to data is highly restricted and limited only to the research team members and the funder. As mentioned above, all the information will be stored securely in a password-encrypted file on the researchers' computers and in a locked cabinet. Your information will not be seen by anyone other than the researchers.**

**From the data gathered, materials may be used publicly such as academic papers for academic journals, books, book chapters, or newspaper articles. The collected data could also be used in public forum such as academic conferences, public interviews of CAI, or advocacy programs. For this reason, CAI and the researchers will protect the privacy and trust of the participants that the names and other personally identifying information that will appear in publicly available documents are anonymized.**

**Whom to contact if you have questions about the study:**

**If you would like to see the results and findings of this study, you may get in touch with the researchers primarily through DR. REYNOLD D. TAN, and we will be able to refer you to Cameleon Association, Inc., the sole proprietor of all the research data generated in this study.**

**If you have any questions about this study, kindly call, text or email any of the following contact persons whose details appear below:**

**FRED P. GUILLERGAN, M.D.**

**Chair, Unified Biomedical Research Ethic Review Committee**

**West Visayas State University**

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**Informed Consent Agreement:**

**Research conducted by:** Reynold Tan, PhD (UPV), Sanley Abila, PhD, Cheryl Joy Fernandez, PhD (UPV), Joy Lizada, PhD (UPV), and Dr. Diosdado Amargo  
College of Medicine, West Visayas State University.

**Research funded and supported by:** Cameleon Association, Inc.

**As an informed participant in this research, I understand and acknowledge that:**

- **I have been duly informed that my responses will be kept anonymous and my personal details and those of any other people or organizations I name will be kept confidential.**
- **I have been properly informed that the details I provide will be used for the completion of a project evaluation report that will be available in the office of Cameleon Association, Inc., and may also be used as material for books or journal articles as well as material for public forum such as a conference.**
- **I have been duly informed that I may choose to end my participation at any time without consequence.**

**Any questions that I had about this research have been satisfactorily answered.**

Name of Participant: \_\_\_\_\_

Signature of Participant: \_\_\_\_\_

Date: \_\_\_\_\_

**(For Verbal Consent) Indicate the Voluntary Response to Participation:**

**Yes**

**No**

**Name of Interviewer:** \_\_\_\_\_

**Signature of Interviewer:** \_\_\_\_\_

**Date:** \_\_\_\_\_

**INFORMASYON PARA SA MAPASAKOP SA PAGTULUN-AN KAG  
PORMAS PARA SA BOLUNTARYO NGA PAGPASAKOP SA SINING  
PAGTULUN-AN**

TITULO SG PAGTULUN-AN: *Impact Evaluation of Luxemburg Government Program*

Dear \_\_\_\_\_,

Mga manunudlo kag manug-usisa (researchers) kami halin sa University of the Philippines Visayas (UPV) kag College of Medicine, West Visayas State University (WVSU) nga magatu-on sg ang mga resulta kag kahulogan (i.e., impacts) sg mga programa nga ginpatuman sg Cameleon Association, Incorporated (ukon Cameleon) kag ginpundohan sg Gobyerno sg Luxemburg. Ini nga pagtu-on ginpundohan kag suportado sg Cameleon.

Nagapamgayo kami sang imo bulig nga magpasakop bilang isa ka impormante sa ini nga pagtuon. Palihog basa sini nga dokumento antis ikaw magdesisyon sa pagpartisipar. Ini nga pagtuon nag-agi sa maid-id nga pagbasa sang “Technical Review” nga ginpangunahan ni Dr. Ida Siason kag sg Unified Biomedical Research Ethics Review Committee (UBRERC) sg WVSU. Nagapasalamat gid kami sa inyo nga kooperasyon.

Ang mga nagasunod nga mga detalye magapaintiende sa imo kung parte sa ano ang amon pagtulun-an, kag ang mga nagakalain-lain nga tikang para masigurado nga ang amon pagtulun-an nagasunod sg maayo nga “scientific practice” (scientifically correct) kag ginarepeto ang kinamatarung sg mga magapasakop (“ethically proper”).

**Tinutuyo sang amon pagtulun-an:**

Ang kabilugan nga tinutuyo sang sini nga pagtuon amo ang pag-intiende sg mga resulta kag kahulogan (i.e., impacts) sg mga programa nga ginpatumansang *Cameleon Association Incorporated* (nga atun tawagon Cameleon) nga ginpunduhan sang Ministry of Foreign Affairs of Luxembourg sugod Septyembre 2012 asta Agosto 2017. Ang Cameleon nag-implimintar sang tatlo ka mga programa kag ini ang: (1) pagtatap sang mga mga bata nga babaye nga biktima sg sekswal nga pangabuso ukon “CSA” (child sexual abuse), ukon nga ginatawag nga “in-house care”, (2) pagsuporta sang mga benepisyaryo sg Cameleon pagkatapos sg “in-house care” ka gang mga naka-puli sa ila mga panimalay ukon ang ginatawag nga “after care”, kag (3) ang programa nahanungod sa adbokasiya ukon panawagan sa pagpangapin sg mga kinamatarung sg mga kabataan labi na guid batok sa pisikal, mental kag sekswal nga pangabuso. Ang ini nga mga programa gindisenyo para mapabalik sa normal nga kahimtangan ang mga bata nga babaye nga naka-ekperyensya

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<sup>2</sup>Revised May 14, 2018. Version 2

sang abuso-sekswal kag ang mga komunidad nga ila ginhalinan. Ang programa nagatuyo man nga:

1. Maglantaw sang epekto sang programa sa pagpabalik sa normal nga kahimtangan, pagbulong o pag-ayo kag sang proseso padulong sa stabilisasyon ukon pagbalik sa normal, pati na paglantaw sang kabakod sang mga bata nga babaye nga mga biktima sang abuso-sekswal.
2. Lantawun kung may pagbag-o sa mentalidad kag may nagaka-angot nga ihibalo nahanungod sa mga isyu nahanugod sa pisikal, mental kag sekswal nga pangabuso sa mga kabataan, nga magaresulta sa pagbag-o sa pamatasan (nga maka-pauntat ukon ma-awat ang pangabuso), kung nagadamo ang pag-report sang mga insidente sg mga pangabuso, kag kung may mga maayo nga mga pamaagi sa pagtatap/pagprotekta sa mga kabataan kontra sa pangabuso.

### **Mga Pamaagi:**

Ang mga datus pagakuhaon pamaagi sa “survey”, “focus group discussion (FGD)” kag “key informant interview (KII)” ukon pag-interbyu sang mga tawo nga may madamo nga nahibaluan nahanungod sa mga isyu nahanugod sa pisikal, mental kag sekswal nga pangabuso sa mga kabataan.

Isa ka “survey” ang pagahiwaton para lantawun ang epekto sang “Rehabilitation Program” sang Cameleon para sa mga bata nga babaye/dalaga nga nakaagi abuso-sekswal. 30 ka mga babaye nga nakabenepisyong sang mga programa sang Cameleon kag indi magnubo sa 15 ka mga babaye nga wala nakaagi baton sang mga benepisyong gikan sa Cameleon ang paga-imbataron para magpsakop sa “survey”. Isa ka psychiatrist para sa mga tigulang kag isa para sa mga bata ang magahatag sg “survey” kag maga-interpretar sg mga resulta sang survey.

Para mahibaluan ang epekto sang Advocacy Program sang, magahiwat sang duha ka “FGD”: isa para sa mga partisipante nga naga-edad 18 anyos pasaka kag isa ka grupo para sa mga bata nga babaye nga 17 anyos kag 364 ka adlaw ang edad asta 7 anyos. May mga interbyuhon man kami nga mga nagakasari-sari nga mga eksperto nahanungod sa mga programa sang Cameleon, representante sg gobyerno nga may mando kag datus nahanugod sa mga pisikal, mental kag sekswal nga pangabuso sa mga kabataan.

Bag-o kami magsugod sa pagtipon sang inpormasyon, ang mga partisipante nga 18 anyos pataas ilihugon nga magbasa kag mag-intindi sang sini nga mga inpormasyon nahanugod sa pagpasakop sa sining pagtulun-an, kag sang pormas para sa *boluntaryo nga pagpasakop* ukon ang ginatawag nga “**Informed Consent Form** ukon *ICF*”. Pagkatapos basa kag intiende sg mga pormas hingyu-on namon nga magpirma sa “ICF” kung hungod kag desidido nga magapaskop sa sining pagtulun-an.

Kay kami nagasunod sa patakaran sg *Philippine National Health Research System* ukon PNHRS(2011) nahanugod sa pagkuha sg *boluntaryo nga pagpasakop sg mga kabataan ukon mga menor de edad* (ukon ang ginatawag nga “Assent”), may ginpreparar kami nga mga pormas para sa *boluntaryo nga pagpasakop sg mga kabataan* ukon “Assent” sg mga

menor de edad. Para sa mga kabataan nga amon paga-imbataron nga magpasakop sa amon pagtulun-an nga naga-edad sang 17 anyos kag 364 ka adlaw asta 7 anyos, ginahingyo namon ang ila ginhikanan ukon ang ila legal nga manugtatatap (legal guardian) nga magpirma sa ICF nga upod sa sini nga dokumento. Santo sa *PNHRS* (2011), kami magahatag sang simple nga pormas para sa boluntaryo nga pagpasakop sg mga kabataan (Assent form) nga naga-edad 15 asta 12 anyos. Para sa mga menor de edad nga naga-edad 7 asta 12 anyos, nagpreparar kami sg verbal nga pormas para sa *boluntaryo nga pagpasakop sg mga kabataan*. Para sa menor de edad nga 5 ka tuig kag mas manubo pa diri ang ginhikanan ukon ang “legal guardian” pagalihugon nga magbasa, mag-intindi kag magpirma sang “ICF”.

Kaangot sini, gina-imbatar ka namon nga magpasakop bilang partisipante sa isa ukon sa duha sa magasunod nga hilikuton (data collection activities):

- \_\_\_ Survey
- \_\_\_ Focus group discussion (FGD)
- \_\_\_ Key informant interview (KII).

Kung hungod sa inyo nga buot kag pagintiende nga kamo magapasakop sa amon pagtulun-an, magasabat kamo sg mga pamangkutanon paagi sa isa ka ‘interview’ kag/ukon sa isa ka survey. Ang inyo partisipasyon nagakahulugan nga:

- a) Magahatag ka inpormasyon nahanugod sa imo naeksperyensyan, opinyon, panghunahuna ukon mga kabalaka parte sa mga programa sg Cameleon kalakip ang programa nila para mabuligan paayo ang mga kabataan nga babayi nga biktima sg sekswal nga pangabuso;
- b) Magahatag ka inpormasyon nahanugod sa imo naeksperyensyan, opinyon, panghunahuna ukon mga kabalaka parte sa programa sg Cameleon natuhoy sa adbokasiya o panawagan (i.e., advocacy) sa pagpangapin sg mga kinamatarung sg mga kabataan labi na guid batok sa pisical, mental kag sekswal nga pangabuso.

### **Kinahanglanon nga Oras Kung Magpasakop sa Amon Pagtulun-an:**

#### a. Survey

Ang ini nga “self-reported assessment” pwede ma-administrar sa sulod sang 15 asta 20 ka minutos. Kaupod sang “socio-demographic information”, magadalagan ang “survey” sa 30 asta 45 ka minutos.

#### b. Focus Group Discussion (FGD)

Para mahibaluan ang epekto sang Cameleon’s “Advocacy Program”, magahiwat sang duha ka “FGD”: isa para sa mga hamtung nga nga partisipante kag isa para sa mga bata nga babaye. Ini nga Focus Group Discussion (FGD) indi maglapaw sa duha ka oras.

#### c. Key Informant interview (KII)

Ang key informant interview indi magsobra sa 90 minutos.

Ang 'interview' (KII ukon FD) pagahimuon sa Hiligaynon. Ang Tagalog kag Ingles ginagamit sg kadam-an sa Pilipinas, para sa amon ang ini nga mga lingwahi (i.e., languages) pagagamiton lang sg nagapamangkot (i.e., interviewer) kung komportable kag kung naga-gamit man ang ginapamangkot (i.e., interviewee). Kag ang mga ini nga mga lingwahi pagagamiton lang kung kinahanglon guid sa pagpakighinun-anon (i.e., interview).

Para sa mga masabat sg amon survey, ini pagahimuon sg amon mga psychiatrists gamit ang "standard clinical scales" ukon talamdam nga ginagamit sg mga psychiatrists sa lain-lain nga nasyon kalakip ang Pilipinas. Ang mga talamdan sa "clinical" surveys ginagamit para sa mga pasyente nga possible may depresyon ukon may "PTSD" (Posttraumatic Stress Disorder). Ang Cameleon may mga pribado nga mga kwarto nga pwede namon gamiton para sa pagsabat sg amon surveys.

### **Mga Benepisyo:**

Ang pagtuon sang epekto sang isa ka proyekto prayoridad gid sang isa ka organisasyon. Ini importante bangud ginalantaw ang pagka-epektibo sang mga nagakasari-sari nga mga aktibidades sang isa ka organisasyon. Pamaagi sa sini nga pagtuon, ang Cameleon kag ang mga ahensya nga nagahatag sa ila sang donasyon maka-intiendi sang pagka-importante kag mga limitasyon sang mga programa kag adbokasiya nahanungod sa rehabilitasyon sg mga biktima sg CSA. Ini makabulig sa ila pagtukib sang mga kakulangan para makahatag sang nagakaigo nga solusyon o interbesyon. Ini nga pagtuon makabulig man sa ila sa pagplastar sang ila mga prayoridad.

### **Mga Risgo:**

Ang isa ka masami nga resulta sang isa ka makangilidlis nga hitabo amo ang pagbalik-balik sang mga negatibo nga paminsaron parte sa natabo nga naga-resulta sa kakulba kag kahadlok kag kalain sang pamatyagan. Ang "survey" nga ini mahimo nga makapahanumdum sang indi mayo nga nagliligad nga natabo sa biktima. Para matapna ang mga negatibo nga resulta, may mga nanari-sari nga mga pamaagi nga pagabuhaton. Una, ang pagsabat sa ini nga pagtuon isa ka boluntaryo nga desisyon. Bangud sini, ang mga may mahuyang nga balatyagun madulaan sang kaisog nga magpartisipar.

Sa mga magpartisipar, ang survey pagahimuon ni Dr. Diosdado Amargo nga isa ka psychiatrist nga may malawig nga tinuig nga ekspersyensya sa pareho nga klase nga pagtuon.

### **Mga suporta-medikal/psychosocial**

**Kung may mga sintomas nga magilinuwa sa mga partisipante samtang ginahiwat ang survey, ini sila pagapakadtuon sa "in-house" psychiatrist sang Cameleon nga si Dr. Valerie Andora-Quilaton.**

**Ang gasto sa pamasahe, pagkaon kag iban pa sang partisipante sang survey, FGD kay KII sa pagkadto sa Passi City ukon Iloilo City magahalin sa research project.**

## **Respeto sa Pribado nga Mga Datus kag Talamdan sa Pagtatap sg mga Pribado Nga Mga Inpormasyon (Confidentiality, Privacy and Management of Data):**

Ang tanan nga mga inpormasyon parte sa pagtuon siguraduhon nga mangin pribado. Ang pagtuon pagahiwaton sa isa ka lugar nga indi sila makilal-an kag mahibal-an. Ang Cameleon may mga pribado nga pasilidad kung sa diin pagahiwaton ang mga interbyu sa syudad sang Passi kag Iloilo. May mga pahanugot ang mga researchers sa pag-gamit sang sini nga mga pasilidad.

Ang mga inpormasyon nga inyo igahatag mangin pribado. Ang detalye sang inyo pagkatawo indi makilan-an kag mahibalu-an sang iban nga mga partido. Tanan nga inpormasyon taguon namon sa pribado kag ‘password-encrypted’ nga mga “personal computers” kag sa isa ka kabinet nga de kandado. Pagkatapos sang sini nga pagtulun-an, ang tanan nga dokumento nga may inpormasyon parte sa partisipante pagadulaon. Ang mga tuod-tuod nga ngalan sang mga nagpasakop indi pag-ibutang sa mga report, mga pangpubliko nga materyales pareho sg libro, “academic papers”, ukon sa mga pangpubliko nga mga hilikuton pareho sg mga “conferences”.

Ang amon mga pormas pareho sg “FGD’s”, “surveys”, “KII’s” kag “Informed Consent/Assent” nagapasigurado sa tanan nga magapasakop sa sining pagtulun-an nga ang tanan ninyo nga mga personal nga inpormasyon kag sabat sa amon pamangkutanon sa survey ukon sa interview magapabilin nga pribado kag sekreto.

## **Boluntaryo nga Pagpasakop, Kinamatarung sa Pag-untat Pagpasakop kag Benepisyo sa Pagpasa (Compensation):**

Ang inyo partisipasyon ukon pagpasakop sa amon pagtulun-an nagasayuron nga ini boluntaryo. Kung kamo maga-desisyon nga maga-untat partisipar bisan pa nakasugod na ang “interview” ukon survey, ang tanan nga mga inpormasyon parte sa inyo pati na ang inyo mga sabat sa amon pamangkutanon pagadulaon. Wala penalidad ukon malain nga kunsikwensya sa inyo pag-untat sa pagpartisipar.

Wala bayad pinansyal sa pagpasakop sa sining pagtulun-an. Magahatag kami sg “tokens” para sa pagpasalamat sa tiyempo sg mga magapasakop. Indi kami magbayad sa mga magapasakop kay para sa amon gusto namon nga boluntaryo ang pagpasakop kag indi tungod ginabayaran ang pagpasakop.

Para sa mapa-interview, mahingyo kami nga i-rekord namon ang inyo mga sabat sa isa ka ‘digital recorder’ para masigurado namon nga intsakto ang amon datus nga naghalin guid sa amon “participants” kung ini pagasulaton na namon.

## **Diin gamiton ang mga datus (research data) sg sini nga pagtulun-an?**

Ang Cameleon amo ang tag-iya sg tanan nga mga inpormasyon nga makuha namon paagi sa sining pagtulun-an. Limitado lang ang makakita kag makagamit sg mga inpormasyon kag datus (research data) sg sining pagtulun-an. Ang mga datus pagagamiton sa “project evaluation report” para sa Cameleon. Hungod man nga pagagamiton ang mga

inpormasyon kag datus bilang parte sg libro ukon sa mga pangpubliko kag akademiko nga mga artikulo (i.e., academic or published articles).

Hungod man pagagamiton ang mga datus sa mga pangpubliko nga mga hilikuton nga naangot sa mga programa sg Cameleon pareho sg mga “public conferences, interviews or debates”.

Sin-o ang pwede istoryahon ukon pamangkuton nahanungod sa sining pagtulun-an? (Contact Persons):

Kung hungod ninyo nga mabal-an ang resulta sg amon pagtulun-an, sarang ninyo matawgan, mapadal-an mensahe paagi sa text ukon sa email si DR. REYNOLD D. TAN para mapadala nya sa Cameleon Association, Inc., ang inyo ginahingyo. Ang Cameleon amo ang tag-iya sg tanan nga mga inpormasyon nga makuha namon paagi sa sining pagtulun-an.

Kung may mga pamangkutanon ukon isyu nahanungod sa sini nga pagtuon, ang ini nga mga personas ang pwede nimo pakipag-angutan sa mga nanari-sari nga pamaagi. Palihog sulat, tawag ukon kontak sg mga nagaka-igo nga mga “contact persons”. Ang mga detalye sg mga contact persons:

**FRED P. GUILLERGAN, M.D.**

Chair, Unified Biomedical Research Ethic Review Committee  
West Visayas State University  
Luna St., La Paz, Iloilo City  
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**REYNOLD D. TAN, PHD**

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## **KASUGTANAN: PORMAS SA BOLUNTARYO NGA PAGPASAKOP (INFORMED CONSENT FORM)**

Ang mga taga-manug-usisa:

Reynold Tan, PhD, Sanley Abila, PhD, Cheryl Joy Fernandez, PhD, Joy Lizada, PhD  
*University of the Philippines Visayas*

Dr. Diosdado Amargo

*College of Medicine, West Visayas State University*

Ang ining pagtulun-an ginkomisyon kag suportado sang **Cameleon Association, Inc.**

### **Pormas sa Pagpahanugot sa Pagpasakop (Informed Consent Form):**

Sa pagpasakop sa sining pagtulu-an, naintiendihan kag nahibaluan ko nga:

- Ginapahibalo ako sg mga nagakaigo nga mga detalye nga ang akon mga sabat kag personal nga inpormasyon, ukon mga inpormasyon sg iban pa nga individwal kag mga organisasyon nga akon pagahingalanan magapabilin nga pribado kag sekreto.
- Ginapahibalo ako sg mga nagakaigo nga mga detalye nga ang akon igahatag nga mga inpormasyon pagagamiton sa sining pagtulun-an (i.e., project evaluation report) kag ang tanan nga mga inpormasyon nga makuha sg sining pagtulun-an ginapanag-iyahan sg kag pagatagu-on sa Cameleon Association, Inc.
- Ginapahibalo ako sg nagaka-igo nga mga detalye nga ang mga inpormasyon kag datus nga makuha sg sining pagtulun-an hungod nga magamit bilang parte sg libro, ukon sa mga pangpubliko kag akademiko nga mga kasulatan (i.e., academic or published articles), sa mga pangpubliko nga mga hilikuton nga naangot sa mga programa sg Cameleon pareho sg mga “public conferences, interviews or debates”.
- Ginapahibalo ako sg nagaka-igo nga mga detalye nga pwede ko guid ipa-untat ang akon pagpsakop bisan pa nakasugod na ang survey ukon interview, kag wala sg mga negatibo nga konsekwensya ang pagbawi ko sg akon pagpasakop.
- Ang tanan tanan ko nga pamangkutanon nasabat na sg naka-igo.

Ngalan sg nagpasakop: \_\_\_\_\_

Pirma sg nagpasakop: \_\_\_\_\_ Petsa: \_\_\_\_\_

*(Para sa gusto nga itugda/iambal lang nila ang ila pagpahanugot sa pagpasakop sa sining pagtulun-an)* Palihog marka ang nagaka-igo nga Boluntaryo nga sabat sg mapasakop:

**Huo**

**Indi**

Ngalan sg 'Interviewer': \_\_\_\_\_

Pirma sg Interviewer: \_\_\_\_\_

Petsa: \_\_\_\_\_

**Annex H.1.**  
**Participant information, informed consent form and assent agreement**  
**English Version**

**PARTICIPANT INFORMATION, INFORMED CONSENT FORM**  
**AND ASSENT AGREEMENT**

RESEARCH TITLE: *Impact Evaluation of Luxemburg Government Funded Program*

Dear \_\_\_\_\_

Greetings!

We are researchers from the University of the Philippines Visayas (UPV) and the College of Medicine, West Visayas State University (WVSU) who are studying the impacts of programs implemented by Cameleon Association Incorporated (hereafter referred to as CAI), and funded by the Government of Luxemburg. This research is funded and supported by CAI.

We would like to invite you to participate as respondent/key informant for this study. Please read this research participant information sheet, *informed consent form* (ICF) for parents or legal guardians, and *assent form* (found below) before you decide to participate in this study. This research has undergone a technical review under Ida Siason, PhD, who is a psychologist and a member of the board of trustees of CAI. For ethical concerns, the Unified Biomedical Research Ethics Review Committee of WVSU has reviewed this study. We are appreciative and grateful for your cooperation to take part in this study. The following sections will guide you understand the nature of this research and the procedures that we are implementing to protect the privacy and trust of our research participants.

**Purpose of the research study:**

This research will evaluate the 5-year program of CAI that was funded by the Ministry of Foreign Affairs of Luxembourg from September 2012 to August 2017. It will examine the impacts of the three associated programs of CAI: (1) the in house program, (2) after care program, and (3) advocacy program. All these programs were designed to address serious problems and concerns in relation to child sexual abuse (CSA) in Western Visayas, particularly rehabilitating female survivors of CSA. Specifically, our research aims to

1. Assess the impact of the rehabilitation program on the healing and stabilization process, the resilience of girls who are victims of sexual violence and;
2. Assess whether there has been a change in mentality, a better knowledge of the issues, resulting in a change in behaviour (prevention of abuse), an increase in reports and an improvement of the protection practices.

## **Procedures and Recruitment of Minors as Research Participants**

Data will be generated through surveys, focus group discussion (FGD) and key informant interview (KII).

A survey will be conducted to assess the impact of CAI's Rehabilitation Program to girls/young ladies who are survivors of child sexual abuse (CSA). **We intend to survey 33 participants who are direct beneficiaries of CAI's programs, and no less than 13 participants for the non-Cameleon beneficiaries. That is, non-Cameleon participants mean survivors of CSA who are referred to government agencies such as the Department of Social Welfare and Development (DSWD).** In order to assess the mental well-being of the participants at the time of this research, clinical assessment using clinical rating scales will be conducted by our psychiatrist-researchers, Dr. Diosdado Amargo, Jr for adult participants, and Child and Adolescent Psychiatrist, Dr. Japhet Fernandez de Leon for child and adolescent participants.

To determine the impact of CAI's Advocacy Program, interviews will be conducted either individually (i.e., KII) or by groups (i.e., FGD). We intend to conduct at least 3 FGDs, two for the adult participants (e.g., parents or guardians of beneficiaries) and one for the direct beneficiaries of the programs (i.e., girls and young ladies who are survivors of CSA). We will also conduct KIIs for key stakeholders such as the founder of CAI, beneficiaries, and government representatives involved in CSA.

Prior to data gathering, participants who are 18 years old and above will be requested to read and understand the *Informed Consent Form* or ICF (below) before giving your consent. We will be happy to respond to any queries about the research and the ICF. For adolescent or child participants (i.e., those who are 17 years and 364 days to 7 years old), the parent or legal guardian will be asked to read, understand and sign the ICF below. Following the guidelines of the *Philippine National Health Research System* (2011) regarding the appropriate assent forms for adolescent and child participants, the adolescent participants are those aged between 12-15 years old, a simplified assent form is prepared separately. For child participants aged 7-12 years old a verbal assent form is provided. For child participants aged 5 years old and below, the parents or legal guardian are required to sign the ICF in behalf of the child.

On this regard, we would like to invite you to be one of the participants in either one of the following:

- Survey
- Focus group discussion (FGD)
- Key informant interview (KII).

As there are several key groups and individuals who will either be interviewed or complete a survey for this study, participation in this study means either:

- a) Answering questions about your or your child or ward's experiences, views and opinions on the rehabilitation program of CAI designed to heal and support young persons traumatized by sexual abuse and violence; and/or
- b) Answering questions pertaining to your or your child or ward's experiences, views, opinions and/or efforts associated with the advocacy programs of CAI in relation to sexual

abuse and violence to young persons.

**Time required and the language used:**

a. Survey

There are two types of surveys, clinical/medical survey and socio-economic survey. The clinical survey will use two clinical scales (Adult/Child PTSD scale and Child/Adult depression scale). These are standard scales used worldwide that could be conducted only by trained experts (i.e., child and adult psychiatrists). Each scale could be completed between 20-30 minutes. The socio-economic survey is a self-reported assessment that can be administered in 30 to 45 minutes.

b. Focus Group Discussion (FGD)

To determine the impact of CAI's programs particularly its advocacy programs, three FGDs will be conducted: two for the adult participants and one for the girls. The FGD will take at least an hour but not more than 2 hours.

c. Key informant interview (KII)

For KII, it will take between 60-90 minutes.

The interview (i.e., KIIs and FGDs) will be conducted primarily using the native language of the interviewee, particularly Hiligaynon. Tagalog and English are widely spoken in the Philippines, thus, these languages will also be used if the interviewee(s) is comfortable and fluent with either of these, and as the need arises.

The survey instruments (i.e., clinical scales and socio-economic survey) are originally in American English language but these have been translated in Hiligaynon/Ilonggo.

**Benefits:**

Measuring and understanding the project impacts are key priorities of any organization. Assessment is important as it measures effectiveness of various activities of the organization. Through this research, CAI and its donor agencies will understand the significance of their rehabilitation and advocacy programs so as to help them with finding out what gaps exist and what future interventions can be developed. Thus, this research will assist them in (re)setting their priorities and in learning lessons and challenges of their past projects. We do not anticipate that you will benefit directly by participating in this study, however indirectly you will be benefited through improved services of CAI.

**Risks:**

One common reaction to traumatic events is an enduring negative emotional reaction to reminders of the event. Reminders of the event can trigger distress including anxiety and general upset. Because the survey asks participants about their experiences, there is the potential for this research to trigger emotional distress in reactive participants. In order to mitigate this potential distress, a layered system of protections is being put in place. The initial layer is the voluntary mechanism of recruitment. Because participants will be asked to take the affirmative step of agreeing to participate in the research before the actual data collection is scheduled, participants who are more reactive are likely to drop out at this stage. Participants who have negative responses to reminders of traumatic events tend to avoid triggers and reminders of the event. As such, they are less likely to choose to

participate in the research, and the structure of consent is such that they will be able to choose not to participate without social pressure to complete the survey.

For those who will decide to participate, Dr. Diosdado Amargo, a psychiatrist will manage the survey. He has a vast experience in handling research on individuals with traumatic experiences.

### **Provision for medical/psychosocial support**

Any clinical symptoms manifested by the participants during the survey who may need immediate attention or follow up therapy will be referred to the in-house psychiatrist, Dr. Valerie Andora-Quilaton for management. This means that we assure that vulnerable participants are already under the care of CAI or DSWD.

During the survey, the transportation and food expenses of the non-Cameleon beneficiaries as well as FGD and KII participants who will be travelling to Passi City or Iloilo City will be shouldered by the research project.

### **Confidentiality, Privacy and Management of Data:**

The objectivity, impartiality and confidentiality of data generation will be maintained by the researchers considering its survey and interview instruments. Interviews will take place in a room that has been booked specifically for this purpose and where privacy and confidentiality are guaranteed. CAI has private function rooms for interviews and/or surveys both in their Iloilo City office and Passi City rehabilitation centers that we have been given permission to use.

Informed consent and assent forms are essential procedures of our research so as to assure you that your responses will remain completely confidential and any personal details that you give us about you or anyone else will be made anonymous, private and confidential.

All the information will be stored securely in a password-encrypted file on the researchers' computers and in a locked cabinet. Your information will not be seen by anyone other than the researchers. Your identity will be kept confidential to the extent provided by law. Your information will be assigned a code number. The list connecting your name to this number, filled up questionnaires and other documents will be kept in a locked file in the researcher's office. When the study is completed and the data have been analyzed, the list will be destroyed. Your name will not be used in any report or publication.

The survey is structured so that personally identifying information is segregated to the first page, which is intended to be separated from the remainder of the survey before the participant completes it. Personally identifying information will be stored separately from the survey copies, and when the data are entered into electronic format only categorical data (such as age, gender, and religion) will be maintained. Names, addresses, and other contact information will not be retained.

For FGDs and KIIs, we will use aliases in the transcribed interviews. Real names and their corresponding aliases will be kept separately in password-encrypted computers. This is to ensure the privacy of our participants as well as the confidentiality of our data.

Voluntary participation, Right to withdraw from the study and Compensation:

Your participation in this study is completely voluntary. Should you elect to discontinue participation, any information already collected will be discarded. There is no penalty or loss of benefit for choosing not to participate. You have the right to withdraw from the study at any time without consequence or penalty.

There are no monetary benefits that will be given to participants but only tokens of appreciation. This is to ensure that participants are not induced financially to participate.

Use of Data Collected from Participants:

All the data collected will be owned by the funder, Cameleon Association Inc (CAI). Access to data is highly restricted and limited only to the research team members and the funder. As mentioned above, all the information will be stored securely in a password-encrypted file on the researchers' computers and in a locked cabinet. Your information will not be seen by anyone other than the researchers.

From the data gathered, materials may be used publicly such as academic papers for academic journals, books, book chapters, or newspaper articles. The collected data could also be used in public forum such as academic conferences, public interviews of CAI, or advocacy programs. For this reason, CAI and the researchers will protect the privacy and trust of the participants that the names and other personally identifying information that will appear in publicly available documents are anonymized.

Whom to contact if you have questions about the study:

If you would like to see the results and findings of this study, you may get in touch with the researchers primarily through DR. REYNOLD D. TAN, and we will be able to refer you to Cameleon Association, Inc., the sole proprietor of all the research data generated in this study.

If you have any questions about this study, kindly call, text or email any of the following contact persons whose details appear below:

**FRED P. GUILLERGAN, M.D.**

Chair, Unified Biomedical Research Ethic Review Committee

West Visayas State University

Luna St., La Paz, Iloilo City

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Mobile No. +63 910 184 8890

Email: [ubrerc\\_wvsu@yahoo.com.ph](mailto:ubrerc_wvsu@yahoo.com.ph); [fpgsci@gmail.com](mailto:fpgsci@gmail.com)

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University of the Philippines Visayas  
Infante Street, Iloilo City  
Email: reynold.tan@gmail.com

**Informed Consent Agreement for Parents or Legal Guardians:**

**Research conducted by:** Reynold Tan, PhD (UPV), Sanley Abila, PhD, Cheryl Joy Fernandez, PhD (UPV), Joy Lizada, PhD (UPV), and Dr. Diosdado Amargo  
College of Medicine, West Visayas State University.

**Research funded and supported by:** Cameleon Association, Inc.

As an informed participant in this research, I understand and acknowledge that:

- I have been duly informed that my and/or my child's or ward's responses will be kept anonymous and my personal details and those of any other people or organizations I name will be kept confidential.
- I have been properly informed that the details I and/or my child or ward provide will be used for the completion of a project evaluation report that will be available in the office of Cameleon Association, Inc., and may also be used as material for books or journal articles as well as material for public forum such as conferences.
- I have been duly informed that I and/or my child or ward may choose to end my participation at any time without consequence.

Any questions that I, or my child/ward had about this research have been satisfactorily answered. Signing here means that you have read this paper or had it read to you and that you are willing to be in this study or you are allowing your child/ward to take part in this study. If you don't want to be in the study, don't sign.

The assent form (below) is only valid if this informed consent form (ICF) is signed by the parent(s) or legal guardian. If the child/ward is 6 years old or younger, this ICF serves for both the parent/guardian and the child. If the child or minor is between 7 to 17 years old, aside from this signed ICF, the minor should sign the assent form, or give a verbal assent.

Name of child/ward: \_\_\_\_\_

Name of Parent(s) or legal guardian: \_\_\_\_\_

Signature of Parent(s) or legal guardian: \_\_\_\_\_

Date: \_\_\_\_\_

Parental or Guardian's Permission on File:  Yes  No

(If **NO**, do not proceed with the assent or research procedure.)

(For **Verbal Consent**) Indicate the Voluntary Response to Participation:

Yes  No

Name of Interviewer: \_\_\_\_\_

Signature of Interviewer: \_\_\_\_\_

Date: \_\_\_\_\_

### **Assent Agreement for Minors Aged 13-17**

(*For Written Assent*) Signing here means that you have read this document, or had it read to you and that you are willing to be part of this study. If you don't want to be in the study, don't sign.

Signature of Child/Minor: \_\_\_\_\_

Date: \_\_\_\_\_

(*For Verbal Assent*) Indicate Child's Voluntary Response to Participation:

Yes  No

### **Assent Agreement for Minors Aged 7-12**

(*For Verbal Assent*) Indicate Child's Voluntary Response to Participation:

Yes  No

Date: \_\_\_\_\_

**INFORMASYON PARA SA MAPASAKOP SA PAGTULUN-AN KAG  
PORMAS PARA SA BOLUNTARYO NGA PAGPASAKOP SG MGA  
MENOR DE EDAD**

TITULO SG PAGTULUN-AN: *Impact Evaluation of Luxemburg Government Program*

Dear \_\_\_\_\_,

Mga manunudlo kag manug-usisa (researchers) kami halin sa University of the Philippines Visayas (UPV) kag College of Medicine, West Visayas State University (WVSU) nga magatu-on sg ang mga resulta kag kahulogan (i.e., impacts) sg mga programa nga ginpatuman sg Cameleon Association, Incorporated (ukon Cameleon) kag ginpundohan sg Gobyerno sg Luxemburg. Ini nga pagtu-on ginpundohan kag suportado sg Cameleon.

Nagapamgayo kami sang imo bulig nga magpasakop bilang isa ka impormante sa ini nga pagtuon. Palihog basa sini nga dokumento antis ikaw magdesisyon sa pagpartisipar. Ini nga pagtuon nag-agi sa maid-id nga pagbasa sang “Technical Review” nga ginpangunahan ni Dr. Ida Siason kag sg Unified Biomedical Research Ethics Review Committee (UBRERC) sg WVSU. Nagapasalamat gid kami sa inyo nga kooperasyon.

Ang mga nagasunod nga mga detalye magapaintiende sa imo kung parte sa ano ang amon pagtulun-an, kag ang mga nagakalain-lain nga tikang para masigurado nga ang amon pagtulun-an nagasunod sg maayo nga “scientific practice” (scientifically correct) kag ginarepeto ang kinamatarung sg mga magapasakop (“ethically proper”).

**Tinutuyo sang amon pagtulun-an:**

Ang kabilugan nga tinutuyo sang sini nga pagtuon amo ang pag-intiende sg mga resulta kag kahulogan (i.e., impacts) sg mga programa nga ginpatumansang *Cameleon Association Incorporated* (nga atun tawagon Cameleon) nga ginpunduhan sang Ministry of Foreign Affairs of Luxembourg sugod Septyembre 2012 asta Agosto 2017. Ang Cameleon nag-implimintar sang tatlo ka mga programa kag ini ang: (1) pagtatap sang mga bata nga babaye nga biktima sg sekswal nga pangabuso ukon “CSA” (child sexual abuse), ukon nga ginatawag nga “in-house care”, (2) pagsuporta sang mga benepisyaryo sg Cameleon pagkatapos sg “in-house care” ka gang mga naka-puli sa ila mga panimalay ukon ang ginatawag nga “after care”, kag (3) ang programa nahanungod sa adbokasiya ukon panawagan sa pagpangapin sg mga kinamatarung sg mga kabataan labi na guid batok sa pisikal, mental kag sekswal nga pangabuso. Ang ini nga mga programa gindisenyo para mapabalik sa normal nga kahimtangan ang mga bata nga babaye nga naka-ekperyensya

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<sup>3</sup>Revised May 14, 2018. Version 2

sang abuso-sekswal kag ang mga komunidad nga ila ginhalinan. Ang programa nagatuyo man nga:

3. Maglantaw sang epekto sang programa sa pagpabalik sa normal nga kahimtangan, pagbulong o pag-ayo kag sang proseso padulong sa stabilisasyon ukon pagbalik sa normal, pati na paglantaw sang kabakod sang mga bata nga babaye nga mga biktima sang abuso-sekswal.
4. Lantawun kung may pagbag-o sa mentalidad kag may nagaka-angot nga ihibalo nahanungod sa mga isyu nahanugod sa pisikal, mental kag sekswal nga pangabuso sa mga kabataan, nga magaresulta sa pagbag-o sa pamatasan (nga maka-pauntat ukon makapa-awat sang abuso), kung nagadamo ang pag-report sang mga insidente sg mga pangabuso, kag kung may mga maayo nga mga pamaagi sa pagtatap/pagprotekta sa mga kabataan kontra sa pangabuso.

### **Mga Pamaagi sa Pagtipon sg datus kag Pag-imbita sa mga menor de edad sa pagpasakop sa sining pagtulun-an:**

Ang mga datus pagakuhaon pamaagi sa “survey”, “focus group discussion (FGD)” kag “key informant interview (KII)” ukon pag-interbyu sang mga tawo nga may madamo nga nahibaluan nahanungod sa mga isyu nahanugod sa pisikal, mental kag sekswal nga pangabuso sa mga kabataan.

Isa ka “survey” ang pagahiwaton para lantawun ang epekto sang “Rehabilitation Program” sang Cameleon para sa mga bata nga babaye/dalaga nga nakaagi abuso-sekswal. 30 ka mga babaye nga nakabenepisyo sang mga programa sang Cameleon kag indi magnubo sa 15 ka mga babaye nga wala nakaagi baton sang mga benepisyo gikan sa Cameleon ang paga-imbitaron para magpsakop sa “survey”. Isa ka psychiatrist para sa mga tigulang kag isa para sa mga bata ang magahatag sg “survey” kag maga-interpretar sg mga resulta sang survey.

Para mahibaluan ang epekto sang Advocacy Program sang, magahiwat sang duha ka “FGD”: isa para sa mga partisipante nga naga-edad 18 anyos pasaka kag isa ka grupo para sa mga bata nga babaye nga 17 anyos kag 364 ka adlaw ang edad asta 7 anyos. May mga interbyuhon man kami nga mga nagakasari-sari nga mga eksperto nahanungod sa mga programa sang Cameleon, representante sg gobyerno nga may mando kag datus nahanugod sa mga pisikal, mental kag sekswal nga pangabuso sa mga kabataan.

Bag-o kami magsugod sa pagtipon sang inpormasyon, ang mga partisipante nga 18 anyos pataas ilihugon nga magbasa kag mag-intindi sang sini nga mga inpormasyon nahanugod sa pagpasakop sa sining pagtulun-an, kag sang pormas para sa ***boluntaryo nga pagpasakop ukon ang ginatawag nga “Informed Consent Form ukon ICF”***. Pagkatapos basa kag intiende sg mga pormas hingyu-on namon nga magpirma sa mga pormas (ICF kag “assent form”) kung hungod kag desidido nga magapaskop sa sining pagtulun-an.

Kay kami nagasunod sa patakaran sg *Philippine National Health Research System* ukon PNHRs(2011) nahanugod sa pagkuha sg *boluntaryo nga pagpasakop sg mga kabataan ukon mga menor de edad* (ukon ang ginatawag nga “Assent”), may ginpreparar kami nga

mga pormas para sa *boluntaryo nga pagpasakop sg mga kabataan* ukon “Assent” sg mga menor de edad. Para sa mga kabataan nga amon paga-imbataron nga magpasakop sa amon pagtulun-an nga naga-edad sang 17 anyos kag 364 ka adlaw asta 7 anyos, ginahingyo namon ang ila ginikanan ukon ang ila legal nga manugtatatap (legal guardian) nga magpirma sa ICF nga upod sa sini nga dokumento. Santo sa *PNHRS* (2011), kami magahatag sang simple nga pormas para sa boluntaryo nga pagpasakop sg mga kabataan (Assent form) nga naga-edad 15 asta 12 anyos. Para sa mga menor de edad nga naga-edad 7 asta 12 anyos, nagpreparar kami sg verbal nga pormas para sa *boluntaryo nga pagpasakop sg mga kabataan*. Para sa menor de edad nga 5 ka tuig kag mas manubo pa diri ang ginikanan ukon ang “legal guardian” pagalihugon nga magbasa, mag-intindi kag magpirma sang “ICF”.

Kaangot sini, gina-imbatar ka namon nga magpasakop bilang partisipante sa isa ukon sa duha sa magasinod nga hilikuton (data collection activities):

- \_\_\_ Survey
- \_\_\_ Focus group discussion (FGD)
- \_\_\_ Key informant interview (KII).

Kung hungod sa inyo nga buot kag pagintiende nga kamo magapasakop sa amon pagtulun-an, magasabat kamo sg mga pamangkutanon paagi sa isa ka ‘interview’ kag/ukon sa isa ka survey. Ang inyo partisipasyon nagakahulugan nga:

- a) Magahatag ka inpormasyon nahanugod sa imo naeksperyensyan, opinyon, panghunahuna ukon mga kabalaka parte sa mga programa sg Cameleon kalakip ang programa nila para mabuligan paayo ang mga kabataan nga babayi nga biktima sg sekswal nga pangabuso;
- b) Magahatag ka inpormasyon nahanugod sa imo naeksperyensyan, opinyon, panghunahuna ukon mga kabalaka parte sa programa sg Cameleon natuhoy sa adbokasiya o panawagan (i.e., advocacy) sa pagpangapin sg mga kinamatarung sg mga kabataan labi na guid batok sa pisical, mental kag sekswal nga pangabuso.

### **Kinahanglanon nga Oras Kung Magpasakop sa Amon Pagtulun-an:**

#### a. Survey

Ang ini nga “self-reported assessment” pwede matapos sa sulod sang 15 asta 20 ka minutos. Kaupod sang “socio-demographic information”, magadalagan ang “survey” sa 30 asta 45 ka minutos.

#### b. Focus Group Discussion (FGD)

Para mahibaluan ang epekto sang Cameleon’s “Advocacy Program”, magahiwat sang duha ka “FGD”: isa para sa mga hamtung nga nga partisipante kag isa para sa mga bata nga babaye. Ini nga Focus Group Discussion (FGD) indi maglapaw sa duha ka oras.

#### c. Key Informant interview (KII)

Ang key informant interview indi magsobra sa 90 minutos.

Ang 'interview' (KII ukon FD) pagahimuon sa Hiligaynon. Ang Tagalog kag Ingles ginagamit sg kadam-an sa Pilipinas, para sa amon ang ini nga mga lingwahi (i.e., languages) pagagamiton lang sg nagapamangkot (i.e., interviewer) kung komportable kag kung naga-gamit man ang ginapamangkot (i.e., interviewee). Kag ang mga ini nga mga lingwahi pagagamiton lang kung kinahanglon guid sa pagpakighinun-anon (i.e., interview).

Para sa mga masabat sg amon survey, ini pagahimuon sg amon mga psychiatrists gamit ang "standard clinical scales" ukon talamdam nga ginagamit sg mga psychiatrists sa lain-lain nga nasyon kalakip ang Pilipinas. Ang mga talamdan sa "clinical" surveys ginagamit para sa mga pasyente nga possible may depresyon ukon may "PTSD" (Posttraumatic Stress Disorder). Ang Cameleon may mga pribado nga mga kwarto nga pwede namon gamiton para sa pagsabat sg amon surveys.

### **Mga Benepisyo:**

Ang pagtuon sang epekto sang isa ka proyekto prayoridad gid sang isa ka organisasyon. Ini importante bangud ginalantaw ang pagka-epektibo sang mga nagakasari-sari nga mga aktibidades sang isa ka organisasyon. Pamaagi sa sini nga pagtuon, ang Cameleon kag ang mga ahensya nga nagahatag sa ila sang donasyon maka-intiendi sang pagka-importante kag mga limitasyon sang mga programa kag adbokasiya nahanungod sa rehabilitasyon sg mga biktima sg CSA. Ini makabulig sa ila pagtukib sang mga kakulangan para makahatag sang nagakaigo nga solusyon o interbesyon. Ini nga pagtuon makabulig man sa ila sa pagplastar sang ila mga prayoridad.

### **Mga Risgo:**

Ang isa ka masami nga resulta sang isa ka makangilidlis ("traumatic") nga hitabo amo ang pagbalik-balik sang mga negatibo nga paminsaron parte sa natabo nga naga-resulta sa kakulba kag kahadlok kag kalain sang pamatyagan. Ang "survey" nga ini mahimo nga makapahanumdum sang indi mayo nga nagliligad nga natabo sa biktima. Para matapna ang mga negatibo nga resulta, may mga nanari-sari nga mga pamaagi nga pagabuhaton. Una, ang pagsabat sa ini nga pagtuon isa ka boluntaryo nga desisyon. Bangud sini, ang mga may mahuyang nga balatyagun madulaan sang kaisog nga magpartisipar.

Sa mga magpartisipar, ang survey pagahimuon ni Dr. Diosdado Amargo nga isa ka psychiatrist nga may malawig nga tinuig nga ekspersyensya sa pareho nga klase nga pagtuon.

### **Mga suporta-medikal/psychosocial**

Kung may mga sintomas nga magilinuwa sa mga partisipante samtang ginahiwat ang survey, ini sila pagapakadtuon sa "in-house" psychiatrist sang Cameleon nga si Dr. Valerie Andora-Quilaton.

Ang gasto sa pamasaha, pagkaon kag iban pa sang partisipante sang survey, FGD kay KII sa pagkadto sa Passi City ukon Iloilo City magahalain sa research project.

### Respeto sa Pribado nga Mga Datus kag Talamdan sa Pagtatap sg mga Pribado Nga Mga Inpormasyon (Confidentiality, Privacy and Management of Data):

Ang tanan nga mga inpormasyon parte sa pagtuon siguraduhon nga mangin pribado. Ang pagtuon pagahiwaton sa isa ka lugar nga indi sila makilal-an kag mahibal-an. Ang Cameleon may mga pribado nga pasilidad kung sa diin pagahiwaton ang mga interbyu sa syudad sang Passi kag Iloilo. May mga pahanugot ang mga researchers sa pag-gamit sang sini nga mga pasilidad.

Ang mga inpormasyon nga inyo igahatag mangin pribado. Ang detalye sang inyo pagkatawo indi makilan-an kag mahibalu-an sang iban nga mga partido. Tanan nga inpormasyon taguon namon sa pribado kag ‘password-encrypted’ nga mga “personal computers” kag sa isa ka kabinet nga de kandado. Pagkatapos sang sini nga pagtulun-an, ang tanan nga dokumento nga may inpormasyon parte sa partisipante pagadulaon. Ang mga tuod-tuod nga ngalan sang mga nagpasakop indi pag-ibutang sa mga report, mga pangpubliko nga materyales pareho sg libro, “academic papers”, ukon sa mga pangpubliko nga mga hilikuton pareho sg mga “conferences”.

Ang amon mga pormas pareho sg “FGD’s”, “surveys”, “KII’s” kag “Informed Consent/Assent” nagapasigurado sa tanan nga magapasakop sa sining pagtulun-an nga ang tanan ninyo nga mga personal nga inpormasyon kag sabat sa amon pamangkutanon sa survey ukon sa interview magapabilin nga pribado kag sekreto.

### **Boluntaryo nga Pagpasakop, Kinamatarung sa Pag-untat Pagpasakop kag Benepisyo sa Pagpsakaop (Compensation):**

Ang inyo partisipasyon ukon pagpasakop sa amon pagtulun-an nagasayuron nga ini boluntaryo. Kung kamo maga-desisyon nga maga-untat partisipar bisan pa nakasugod na ang “interview” ukon survey, ang tanan nga mga inpormasyon parte sa inyo pati na ang inyo mga sabat sa amon pamangkutanon pagadulaon. Wala negatibo ukon malain nga kunsikwensya sa inyo pag-untat sa pagpartisipar sa amon pagtulun-an.

Wala bayad pinansyal sa pagpasakop sa sining pagtulun-an. Magahatag kami sg “tokens” para sa pagpasalamat sa tiyempo sg mga magapasakop. Indi kami magbayad sa mga magapasakop kay para sa amon gusto namon nga boluntaryo ang pagpasakop kag indi tungod ginabayaran ang pagpasakop.

Para sa mapa-interview, mahingyo kami nga i-rekord namon ang inyo mga sabat sa isa ka ‘digital recorder’ para masigurado namon nga intsakto ang amon datus nga naghalin guid sa amon “participants” kung ini pagasulaton na namon.

### **Diin gamiton ang mga datus (research data) sg sini nga pagtulun-an?**

Ang Cameleon amo ang tag-iya sg tanan nga mga inpormasyon nga makuha namon paagi sa sining pagtulun-an. Limitado lang ang makakita kag makagamit sg mga inpormasyon kag datus (research data) sg sining pagtulun-an. Ang mga datus pagagamiton sa “project evaluation report” para sa Cameleon. Hungod man nga pagagamiton ang mga

inpromasyon kag datus bilang parte sg libro ukon sa mga pangpubliko kag akademiko nga mga artikulo (i.e., academic or published articles).

Hungod man pagagamiton ang mga datus sa mga pangpubliko nga mga hilikuton nga naangot sa mga programa sg Cameleon pareho sg mga “public conferences, interviews or debates”.

**Sin-o ang pwede istoryahon ukon pamangkuton nahanungod sa sining pagtulun-an? (Contact Persons):**

Kung hungod ninyo nga mabal-an ang resulta sg amon pagtulun-an, sarang ninyo matawgan, mapadal-an mensahe paagi sa text ukon sa email si DR. REYNOLD D. TAN para mapadala nya sa Cameleon Association, Inc., ang inyo ginahingyo. Ang Cameleon amo ang tag-iya sg tanan nga mga inpormasyon nga makuha namon paagi sa sining pagtulun-an.

Kung may mga pamangkutanon ukon isyu nahanungod sa sini nga pagtuon, ang ini nga mga personas ang pwede nimo pakipag-angutan sa mga nanari-sari nga pamaagi. Palihog sulat, tawag ukon kontak sg mga nagaka-igo nga mga “contact persons”. Ang mga detalye sg mga contact persons:

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**KASUGTANAN: PORMAS SA BOLUNTARYO NGA PAGPASAKOP  
PARA SA MGA GINHIKANAN UKON MGA LIGAL NGA  
MANUGTATAP (INFORMED CONSENT FORM)**

Ang mga taga-manug-usisa:

Reynold Tan, PhD, Sanley Abila, PhD, Cheryl Joy Fernandez, PhD, Joy Lizada, PhD  
*University of the Philippines Visayas*

Dr. Diosdado Amargo

Ang ining pagtulun-an ginkomisyon kag suportado sg **Cameleon Association, Inc.**

**Pormas sa Pagpahanugot sa Pagpasakop (Informed Consent Form):**

Sa pagpasakop sa sining pagtulu-an, naintiendihan kag nahibaluan ko nga:

- Ginapahibalo ako sg mga nagakaigo nga mga detalye nga ang akon mga sabat kag personal nga inpormasyon, ukon ang mga sabat kag mga personal nga inpormasyon sg akon bata/sinakpan, ukon mga inpormasyon sg iban pa nga individwal kag mga organisasyon nga akon pagahingalanan magapabilin nga pribado kag sekreto.
- Ginapahibalo ako sg mga nagakaigo nga mga detalye nga ang akon igahatag nga mga inpormasyon, ukon ang mga sabat kag mga personal nga inpormasyon sg akon bata/sinakpan, pagagamiton sa sining pagtulun-an (i.e., project evaluation report) kag ang tanan nga mga inpormasyon nga makuha sg sining pagtulun-an ginapanag-iyahan sg kag pagatagu-on sa Cameleon Association, Inc.
- Ginapahibalo ako sg nagaka-igo nga mga detalye nga ang mga inpormasyon kag datus nga makuha sg sining pagtulun-an hungod nga magamit bilang parte sg libro, ukon sa mga pangpubliko kag akademiko nga mga kasulatan (i.e., academic or published articles), ukon sa mga pangpubliko nga mga hilikuton nga naangot sa mga programa sg Cameleon pareho sg mga “public conferences, interviews or debates”.
- Ginapahibalo ako sg nagaka-igo nga mga detalye nga pwede ko, ukon pwede sg bata/sinakpan ko ipa-untat ang akon pagpsakop bisan pa nakasugod na ang survey ukon interview, kag wala sg mga negatibo nga konsekwensya ang pagbawi ko sg akon pagpasakop.
- Ang tanan tanan ko nga pamangkutanon nasabat na sg naka-igo.

Kung magpirma ka diri nagasayuron nga nabasa mo ukon ginbasa sa imo ang pormas sa pagpahanugot para sa menor de edad kag hungod mo nga ipasakop ang imo bata ukon sinakpan sa sini nga pagtulun-an. Kung indi mo gusto ipasakop ang imo bata ukon sinakpan sa sini nga pagtulun-an, indi mo kinahanglan magpirma.

Ngalan sg bata: \_\_\_\_\_

Ngalan sg ginhikanan/ligal nga manugtatap: \_\_\_\_\_

Pirma sg ginhikanan/ligal nga manugtatap: \_\_\_\_\_

Petsa: \_\_\_\_\_

*(Para sa gusto nga itugda/ihambal lang nila ang ila pagpahanugot sa pagpasakop sa sining pagtulun-an)* Palihog marka ang nagaka-igo nga Boluntaryo nga sabat sg mapasakop:

Huo

Indi

Ngalan sg 'Interviewer': \_\_\_\_\_

Pirma sg Interviewer: \_\_\_\_\_

Petsa: \_\_\_\_\_

**Pormas sa Pagpahanugot sa Pagpasakop sg Menor de Edad**  
**(13-17 anyos) (ASSENT FORM)**

Kung magpirma ka diri nagasayuron nga nabasa mo ukon ginbasa sa imo ang pormas sa pagpahanugot para sa menor de edad kag hungod mo nga ipasakop ang imo bata ukon sinakpan sa sini nga pagtulun-an. Kung indi mo gusto ipasakop ang imo bata ukon sinakpan sa sini nga pagtulun-an, indi mo kinahanglan magpirma.

Pirma sg bata: \_\_\_\_\_

Petsa: \_\_\_\_\_

**Pormas sa Pagpahanugot sa Pagpasakop sg Menor de Edad**  
**(7-12 anyos) (VERBAL ASSENT FORM)**

*(Pagpahanugot sa pagpasakop para sa menor de edad paagi sa ukon tawag nga 'Verbal Assent')*

Palihog Ibutang ang Boluntaryo nga sabat sg bata sa pagpasakop sa sining pagtulun-an:

Huo

Indi

Petsa: \_\_\_\_\_

**Annex I. Translation of scale for research**

20 May 2018

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**TRANSLATION OF SCALE FOR RESEARCH**

Dear \_\_\_\_\_

Greetings!

We are researchers from the University of the Philippines Visayas (UPV), and the College of Medicine, West Visayas State University (WVSU) who are studying the impacts of programs implemented by Cameleon Association Incorporated (CAI), and funded by the Government of Luxemburg. CAI is a registered non-governmental organization in the Philippines' Securities and Exchange Commission, and delivers social welfare and development services. UPV and WVSU are public universities in the Philippines. This research was reviewed by the Unified Biomedical Research Ethics Committee (UBRERC), West Visayas State University, Iloilo City, Philippines.

We would like to inquire about the translation of your clinical scales to our local dialect (Hiligaynon/Ilonggo) for research purposes. Do you allow your work to be translated?

We would be happy to discuss our queries further.

Sincerely yours,

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**Research funded and supported by:** Cameleon Association, Inc.

**Research Reviewed by:** Unified Biomedical Research Ethics Committee, Iloilo City, Philippines website: <http://wvsu.edu.ph/ubrerc/>

## Annex J. Operational Definition of Symptoms

### PTSD Symptoms

The definitions of the Post-traumatic Stress Disorder Symptoms used in this study are as follows:

- **Intrusions** is the inability to keep memories of the event from returning which may be manifested in the form of “flashback”.
- **Dysphoria** is feeling very emotionally upset when reminded of the stressful experience.
- **Avoidance** is a behavior of trying to avoid thoughts, feelings, or physical sensations that remind of a stressful experience
- **Blaming** refers to the thoughts that the stressful event happened because the individual or someone else (who didn’t directly harm the individual) did something wrong or didn’t do everything possible to prevent it, or because of something about the individual
- **Negative Emotions** refers to a very negative emotional state (experiencing lots of fear, anger, guilt, shame, or horror) after a stressful experience.
- **Anhedonia** is losing interest in activities used to enjoy before having a stressful experience
- **Hypervigilance** refers to being “super alert,” on guard, or constantly on the lookout for danger
- **Hyperarousal** refers to feeling jumpy or easily startled upon hearing an unexpected noise
- **Irritability** is the state of being extremely irritable or angry to the point where you yelled at other people, got into fights, or destroyed things.

### HAM-D Symptoms

The definitions of the Depressive Symptoms used in this study are as follows:

- **Depressed Mood** refers to a mental state characterized by feelings of sadness, loneliness, despair, low self-esteem, and self-reproach.

- **Feelings of Guilt** refers to an emotional state associated with self-reproach and the need for punishment.
- **Suicide** refers to self-harm. Suicide is a completed act of killing oneself, while **Suicidal Ideation** refers to thoughts or intent of taking one's own life.
- **Insomnia** refers to difficulty in falling asleep or difficulty in staying asleep. It may present in the initial, middle or late stages of sleep.
- **Work and Interests** refers to the individuals feeling of **anhedonia** which is the loss of interest in and withdrawal from all regular and pleasurable activities.
- **Retardation (Psychomotor)** involves a slowing-down of thought and a reduction of physical movements in an individual
- **Agitation (Psychomotor)** is a state of Physical and mental overactivity that is usually nonproductive and is associated with a feeling of inner turmoil, as seen in agitated depression.
- **Anxiety** is the feeling of apprehension caused by anticipation of danger, which may be internal or external. **Psychic symptoms** of anxiety may manifest in the form of tension and irritability, worrying about minor matters, apprehensive attitude and fears. **Somatic symptoms** of anxiety may present with palpitations, indigestion, headaches and difficulty in breathing.
- **Somatic Symptoms** refers to bodily symptoms experienced by the individual. In this study, it may present as a **General** bodily symptom such as heaviness in limbs, back or head; diffuse backache; loss of energy and fatiguability. **Gastrointestinal** symptoms may manifest as loss of appetite, feeling heavy in abdomen or constipation.
- **Genital Symptoms** refers to psychosexual symptoms of the individual such as loss of libido or disturbances in the menstruation.
- **Hypochondriasis** is the exaggerated concern about health that is based not on real medical pathology but on unrealistic interpretations of physical signs or sensations as abnormal.
- **Insight** is the conscious recognition of one's own condition. **Poor insight** would refer to being unable to consciously aware and understand one's own symptoms of maladaptive behavior.

Source: Sadock, Benjamin J., Synopsis of Psychiatry: Behavioral Sciences/Clinical Psychiatry.11th edition, 2015, Wolters Kluwer, Philadelphia, PA.