

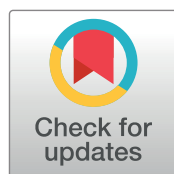
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Social Pediatrics Unit: Interdisciplinary and intersectoral care model for patients who are victims of child abuse

Unidad de Pediatría Social : Modelo de atención interdisciplinar e intersectorial para pacientes con maltrato infantil

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Abstract

Background:

Children and adolescents (CHI) who experience child abuse face serious consequences for their physical, mental, and social development (perpetuation of violence, poverty, and inequality). The WHO recognizes this as a public health problem, highlighting the need to heal complex trauma and ensure its non-repetition. Although an intersectoral pathway in Colombia exists involving health, protection, and justice, the lack of specialized centers leads to revictimization, reprocessing, and failures in comprehensive care. Additionally, the Ministry of Health guidelines do not include outpatient protocols for trauma healing.

Methods:

In response, the Universidad del Valle and the Hospital Universitario del Valle Evaristo García (HUV) at Cali, Colombia developed an innovative program based on the ecological model of health, the WHO INSPIRE strategy, and the Convention on the Rights of the Child.

Results:

The Social Pediatrics Unit offers person-centered interprofessional care, integrating clinical actions and actions from the justice and protection sectors, preventing revictimization, improving processes, and ensuring trauma healing. The narrative describes the challenges to program sustainability, lessons learned from the model's implementation, and intersectoral work.

Conclusion:

After providing care to 3,602 children and adolescents, 1,454 of whom suffered child abuse, it can be concluded that these programs are essential for breaking cycles of violence, demonstrating that comprehensive, person-centered, and evidence-based care can mitigate the impact of child abuse on the individual and the region.

Conflict of interest

None

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Resumen

Antecedentes:

Los niños, niñas y adolescentes (NNA) con maltrato infantil enfrentan consecuencias graves en su salud física, mental y desarrollo social (perpetuación de violencia, pobreza y desigualdad). La OMS lo reconoce como un problema de salud pública, destacando la necesidad de reparar el trauma complejo y garantizar la no repetición. En Colombia, aunque existe una ruta intersectorial que involucra salud, protección y justicia, la falta de centros especializados lleva a revictimización, reprocesos y fallas en la atención integral. Adicionalmente, las guías del Ministerio de Salud no incluyen protocolos ambulatorios para la reparación del trauma.

Métodos

Frente a esto, la Universidad del Valle y el Hospital Universitario del Valle Evaristo García (HUV) en Cali, Colombia desarrollaron un programa innovador basado en el modelo ecológico de la salud, la estrategia INSPIRE (OMS) y la Convención de los Derechos del Niño.

Resultados

La Unidad de Pediatría Social ofrece atención interprofesional centrada en la persona, integrando acciones clínicas, acciones del sector justicia y protección; evitando la revictimización, mejorando los procesos y garantizando la reparación del trauma. A través de la narrativa se describen los desafíos para la sostenibilidad del programa, las enseñanzas de la implementación del modelo y del trabajo intersectorial.

Conclusiones

Posterior a la atención de 3,602 NNA; 1,454 con maltrato infantil, se puede concluir que estos programas son esenciales para romper ciclos de violencia, demostrando que la atención integral, centrada en la persona y basada en evidencia puede mitigar el impacto del maltrato infantil en el individuo y el territorio.

Introduction

The Social Pediatrics Unit is structured within the current international and national regulations that protect children and adolescents, the recognition of maltreatment as a public health problem, and the intersectoral and interprofessional approach as the most effective strategy to address this issue. The following section describes the guidelines and key concepts that gave life to the proposal.

The recognition of childhood as a fundamental stage of human development is relatively recent. It was only in 1900 that Ellen Key proclaimed the new century as the “century of the child”¹, proposing that a transformation in upbringing and education could improve society.¹⁾ This paradigm shift laid the foundation for public policies and international agreements that recognize children and adolescents as subjects of rights and social actors.

A key milestone was the Convention on the Rights of the Child (1989), ratified by Colombia in 2006 with the new Code of Childhood and Adolescence (Law 1098)⁽²⁾. The Convention establishes principles such as the best **interests of the child**, **comprehensive protection**, and **shared responsibility** among family, state, and society³. However, despite this regulatory framework, serious shortcomings persist in Colombia in the care of children and adolescents who are victims of child abuse and neglect, particularly regarding trauma recovery and the prevention of revictimization.

In Colombia, health care for children and adolescents who are victims of maltreatment is governed by the Child Maltreatment Guide (2012) and Resolution 0459, which prioritize initial medical care but lack a rights-based approach centered on NNA. Although an intersectoral pathway is promoted (health, protection through the Colombian Family Welfare Institute -ICBF/Family Commissary, and Justice)^{4,5}, the absence of unified protocols and integrated information systems forces Children and adolescents to repeat testimonies and evaluations, leading to reprocessing and revictimization.

Moreover, comprehensive trauma recovery is not guaranteed. Despite Resolution 2481 of 2020, which mandates specialized therapies for victims of domestic violence⁶, the absence of trained providers and updated protocols leaves thousands of children and adolescents without access to comprehensive mental health rehabilitation.

This operational fragmentation perpetuates the cycle of violence; since without trauma recovery, children and adolescents develop sequelae that affect their mental health and neurodevelopment, perpetuating poverty and exclusion⁷⁻⁹.

Child maltreatment: a public health problem

Child maltreatment, defined by the WHO as *any form of abuse or neglect toward persons under 18 years of age that threatens their health, development, or survival*, affects **one billion children worldwide**^{7,10}. In Colombia, the statistics are alarming: in 2024 alone, **3,390 cases of psychological violence, 13,378 cases of physical violence, 18,372 cases of neglect, and 28,650 cases of sexual violence** against minors were reported¹¹. These statistics, together with the severe physical, emotional, and social consequences it generates, consolidate maltreatment as a critical public health problem.

The consequences of maltreatment also affect the social and human development of nations, as these children and adolescents present cognitive problems and poor social skills. Cognitive problems lead to low learning abilities with poor academic and occupational development and high poverty rates. The lack of social skills is associated with the perpetuation of the transgenerational cycle of violence^{8,12,13}.

On the other hand, there is a causal relationship between child maltreatment and the prevalence of chronic disease. The studies by Felitti *et al.*¹⁴, on Adverse Childhood Experiences (ACEs) demonstrated that child maltreatment, like other ACEs, triggers an **altered neuroendocrine stress response**, with chronic release of cortisol and catecholamines without negative feedback^{13,14}. This imbalance (Figure 1) generates structural changes in the brain (hippocampus, amygdala, prefrontal cortex), affecting cognitive and emotional development, while also increasing the risk of early-onset chronic diseases (coronary disease, diabetes, depression, immunological disorders), reducing life expectancy by 20 years¹³⁻¹⁵.

Thus, child abuse and neglect affect the health of the individual throughout the entire life cycle, causing short-, medium-, and long-term consequences:

- Short term: Alterations in learning, emotional regulation, and behavior (affective disorders, anxiety, impulsivity)^{13,15-17}(Figure 2).
- Medium term: Risk behaviors (use of psychoactive substances, hypersexual behaviors, social violence) as coping mechanisms for trauma¹⁴⁻¹⁶.
- Long term: High burden of chronic disease and socioeconomic costs due to disability and loss of productivity^{13,14,15}.

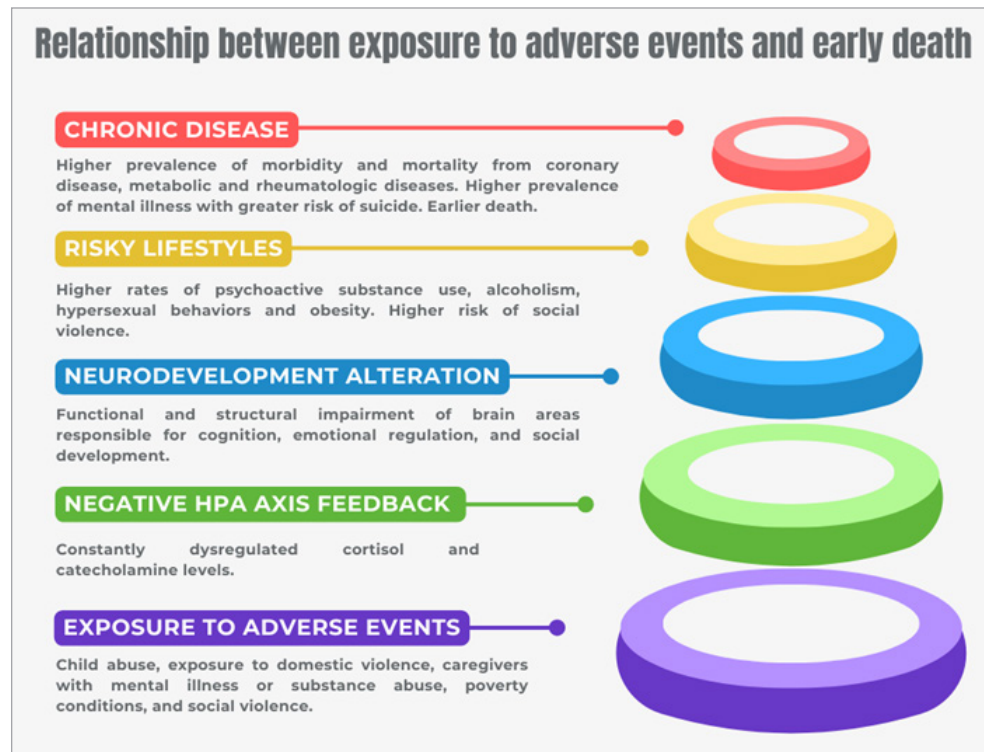


Figure 1. Causal relationship between adverse childhood experiences (ACEs) and chronic disease. Exposure to ACEs leads to dysregulation of the hypothalamic-pituitary-adrenal axis, with loss of negative feedback, resulting in chronic cortisol and catecholamine release. This neuroendocrine imbalance contributes to structural brain changes and increases the risk of chronic diseases

Intersectoral and interprofessional care model

Given the multisystemic impact of child maltreatment, the WHO proposes the **INSPIRE** strategy, a set of seven evidence-based approaches for its prevention and management. Among its recommendations, the creation of **specialized child protection centers** is highlighted, integrating medical, psychosocial, and legal services in the same space, in alignment with the **ecological model of health** (which recognizes that the well-being of children and adolescents depends on the interaction between individual, family, community, and social factors) ⁷.

Specialized child protection centers are successful strategies implemented in different countries; in the United States, trauma centers exist with varying levels of complexity (ranging from basic care to centers of excellence with research and public policy components) ¹⁸, while in several European countries (Iceland, Sweden, and Spain) the Barnahus or “Children’s House” Model has been developed. The latter has reduced revictimization by bringing together forensic experts, prosecutors, social workers, and health teams in the same space ¹⁹.

Colombian reality: fragmentation vs. incipient advances

In Colombia, children and adolescents who suffer child abuse and neglect, upon entering the intersectoral pathway, must attend multiple institutions to ensure protection and justice (zonal centers of the ICBF, family commissioners, prosecutors’ offices, hospitals), repeating their accounts and undergoing redundant evaluations. This leads to secondary and tertiary revictimization, as well as delays in trauma recovery. Although initiatives exist, such as the Casas de Justicia in Cali (strategies that integrate protection and justice entities) ^{20,21}, or the Center for Assistance to Victims of Sexual Violence (CAIVAS), which brings together protection, justice, and forensic medicine services in a single location ^{20,21}, a critical gap persists: the absence of strategies that integrate the health sector.

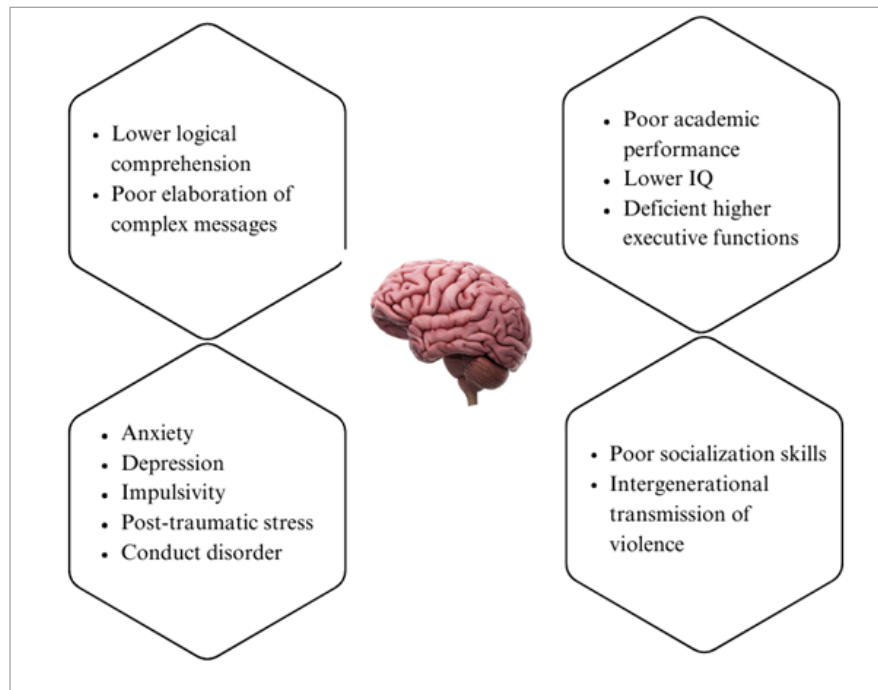


Figure 2. Summary of short-term symptoms of child maltreatment. The primary target organ of the neuroendocrine stress response in childhood is the brain; therefore, these children and adolescents may present altered attention, memory, language, higher executive functions, early-onset mental illness, and poor social skills, which perpetuate the intergenerational transmission of violence

Justification

The Social Pediatrics Unit is an innovative program that, through its conceptual soundness and operational flexibility, has adapted person-centered care strategies by articulating the intersectoral pathway, thereby reducing the impact of maltreatment and improving the functioning of the care route. Care tailored to the needs of children and adolescents affected by child maltreatment enables timely diagnoses, assessment of the impact of abuse (screenings for mental illness, cognitive deficits, disability), and repair of complex trauma.

The intersectoral articulation that integrates health, justice, and protection within a single space incorporates coordinated actions that reduce the number of interviews, allow for more comprehensive accounts, improve the collection of evidentiary material with more timely justice and protection measures, decrease revictimization, and enhance institutional processes^{22,23}.

The description of the implementation and consolidation of the program, together with the dissemination of lessons learned, challenges, and outcomes, is essential for the design and implementation of similar programs that contribute to ensuring the repair of complex trauma and the prevention of further episodes of violence among children and adolescents who have experienced child abuse and neglect.

Materials and Methods

Through a narrative approach, drawing on monthly reports from the Social Pediatrics Unit, a review of the program's documentary base, and theoretical frameworks, the design, implementation, consolidation, and projection of a program are described using a timeline. This program provides specialized care with an intersectoral and interdisciplinary approach for children and adolescents affected by child abuse and neglect, at Hospital Universitario del Valle, Evaristo García (HUV), in partnership with Universidad del Valle in Cali, Colombia.

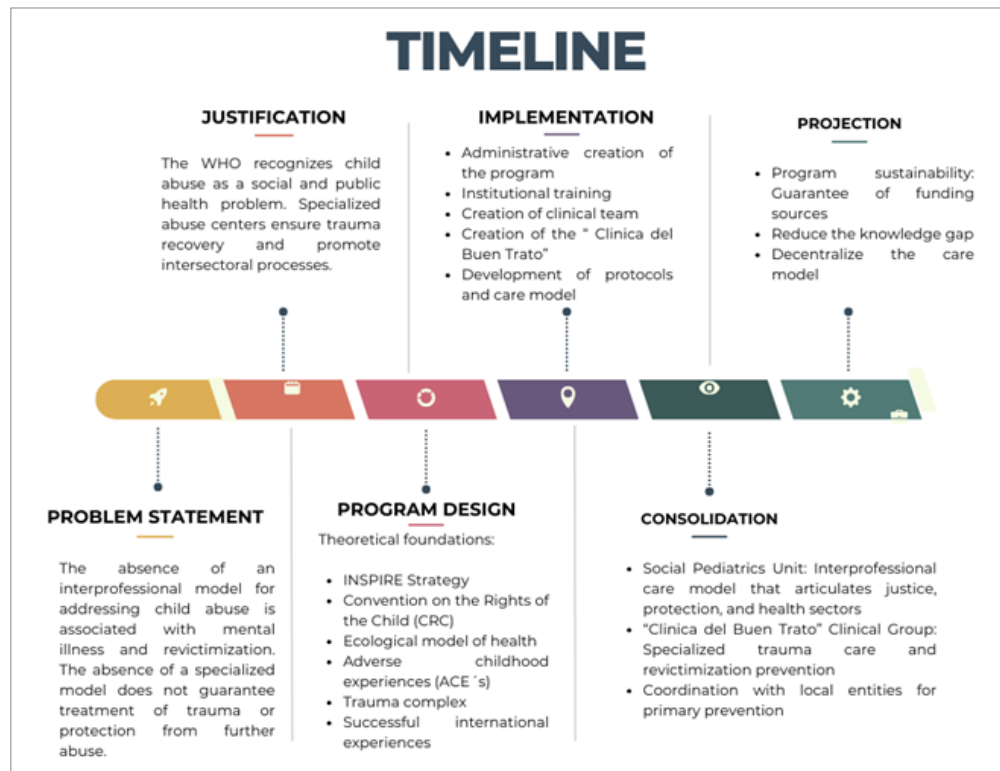


Figure 3. A timeline summarizes the process of creation, design, implementation, and execution of the program.

A look through time: Design, implementation, consolidation, and projection

The process of design, implementation, consolidation, and projection of the program is summarized in Figure 3.

Design of the Social Pediatrics Unit (2012-2018)

Recognizing that in Colombia, children and adolescents who survive maltreatment face the fragmentation of health, protection, and justice services—a reality associated with the perpetuation of cycles of violence and the persistence of complex trauma sequelae—the Social Pediatrics Unit emerged as an innovative initiative. It was inspired by the WHO's INSPIRE strategy and by successful international models, such as the Social Pediatrics Unit at Hospital Niño Jesús (Madrid) and the Child Protection Teams (United States).

This program is structured around three strategic pillars: **Education, Research, and healthcare**. These pillars are interconnected and articulated through a teaching-care alliance between Hospital Universitario del Valle, Evaristo García (HUV), and Universidad del Valle. This collaboration has been key to the sustainability and projection of the program.

Although the program's activities are transversal across the pillars, each pillar has a specific objective. The **Research pillar** seeks, through knowledge management, to establish the validity of the care model and the sustainability of the program, while also contributing to the reduction of the knowledge gap through the dissemination of outputs. The **Education pillar** aims to strengthen the qualifications of health professionals in the detection of maltreatment, assessment of its impact, and treatment. It also seeks, through the social appropriation of knowledge, to provide tools for the prevention of child maltreatment. Finally, the **Healthcare pillar** seeks to offer care centered on the specific needs of this population, considering as essential the integration of the health, protection, and justice sectors within a single physical space. Figure 4 summarizes the main activities of each pillar.

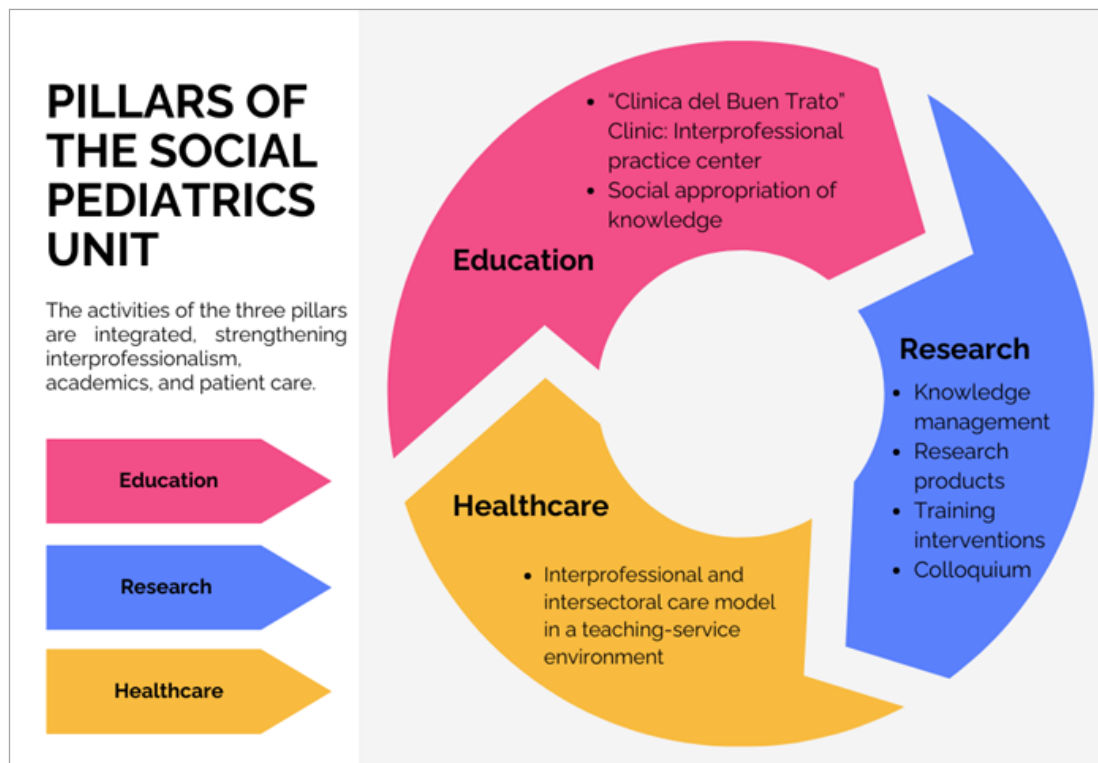


Figure 4. Pillars of the Social Pediatrics Unit. The main activities of each pillar are described.

The challenge of implementing the envisioned program (2019-2021)

Following the design of the program, it was presented to the Director of the School of Health at Universidad del Valle and the Coordinator of Pediatrics at HUV. After receiving a favorable evaluation, it was subsequently presented to the Manager of HUV; with his endorsement, the challenge of implementing the first Social Pediatrics Unit in the country began.

Key actions and challenges during implementation:

Creation of a new Social Pediatrics service at HUV with financial sustainability

Challenges: Implementation of the first Social Pediatrics Unit in Colombia, without local precedents or recognized subspecialties in child abuse.

Strategies: Inclusion in the medical records system as a clinical specialty. In pursuit of the program's sustainability, care packages were designed to allow billing and reimbursement of healthcare services as pediatric care. Subsequently, since in Colombia there is no subspecialty in child abuse or a master's degree in social pediatrics, as exists in the United States and Spain, the program was incorporated into the organizational structure as part of the Social Responsibility framework, which provides flexibility for financing the unit.

Creation of the healthcare team.

Challenges: Replicating specialized teams from U.S. and Spanish programs within a limited socioeconomic context.

Strategies: The model was adapted and initially implemented by a pediatrician trained in child abuse and social pediatrics, supported by psychosocial staff (social work and psychology) from other HUV departments. Together with psychosocial teams, a program activation pathway was designed (inclusion criteria, coordinated interprofessional intervention, and reporting to territorial entities). This pathway was developed in accordance with the Ministry of Health's child maltreatment care guidelines ⁷⁾ and aligned with the principles of the Convention on the Rights of the Child.

Institutional transformation:

Challenge: Training and raising awareness among all HUV staff on child abuse and the new care pathway.

Strategies:

Through a training schedule directed at all healthcare personnel (administrative staff, nurses, psychosocial team, physicians) from HUV departments that provide care to children and adolescents (emergency, hospitalization, surgery, orthopedics, mental health, and obstetrics), the new care pathway was disseminated, and strategies were provided to enable timely diagnosis of different types of child abuse.

Faculty development of the Clínica del Buen Trato at Universidad del Valle and design of the care model

Challenge: Recruiting faculty members from different disciplines interested in joining the program. Development of program protocols in the absence of national references.

Strategies: Individual meetings were held with each faculty member who constituted the interdisciplinary team: Psychology, Occupational Therapy, Speech Therapy, Neuropsychology, and Pediatrics. Through academic activities and formative research projects, care protocols were developed for each discipline (initial assessment, screenings to diagnose the impact of maltreatment, screenings for caregiver qualification, and the design of comprehensive outpatient therapies) and for the interprofessional coordination pathway.

For the construction of the care model based on the needs of this population, epidemiology, concepts from neuroscience, and the ecological model of health were considered. This model is composed of validated scales for Spanish-speaking children and adolescents, which can be applied by trained health professionals from any discipline, with the aim of decentralizing care model. Figure 5 describes the care pathway for children and adolescents with child maltreatment at HUV, and Figure 6 illustrates the services of the *Clínica del Buen Trato*.

Consolidation of the Social Pediatrics Program: Healthcare and Academic Impact on Child Maltreatment Care. (2022-2025)

Following its implementation, the **Social Pediatrics Unit** was consolidated as the first specialized inpatient center for child abuse in Cali, integrating health, justice, and protection under an interprofessional approach. The results of the program's consolidation demonstrate a transformative impact:

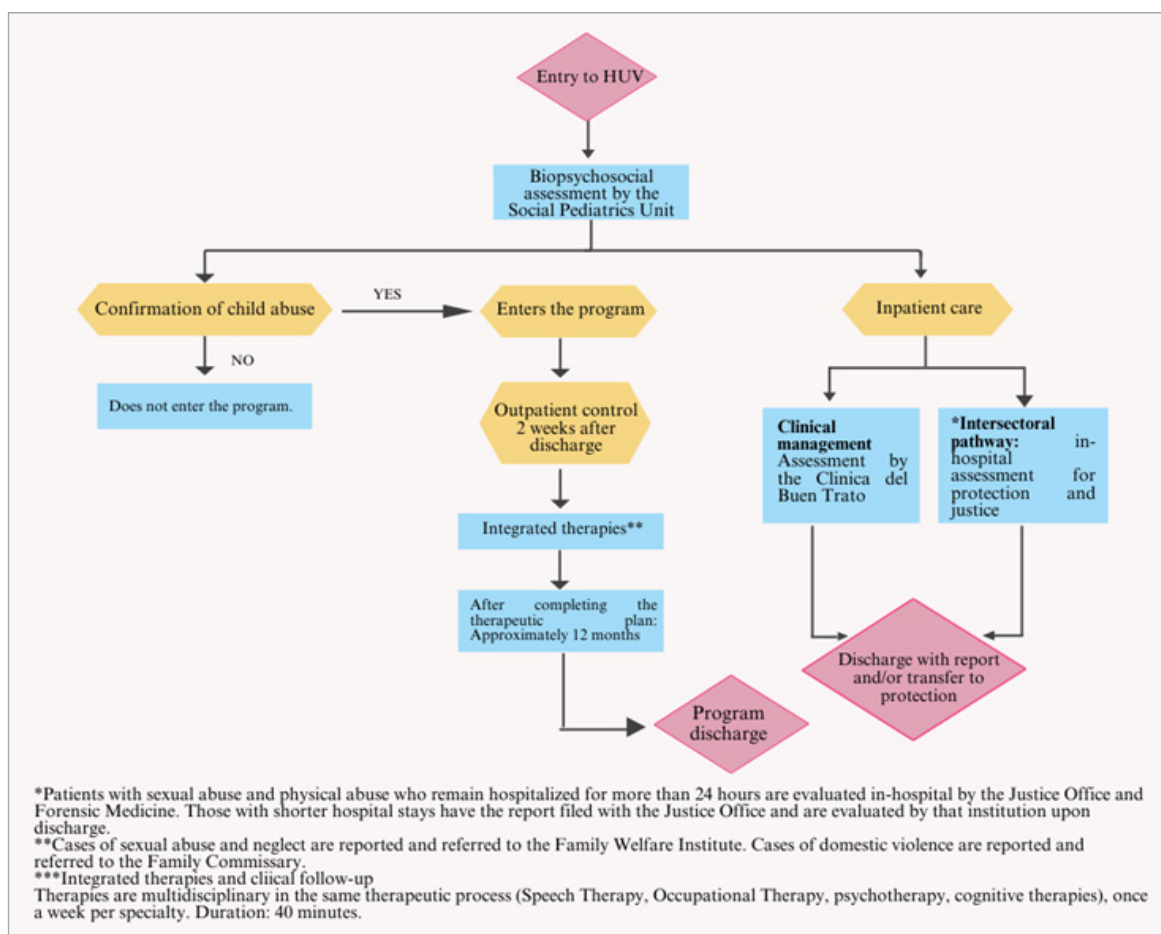


Figure 5. Inpatient and outpatient care pathway of the Social Pediatrics Unit.

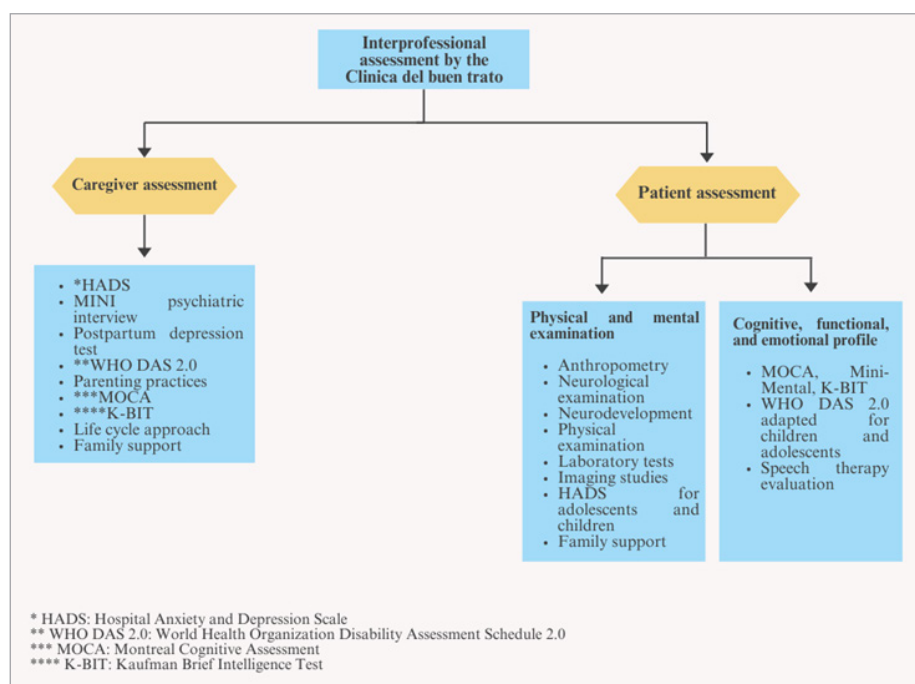


Figure 6. Clínica del Buen Trato. Screenings used for assessing the impact of maltreatment and caregiver qualification.

Healthcare impact: Early detection and interprofessional care

- Early diagnosis with expanded coverage: From the implementation of the program (November 2019) through December 2024, a total of 3,602 patients were treated, of whom 1,454 children and adolescents were diagnosed with maltreatment. The analysis of case increase over time shows a rise in early diagnosis from 20.7% to 43.9% (an increase of 112%), reflecting greater institutional sensitivity that leads to broader coverage.
- Specialized team: The increase in cases has led to the growth of the healthcare team, which currently includes two pediatricians trained in social pediatrics, a psychologist, and an outpatient social worker; a biopsychosocial team that ensures comprehensive care.
- Implementation of an interprofessional care model centered on the needs of children and adolescents experiencing maltreatment: Through the ecological approach to health, a biopsychosocial assessment of patients is carried out, making use of the screenings described in Figure 6 for evaluating the impact of maltreatment and assessing the parental capacities of caregivers. This facilitates the development of therapeutic plans that address complex trauma repair and work with caregivers to ensure non-repetition. The innovative aspect of this care model is that the screening tools can be applied at low or medium levels of complexity by trained health professionals from any discipline.
- Document management: The creation of the operational manual and protocols standardized care, optimizing the quality of institutional interventions.

Administrative innovation: Sustainability and guaranteed access

In 2025, the care packages were updated, and self-management of outpatient services was initiated, achieving **73.3% of approved authorizations** by health insurance entities. HUV assumed active management, relieving caregivers of administrative procedures, thereby ensuring adherence to outpatient care and reimbursement of services.

Intersectorality

- Creation of a child maltreatment medical record in partnership with Forensic Medicine and the Prosecutor's Office. This format is a confidential document to which only the program's pediatricians have access, despite being integrated into the hospital's medical record system. This registry expedites reporting, protects the testimony of NNA children and adolescents and prevents revictimization.
- Integration of the Prosecutor's Office hospital chat: Reduced the time required for judicial and forensic medical assessments, since timely reporting ensures that patients with sexual abuse and physical maltreatment are evaluated within the hospital by these institutions, thereby improving the collection of evidentiary material.
- Working groups with ICBF and Family Commissioners: Cases requiring urgent protection are jointly assessed at HUV by the psychosocial teams of these institutions, ensuring immediate protection measures (e.g., removal of abusive caregivers, referral to ICBF care modalities upon discharge).
- Thanks to coordination with territorial entities, large-scale activities of **knowledge translation and community engagement** are carried out with the aim of implementing primary prevention.

Academic impact: The Clínica del Buen Trato as a center for interprofessional child maltreatment training

Thanks to the integration of knowledge and the co-leadership of Teachers, a clinical training plan was developed with micro-curricula and clearly defined educational objectives for each discipline. Thus, Universidad del Valle established the first interprofessional child maltreatment training center, which, up to the time of writing this article, has trained **108 undergraduate and graduate students** in clinical competencies for the prevention, detection, and management of child maltreatment, as well as in soft skills (leadership, assertive communication, teamwork), fostered by the interprofessional orientation of the training program²⁴. The consolidation of this training center has strengthened research, patient care, and knowledge translation and community engagement. Formative research was further reinforced with the launch of the **Annual Colloquium** (since 2023), a community outreach space where research outputs are disseminated. The initiation of interprofessional clinical training has also opened new spaces for comprehensive outpatient therapies, in which patients are jointly treated by two disciplines for **40-60 minutes once a week**. This approach improves adherence and outcomes by providing an integrated, interprofessional therapeutic plan within a single consultation.

The implementation of workshops aimed at the prevention of child maltreatment, directed toward parents of hospitalized patients at HUV, has strengthened knowledge translation and community engagement. These spaces have become not only mechanisms to enhance caregivers' parental skills but also a humanizing tool that reduces the impact of prolonged hospitalization.

Despite the advances and impact of the program, **challenges remain regarding the intersectoral pathway, adherence to follow-up, and the sustainability of the program**. The intersectoral alliance with ICBF and Family Commissioners has been largely unproductive, as the absence of these institutions from the working groups has prevented full coordination. This lack of articulation, combined with the limited resources of ICBF service providers and families, has hindered patient follow-up, leaving a large proportion without therapeutic management and without the possibility of outreach. In other words, despite entering the program and the intersectoral child maltreatment pathway, they are not guaranteed reparative treatment for complex trauma. The challenge of sustainability lies in the lack of recognition by health insurance of complex trauma as a health condition requiring specialized management. Consequently, to ensure authorization of services, the HUV administrative team (finance, contracting, and social responsibility leadership) must hold regular working groups to present the program and care packages, thereby securing their approval and contracting.

Program projection: Toward a center of excellence in child protection (2025-2030)

The **Social Pediatrics Unit** has been consolidated as a replicable model of social innovation in health, whose results—documented at the institutional, academic, and community levels—lay the foundation for its expansion into a **Center of Excellence in Child Protection**. The projection will be developed along four **strategic pillars**: the strengthening of academic and research capacity, the creation within the hospital of a space with specialized infrastructure, and the decentralization of the care model.

The strengthening of academic and research capacity is aimed at reducing the existing knowledge gap and disseminating the care model protocols; to this end, work is being carried out on the development of academic extension models and academic publications. Thanks to the growth of HUV, a space is planned for the specialized infrastructure of the Unit, including a Gesell chamber, areas for intersectoral evaluations, and equipment to support comprehensive therapies. The ultimate goal of the projection is the creation of a hospital network of centers specialized in child maltreatment care. This will allow for the standardization of care and the reduction of geographic barriers that may be associated with lack of adherence; in this way, more NNA children and adolescents experiencing maltreatment could be guaranteed timely diagnosis and management.

In the projection of the program, major challenges are anticipated, including the establishment of working groups to enable the creation of the network of **child protection centers** and the pursuit of funding to support it.

Discussion

The experience of the **Social Pediatrics Unit** demonstrates how the articulation of the WHO's INSPIRE strategy with the ecological model of health can transform child abuse care in resource-limited contexts. This program not only operationalizes the seven components of INSPIRE (ranging from the implementation of laws to the creation of safe environments) but also adapts them to the Colombian reality through an interprofessional approach centered on the health needs of children and adolescents affected by maltreatment. The articulation of these concepts is outlined below:

Actions in exosystems and macrosystems that strengthened the implementation of the regulatory framework

The **Social Pediatrics Unit** materialized the principle of the *best interests of the child* (Law 1098/2006) by integrating health, justice, and protection within the same space, thereby overcoming the existing regulatory fragmentation. An example of this is the use of a confidential medical record format co-designed with the Prosecutor's Office and Forensic Medicine, which expedited reporting and reduced revictimization. One of the most important lessons from this articulation is the recognition of institutional will as the key factor in translating legal frameworks into concrete actions. Thus, institutional will becomes the main challenge for the decentralization of the care model and the development of a network of healthcare centers specializing in child protection.

The intersectoral articulation described in the INSPIRE strategy was achieved by coordinating HUV's clinical care with the intrahospital services of other sectors, thereby optimizing the response times of the Prosecutor's Office and Forensic Medicine while also preventing revictimization. However, intersectoral collaboration with ICBF and Family Commissioners remains a challenge, a situation that results in the loss of patients and the lack of guarantees for the repair of complex trauma.

Actions in microsystems: work with caregivers and environments

Humanized parenting workshops and screenings of parental capacities addressed dysfunctional family dynamics, thereby enabling the identification of risk and protective factors within the environments of our patients, with the aim of fostering a safe home where no new episodes of maltreatment occur, and where caregivers have stronger parental tools.

Activities of knowledge translation and community engagement promote a culture of **positive parenting of children** and the prevention of child abuse and neglect.

Direct actions at the individual level: Interprofessional care

The innovation of interprofessional therapies (e.g., psychology + occupational therapy) demonstrated an increase in adherence among our patients, reducing socioeconomic barriers by ensuring self-management through HUV and providing comprehensive care within a single health institution once a week.

The healthcare model, with emphasis on the diagnosis and treatment of complex trauma, articulating clinical care with intersectoral actions, represents the main benefit for program patients. Through this strategy, patients who adhere to treatment are able to achieve the repair of complex trauma, the protection of their rights, and access to justice, all without revictimization.

Lessons learned

A key element in the implementation of the program was administrative flexibility. Registering the **Social Pediatrics Unit** under the **Social Responsibility framework** made it possible to overcome regulatory gaps, such as the absence of a subspecialty in child abuse or social pediatrics in Colombia, thereby enabling the provision of specialized care despite this limitation.

Intersectoral work will continue to be one of the main challenges of the program, since the functioning of the working groups may be affected by the interests of officials, staff turnover, or lack of resources within institutions.

The health care guidelines for children and adolescents in Colombia must be updated to include diagnostic tools for assessing the impact of maltreatment and biopsychosocial strategies for its management.

The scalability of the care model will not only enable HUV to advance toward becoming a center of excellence in child protection, but also, by improving the availability of health services, more children and adolescents may benefit from increased access to providers offering specialized care for the detection and management of child maltreatment.

Finally, this narrative highlights three key elements for the development of public policies to improve care for children and adolescents experiencing child abuse and neglect. First, there is evidence that specialized child protection centers are cost-effective, as they reduce costs associated with the reprocessing of the care pathway. Second, the care model is replicable and adaptable to health centers of medium and low complexity. Finally, this program demonstrates the urgent need to recognize child maltreatment as a public health issue that requires formalized care provided by trained professionals. Thus, the establishment of social pediatrics as a subspecialty in Colombia becomes mandatory to guarantee the rights of children and adolescents affected by child abuse and neglect.

Conclusion

Interprofessional and intersectoral care for child maltreatment impacts public health by improving indicators of child health, mental health, and the prevention of chronic noncommunicable diseases. Moreover, it impacts social development by preventing the intergenerational transmission of violence. Thus, specialized child protection centers represent health strategies that enhance the social and human development of the region.

As a personal reflection, I recognize that repairing trauma in patients who have experienced child maltreatment makes us more vulnerable and sensitive to human suffering, giving us the opportunity not only to be more empathetic with patients but also to heal our own childhood and reframe our history. To the children and adolescents who have entered the program, thank you for your trust, your courage, and your resilience, which strengthen us to continue working to guarantee your opportunity to build your existence in a place different from violence; and with it, to believe that it is possible to build a country at peace.

My gratitude extends to the team that accompanies me in this challenge; to the teachers of the *Clínica del Buen Trato* for their co-leadership, and to the administrative staff of HUV for trusting the process. The results presented here are thanks to the effort, passion, and dedication of a great working team (program care staff, faculty of the *Clínica del Buen Trato*, and the HUV Social Responsibility framework team).

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