FACTORS AFFECTING THE INTEGRATION OF ONE STOP CRISIS CENTRE (OSCC) IN PENANG

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by

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LIST OF ACRONYMS

A&E	Accident and Emergency Department
AWAM	All Women's Action Society
DAIP	Domestic Abuse Intervention Project
DV	Domestic Violence
ETD	Emergency and Trauma Department
GBV	Gender Based Violence
HIV	Human Immunodeficiency Virus
JAG	Joint Action Group
IPV	Intimate Partner Violence
MOH	Ministry of Health
NGO	Non-governmental Organization
OSCC	One Stop Crisis Centre
PATH	Program for Appropriate Technology in Health
VAW	Violence against Women
WHO	World Health Organization

FAKTOR-FAKTOR YANG MEMPENGARUHI INTEGRASI PUSAT KHIDMAT SEPADU (OSCC) DI PULAU PINANG

ABSTRAK

Kajian ini mengenalpasti faktor-faktor yang mempengaruhi integrasi Pusat Khidmat Sepadu (OSCC) dan menerokai idea dan konsep integrasi dari perspektif beberapa pemegang taruh yang terlibat termasuk penyedia perkhidmatan, klien dan juga informan utama/pembuat polisi. Kajian ini menggunakan kaedah kualitatif dan temubual secara bersemuka dijalankan keatas empat puluh empat responden yang terdiri daripada dua puluh lapan penyedia perkhidmatan dari pelbagai agensi yang terlibat dengan OSCC, sepuluh orang klien yang pernah mendapatkan perkhidmatan di OSCC dan enam orang informan utama yang merupakan perintis dan juga pembuat polisi dalam pembentukan awal OSCC. Dapatan kajian menunjukkan bahawa OSCC merupakan perkhidmatan yang berelemen bersepadu (integrasi) namun beroperasi pada tahap 'koordinasi'. Terdapat enam elemen yang mempengaruhi kepada proses integrasi untuk berlaku termasuk sikap dan pengetahuan penyedia perkhidmatan, komunikasi, penyedia utama atau peneraju utama, garis panduan piawaian atau cara kerja, akauntabiliti dan kebolehcapaian perkhidmatan. Sebagai tambahan, penemuan juga mendedahkan dua elemen baru yang perlu diambil kira untuk integrasi perkhidmatan berlaku iaitu peneraju utama dan juga komunikasi dan dua elemen ini dapat menyumbang kepada pembentukan model konseptual. Kesimpulan penting dari kajian ini adalah integrasi perkhidmatan OSCC memerlukan pemerkasaan semua agensi yang terlibat dan juga pelarasan kepada halangan peringkat sistem untuk memperkasakan wanita dan juga komuniti dalam isu berkaitan dengan keganasan terhadap wanita. OSCC yang merupakan respon sektor kesihatan yang

komprehensif mempunyai potensi untuk memperbaiki perkhidmatan kepada lebih baik dan lestari.

FACTORS AFFECTING THE INTEGRATION OF ONE STOP CRISIS CENTRE (OSCC) IN PENANG

ABSTRACT

This study identify the factors affecting the integration of One Stop Crisis Centre (OSCC) and explores the idea and working concept of integration for OSCC from the perspectives of the stakeholders including service providers, clients and policy makers/key informants. A qualitative methodology was applied in this study and face to face interview was carried out to fourty-four respondents. They were twenty eight service providers from various agencies related to OSCC, ten clients who were ever attended the services and six key informants who were the pioneer and at the policy makers level of the setup of OSCC. The results of the study indicate that OSCC has not achieved the level of integration and still working at the coordination level. There are six elements that affect the integration to happen include the attitude and knowledge of the staff, communication, key personnel, standardised guidelines, accountability and accessibility of the services of which OSCC is still trying to achieve. In addition, the findings revealed two emerging elements that should be considered for the integration of the OSCC to happen, that is, by having a champion or key driver and communication and this can contribute to the conceptual model. Important conclusion drawn from this study is that the integration of the OSCC services requires the empowerment of agencies involved and adjustments to barriers at system level in order for the services to empower women and community on the issue of VAW. A comprehensive health services such

as OSCC has the potential to significantly sustain and improve the services to respond to VAW.

CHAPTER ONE

INTRODUCTION

1.0 Introduction

This study aims to explore the factors affecting the integration of services of the One Stop Crisis Centre (OSCC) in Penang. Integration as a concept and process of work among various service providers including health providers, police, social workers, legal aid officers and non-governmental organisations will be examined and input from clients who have utilised the services will be gathered. Several studies have been done on OSCC and this will be a new exploration by taking clients into account in examining the effectiveness of the services. Presenting the voices of clients to policy makers will at least bring some awareness and provide some assistance to them when revising and formulating better programmes for the system in the future.

This introduction outlines the overview and direction of the study, provides the background, research problem, research questions, objectives, scope and significance of the study. The final part of the chapter describes the definition of variables used in the study.

1.1 Background of the study

The United Nations defines violence against women (VAW) as 'any act of gender-based violence that results in, or is likely to result in, physical, sexual or mental harm or suffering to women, including threats of such acts, coercion or arbitrary deprivation of liberty, whether occurring in public or in private life. Such an act may be carried out within the home (domestic violence), in the community (rape, sexual harassment, trafficking and

forced prostitution) or by the state (custodial torture, violence against refugees, rape by government officials during war or ongoing conflict)' (WHO, 2016). It may take various forms such as physical assaults, emotional abuse, sexual violence and economic control/deprivation (Deosthali, Maghnani and Malik, 2005). Violence against women affects people regardless of their social class, age or their ability. Abuse is a health care issue that impacts people of all ages including children, adolescents and the elderly; its impact can manifest throughout the lifespan (Salber, 1999).

VAW is more common than many diseases that affect women for which health plans routinely screen such as breast cancer, cervical cancer and diabetes (Zink et al, 2007). More serious, injury sustained by victims during violent episodes, physical and psychological abuse is linked to a number of adverse medical health effects such as hypertension, risk of antepartum haemorrhage and of miscarriage, human immunodeficiency virus (HIV) and transmitted disease infections, gastro-intestinal problems, depression and suicide, etc. (Coker et al, 2002; Dutton et al, 2006). The immediate health consequences of domestic violence can be severe and sometimes fatal. In addition, new research also links a history of victimisation to significant long-term chronic health problems and health risk behaviours. Domestic violence is associated with eight out of ten of the leading indicators in *Healthy People 2010*. The list of reported health consequences is long and sobering (Salber, 1999). The seriousness of injuries and health problems leads women to seek help in the health care setting and they will usually get the first treatment after being abused in a hospital. Health care providers can play a crucial role in detecting, referring and caring for women living with violence. According to Garcia-Moreno (2002), abused women seek services even more for their ailments

related to their abuse. Due to that, many countries have set up a special place in the health care setting and give special services for women who are involved in VAW cases.

In Malaysia, VAW has already been accepted as a public health issue. The health sector has responded by setting up services known as One Stop Crisis Centre (OSCC) in 1994. It was initiated by Hospital Kuala Lumpur in collaboration with non-governmental organisations or women's organisations (NGOs) and was offered in one location at the accident and emergency departments of urban public hospitals and integrated with many agencies. It is a round-the-clock 24-hour operation. The philosophy and framework of OSCC is to provide an integrated and coordinated multi-sectoral and inter-agency network for the management of survivors of violence against women and children that respects their dignity, safety and confidentiality (Bairagi et al, 2006; Kelly & Lovett, 2005). Thus far, six agencies have been involved in providing and handling the services; health services, the police department and social welfare department as the main core service support system while the legal aid bureau, non-governmental organisations or women's organisations (NGOs) and religious department will be involved for the cases that need special attention in the crisis. OSCC in Malaysia can be considered one of the established models and its approach had been replicated by many other countries such as Thailand, Bangladesh and Namibia. Currently, it is estimated that there are more than 100 OSCCs in state and district hospitals across Malaysia (Chew, 2010).

1.2 Problem identification

Though OSCC cannot 'fix' the problem of violence against women especially on the issue of domestic violence because the nature of domestic violence is complex and recurring, it can support abused patients, understand their situation and recognise the impact of abuse

on their health. Routine inquiry and assessment for domestic violence is meant to perform a life-changing, even life-saving, intervention. It can come together and build an effective health care response to domestic violence by offering support and referrals to reduce isolation and improve options for health and safety of abused patients (Salber, 1999). Responsibility for addressing interpersonal violence rests clearly with national and subnational governments. Addressing such violence requires a multisectoral response, where the health and other sectors need to work together. However, after twenty years of implementation, the response of the health sector to such OSCCs is still limited, not greatly proven as adequate to respond initially towards battered women and later on extended to rape and sexual assault.

In Malaysia, statistics have shown a high incidence of VAW cases in OSCC. For example, in 2008, 10,098 VAW cases were recorded in OSCCs all over Malaysia (Siti Hawa, 2011). For Penang state itself, the number increased from 564 cases in 2008 to 575 cases with various abuses reported in 2010 (Annual Report, 2010). This proves that OSCC is a critical service that must be provided by the health sector for handling this issue. Responding to domestic violence is clearly a complex task for any agency. It is rarely the only issue which requires action and the longer such issues continue to develop, the more difficult they are to resolve. Responding to domestic violence at the crisis stage often limits the effectiveness of any intervention and it is widely recognised that intervening at earlier stages is vital to the reduction of domestic violence and associated issues. As a model to provide that kind of service, a debate currently exists about the effectiveness of such responses. How active and efficient are they to respond on this issue? Even though the OSCC model is established, many of the OSCC services in Malaysian hospitals could not operate actively and need to be evaluated (Rastam, 2002). This has been due to the

failure to provide the full complement of services especially with the integration of intra- and inter-agencies as well as inconsistency in service provision among hospitals (Kelly & Lovett, 2005) and other sectors (Colombini et al, 2008).

According to Siti Hawa (2007), there are various challenges and issues of integration of services in a multi-sectoral support system especially on understanding violence against women among service providers and practices among agencies and within agencies. A previous study done by Colombini et al (2008) ascertained that the OSCC model must be an integrated model. However, there is no single integrated model of the services among and within agencies involved. Therefore, it is important for the health sector to establish effective integration within departments and with multi-sector agencies to coordinate their responses to VAW. Currently, the service is accepted as a coordinated package rather than as an integrated one. Integration is a process and concept of which ~~of~~ the multi-sector agencies work together as one entity in harmonious relationship, whereas coordination refferd to as working together as separate entities but equal in rank. A fully integrated service has one set of management support systems (financial and human resource management, logistics and supplies, etc.) supporting the service as a whole (WHO, 2008). To achieve the philosophy and framework of the OSCC, the services must be integrated in order for the services to function effectively. Based on the Duluth model[1], a workable integration with multiple agencies is an important element of intervention in handling VAW. Workable integration is measured by four basic

[1]The Duluth model is a comprehensive model for inter-agency intervention on the handling of domestic abuse cases. It was developed in 1980 in Duluth, Minnesota under The Domestic Abuse Intervention Project (DAIP).

principles: it must reach agreement on operative assumptions, theories and concepts to be embedded in written policies and administrative practices to develop oneness.

In the context of handling the OSCC services, the definition of integration is 'coordinated effort by all sectors (governmental and non-governmental) and disciplines within and intra-organisation in order to respond (in terms of addressing the issue and providing services) effectively to the need of the survivors of interpersonal violence' (Siti Hawa, 2007). Fox and Butler (2004) states that 'the activities undertaken are developed, implemented and "owned" by the group. The stakeholders are committed to co-designing and planning for the shared purpose. The organisations involved are brought into a new structure with commitment to a common mission.' The definition also applies to OSCC service. Based on literature, the concept of integration can be operationalised by having a similar understanding and knowledge of the services (Grisurapong, 2002; Siti Hawa, 2007), appropriate work procedures for multiple agencies (Colombini, 2008; Grisurapong, 2002; Rastam, 2002), accessibility (physical and functionally) of the services (Duluth Model, 2005; Grisurapong, 2002), accountability of the services (Colombini, 2008; Duluth Model, 2005), financial assistance (Colombini, 2008; Deosthali, Maghnani and Malik, 2005; Kelly & Lovett, 2005), sufficient resources (Bairagi et al, 2006; Colombini, 2008; Kelly & Lovett, 2005), skills and expertise (Bairagi et al, 2006; Deosthali, Maghnani and Malik, 2005; Grisurapong, 2002; Kelly & Lovett, 2005) as well as service providers' attitude towards the services (Colombini, 2008).

1.3 Problem statement

All too often, health and other institutions are slow to recognise and address this violence, and services are not available or have limited capacity (WHO, 2015). With regards to the idea of integration, it is clear that the integration services of the OSCC are not working

effectively. It must be understood that OSCC is not a place for the medicalisation of violence against women, instead it is a place which recognises the key role of health in supporting the issue. OSCC is a critical service because it is an entry point and often the only point of contact with public services which may be able to offer support and information to the victim. Women who experience violence are more likely to use health services than those who do not, although they rarely explicitly disclose violence as the underlying reason (Ansara & Hindin, 2010).

Health care providers are often the first point of professional contact for survivors/victims of violence. Several results (Colombini et al, 2009; UNFPA, 2010; WHO, 2003) show that health services have a potential role in helping to identify and support women who have experienced abuse and facilitate their referral to specialised services. Multi-agency responses to domestic and family violence are high on the strategic agenda of most states and territories. With the successful introduction of coordinated responses and the ongoing development of so-called 'OSCC,' it is timely to examine coordination models from a 'good practice' perspective. One of the good practice indicators developed by United Kingdom (UK) researchers studying services working with families with domestic violence (Humpreys, Hague, Hester & Mullender, 2000) was multi-agency integration.

The reasons behind the development of an integrated response vary, ranging from local issues, such as a preventable homicide or child abduction, to a ministerial level commitment to addressing domestic violence. The prompting factor leading to the initiation of interagency collaboration is a threshold issue in determining promising models. Mulroney (2003) defines integration as a development of response that aims to enhance victim safety, holding abusers accountable for their violence and reducing

secondary victimisation by the services. Surprisingly, this is not the impetus for all multi-agency responses. Process issues for agencies, or cost-saving agendas for government can provide the main rationale for program development with the danger that they either fail to address victim safety or actually lead to increased danger (for example if they are not culturally safe), while draining time and resources away from service delivery. Where the integration is driven by other aims, such as the desire to improve relations between agencies and services, these might be better achieved through alternative strategies, such as joint work on community campaigns or forums, or stakeholders involvement on management committees. Integration efforts seem to be more successful when implemented in the context of stronger health systems with less structural problems (e.g., systems with a strong steering role of the national health authority, less segmentation, and adequate levels of financing).

The evidence base informing the scale-up of intimate partner violence (IPV) interventions and their integration into health systems is lacking. However, examples of published investigations that exist provide lessons of interest to those wishing to institute an appropriate response to IPV. In Malaysia, the possibility of national scale-up of One Stop Crisis Centres, as an integrated health sector response to IPV, has been investigated (Colombini et al, 2011). Factors relating to health system structure and organisation as well as external policy constraints were found to be barriers to the implementation of integrated services. Commitment at policy level was found to be necessary; this could be communicated to service delivery level by incorporating appropriate indicators into routine reporting. Adequate training as well as adjustments to service delivery were required in order to ensure that providers had the necessary time available to them. Finally,

flexibility of the model was important so as to allow for its implementation at different levels of care.

In order to establish the effective integration of multiple agencies which has not been studied before, it is crucial for my study to identify the contributing factors affecting the integration of these multi-sector services responding to this issue. This study also will focus on clients' perception and experiences on utilising the services. Female participants in many studies reported that they think providers should ask routinely about the violence; they also valued the assessment as a part of their complete medical history as long as it did not create an atmosphere of interrogation (Chang et al, 2005). Therefore it is important for this study to get patients/clients as subjects in order to provide the voices of the clients as a significant reason for integration to happen.

1.4 Research questions

Based on the background of the study and the research problems identified above, this study has proposed several research questions as listed below:

1. What are the factors affecting the integration of the multi-sector services in responding to VAW in the Penang hospital?
2. In what ways are the factors connected to one another and produce a workable and effective integration?
3. What are the strategies to develop and strengthen the integration system of OSCC in the Penang hospital?

1.5 Research objectives

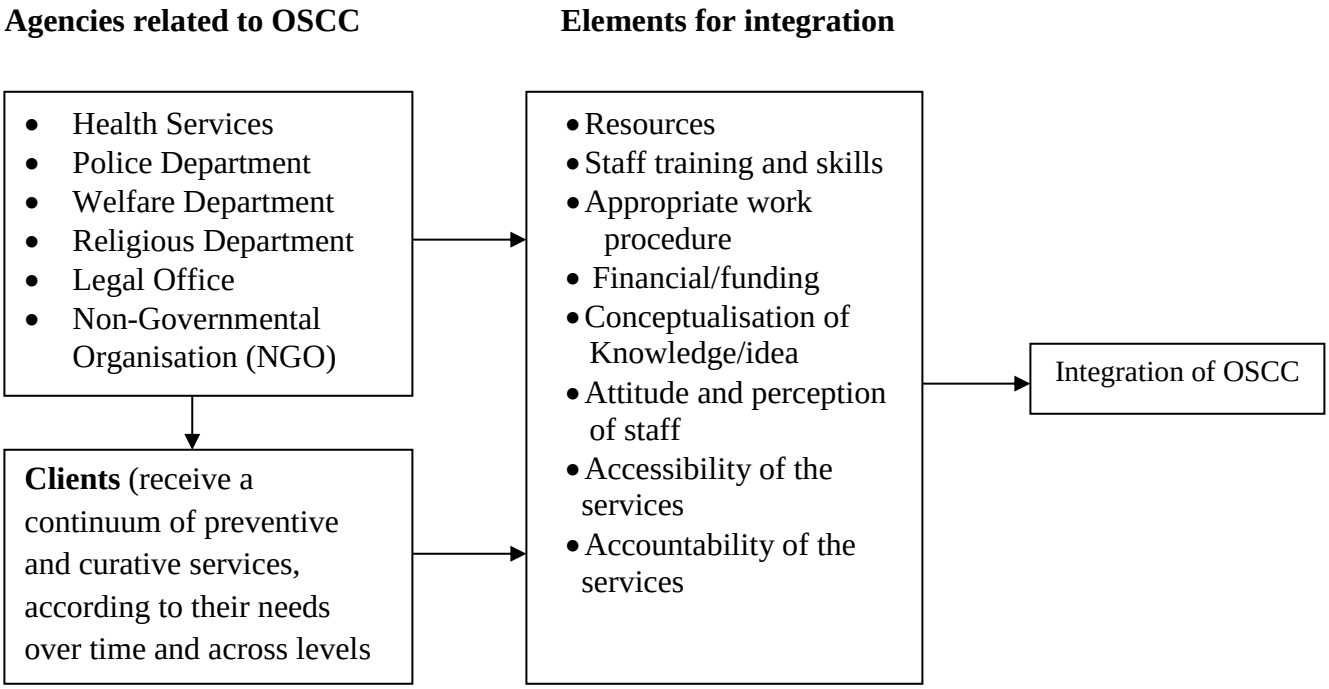
This study has three objectives:

1. To identify the factors affecting the integration of these multi-sector services in responding to VAW in the Penang hospital
2. To investigate the connecting factors to produce a workable and effective integration
3. To identify the strategies that need to be developed to strengthen the integration system of OSCC in the Penang hospital.

1.6 Conceptual framework

The proposed framework of the study is illustrated below:

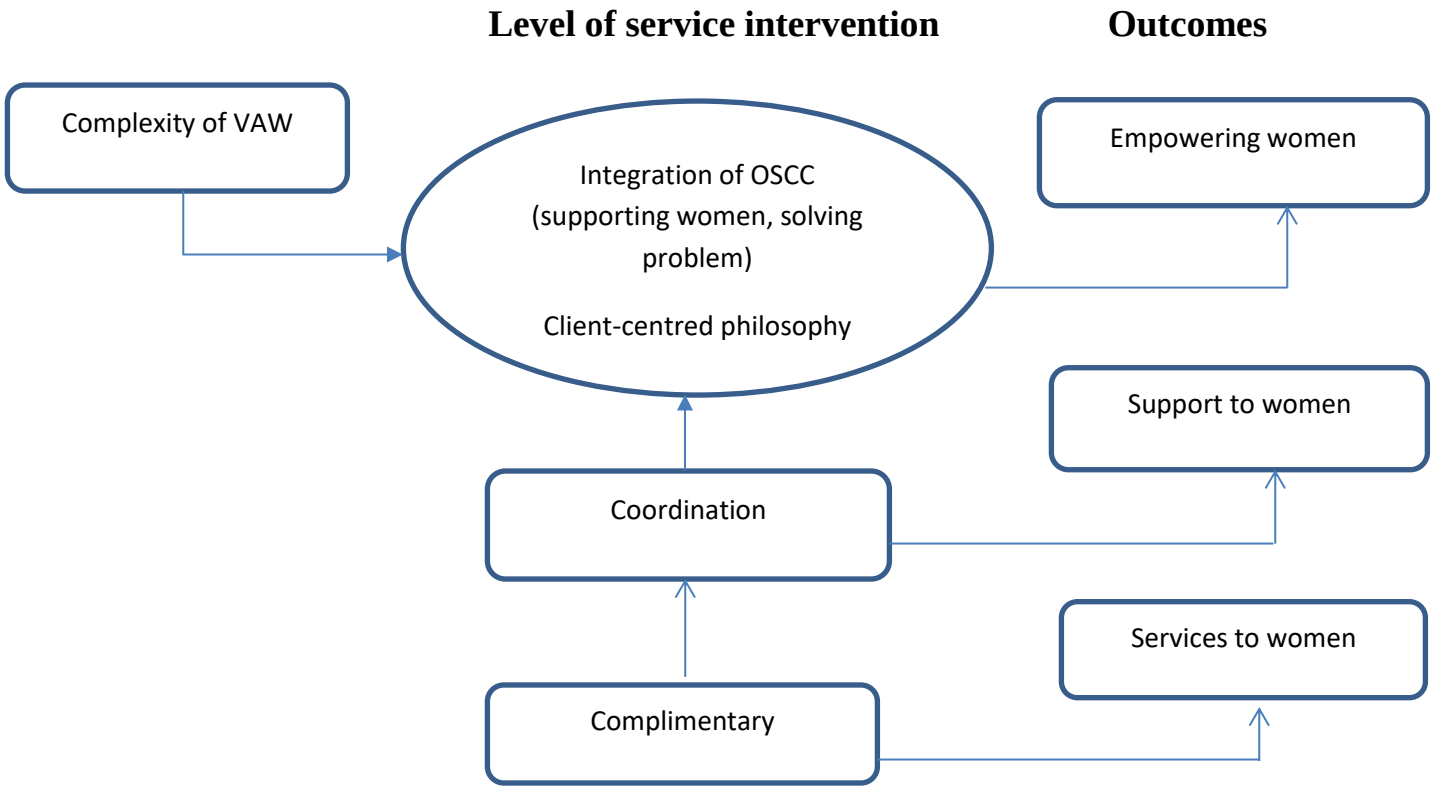
Figure 1.6a: Conceptual framework



The agencies such as health services, police departments, welfare departments, religious departments, legal offices and NGOs must amalgamate all the elements of integration to make a whole in order to provide effective integrated services of OSCC to the clients. In

this study, continuity of care refers to an attribute of healthcare organisations (in this case of OSCC) and also the subjective perception of the clients experiencing the coordinated services.

Figure 1.6b Framework of the level of health sector response to VAW



At the complimentary level, OSCC is just a place for providing services to abused people (particularly women and children experiencing violence). However, because the nature of domestic violence is complex and recurring, it requires a response that is comprehensive, coordinated and meaningfully engages community and government service providers (Spohn, 2008) to support women. After more than two decades, the system has been recognised to respond to the issue. The OSCC agenda not only concentrates on supporting women and solving their problems but focuses more on

empowering women who are experiencing violence. Therefore, integrated services are needed to achieve the objective.

The majority of integrated service delivery models aim to improve the safety and well-being of people affected by domestic and family violence in order to reduce the demand on current service systems (statutory, courts, human services); increase the efficiency and effectiveness of the human service and justice systems in responding to domestic and family violence; and build the skills of service providers to increase their ability to provide the best possible services to clients and break down the barriers to integrated working. Rogers and Sheaff (2000) stated that 'justification for integrated delivery systems is to meet clients' needs rather than providers.' Organisations that fail to place the client at the centre of their integration efforts are unlikely to succeed. (Coddington et al, 2001).

1.7 Scope of the study

This study uses qualitative methodology and face-to-face interview methods together with a domain of enquiry as guideline questions which aim to identify the factors affecting the integration of the OSCC services and to recommend the strategies that need to be developed to strengthen service integration. Information was obtained from various stakeholders that offer services at OSCC, such as health providers, social workers, police officers, legal advisors, religious counsellors and NGO workers. Information was also gathered from clients who ever used OSCC services and key informants. The table below shows the role of related agencies in providing services to the survivors at OSCC.

Agencies	Sector	Role
Health providers (including doctors, forensic specialist, nurses, medical social workers, counsellors)	Health	Provide medical based treatment, screening/routine enquiry, forensic examination
Police officers	Criminal system, D11	Provide information and support services and access to justice, i.e. police report
Social workers	Social welfare	Provide counselling, Interim Protection Order (IPO) if necessary, shelters, financials
Legal advisor	Justice system	Provide information and support services and access to justice
Religious officer	Religious Department	Provide counselling to Muslim partner
Non-governmental organisation officer (NGO)	Civil society	Provide information and support services such as advocacy, counselling, shelters for the survivors.

Table 1.8 Role of related agencies to OSCC

1.8 Significance of the study

The proposed study fulfils the requirement of originality and substantial contribution to knowledge in a number of ways:

1. There is no specific study in Malaysia that examines the factors affecting and promoting the integration services of the OSCC; and
2. There is no single study that takes patients/victims into account in examining the effectiveness of the services. Presenting the voices of clients to policy makers will bring some awareness and provide some assistance to them when revising and formulating better programmes for the system in the future.

1.9 Operational Definition

There are several key terms used in this study that are operationally defined as follows:

- Violence against women (VAW): any act of gender-based violence that results in, or is likely to result in, physical, sexual or mental harm or suffering to women, including threats of such acts, coercion or arbitrary deprivation of liberty, whether occurring in public or in private life (United Nations)
- One Stop Crisis Centre (OSCC): A centre that offers a service to treat and support people who have been abused and assaulted in one location at the Emergency and Trauma Departments (ETD) of urban public hospitals and is integrated with many agencies such as police, social welfare, legal aid bureau, religious department and NGOs
- Integration: The activities that are undertaken are developed, implemented and 'owned' by the group. The stakeholders are committed to co-designing and planning for the shared purpose. The organisations involved are brought into a new structure with commitment to a common mission (Fox & Butler, 2004, p. 39). It must be a coordinated effort by all sectors (governmental and non-governmental) and disciplines within and intra-organisation in order to respond (in terms of addressing the issue and providing services) effectively to the need of the survivors of interpersonal violence (Siti Hawa, 2007)
- Service providers: the persons in charge of, coordinate the services and handle the cases

- Clients: Survivors or women who have ever used OSCC services in the past one year
- Conceptualisation of the knowledge: An understanding on the issue of violence and knowledge among stakeholders must be similar in service provision (Siti Hawa, 2007; Grisurapong, 2002)
- Appropriate work procedures: The protocols and guidelines of service must be consistently available for and followed by stakeholders (Colombini, 2008; Grisurapong, 2002; Rastam, 2002)
- Accessibility of the services: The accessibility of the services includes the operational time, waiting time and delayed time of the services (Deosthali, Maghnani and Malik, 2005; Grisurapong, 2002)
- Accountability of the services: The accountability of the services includes inter-agency tracking and information sharing systems, inter-agency meetings and written policies (Colombini, 2008; Deosthali, Maghnani and Malik, 2005).
- Financial assistance: Budget allocation in service provision (Colombini, 2008; Deosthali, Maghnani and Malik, 2005; Kelly & Lovett, 2005).
- Resources: The resources such as staff, logistics and equipment must be sufficient to provide services to the client (Bairagi et al, 2006; Colombini, 2008; Kelly & Lovett, 2005).
- Training and skills: All the staff and stakeholders handling services must be well trained on appropriate strategies, including gender issues and sensitivity of the clients (Bairagi et al, 2006; Deosthali, Maghnani and Malik, 2005; Grisurapong, 2002; Kelly & Lovett, 2005).

- Attitude of service providers: The attitude of service providers toward clients as either supportive or destructive (Colombini et al, 2013).

CHAPTER TWO

LITERATURE REVIEW

2.0 Introduction

This chapter first discusses the definition of the integration of health sector response to violence against women. This is followed by conceptualisations of the theory and model applied in this study, theory of integration and an elaboration of the Duluth Model. Then, the discussion focuses on the brief history of violence against women and the One Stop Crisis Centre (OSCC) in Malaysia. This leads to the discussion of the agencies involved and how the process is structured. A brief discussion of antecedents of each mentioned variable is also highlighted. This is followed by details of the elements of integration, i.e., resources, skills and training, attitude and perception of staff, accessibility, accountability, financials and work procedures. Arguments for the relevance of integration will lead to the identification of integration gaps that justify its importance.

2.1 Current status of violence against women (VAW)

2.1.1 Violence against women worldwide

Violence against women is a ubiquitous problem faced by women worldwide. Violence has been and continues to be a tactic used to target a specific group to maintain the *status quo* and enforce domination of one group over another. Around the world, the term 'violence against women' is used to refer collectively to violent acts that are primarily or exclusively committed against women. The legacy of violence against women is tied to the history of women being viewed as property and assigned a gender role that is subservient to men and also to other women.

This violence is perpetuated, fostered, and tolerated by institutional practices and social norms (values). For instance, a look at the legal system reveals some of the ways that violence against women has been institutionalised. In the United Kingdom, the traditional right of a husband to inflict moderate corporal punishment on his wife in order to keep her 'within the bounds of duty' was removed in 1891. In the more recent past, until 1976, marital rape was legal in every state in the United States. Today, very few reports of rape end in a conviction of rape and many victims face barriers in terms of time and the difficulty of the process when attempting to utilise the criminal justice system to seek accountability.

The World Health Organisation (WHO) states that 'Violence against women and girls is one of the most widespread violations of human rights.' In describing the worldwide impact of violence against women, WHO reports that violence against women puts an undue burden on health care services with women who have suffered violence being more likely to need health services and at higher cost, compared to women who have not suffered violence (WHO, 2013). The violence against women movement is about liberty, dignity and justice. It is not only about ending violence. It is about understanding that violence will only end when sexism, racism, classism, heterosexism, ableism and other oppressions have ended.

The United Nations General Assembly defines violence against women as 'any act of gender-based violence that results in, or is likely to result in, physical, sexual or mental harm or suffering to women, including threats of such acts, coercion or arbitrary deprivation of liberty, whether occurring in public or in private life.' The 1993 Declaration on the Elimination of Violence against Women noted that this violence could be perpetrated by assailants of either gender, family members and even the State itself.

The UN Declaration on the Elimination of Violence against Women states:

> Violence against women is a manifestation of historically unequal power relations between men and women, which have led to domination over and discrimination against women by men and to the prevention of the full advancement of women, and that violence against women is one of the crucial social mechanisms by which women are forced into a subordinate position compared with men.

The World Health Organisation reports:

> Violence against women and girls is one of the most widespread violations of human rights. It can include physical, sexual, psychological, and economic abuse, and it cuts across boundaries of age, race, culture, wealth, and geography. It takes place in the home, on the streets, in schools, the workplace, in farm fields, refugee camps, during conflicts and crises. It has many manifestations – from the most universally prevalent forms of domestic and sexual violence, to harmful practices, abuse during pregnancy, so-called honour killings and other types of femicide.

The United Nations Population Fund describes it thus:

> Gender-based violence both reflects and reinforces inequities between men and women and compromises the health, dignity, security and autonomy of its victims. It encompasses a wide range of human rights violations, including sexual abuse of children, rape, domestic violence, sexual assault and harassment, trafficking of women and girls and several harmful traditional practices. Any one of these abuses can leave deep psychological scars, damage the health of women and girls in general, including their reproductive and sexual health, and in some instances, results in death.
>
> Violence against women has been accepted and even condoned throughout history.

More than two thousand years ago, Roman law gave a man life and death authority over his wife. In the 18th century, English common law gave a man permission to discipline his wife and children with a stick or whip no wider than his thumb. This ‘rule of thumb’ prevailed in England and America until the late 19th century. Many feminists claim violence against women is the result of a deeply entrenched patriarchal culture that encourages and rewards male domination. They say that in a patriarchal culture, men are more likely to use violence to keep their dominant position. While society claims to abhor

violence, we often make heroes of men who are aggressive. In the culture of masculinity, heroes are often predicated on some kind of violent action. The traditional model of masculinity encourages men to exude an aura of daring and aggression.

2.1.2 Violence against women as a public health issue

Violence against women is also a social health issue due to its linkages with social, criminal, public health, economic and human security issues. It has been declared a public health issue because the seriousness of the problem is related to health. According to Coker et al (2002) and Dutton et al (2006) stated that health effects such as hypertension, risk of antepartum haemorrhage and of miscarriage, HIV and transmitted disease infections, gastro-intestinal problems, depression and suicide can be caused of violence. The immediate health consequences of domestic violence can be severe and sometimes fatal.

There are three major reasons why violence against women should be a priority for the health sector:

1. Violence causes extensive suffering and negative health consequences for a significant proportion of the female population (more than 20 per cent in most countries)
2. Violence has a direct negative impact on several important health issues, including safe motherhood, family planning and the prevention of sexually transmitted diseases and Acquired Immune Deficiency Syndrome (HIV/AIDS)
3. For many women who have been abused, health workers are the main and often the only point of contact with public services which may be able to offer support and information.

According to WHO (2013), intimate partner and sexual violence have serious short- and long-term physical, mental, sexual and reproductive health problems for survivors and for their children and lead to high social and economic costs. Intimate partner violence and sexual violence can lead to unintended pregnancies, induced abortions, stillbirth, pre-term delivery and low birth weight babies, gynaecological problems, and sexually transmitted infections, including HIV. IPV can have fatal results like homicide or suicide. It can lead to injuries, with 42 per cent of women who experience intimate partner reporting an injury as a consequence of this violence. The WHO (2013) analysis found that women who had been physically or sexually abused were 1.5 times more likely to have a sexually transmitted infection and, in some regions, HIV, compared to women who have not experienced partner violence. They were also twice as likely to have an abortion.

These forms of violence can lead to depression, post-traumatic stress disorder, sleep difficulties, eating disorders, and emotional distress and suicide attempts. The WHO study found that women who have experienced intimate partner violence were almost twice as likely to experience depression and problem drinking. The rate was even higher for women who had experienced non-partner sexual violence.

Health effects can also include headaches, back pain, abdominal pain, fibromyalgia, gastrointestinal disorders, limited mobility and poor overall health.

Sexual violence, particularly during childhood, can lead to increased smoking, drug and alcohol misuse, and risky sexual behaviours in later life. It is also associated with perpetration of violence (for males) and being a victim of violence (for females).

2.1.3 Violence against women in Malaysia

In Malaysia, violence against women was first recognised in the Sixth Malaysia Economic Plan (1991–1996) as a social issue that constrains women from participating in development (EPU, 1991). Even though it became an agenda item in the Ninth Malaysia Plan (2006–2010) to reduce violence against women with a focus on raising public awareness through campaigns, training on gender roles and creating new shelters (EPU, 2006), statistics from police reports in 2012 have shown that women faced with violence numbered 8,905; these comprised all sort of assaults and abuses such as domestic violence, rape, incest, abuse of domestic workers, child abuse and molestation (Royal Police & Ministry of Women, 2012). Data from the Ministry of Health showed that in 2014, 5481 OSCC cases involved women and girls (OSCC MOH, 2015).

The numbers have been increasing year by year and this can be significant evidence that the problem is on the rise. Several researchers argue the increase was because women were already aware about the issues and were not afraid to report the cases. This was supported by the Ministry of Women, Family and Community Development that the increase in reported cases was due to greater awareness among people that domestic violence is an offence under the Domestic Violence Act 1994. Malaysia was the first Muslim country and one of the first states in the region to adopt a law on violence, DVA in 1994. Enforcement began in 1996. However, those arguments were not something that we looked at recently; the increasing number of cases must be examined seriously for why they were still increasing and how much services can respond to the issues thoroughly by involving all stakeholders including service providers and policy makers.

Interestingly, according to research done on VAW, factors affecting violence in Malaysia were similar to other countries and the types of violence were also similar. It

means that violence is a typical core issue worldwide. Society must be aware that violence can happen unpredictably and can affect people regardless of their age, race, class, status, ability, sexual and gender identity, religious affiliation and immigration (Salber, 1999). A study in Malaysia in 1989 estimated that 1.8 million women, or 39 per cent of women aged 15 years or older, had been physically beaten by their husbands or boyfriends. (Abdullah et al, 1995, p. 5). Those who reported knowing women who had been beaten represented all socioeconomic classes and all ethnic groups in both rural and urban areas in peninsular Malaysia, although the Indian population was over-represented, at 22 per cent as compared to 9 per cent of Chinese and 8 per cent of Malays (Abdullah et al, 1995, p. 5).

The survey done by Rashidah et al (2013) found that approximately 9 out of 100 Malaysian women experience abuse by a current or former intimate partner. In spite of the data, there are those who continue to argue that men and women are equally victimised by their spouses. This position generally arises from the results of quantitative research using the Conflict Tactics Scale (Strauss, 1979) which does not account for the context in which the abuse occurs nor the impact on the victim (for further discussion, see Kimmel, 2002; Mulroney & Chan, 2005).

In their review of the literature, Bagshaw and Chung (2000) found the following gender differences in relation to intimate partner abuse:

> Males reported that they were not living in an ongoing state of fear from the perpetrator; males did not have prior experiences of violent relationships; and males rarely experienced post separation violence and, in the one reported case, it was far less severe than in male to female violence (cited in Mulroney & Chan 2005, p. 5).

Kimmel (2002) argues that while women's violence is often a result of a desire to improve the communication between partners (e.g., a woman slapping or pushing their male

partner in an attempt to get their attention rather than inflict pain or punish), the extent of physical, economic and psychological injury inflicted by men on women is understandably more frequent and more severe.

2.1.4 Violence against women in Penang

The earliest research on the issue of domestic violence and rape in Penang was done by Rohana Ariffin and Rachel Samuel in 1993 to 1994. The focus of the study was about intimate partner violence. The concept of 'violence' in this study more often referred to physical violence such as beating, slapping, kicking and sexual violence compared to emotional violence.

According to *Bernama* (2013), as stated by the Penang police chief, violent cases/crimes against women in Penang have dropped 15 per cent from last year. Crimes against women comprised rape, domestic violence, molestation and maid abuse. It declined due to the thorough monitoring from the team unit (D11) and also from having more policewomen (1,200) in Penang. However, as mentioned by several previous studies, many cases go unreported or unknown to outside organisations or cases were reported only to certain organisations. This does not mean that intimate partner violence is decreasing. According to Rohana & Rachel (1996), most cases reported were categorised as non-seizable cases which meant that most police regarded it as a 'domestic dispute' and would only advise clients to make it a civil case or refer it to other agencies. This stopped clients from reporting cases to the police because they felt discouraged and upset while at the same time no effective help could be obtained from the police.

2.2 Conceptualising intimate partner violence