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THE ROLES AND FUNCTIONS OF THE NURSES IN ONE-STOP CRISIS CENTRE: A QUALITATIVE STUDY

by

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ABSTRACT

In response to high incident rate of violence against women, One Stop Crisis Center, OSCC, is established to meet the needs of victims and provide them with appropriate care in the aftermath. The center deals with victims of domestic violence, sexual assault as well as child abuse. This paper is to study the roles and functions of nurses who dealt with victims of abuse/violence in OSCC. A guideline questionnaire is developed for guidance purpose in the interview regarding current levels of knowledge, the skills needed to be mastered, and the obstacles for the achievement of effective crisis intervention as well as the perception of the training needs of the nurses to identify their understanding of their roles and responsibilities in handling the cases of abuse and violence. Each respondent is interviewed in depth to gain the data. The data is collected by recording and writing down manually. Data shows that the OSCC nurses play many roles in handling the case. The nurses manage the victim/survivor and the flow of the case. They interact and collaborate with multiple agencies including physicians, law officer and social worker. They help to prepare the victim/survivor physically and psychologically in routine assessment and evidence collection. The procedures done are documented and they are always standby to be called to testify in the court. Their roles are extended to follow care in the clinic. As a conclusion, the research explores the roles and functions of nurses in OSCC as well as provides useful suggestions for future nursing development and the improvement of the services delivered by other OSCCs in Malaysia.

Key words: Sexual assault; Domestic violence; Child abuse; Nurses; Knowledge of roles; Skills of evidence preservation, aseptic technique, communication, psychological care ; Obstacles; Perceived training needs.

ABSTRAK

Untuk respon kepada kadar insiden keganasan terhadap wanita yang tinggi, One Stop Crisis Center, OSCC, telah didirikan untuk memenuhi keperluan mangsa dan membekalkan penjagaan yang bersesuaian untuk mereka selepas kejadian trauma. Pusat ini menguruskan mangsa keganasan seksual, keganasan rumahtangga dan penderaan kanak-kanak. Kertas ini adalah untuk mengaji peranan dan fungsi jururawat yang berdepan dengan mangsa penderaan/keganasan di OSCC. Satu borang soal selidik berpandu telah dibentuk untuk tujuan memandu semasa temuramah berkenaan tahap pengetahuan terkini, kemahiran yang perlu dikuasai, halangan dijumpai dalam pencapaian pemberian intervensi krisis yang berkesan dan persepsi keperluan latihan jururawat untuk mengenalpasti kefahaman mereka terhadap peranan dan tanggungjawab dalam menguruskan kes penderaan dan keganasan. Setiap responden ditemuramah secara mendalam untuk mendapatkan data. Data dikumpul melalui rakaman dan menulis. Data menunjukkan jururawat OSCC memainkan pelbagai peranan dalam menguruskan kes. Mereka menguruskan mangsa dan juga aliran kes itu. Mereka berinteraksi dan bekerjasama dengan baik dengan pelbagai agensi termasuk doktor, polis dan pekerja social. Mereka membantu menyediakan mangsa dari segi fizikal dan psikologikal dalam pemeriksaan rutin dan pengumpulan bukti. Prosedur yang dilakukan akan dicatat dan mereka sentiasa bersedia untuk mempersaksikan dalam mahkamah. Peranan mereka disambung ke penjagaan susulan di klinik. Kesimpulannya, kajian ini menerokai peranan dan fungsi jururawat di OSCC juga membekalkan cadangan yang berguna untuk perkembangan kejururawatan pada masa depan dan penambahbaikan perkhidmatan yang diberi oleh OSCC yang lain di Malaysia.

Kata kunci: Keganasan seksual; Keganasan rumahtangga; Penderaan kanak-kanak; Jururawat; Pengetahuan peranan; Kemahiran memelihara bukti; Teknik aseptik; Komunikasi, Penjagaan psikologi; Halangan, Persepsi keperluan latihan.

CHAPTER 1

INTRODUCTION

1.1 Background of the study

Violence against women (VAW) present in any society. It happens to any women of any race, social status, age and size (Women Crisis Center, 2005). Data from WHO showed that between 10% and 50% of women reported they had been physically abused by an intimate partner in their lifetime. Population-based studies reported that between 12% and 25% of women had experienced attempted or completed forced sex by an intimate partner or ex-partner at some time in their lives (WHO, 2000). There are many forms of VAW includes incest/rape, a husband beating his wife, a victim of snatch thief or office sexual harassment to female colleagues by males (Women Crisis Center, 2005).

The violence exerted had a profound effect on women across the life span from infancy to elder age. Therefore, VAW was agreed as a public health priority during the Forty-ninth World Health Assembly in 1996 (WHO, 1997). There was a consensus obtained to use the definition adopted by United Nations General Assembly in 1996. The Declaration on the Elimination of Violence Against Women, adopted by the United Nations General Assembly in 1993, defines 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" (WHO, 2000).

Any kind of physical, mental and psychological violence could have a damaging impact on women's health and future life. The survivors might suffer from physical injuries to any part of their body such as scratches, welts and bruises after the trauma. Rape, the common type of VAW puts the victims at the risk of exposure to Human Immunodeficiency Infection (HIV) and other sexually transmitted diseases (STDs) as well as the incidence of pregnancy. Mental health problem like anxiety, depression and post traumatic stress disorder for instance, is not uncommon to survivors and negatively affects their health. Most of them engage in particular behaviors that harm their health such as smoking, substance abuse and changing in eating pattern, when they fail to cope with the trauma.

The ongoing health problems can affect one's ability to function in daily activities like adhering to work/school and maintaining relationships. Diminished functioning can lead to the failure of reaching academic goals, maintaining gainful employment and fulfilling potential. Changes in the attitudes of health care seeking may also be found in the victims as they overuse the health care services or completely neglect their health. Sometimes psychological distress can be misinterpreted as physical illness. These misinterpretations can lead to inappropriate use of medical care and failure to receive appropriate treatment (Weaver & Resnick, nd).

There is evidence that woman who suffering from violence present to health care setting with other short-term and long-term consequences of ongoing abuse other than the obvious physical trauma. They do not disclose that they are victims. They often brought to Emergency Department (ED) for care and treatment. The ED nurses will be

the first person a patient encounters after the incident. They identify the needs for forensic evidence collection, and for collecting and preserving evidence as these are a part of scientific investigation related to medico-legal issues (Duma & Ogunbanjo, 2004, Emergency Nurse Association, 2003).

However, Littel found that those who work with victims had long recognized victims were often retraumatized when they came to hospital emergency departments for medical care and forensic evidence collection. For examples, victims had to wait for a long time to be examined, those who performed the exams often lacked of training and experience in working with sexual assault victims and in gathering forensic evidence (Little, 2001). Therefore, there are several programs established and grow rapidly to respond to the phenomenon. Forensic nursing, a branch of nursing, which trains the nurses to be able to apply forensic science, combine with clinical nursing practice to take part in the law of enforcement arena (International Association of Forensic Nursing, n.d.)

Malaysian scenario

In Malaysia, an idea of integrated and coordinated teamwork of multisectoral and interagency network was mooted and finally came into existence for the management of survivors through the combination of the effort of all- the set up of One Stop Crisis Centre, OSCC. The OSCC was setting up in the early 1994 at Hospital Kuala Lumpur. By 1995, OSCC was set up in General Hospital Penang and exposure training for the staff is begun. The effort was going on to everywhere else in Malaysia to make sure the victims/survivors will benefit from the services provided.

Before the end of 1996, all general hospitals in the country received the circular with

the emphasis of Minister of Health encouraging them to set up OSCC. In order to support and sustain the idea, Women Crisis Centre in Penang organized the first country wide training seminar for OSCC in September 1996. By 1998, the Minister of Health acknowledged the existence of 94 OSCCs all over the country (Siti Hawa, 2000).

There is a broad spectrum of services provided by OSCC to guarantee quality crisis intervention will be offered to survivors in one stop environment. The services may vary from one centre to another. The common services available include crisis hotline and information and referral, crisis counseling, screening and crisis intervention, legal advice, social service linking, temporary shelter and follow up care. The OSCC of Hospital Universiti Sains Malaysia (HUSM), Kelantan, which was studied in this research provides services include handling the cases of domestic violence, sexual assault as well as child abuse.

OSCC of HUSM

In HUSM, the OSCC is located in Emergency Department (ED). The nurses involve in OSCC are the emergency nurses who have been trained to assist in clinical preparation in forensic exam. Survivors of any forms of violence are treated. The health care providers will first perform the triage to all survivors presented to the department. The survivors are categorized based on their medical conditions. All medical emergencies will be first identified and treated.

There are three zones in the department to highlight survivors' condition. The green zone represents the general condition of the survivors is stable and will be sent to OSCC for further checking up by multidisciplinary team. Here, the survivors will be assessed by

obstetrician/gynecologist, psychiatrist and social worker to prioritize medical treatment to be given to the survivors. Survivors less than sixteen years old will be assessed by pediatrician and hospitalized. For survivors that sent to yellow and red zone are those semi-critical and critical cases. Here the cases are serious and need rapid attention as well as treatment from health care providers. They will be admitted to the ward after prompt treatment given. The psychiatrist, social worker and pediatrician will then review the survivors in the ward. Until the survivors are stable, they are allowed to discharge and follow up care will be provided by social worker afterward.

Not all the presented cases are fresh cases. The cases in which assaults or violence happened after 72 hours are referred as 'cold case'. However, forensic evidence collection is very important in both fresh and cold cases. Physical assessment is performed and specimens are taken for legal purposes. Other services including routine screening on infectious diseases (Hepatitis B/C), venereal disease research laboratory test (VDRL), pregnancy, blood group and Rhesus factor as well as DNA collection. All the samples and evidence collected will be well-handled for future prosecution. Medication is given as prophylaxis and medical condition of the survivors is treated. The assault history of the survivors is documented for treatment and assessment of their physical, emotional and mental well-being purpose. The documentations are useful for legal purpose and accurate hospital records.

1.2 Problem statement

These three types of violence against women and children are handled accordingly by their institutional protocol and clinical guidelines at each crisis center or emergency department (Littel, 2001). Some of the centres facilitated with special nurse program which assign the well-trained nurse to provide violence screening and crisis intervention, e.g., SANE and PNP program. In Malaysia, the OSCCs are founded since 1994 with few intensive specialized training/program given to the nurses who working in the ED or OSCC. This paper studied the extent of the roles and functions of nurses who involved in the patient management in OSCC in HUSM.

1.3 Objectives of the study

To examine the roles and functions of nurses in One Stop Crisis Center.

1.3.1 Specific objectives

a. To identify current level of knowledge of the nurses about their clinical nursing roles in a Malaysian One Stop Crisis Center with the reference to universal guidelines.
b. To examine the clinical nursing skills used in handling different cases.
c. To identify the obstacles in the achievement of effective work.
d. To explore the perception of nurses about the need for further training in assisting victims.

1.4 Research questions

1. What are the nurses' roles in OSCC, HUSM?
2. What are the nurse's skills needed to provide quality care?
3. What are the obstacles found in the accomplishment of effective work?
4. To what extent is further training a priority for nurses who work in OSCC?

1.5 Definition Of terms

Nursing

According to second edition of ANA's Nursing Social Policy Statement (2003):

> Nursing is defined as the protection, promotion and optimization of health and abilities, prevention of illness and injury, alleviation of suffering through the diagnosis and treatment of human response, and advocacy in the care of individuals, families, communities, and populations.

The professional nursing provides caring relationship that facilitates health and healing. They pay attention to the range of human experiences and responses to health and illness within the physical and social environments and they also influence on social and public policy to promote social justice. They integrate objective data with knowledge gained from an appreciation of the patient's or group's subjective experience. They use judgment critical thinking to apply scientific knowledge to the process of diagnosis and treatment. The professional nursing knowledge is advanced through scholarly inquiry (OHIO Nurses Association, n.d.)

Forensic nursing

International Association of Forensic Nurses defines that forensic nursing as:

> The application of nursing science to public or legal proceedings; the application of the forensic aspects of health care combined with the bio-psycho-social education of the registered nurse in the scientific investigation and treatment of trauma and/or death of victims and perpetrators of abuse, violence, criminal activity and traumatic accidents.

Direct services to individual clients are provided by forensic nurses. They also offer consultation to nursing, medical and law related agencies as well as expert court testimony in areas dealing with trauma and/or questioned death investigative processes, adequacy of services delivery, and specialized diagnoses of specific conditions as related to nursing (International Association of Forensic Nurses, n.d)

Nursing skill

Nursing profession requires expertise in a broad range of skills. A competent nurse has the skill to evaluate the effectiveness of health care programs as well as complex and varied administrative problems and take appropriate action, in order to promote quality patient care and maintain safety and security of institution/community. A nurse must also skillful in working effectively with a variety of administrators and others responsible for line operations. Effective communication and maintenance of a favorable work environment and promotion of equal job opportunity are of the skills must be mastered by a nurse as well. A nurse also must be able to provide consultation in the planning,

development, implementation, evaluation and monitoring of health services programs to promote quality patient care along with the ability of operating a computer in order to access, enter, update, and retrieve information (Edited KSA Listing, n.d.).

Forensic nursing skill

The additional skills needed by forensic nurses include evidence collection, photographic and written documentation as well as testifying in legal proceedings. They also need to be able to cope with the emotionally draining task of working with victims and/or perpetrators of violent crime or abuse.

a. Evidence collection

   Evidence is collected by assessing psychosocial history, separating the injuries from the story and asking hard question in non-judgmental mannerism with privacy is ensured. The evidence collected preserved for future prosecution.

b. Documentation

   Accurate documentation of wounds and other forensic evidence, forensic photography (use a digital camera, an omnichrome or a coloscope), clear documentation of relevant legal documents and good record keeping skills are of the knowledge and skill needed in forensic documentation

c. Testifying

   A forensic nurse is qualified to testify in court as an expert witness or a fact witness. The nurse gives his/her opinion while on the witness stands in order to shed light on the case in expert witness. While as a fact witness the nurse is only to state the details

and answer the questions. All information statement should be given in an objective manner. (Emergency Nurse Association, 2003; Duma & Ogunbanjo, 2004; Johnson, 2005)

Violence Against Women

'A group of international experts convened by WHO in February 1996 agreed that the definition adopted by the United Nations General Assembly provides a useful framework for the Organization's activities.' The *Declaration on the Elimination of Violence against Women* (1993) 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 (WHO, 2000).

Sexual assault

The definition of sexual assault is quoted from online homepage of Southern Arizona Center Against Sexual Assault. The center defines sexual assault as 'any type of sexual activity that a person intentionally or knowingly engages without the consent of the other person in one or more of the sexual activities including sexual intercourse (penetration of penis, vulva, or anus with any part of the body or with an object), masturbatory contact with the penis or vulva, oral sexual contact (with the penis, vulva or anus), inappropriate touching and child molestation. 'SA can be verbal, visual or anything that forces a person

to join in unwanted sexual contact or attention'.

Without 'consent' can mean:

> The attacker uses physical force to empower and control the victim, or the victim fears of being hurt if doest not do what the attacker wants and the attacker could have known this to be the case, or the victim unable to either give or deny consent due to state of consciousness, or the victim is under the influence of drugs or alcohol to the point of intoxication and attacker could have known this to be the case, or the victim is not able to make informed sexual decisions or understand the distinctly sexual nature of the act and the attacker could have known this to be case, or the victim was tricked about the nature of the act or was tricked about the marital relationship with the attacker (Southern Arizona Center Against Sexual Assault, 2004).

Domestic violence

According to Domestic Violence Act 1994, domestic violence means:

> The commission of willfully or knowingly placing, or attempting to place, the victim in fear of physical injury; causing physical injury to the victim by such act, which is known or ought to have been known would result in physical injury; compelling the victim by force or threat to engage in any conduct or act, sexual or otherwise, from which the victim has a right to abstain; confining or detaining the victim against the victim's will; or causing mischief or destruction or damage to property with intent to cause or knowing that it is likely to cause distress or annoyance to the victim.

By a person against 'his or her spouse; his or her former spouse; a child; an incapacitated adult; or any other member of the family' (Women Learning Partnership, n.d.).

Another definition is quoted as below according to U.S. Office on Violence Against Women, domestic violence is a 'pattern of abuse behavior in any relationship that is used by one partner to gain or maintain power and control over another intimate partner. Domestic violence can take many forms including physical abuse, sexual abuse, emotional, economic, or and/or psychological abuse' (Wikipedia, 2007).

a. Physical abuse

'The intentional use of physical force with the potential for causing injury, harm, disability or death, for example, hitting, shoving, biting, restraint, kicking or use of a weapon' (Ibid).

b. Sexual abuse

'Forcing someone to participate in unwanted, unsafe, or degrading sexual activity, e.g., sexual assault, or using unwanted sexual advances to gain power over someone, e.g., sexual harassment' (Ibid).

c. Emotional/Psychological abuse

Mental, emotional/psychological abuse can be verbal or non-verbal. It consists of more subtle actions or behaviors than physical abuse. It can include 'humiliating the victim, controlling what the victim can and cannot do, withholding information from the victim, deliberately doing something to make the victim feel diminished or embarrassed, isolating the victim from friends and family, and denying the victim

access to money or other basic resources' (Ibid).

d. Economic abuse

'The abuser has complete control over the victim's money and other economic resources. Money will be withheld at will and victim forced to beg for the money until the abuser gives them some money. It also includes (but is not limited to) preventing the victim from finishing education or obtaining employment' (Ibid).

e. Stalking

According to Office for Victims of Crime, stalking is 'virtually any unwanted contact between two people that directly or indirectly communicates a threat or places the victim in fear. It can be taken place during the relationship—with intense monitoring of the partner's activities—or after a break-up. The stalker may be trying to get back, or they may wish to harm their ex as punishment for their departure' (Benedicts et al, 2007).

Child abuse

The following definitions are quoted from The Federal Child Abuse Prevention and Treatment Act (CAPTA) (42 U.S.C.A§ 5106g). Child abuse is 'any recent act of failure to act one the part of a parent or caretaker which results in death, serious physical or emotional harm, sex abuse or exploitation; or an act or failure to act which presents an imminent risk of serious harm' (Child Welfare Information Gateway, 2006).

a. Physical abuse

'Physical injury that ranging from minor bruises to severe fracture or death as a result of punching, beating, kicking, biting, hitting, burning, stabbing, choking, shaking,

throwing or otherwise harming a child regardless of whether the caretaker intended to hurt the child'(Ibid).

b. Sexual abuse

'The employment, use, persuasion, inducement, enticement or coercion of any child to engage in, or assist any person to engage in, any sexually explicit conduct or simulation of such conduct for the purpose of producing visual depiction of such conduct; or the rape, and in cases of caretaker or interfamilial relationships, statutory rape, molestation, prostitution, or other form of sexual exploitation of children, or incest with children' (Ibid).

c. Emotional abuse

Emotional abuse is 'a pattern of behavior that impairs a child's emotional development or sense of self-worth. This may include constant criticism, threats or rejection as well as withholding love, support or guidance. It is often difficult to prove and intervene without evidence of harm to the child. It almost always present when other forms are identified' (Ibid).

d. Neglect

Neglect is 'failure to provide for a child's basic needs, including physical (e.g., failure to provide necessary food or shelter, lack of appropriate supervision), medical (e.g., failure to provide necessary medical or mental health treatment), educational (e.g. failure to educate a child or attend to special education needs) and emotional (e.g., inattention to a child's emotional needs, failure to provide psychological care or permitting child to use alcohol or other drugs)' (Ibid)

1.6 Significance of the study

- While there has been a growth in the development of OSCC and in clinical reports supporting their general usefulness, there remains a paucity of qualitative research in the area.
- Identifying the nursing practices in OSCC is an important step in the continuing evolution of evidence-based best practices of specialized care services for any form of violence and abuses.
- The study sought to add to the literature on specialized nursing care by examine the clinical nursing roles and functions of the nurses in OSCC with the reference to the outline of the universal practice and guidelines of care.

CHAPTER 2

LITERATURE REVIEW

2.1 Sexual assault

Sexual assault (SA) is any type of sexual activity that a person intentionally or knowingly engages without the consent of the other person in one or more of the sexual activities including sexual intercourse (penetration of penis, vulva, or anus with any part of the body or with an object), masturbatory contact with the penis or vulva, oral sexual contact (with the penis, vulva or anus), inappropriate touching and molestation. SA can be verbal, visual or anything that forces a person to join in unwanted sexual contact or attention (U.S. Department of Health and Human Services-The National Women's Health Information Centre, 2005). Direct patient care is given whenever the survivors of SA present to hospital emergency department or crisis centre. The health care providers who are trained specially and certified professional skilled will perform quality forensic medical-legal exams and crisis interventions.

2.1.1 Sexual Assault Nurse Examiner (SANE) Program

SANE program is a program which is established to meet the needs of any locality or region to provide a victim-sensitive solution to systemic gaps in the medical-legal response to sexual assault victims. The nurses in the program are the Sexual Assault Nurse Examiners (SANEs), who have advance education and clinical preparation in forensic examination of sexual assault. They offer prompt, compassionate care to the

victims and comprehensive forensic evidence collection as well as preserving the dignity of the victims and reducing their psychological trauma.

The program is established in the response to the issues face sexual assault victims when they come to ED for medical care and forensic evidence collection, including long waiting times, victims often are not allowed to eat, drink, or urinate while waiting for health care providers to conduct the evidentiary exam to avoid destroying evidence; the staff frequently regard the needs of victims as less urgent as they do not sustain severe physical injuries; exams may be conducted in ways that inadvertently add to survivor trauma such as in blaming or insensitive treatment of survivors, health care providers may not be knowledgeable to special circumstances and the needs of survivors as well as the lacking of specialized training for staff working with sexual trauma victims thus cause the survivors do not get proper health care; limited time and energy for health care providers to explain and implement unique procedures and the survivors may be billed for the services that increase their financial burden.

In addition, the health care providers in the department lack of specialized training in forensic evidence collection and may not conduct forensic exams frequently to maintain proficiency might miss important evidence, inadequately document the evidence and fail to maintain the chain of evidence which diminishes the integrity of the findings. Some physicians are reluctant to perform evidentiary exams because they know that they might be called from the hospital to testify in court and that their qualifications to conduct the exam might be questioned due to a lack of training and experience. These barriers could make the experience of seeking medical care a negative experience for the survivors

(Littel, 2001; Logan, Cole and Capillo, 2007).

According to Ciancone et all (2000), Stermac and Stirpe (2002), the scope of assessment and treatment of the individual SANE programs typically includes crisis intervention, physical assessment, forensic evidence collection, assault and injury documentation, screening for sexually transmitted infection (STIs) and pregnancy, providing treatment and medications and testifying in court. There are several strong points of SANE program. Du Mont & Parnis (2000) states that SANE program offer many well-documented advantages over traditional emergency care. Besides, Ledrav and Simmelink (1997) states that Sexual Assault Evidence Kits processed by SANES contain no critical errors and are more thorough and better documented than those completed by non-specialized staff. Greenwood, (2003) and Selig (2000) have noted overall high level of care and positive effect that SANE programs have on sexual assault victims as well as sensitive care required in the aftermath are well met the needs of the victims. There are studies provide positive support for the SANE's role in criminal justice proceedings as well as the client satisfaction with SANE programs, preference for SANE personnel among clients is noted (Eriksen et al., 2002; Stermac, 2005).

A study was done by Stermac in 2005 to examine SANE clinical nursing practices at one Canadian sexual assault urgent care center. Results showed that majority of clients consented to a physical exam and about half had forensic evidence. Client who consented to completion of an evidence kit have the option of freezing the kit for six months to allow for a decision about the release of evidence to police to be made at a later date. Other services included police involvement, prophylaxis and screening for

STIs and pregnancy, urine or blood pregnancy tests. Few patients came to the hospital via ambulance and very small number was admitted to the hospital. The total average time between arriving at and leaving the hospital was approximately 3 hours. There was physician involvement requested in physical requiring investigation or examination as well as anal assault and client drugging.

Another study done by Logan, Cole and Capillo (2007) states 38.5% of the programs state they have a formal system in place to provide feedback about cases involving arrests to know the status of the cases in the criminal justice systems. Over half of the programs indicate their program require survivors to report the assault to law enforcement for a SANE to conduct the forensic exam, mainly to comply with requirements for reimbursement. In cases where the survivors do not choose to report law enforcement at the time of presenting to SANE, survivors are provided a medical exam and care through regular Emergency Department (ED) procedures.

Besides, over three-quarters of the programs indicate that have an excellent working relationship with the rape crisis center in their community. Just over half of the programs indicate they have excellent working relationships with law enforcement, domestic violence agencies, the prosecutor's office, and hospital administrators and hospital staff. Yet about 20% of programs indicate that their relationship is less than excellent.

It is about 99% of the programs indicate they offer STD prophylaxis, fewer indicate they offer STD testing (57.8%) and HIV testing (38.3%). 44% of SANE program coordinators indicate they follow up with survivors by phone and about one-third indicated by follow up visits.

2.1.2 Barriers encountered in SANE practice

Primary documentation tool

According to the study done based on previously published national surveys of SANE programs, with a random sample of 243 SANE programs surveyed, the majority use photographs, colposcope and Woods lamp or other UV light source as primary documentation tool most of the time or always. 20% of the program report they never use colposcope as they could not afford one or the one they had was not in working condition. 53.1% of the samples report their outside time parameter for forensic evidence collection is 72 hours. Some are up to 120 and over hours (18.4%). Over 80% of programs report they would document injury beyond the standard outside time parameter.

Follow up care

It is about 1 in 5 sexual assault survivors is seen for a follow up appointment. Several programs use follow up as a documentation technique to document injury healing patterns. The low rate of follow up care is likely due to lack of funds and staff.

Staffing, funding and conflicts/lack of communication with community and agencies

The most frequently mentioned problems included staffing, funding, and conflicts or lack of communication with the community and various agencies. Staffing issues include problems with staff recruitment, retention and scheduling. The problems of funding include for nurses/staff, issues with billing survivors or obtaining compensation from state victim compensation funds, funding for training/education for staff and lack of funding for new and/or updated equipment.

Others

Besides, problems related to initial SANE training and/or continuing education for staff mentioned by nearly one-quarter of the programs, such as lengthy training, inaccessibility of training, and travel time to training sites. Finally, a small percentage of programs mention geographical barriers to services which creates long response times (Logan, Cole, Capillo, 2007).

2.2 Domestic violence/Intimate partner violence

Apart from the definition of Malaysian's Domestic Violence Act 1994, according to the U.S. Office on Violence Against Women which is a part of the U.S. Department of Justice that deals with VAW, defines that domestic violence (DV) as a 'pattern of abuse behavior in any relationship that is used by one partner to gain or maintain power and control over another intimate partner. DV can take many forms including physical abuse, sexual abuse, emotional, economic, or and/or psychological abuse. 'Intimate partner violence' (IPV) is sometimes used synonymously (Wikipedia, 2007).

The outcomes of DV are complicated and often negatively affect the physical health and well-being of the victims. The diagnosis of DV is full of challenges as the victims mostly present to heath care setting with a variety of symptoms and physical findings. Virtually health care system can be a primary resource for the victims as women interacts with the health care system at some point in their life—whether it is for routine health maintenance, pregnancy, childbirth, illness, injury or bringing her child for health care

services. Unfortunately, most of women attend to health care system often treated without inquiring about abuse, even the injuries resulted are obviously inflicted by another person. Glass, Dearwater & Campbell (2001) indicate majority of women who seek treatment in ED are not questioned about history of IPV. Healthcare providers often record the injuries and treat the presenting problem without enquiring about the cause of the injuries. Studies show that individuals often hope to be asked whether they have been abused and, if asked in a caring and sensitive fashion, will often discuss their history of abuse (New York Department of Health, 2002).

In Malaysia, women continue to suffer in silence because they see DV as a stigma and as bringing shame to the family even though the country has had a Domestic Violence Act (DVA) in place since 1994. Data collected by Police Headquarters from January 2000 to July 2002 show that the DV cases appear to be declining. The data shown does not indicate the fall in the incidence of cases. It could be instead be due to other reasons such as decline in reporting (All Women's Action Society, n.d.).

Thus routine screening for DV by health care providers is necessary in order to identify the women who suffering from DV or at risk of DV regardless of their age, gender, socioeconomic status and demographic characteristics. Early identification of the victims would enable the providers to intervene to help patients understand their options, live more safely within the relationship or safely leave the relationship. Consequently the morbidity and mortality will be reduced (Koistinen, 2006).

Yet, there is an article reviews the literature related to IPV reveals that there were efforts made for the recommendations regard to screening and treatment to IPV in United

States. The United States Preventive Services Task Force (USPSTF) found insufficient evidence to recommend for or against routine screening of women for a history of IPV. There are no studies determined the accuracy of screening tools or the effectiveness of interventions too. In addition, studies have also not addressed the possible harmful aspects of screening and interventions for IPV which may include loss of contact with support systems, psychological distress, and an escalation of abuse (Johnston, 2007).

2.2.1 Nurses' role in DV/IPV screening and treatment

Early identification is important when caring a victim of IPV. Nurses and other health care professionals are playing an important role in identifying and preventing IPV. There are number of ways how the providers can help the victims (Koistinen, 2006). According to report written by Taket in tackling DV, there are three types of actions are needed to be done by health service which has shown as below:

a. Improving availability of information on domestic violence and services for those who experience it- a variety form of information posters, leaflets, small cards with contact number etc) about DV can be available for all public and health professionals in all health service settings, reception areas, waiting areas, consultation rooms, cafeterias and toilets.

b. Providing/acquiring appropriate training for health professionals- Appropriate training can overcome health professionals' concerns about raising the subject and enable them to provide more appropriate care for their patients.

c. Instituting systems of enquiry about domestic violence- All health

professionals should practise routine and selective enquiry to form the basis for providing women who are experiencing abuse with information about the local specialized services available to them (Taket, n.d.).

Furthermore, Koistinen (2006) states that being empathic is a part of nurse's essential skill. Nurses should be caring, concerned and curious to know. They should ask directly without hesitations when suspecting that a patient is a victim of IPV to encourage her to seek help. They need to find a quiet and secure place and never ask in front of the partner or children. They should use the straightforward, comprehensive and non-judgmental questions when talking to the patient. Smiling and having eye contact, and also being open, honest and relax are the important in building patient-nurse relationship. Also, nurses should always remember to tell the patient about the confidentiality issues. In addition, nurses will never use the family members or the partners as the interpreter/translator when the language used by the nurse is not completely understood by the victim.

Besides, nurses are responsible to take photograph in the cases of overt injuries or breaks. All findings must be documented. It would be best to use the exact words of the patient in case it is needed later. Follow up calls or visits are in place when the patient is back home

In addition, IPV educators are urged to turn to the nursing profession as nurses are in an advantageous position to identify victims in ED. The nurses focus on the whole patient and recognize IPV as a high priority. Giffin and Koss (2002) recommend that nurses screen all patients for a history of IPV and identify the victims by the use of