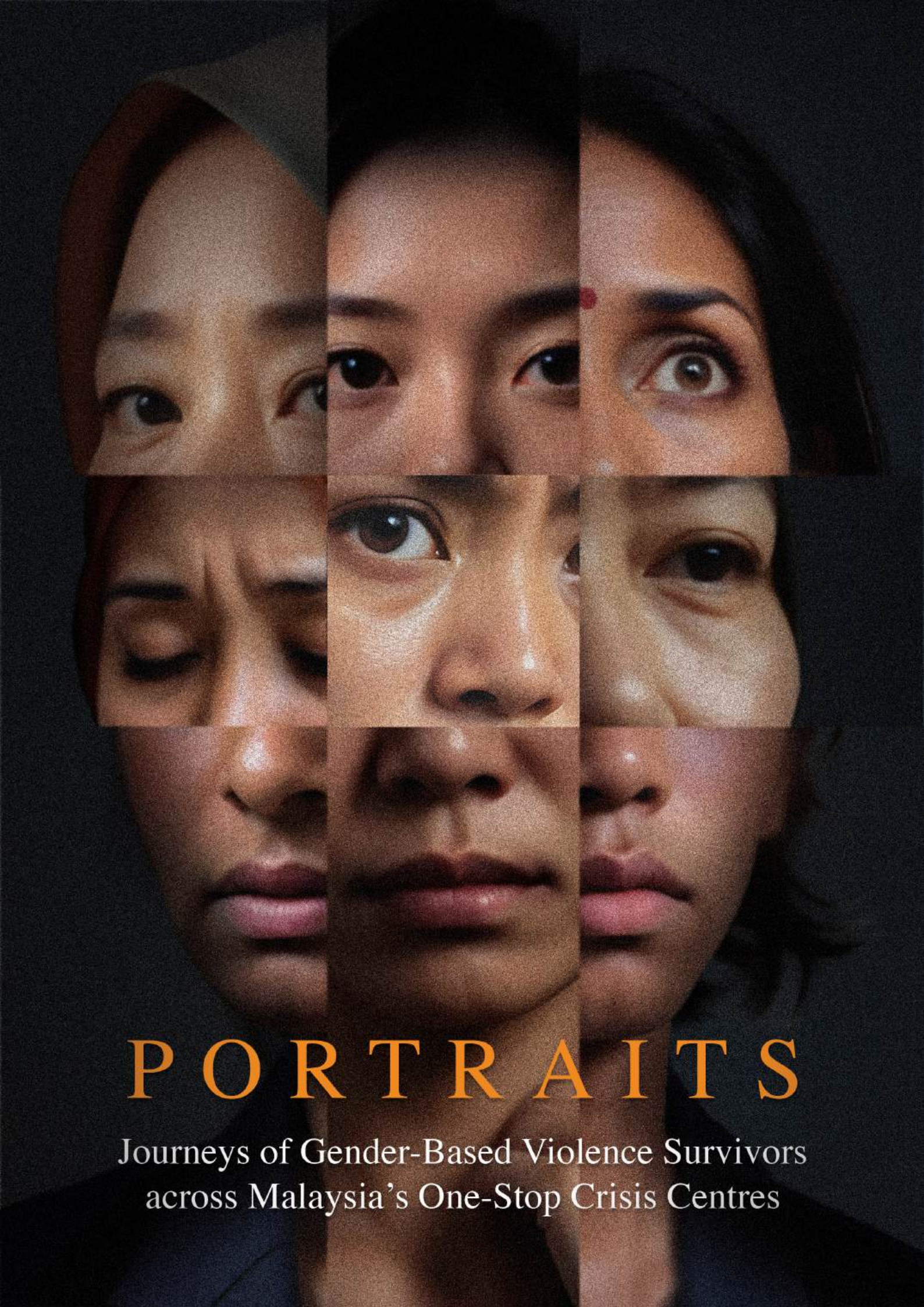

PORTRAITS

Journeys of Gender-Based Violence Survivors across Malaysia's One-Stop Crisis Centres

Acknowledgements

We extend our heartfelt gratitude to all the survivors who trusted us and shared their personal stories and experiences. We also thank the Civil Society Organisation representatives for their constant support, and invaluable suggestions. We sincerely thank our research consultants for their expert advice and support in shaping this study. Finally, we want to specially thank United Nations High Commissioner for Refugees (UNCHCR) and civil society organisations – in particular Women's Aid Organization, Sisters in Islam, and Seed Foundation Malaysia – for their relentless support that has made this research possible.

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Disclaimer

This research was conducted between 2020 and 2023, with findings based on data and policies relevant during that period and efforts to ensure accuracy. Any relevant developments since then are to be considered when interpreting the results.

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Executive Summary

The One-Stop Crisis Centre (OSCC) model in Malaysia presents a pioneering approach to address gender-based violence (GBV) and intimate partner violence (IPV) in particular. This model has significantly evolved since its inception in the 1980s, driven by the collaborative efforts of health workers, women's non-governmental organisations (NGOs), and the government. The development of the OSCC model and its strengths are highlighted through the establishment of a legal and organizational frame work that recognizes GBV as a national issue, prompting the creation of service protocols and the pilot of OSCC services.

Among the key strengths of the OSCC model are its comprehensive and integrated approach to service delivery for survivors of physical and sexual violence. By co-locating medical, counselling, and police services within hospital settings, particularly in Accident and Emergency departments, OSCCs provide a centralized point for accessing a range of support services. This model not only facilitates immediate and coordinated care but also addresses the multifaceted needs of survivors, encompassing physical, psychological, and legal assistance.

The establishment of OSCCs was greatly influenced by the advocacy of womens groups and the strategic partnerships between health professionals and NGOs. These collaborations were instrumental in shaping the service protocols and ensuring that the services are sensitive to the survivors' needs. For example, the initiative for the OSCC model was largely driven by an influential doctor at the General Hospital in Kuala Lumpur, who recognized the importance of addressing the psychological needs of abused women alongside their physical injuries. This led to the pilot OSCC at the Kuala Lumpur General Hospital in December 1993, which served as a blueprint for the nationwide implementation of the model.

Moreover, the OSCC model emphasizes the training of healthcare providers and the development of operational guidelines to manage IPV cases effectively. This focus on capacity building ensures that frontline staff are equipped with the necessary skills and knowledge to provide appropriate care and support to survivors. The establishment of clear guidelines and standard operational procedures (SOPs) for handling IPV cases has been critical in streamlining the management process and ensuring consistency in the delivery of services across different OSCCs.

Another significant strength of the OSCC model is its ability to facilitate interagency collaboration and coordination. Regular interagency meetings with partners from the police, social welfare, legal aid, and NGOs have enhanced the quality of OSCC services and enabled government agencies to monitor their services more closely. This collaborative approach has led to a more holistic and effective response to GBV, enabling a seamless integration of health, legal, and social services.

The OSCC model in Malaysia represents a comprehensive and integrated approach to addressing GBV. Its strengths lie in its collaborative foundation, emphasis on training and capacity building, and the establishment of a coordinated service delivery mechanism that addresses the physical, psychological, and legal needs of survivors. The success of the OSCC model in Malaysia offers valuable lessons for other countries seeking to develop similar integrated response systems for gender-based violence.

Despite Malaysia's establishment of GBV response systems and the development of ideal OSCC guidelines, there remains an

imperative need for rigorous evaluation and monitoring of these services. The lack of secondary information on the effectiveness and implementation of these guidelines highlights a gap in understanding how well the system serves from a survivor-centric perspective. Recognizing this need, this comprehensive research study was initiated, supported by UNU-IIGH and UNFPA Malaysia, which delves into the complexities of GBV in Malaysia, exploring the multifaceted care pathways and experiences of survivors from their perspectives as well as those of key civil society stakeholders. This research aims to provide a nuanced understanding of the survivor's journey through the OSCC services, identifying potential areas for improvement to ensure that the system is truly responsive to the needs of those it aims to support. This study positions itself at a crucial juncture, seeking to bridge the gap between policy intentions and actual service delivery outcomes, thereby contributing to the enhancement of Malaysia's GBV response mechanisms.

Utilizing qualitative research methodologies, including case studies, in-depth interviews and thematic analyses, the study aims to shed light on the barriers to care, the interplay of societal and individual factors influencing GBV survivors' journeys and the efficacy of support systems in place. Through the development of detailed personas and care pathways, the research encapsulates the personal narratives of GBV survivors, providing a profound insight into their struggles and resilience.

The study underscores the prevalence of GBV in Malaysia as a significant public health concern and a violation of human rights, highlighting the inconsistencies in available data and the gaps in support services. The OSCC initiative is a commendable step toward providing comprehensive care for survivors; however, challenges persist due to the dual legal systems, societal norms that discourage survivors from seeking help and various internal barriers within the service implementation to access care.

The findings — based on in-depth interviews with survivors, and consultations with CSOs representatives and social workers — indicate that survivors of GBV encounter a multifaceted and iterative care system with various entry points and trajectories. Initial medical treatment often lacks the necessary empathetic and holistic approach, neglecting psychological and social welfare needs. Interactions with law enforcement can exacerbate trauma due to a lack of GBV-sensitive training. Legal pursuits add further complexity, with survivors facing

systemic delays and evidentiary challenges. The care process is marked by cycles of seeking aid, returning to potentially abusive situations and re-seeking assistance. Furthermore, the support network for long-term healing is obscured, highlighting a gap in services for sustainable recovery and community reintegration, as well as the need for comprehensive care which includes psychological support, legal aid, and community assistance.

The study concludes with a strong recommendation for comprehensive policy reforms and improvements in both the legal and healthcare frameworks to better address GBV in Malaysia. It advocates for the integration of comprehensive, accessible, and culturally sensitive services across all levels of GBV support. The recommendation includes the implementation of targeted public awareness campaigns, the development of inclusive and adaptable service provisions that respect the diverse needs of survivors, and the establishment of robust training programmes for the first responders of GBV. Additionally, the recommendation calls for the reinforcement of inter-agency coordination to ensure a seamless referral system and the adoption of policies that prioritise the safety, dignity, and autonomy of survivors. This approach not only addresses the immediate needs of GBV survivors but also fosters a supportive environment conducive to their long-term recovery and empowerment, addressing their mental health and wellbeing.

In synthesizing the experiences of GBV survivors with the structural and societal factors influencing their care pathways, this study offers a crucial insight into the barriers faced by survivors and provides a solid foundation for developing targeted interventions. The ultimate goal is to support survivors more effectively and work towards ending GBV in Malaysia, ensuring a safer, more supportive environment for all individuals, regardless of their background or circumstances.


The OSCC model in Malaysia represents a comprehensive and integrated approach to addressing GBV but *there is a need for rigorous monitoring and implemetation* to address challenges in the delivery of services.

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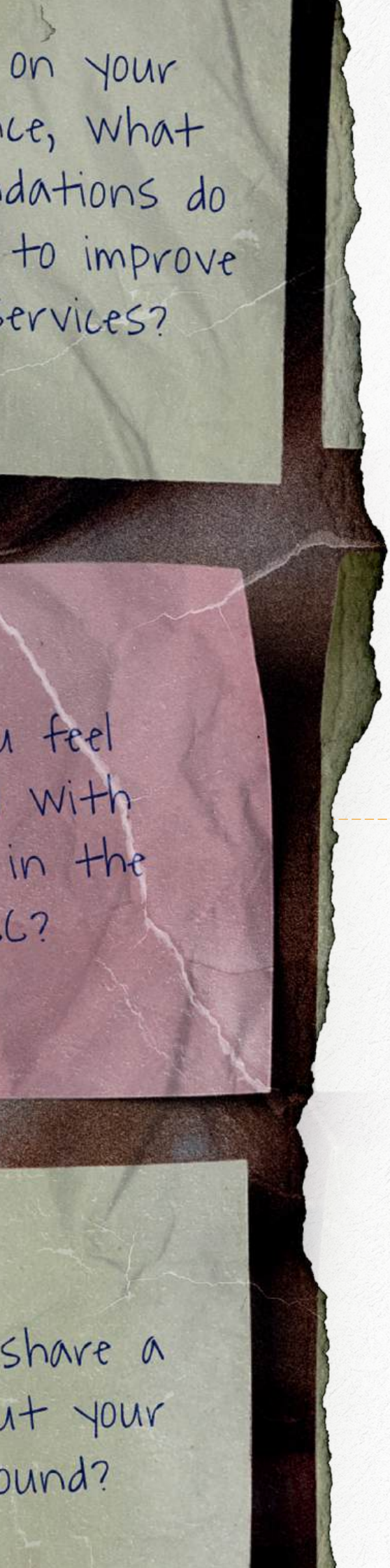

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List of Acronyms

AWAM	All Women's Action Society
CSO	Civil Society Organizations
GBV	Gender-based violence
DV	Domestic Violence
DVA	Domestic Violence Act
GP	General (Medical) Practice/ General Practitioner
IPV	Intimate partner violence
LGBTIQ+	Lesbian, gay, bisexual, transgender, intersex, queer and others
UNU-IIGH	United Nations University International Institute for Global Health

OSCC	One-Stop Crisis Centre
TFGBV	Technology-facilitated gender-based violence
UNHCR	United Nations High Commissioner for Refugees
UNFPA	United Nations Population Fund
UNU	United Nations University
WAO	Women's Aid Organisation
UX	User Experience
UNDP	United Nations Development Programme

Introduction

Gender-Based Violence (GBV) is an umbrella term for any harmful act that is perpetrated against a person's will and that is based on socially ascribed (i.e. gender) differences between women and men or gender diverse individuals. It includes acts that inflict physical, sexual, or mental harm or suffering, threats of such acts, coercion, and other deprivations of liberty. These acts can occur in public or in private. GBV is interchangeably used with violence against women as women remain the most at risk and affected by GBV. GBV is broader and can also include violence perpetrated against gender non-conforming individuals and men. GBV is a violation of fundamental human rights and a significant international public health concern, with long-term consequences and costs[1]. Nearly one in three women will experience physical and/or sexual intimate-partner violence (IPV), non-partner sexual violence, or a combination of both at least once in their lifetime (UN Women, 2023)[2]

In Malaysia, the limited data on GBV renders a fragmented and inconsistent picture of the issue. Data available from 2018 shows an estimated 19% lifetime prevalence of IPV in Malaysia for married/partnered women aged 15 to 49 years (WHO, 2018). However, Malaysia is the only country in the WHO Western Pacific region that has no recorded IPV prevalence since 2018 (WHO 2018[3]). A 2020 systematic review of the literature on GBV in Malaysia (Kadir Shahar, et al., 2020[4]) reported that IPV prevalence ranges widely between 4.94% (Othman et al., 2021[5]) and 35.9% (Haron et al., 2021[6]). An earlier study, however, placed the prevalence of IPV among 710 female healthcare patients at 22%[7]. Furthermore, a total of 1234 cases of domestic violence (DV) were reported by the Department of Social Welfare in 2021, with the main perceived causes for domestic violence being hot temper (322 cases), misunderstanding (213 cases), and drug use (123 cases) (DOSW 2021)[8]. However, this data pose a high risk of inaccuracy for DV prevalence as these cases represent merely those reported to the Royal Malaysia Police.

A limited picture of the GBV issue in Malaysia

As of 2018, Malaysia is the only country in the WHO Western Pacific region with no recorded IPV prevalence data.

The data presented is derived ONLY from officially recorded cases.

1,234 cases

of domestic violence were reported in 2021.

322 cases

of domestic violence were attributed to 'hot temper'.

213 cases

of domestic violence were attributed to misunderstandings.

123 cases

of domestic violence were attributed to drug use.

Sourced from: The Department of Social Welfare, 2021

One-Stop Crisis Centres

GBV is a key public policy concern which inflicts health, social, and economic costs to women, families, and communities. Governments are increasingly acknowledging the need to address GBV, with many countries actively seeking to develop a health sector response. Integrating violence-focused services into different health service entry points, i.e. maternal health and accident and emergency services[9], has been a key focus for many countries. Malaysia has been at the forefront of the development of the One-Stop Crisis Centres (OSCC) - an integrated health sector model – that aims to provide comprehensive care for women and children experiencing physical, emotional, and sexual violence. (MoH, Malaysia, 2015[10]; Columbini, 2011[11]). The first OSCC was established in 1994 in the Accident and Emergency Department of the General Hospital in Kuala Lumpur, in partnership with women-centred NGOs. In 1996, the Ministry of Health (MoH) directed all state hospitals to set up OSCCs for women survivors of violence, located within the hospitals' Accident and Emergency Departments. This model has since been replicated in other Southeast Asian countries.

The OSCCs were designed and integrated within the health system to provide comprehensive and coordinated services to GBV survivors of various forms of violence and abuse (MoH, Malaysia, 2015[12]). According to the OSCC guidelines developed by the Kuala Lumpur General Hospital in 1994, its main aim is to provide round-the-clock patient-centred services for violence victims in one site, with the potential benefit of proximity to all services, reduced or no delays for examination, and ease of referral to specialized and non-health services[12]. The comprehensive service provision model includes immediate medical care, counselling services, police and legal support, social support, and referrals to shelter homes. Internal referral systems were created to refer

1994

The first OSCC was established at Kuala Lumpur General Hospital's Emergency Department in collaboration with women-focused NGOs.

1996

The Ministry of Health mandated state hospitals to establish OSCCs for women survivors of violence in their Emergency Department.

Purpose of OSCC

To provide round-the-clock patient centred services for violence victims in one site, with the potential benefit of proximity to all services, reduced or no delays for examination.

OSCC cases to other specialized services on-site at the hospital, while a collaborative network of police and social workers ideally facilitate external referrals to social welfare, shelter homes, and NGOs.

Since the OSCC's inception in 1994, there were various developments in the women's movement, the health system, and the legal system, including the MOH's leadership and commitment to a national scaling up of the OSCCs. However, this rapid scaling up has now put the spotlight on the effectiveness and sustainability of these services. Several important legal frameworks and health system attributes limit the practical function and operation of OSCC services around Malaysia.

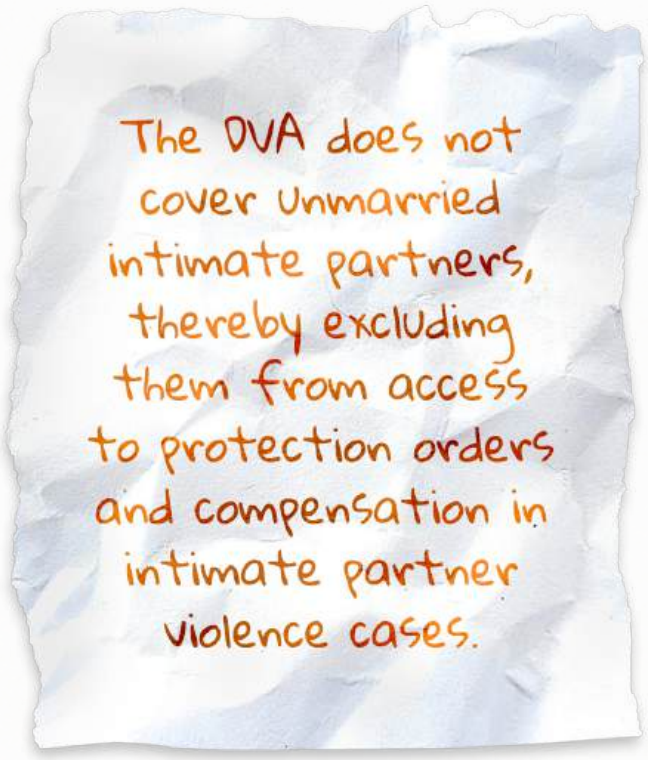
Legal frameworks

The Domestic Violence Act 1994

The Domestic Violence Act (DVA) was passed in 1994 (Act 521) and has since been amended in 2012 and 2017. The DVA defines acts of domestic violence but does not introduce new punishments for these acts. Instead, these acts of domestic violence correspond to existing offences under the Penal Code (Act 574) and other relevant laws, under which perpetrators may be charged and punished[13]. The DVA criminalises various forms of domestic violence, including physical, psychological, sexual, and financial abuse, and applies to immediate family members including spouses, ex-spouses, de facto spouses, children (including adopted children), adults with mental or physical disabilities, and other persons considered part of the family. Importantly, the DVA applies to everyone; Muslims and non-Muslims, citizens or non-citizens. Positively, the DVA therefore allows a broad definition of the constituent acts of domestic violence. However, the DVA does not cover unmarried intimate partners, thereby excluding them from access to protection orders and compensation in intimate partner violence cases.

Other legal contexts

In addition, Malaysian law does not recognise marital rape although it was recommended in both the 2006 and 2018 reports by the CEDAW Committee for the Malaysian government to criminalise it (paragraph 22[14] and paragraph24b[15]). Furthermore, Malaysian law is also incongruent with Article 36 of the Istanbul Convention 2011[16] which includes involuntary consent as a critical component of sexual assault, including rape. Another divergence from the Istanbul Convention 2011, Malaysia also criminalises consensual oral and anal sex (Sec 377A)[17], which further excludes sexually diverse people from society.



Health system framework

Whilst having OSCCs embedded in the health system offers unique proximity to other necessary medical services, this can limit the services available; focus remains on immediate medical care rather than holistic, forward-thinking support which are critical for violence survivors[18]. Furthermore, Colombini et al. (2012)[19] have identified that the implementation of the OSCC model differs between hospital settings which leads to inconsistent care services delivery. This study also identified that health providers lack training to effectively deal with violence survivors, and facilities have limited budgets and lack referral systems to external support services. A lack of clarity about standard operational procedures (SOPs) for DV and IPV OSCC cases was also identified as a key barrier by providers (Colombini et al. 2012)[19].

The Women's Aid Organisation (WAO)[20] similarly reported that the quality of OSCC services differs among hospitals in Malaysia, and significant barriers keep OSCCs from functioning as intended. These barriers include: (1) A lack of routinely available emergency contraception; (2) The dependence of abortion referrals for unwanted pregnancies on the views of the Head of the Obstetrics and Gynaecology Department; (3) Low levels (or lack) of follow-up to identify and treat HIV and other infections; and (4) Low levels (or lack) of support for the emotional wellbeing of the women who access the centres.

Rural services

The WAO[21] also reported that many survivors of domestic violence and rape live in rural areas with no access to a coordinated service; not all hospitals have a dedicated OSCC room for survivors and this problem is more pronounced in rural areas[22]. In Malaysia, rural women, including Indigenous women, are deemed socially and economically disadvantaged vis-à-vis their urban counterparts due to their limited access to economic resources and opportunities. These existing inequalities may give rise to the manifestation of violence although the data is scarce. It is imperative that more OSCC services are made available for Indigenous and non-Indigenous women in rural areas to ensure they have accessible and coordinated services when needed without having to travel long distances to urban hospitals.

Internal barriers to care

Societal views

Apart from legal and health system frameworks that limit the practical function and operation of OSCC services, violence survivors also experience internal barriers to care pathways. Othman et al. (2014) identified the following barriers to discussing domestic violence in clinical consultations:

1. Socio-cultural norms such as valuing privacy
2. Preserving the family unit and maintaining the family's reputation
3. Upholding traditional gender roles
4. Fear of the abuser
5. Feeling ashamed and self-blame

The literature shows that many Malaysian GBV survivors hold very skewed views on GBV. For example, in the study by WAO in 2021,

52.4% women respondents justify domestic violence as a normal reaction to everyday stress and frustration.

Similarly, in this report, WAO[23] identified the following community attitudes towards VAW as the most prevalent in Malaysia:

1. Excusing the perpetrator and holding women accountable
2. Disregarding women's right to consent
3. Mistrusting women's reports of violence

They report that only about:

52.7%

of Malaysians are likely to oppose violence-endorsing attitudes (WAO, 2021[23])

46.3%

of Malaysians support gender equality (WAO, 2021[23])

Men, particularly older men, displayed more negative and uncertain/neutral responses compared to women.

Non-physical violence and cyber harassment

Generally, there is minimisation of non-physical violence in Malaysia in comparison with physical violence, according to a WAO 2021 study, which can lead to less help-seeking from survivors. According to the findings, 15.2% of the study population does not consider cyber stalking as a form of violence, while 6.7% express uncertainty. The minimisation and/or lack of knowledge towards cyber harassment as a whole is a recurring theme, as seen by the 64.6% of Malaysians who endorse the dissemination of nudes without the consent of the sender, as well as from survivors' internalised doubt of the violence experience and the lack of formal support mechanisms in place for online abuse.

An increasing trend of online technology use has facilitated an increase in technology-facilitated GBV (TFGBV) in recent years which are more difficult to track, record, and report. Disrupting Harm in Malaysia 2022[24], a research project generating evidence on the nature and scope of online child sexual exploitation and abuse, highlights the issues around sexual GBV and child sexual abuse in the country; they found that discomfort discussing sex and stigmatisation of victims discourages children from raising concerns and can deter both children and adults from reporting incidences of online child sexual abuse and exploitation. 82% of frontline workers interviewed said that they believed that stigma from the community negatively influenced reporting. Additionally, there is a lack of knowledge about reporting mechanisms that children, caregivers, and the community can access. 74% of frontline workers agreed that a lack of knowledge around reporting mechanisms was a key barrier to tackling online child sexual exploitation and abuse in Malaysia.

General low help-seeking behaviours

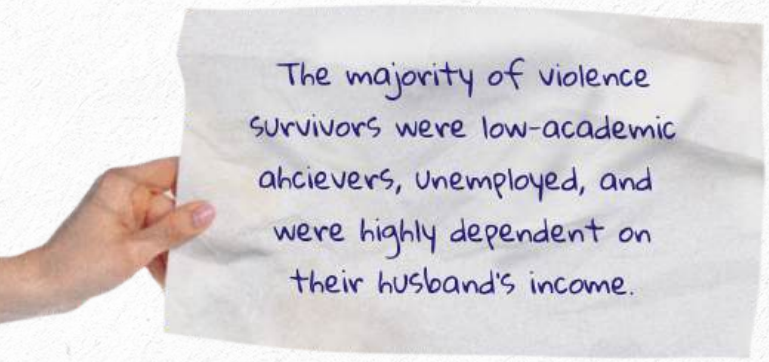
There is generally a low proportion of violence survivors who seek formal OSCC or hospital support services, indicating an overwhelming lack of awareness towards health services as a resource for support. A 2021 study by WAO[25] that described help-seeking behaviours of 1000 participants from the general Malaysian population and 106 survivors found that 30.5% of women who experienced domestic violence would approach family members and only 29.2% would reach out to the police. Notably, only 0.4% of respondents would approach health clinics and 1.4% would approach hospitals. Attitudes in seeking help slightly shifted for sexual harassment, as most Malaysians would first approach the police (34.4%), followed by family members (26.0%). The report found only 1.2% and 0.3% of respondents would approach hospitals or health clinics respectively following incidents of sexual harassment. Since disclosing one's experience of GBV is the first step in seeking help and accessing care pathways, further research is needed to explore and fully understand these low help-seeking behaviours. A better understanding of these internal barriers to care will help to increase survivors' awareness of OSCCs and feel comfortable using the services available.

Intersectionality

Individuals experience violence differently based on the complex interplay of their multiple identities and social contexts, making intersectionality approaches of gender with other social strata such as age, ethnicity, education, and class, imperative to understanding GBV and support survivors. Evidence suggests that the estimated prevalences and experiences of GBV in Malaysia vary hugely across different groups, particularly among those who are uneducated and unemployed, those who have diverse gender and sexual identities, and among refugee groups and disabled women. For this reason, these stratas must be considered in GBV and OSCC service research and policy making.

In the study of 710 female healthcare patients conducted by Yut-Lin and Othman (2008)[26], Malaysian Indian (57.5%) had the highest positive screening of IPV, followed by Malay women (32.5%) and the lowest were among Malaysian Chinese women (10%). Compared with women who had not experienced IPV, IPV survivors were much younger, less educated, and less affluent. In other words, women from lower-income households were twice as likely to experience IPV as women from higher-income households. Similarly, a 2016 qualitative study by Ghani et al.[27] suggested that women who are unemployed and uneducated are more at risk of domestic violence; the majority of the violence survivors in their study were low-academic achievers, unemployed, and were highly dependent on their husband's income. These findings reflect that women who are incapable of financially providing for themselves and their children are more at risk of experiencing GBV.

Hamid (2021)[28] reported that transgender women in Malaysia experience high rates of GBV including domestic violence, exploitation, and harassment. This population also often experience difficulties accessing support services and receive inadequate,



and stigmatising treatment from service and care providers, with the COVID-19 pandemic compounding existing factors (Osborn, 2022)[29]. Possible reasons why transgender women experience higher rates of GBV compared to their cis-gender counterparts, and why it can be challenging for them to access services include greater financial reliance on their live-in partners which creates greater opportunity for financial abuse[30], they often face difficulties accessing medical treatment[31], and they face more barriers to finding stable housing and employment[32]. Although many transgender people in Malaysia belong to the B40 group, many are ineligible to receive government aid due to their gender presentation (Hamid 2021)[33]. Other members of the LGBTIQ+ community, including sexually diverse people, are also subjected to high rates of sexual harassment, violence, and discrimination; whilst there is insufficient data to support this, Mallow and Ying (2019)[34] conclude that this violence stems from social stigma.

Further, a policy brief by the WAO (2021)[35] draws on findings from capacity-building workshops to explore sexual and GBV (SGBV) among refugee communities in Malaysia. They report that refugee women are at significant risk of SGBV due to their lack of legal status in the country, the normalisation of violence within the refugee communities, and the inaccessibility of protection and justice mechanisms. These factors are exacerbated by xenophobia against refugees which also hinders their ability to seek help. WAO (2021)[36] reports that refugees experiencing SGBV and harassment at the hands of their informal employers are reluctant to file a report of the violence with the police for fear of being detained and refugees who have experienced GBV by Malaysian nationals fear that no one, including authorities, will believe the word of a refugee over a Malaysian.

In addition, women and girls with disabilities experience both GBV and unique forms of abuse and violence that are disability based. Their vulnerability to violence is exacerbated by other forms of social exclusion such as age, location, ethnicity, sexual and gender diversity, class, and importantly, the nature of their disability. For instance, people with disabilities face many myths and misconceptions about their sexuality that perpetuate stigma, discrimination, and violence; they can be seen

as incapable of making their own reproductive decisions, are often viewed as being hypersexual, and as unworthy of pleasure and intimacy (ARROW, 2021[37]).

COVID-19 pandemic

The COVID-19 pandemic not only worsened domestic violence cases around the country, but also made it more challenging for survivors to seek care and support, particularly for those from minority groups. The WAO[38] reported a 150% increase in calls to its hotline and an 80% increase in messages to its WhatsApp distress channels compared to the same period in the previous year pre-pandemic lockdowns. Further, the Royal Malaysia Police recorded 3,258 domestic violence cases during the first COVID-19 Movement Control Order (MCO) (October 2019–March 2020) and 3,080 cases during the second MCO (March 2020–October 2020), and the rate of domestic violence cases reduced slightly after the government loosened the MCO restrictions (Mulok et al., 2022[39]). Based on reports, domestic violence increased during the MCOs due to: (1) Abusers were always with the victim, increasing the chance of proximal conflict; (2) Social isolation reduced opportunities for other outlets to channel stress; (3) Financial problems and future uncertainties increased conflicts; (4) Victims were unable to run away from the domestic violence situation due to movement restrictions; (5) Absence of support from others with no place to seek recovery or support as many services closed during MCOs and; (6) Victim's dependence on the abuser may have increased as a result of restrictions, which exacerbates abusive potential. Importantly, it was not the MCOs that led to increased abuse directly, but rather that domestic violence that was already happening was made worse by the fact that victims were unable to flee from their attackers.

Therefore, with this background, this study aims to conduct an overall assessment of GBV responses and OSCC services in Malaysia for generating evidence to inform recommendations for the delivery of said services. Several key background considerations are necessary for this report. These include: (1) The intersection of civil and Syariah laws in domestic violence cases; (2) Other legal framework gaps; (3) Health system shortcomings including a lack of funding, a lack of training for healthcare and frontline workers and inconsistent referral pathways; (4) The absence of coherent services for rural and Indigenous women; and (5) Internal care barriers, societal perceptions, and stigmas.

Essentially, the law plays an important role in preventing violence, guaranteeing protection including remedy, reliefs, and support services to those who have experienced violence, and supporting the recovery of survivors of violence by continuing to protect and offer services for recovery. There are critical gaps in the legal framework that do not resonate with Malaysia's international commitments to human rights, equity, and gender equality.

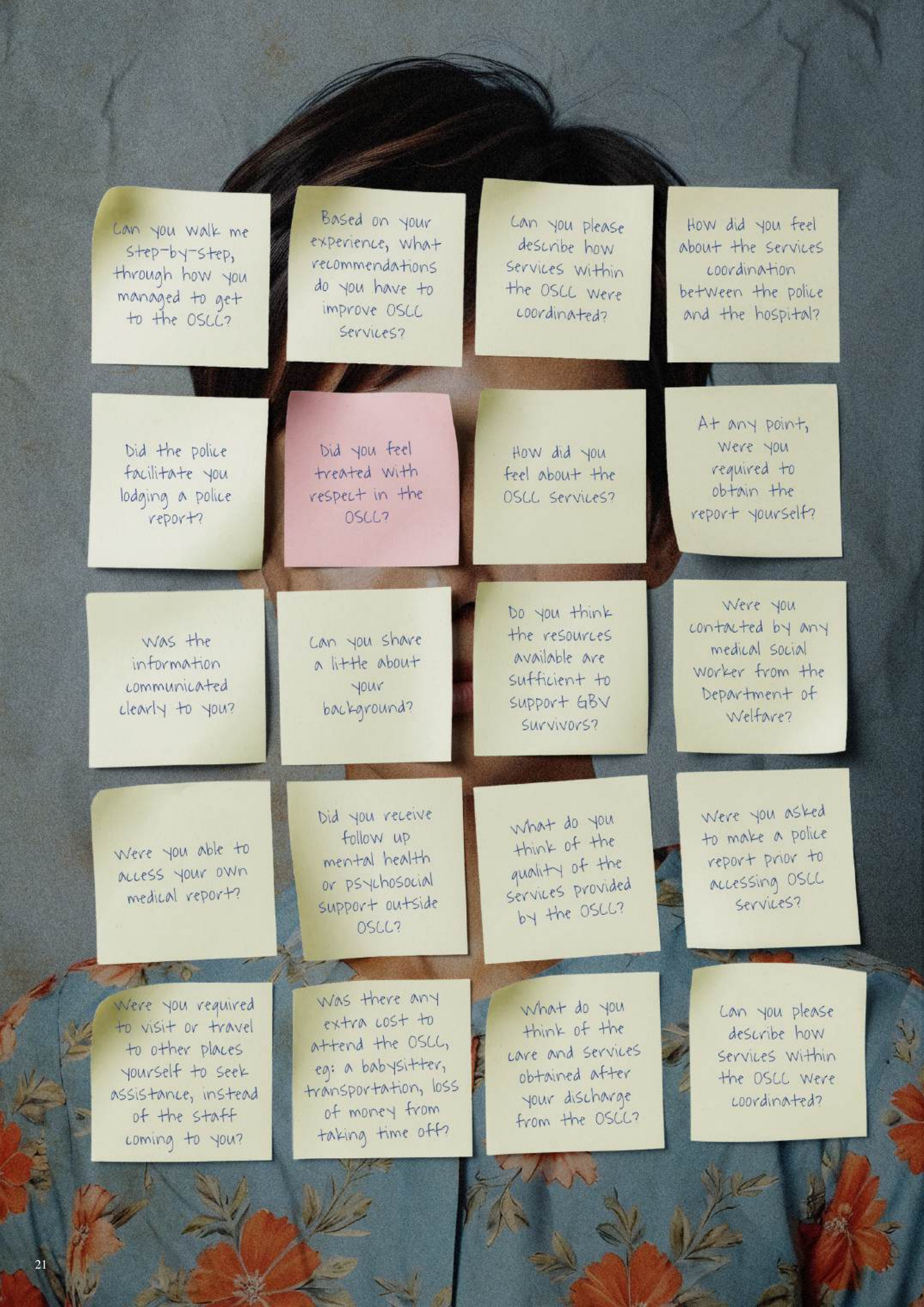
Intersectionality is also a key focus in this study, aiming to understand how different social stratas contribute to experiences of violence, including rates of violence among certain groups and barriers to accessing and seeking OSCC care services. Perspectives from a range of diverse communities have been gathered in this study to better understand the nuanced importance of different stratifies on violence experiences in Malaysia.

Objectives of the study

1. To assess the care pathways and bottlenecks related to the awareness, access, referrals and quality of services available (e.g., reporting, medical help, counselling shelters, OSCC) from the perspectives and experiences of survivors, and key civil society stakeholders (e.g., NGOs, CSOs, activists).

2. To identify the intersectionality of gender with poverty, ethnicity, race, religion, education, disability, marital and migration status and evaluate its impact in shaping women's experiences with GBV support services.

3. To suggest policy recommendations for strengthening the health system response to GBV in Malaysia.


Can you walk me step-by-step, through how you managed to get to the OSCC?
Based on your experience, what recommendations do you have to improve OSCC services?
Can you please describe how services within the OSCC were coordinated?
How did you feel about the services coordination between the police and the hospital?
Did the police facilitate you lodging a police report?
Did you feel treated with respect in the OSCC?
How did you feel about the OSCC services?
At any point, were you required to obtain the report yourself?
Was the information communicated clearly to you?
Can you share a little about your background?
Do you think the resources available are sufficient to support GBV survivors?
Were you contacted by any medical social worker from the Department of Welfare?
Were you able to access your own medical report?
Did you receive follow up mental health or psychosocial support outside OSCC?
What do you think of the quality of the services provided by the OSCC?
Were you asked to make a police report prior to accessing OSCC services?
Were you required to visit or travel to other places yourself to seek assistance, instead of the staff coming to you?
Was there any extra cost to attend the OSCC, eg: a babysitter, transportation, loss of money from taking time off?
What do you think of the care and services obtained after your discharge from the OSCC?
Can you please describe how services within the OSCC were coordinated?

Methodology

Qualitative research methods such as in-depth interviews, case studies, and storytelling were used. Detailed guidelines were prepared to facilitate the interviews and discussions with the GBV survivors and other stakeholders. The participants were recruited with the help of civil societies supporting GBV survivors and the field work was carried out by trained UNU-IIGH researchers accompanied by translators who speak Malay or Chinese or Tamil fluently. The minimum cutoff date for the selection of the participants was maintained to survivors who had sought services at OSCC in 2019 or later. Several survivors sought the services before 2019 but continued to come to the OSCC multiple times until recently due to their situations. Some of the participants did not seek any services at the OSCC due to multi-layered barriers, which are discussed in detail in the findings section. The stories and experiences of these survivors were retained and presented in the study as they are crucial to inform the findings for ensuring that the services are trauma-informed and inclusive to all genders. Efforts were made to identify GBV survivors across the demographics, especially vulnerable communities which include those with people of various age groups, ethnicity and religion, women with disabilities, marital status, people with refugee or migrant status, gender-diverse individuals, disadvantaged socioeconomic groups and pregnant women. Due to difficulties in accessing GBV survivors from Sabah and Sarawak, they were not interviewed but CSO representatives and medical social workers who closely support survivors in Sabah and Sarawak were included in the interviews.

We used semi-structured interview guidelines to conduct the interviews and the case studies. This was guided and modified by the GBV service assessment methodology (2020). The qualitative data were analysed with the help of NVivo software using a thematic framework approach. The interview guide and analysis were guided by the lenses of gender, human rights, trauma-informed care, and the World Health Organization's (WHO) Guidelines for Medico-Legal Care for Victims of Sexual Violence and the WHO's Ethical and Safety Recommendations for Intervention Research on Violence Against Women. The GBV services at the OSCC were assessed by looking into the nine key areas proposed by UN Women in their 17 GBV assessment service methodology (2020)[40]. This guide highlights how an assessment is necessary to identify the needs, existing capacity to meet those needs, needs that are not being met, and establishing goals and objectives for meeting the unmet needs (UN Women, UNFPA, WHO, UNDP, and UNODC, 2015).

The case studies were presented in the form of personas and journeys of GBV in the health system. The key findings emerging from the qualitative data were presented as excerpts and narratives. The narratives presented have been made anonymous and paraphrased for few cases as necessary to protect the identities and confidentiality of the individuals involved. Paraphrasing has been employed to ensure clarity and coherence of the stories while maintaining the integrity and essence of the original accounts. This approach enables a respectful and ethical presentation of sensitive experiences, facilitating a broader understanding without compromising personal privacy. Graphical illustrations were used to show the typical journey of GBV survivors.

Stakeholders workshop

A stakeholders' workshop with CSOs, NGOs, researchers, doctors, lawyers, and activists promoting gender rights working on GBV were convened to gain a more nuanced understanding of the challenges faced by survivors in Malaysia. Different participatory activities were used such as 'problem tree', 'desired changes', and 'low and high hanging

fruits' to engage participants and collect data during the workshop. The personas and key findings of this study were also presented during the workshop to validate the findings and seek more information on the barriers and gaps that survivors face in accessing support at the OSCC in Malaysia. Efforts were made to ensure the nuances of the GBV services are well understood collectively through in-depth consultations with the CSOs during the stakeholder's workshop.

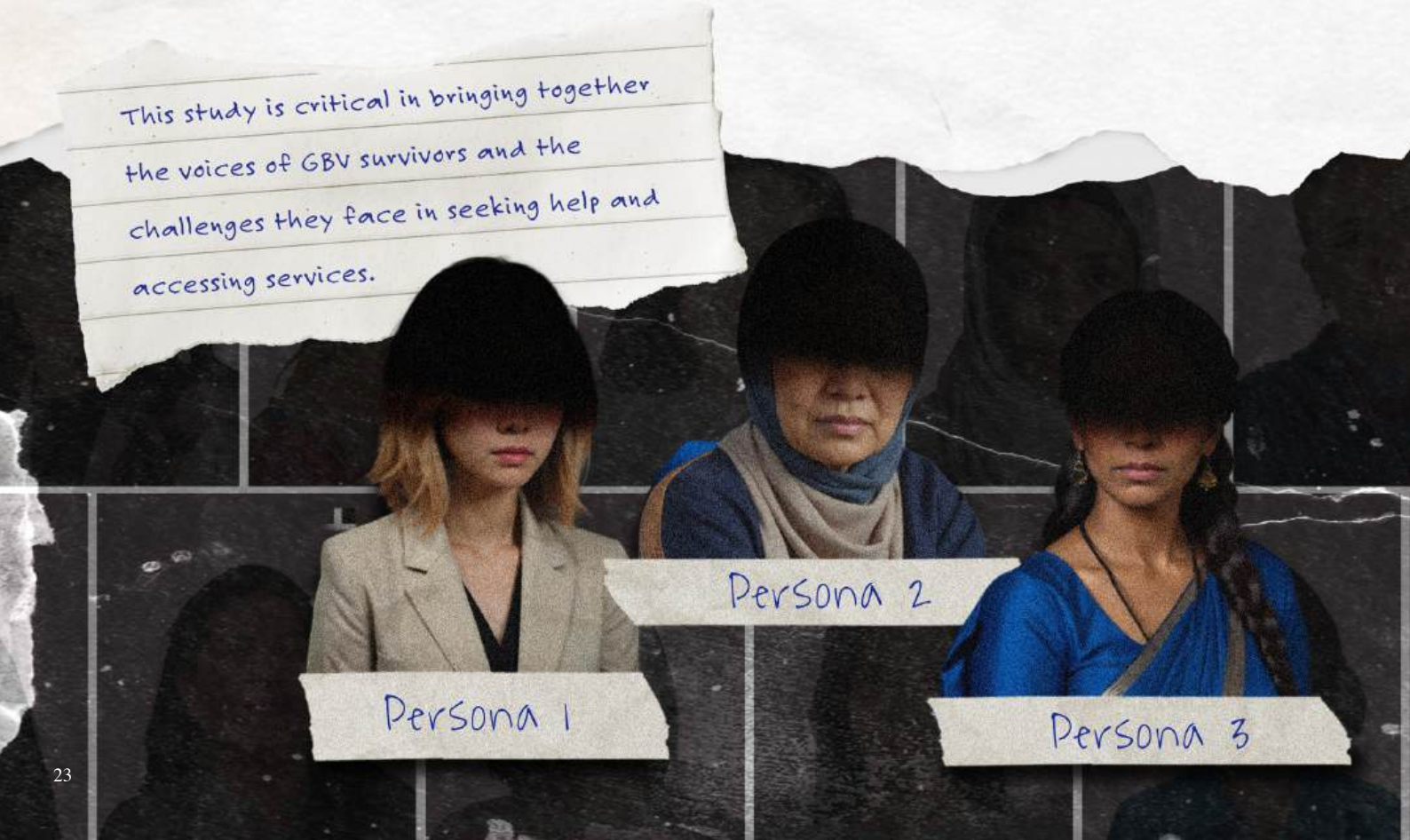
Ethical considerations

The United Nations University Ethics Review Board approved the study (ERB Ref No.: 202006/05, dated 23rd June 2023). For the next stage of the study, we proposed a separate study to collect health/patient data from the OSCC for which protocol was submitted to the Medical Research Ethics Committee of the Ministry of Health for research ethics clearance. A signed Memorandum of Agreement between UNU-IIGH and the Ministry of Health was obtained before the submission. However, the progression of this research phase was contingent upon the willingness of the involved parties to share the relevant data and the availability of funding for the research project.

Before any data collection, informed consent was obtained from participants, clearly explaining the study's purpose, data use, and their rights, with materials available in various formats for accessibility through a participant information form. We prioritised confidentiality and anonymity, removing identifiable information, and securing data access to protect participants. Recognising the sensitive nature of GBV, measures were taken to ensure participants' safety and well-being, providing support resources and professional assistance for those distressed by the discussion.

Limitations of the study

This study drew insights primarily from interviews conducted with GBV survivors and representatives from CSOs with a focus on the demand side of service provision. While this perspective is invaluable in understanding the experiences and needs of survivors, it is important to acknowledge that the absence of perspectives from hospital staff working in the

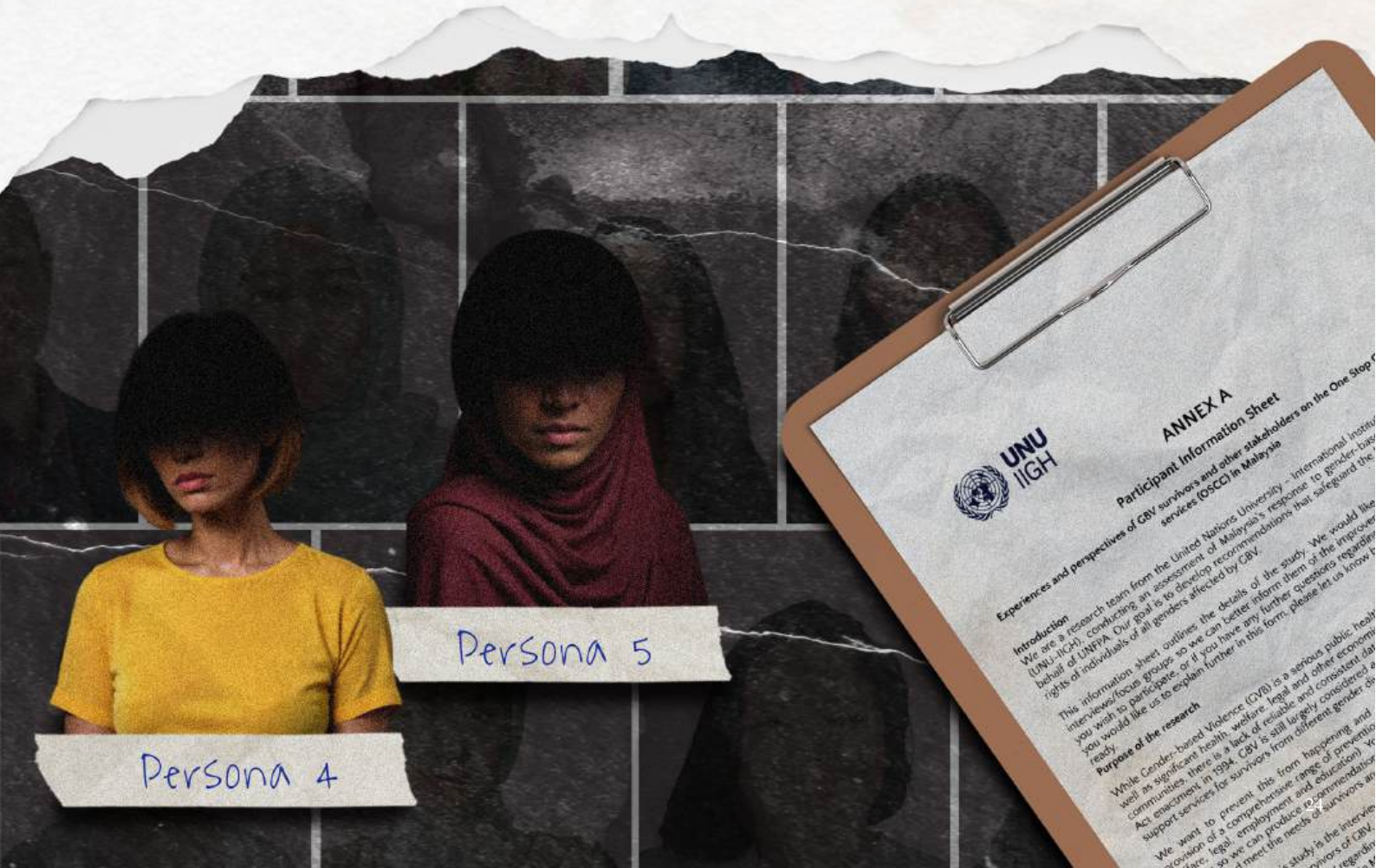


OSCC significantly limits the outcome of the study. These professionals face their own set of challenges – i.e., understaffing, high work pressure, inadequate resources, and potentially a lack of specialised training in dealing with GBV cases – which can profoundly impact the quality and effectiveness of the care provided to survivors.

Moreover, the findings of this study are based on a limited number of interviews which may not capture the full spectrum of experiences and challenges faced by GBV survivors. However, it remains a matter of concern that warrants urgent attention even if only one GBV survivor faces barriers to receiving care and support. Everyone has the right to access health care and support services irrespective of their background or the frequency of such cases. Recognising and addressing the challenges faced by both survivors and healthcare providers are crucial steps toward improving the support system for all individuals affected by GBV.

In light of these limitations, future research that aims to incorporate the experiences and challenges faced by the hospital and OSCC staff is key. Understanding these perspectives is essential for developing comprehensive strategies that address the needs of both service providers and survivors, ensuring that the healthcare system is equipped to offer empathetic, informed, and effective support to all GBV survivors.

Despite its limitations, this study is critical in bringing together the voices of GBV survivors and the challenges they face in seeking help and accessing services. It captures various intersectionalities of gender and illustrates how these affect and impact GBV survivors. The findings have the potential to inform policymakers to strengthen the existing system for better implementation, adhering to the principle of leaving no one behind. Every experience, regardless of its nature, deserves recognition and inclusion in our efforts to improve support systems and healthcare services.



Overview of research questions, methods and evidence

The study addressed three questions:

1

How do GBV survivors and critical civil society stakeholders assess the care pathways and bottlenecks related to the awareness, access, referrals, and quality of services available (e.g., reporting, medical help, counselling, shelters, OSCC)?

2

Which intersecting identities with gender have the highest influence (both positively and negatively) on how survivors experience GBV services in Malaysia?

3

How can the health system's response to GBV in Malaysia be strengthened to address women's positive and negative experiences?

The study drew primarily from qualitative, one-on-one, semi-structured interviews conducted with GBV survivors primarily in English. In cases where a translator was needed (e.g. Somalia, Burmese Chin or Rohingya survivors), the researchers were accompanied by CSO representatives to help in translating the interview process. There were two rounds of interviews: the first round was undertaken mainly with the survivors while the second round included the CSO representatives and medical social workers. Findings from the first round helped improve the methodology for the second round and to triangulate the findings that emerged from the first round of interviews directly with the survivors.

In the first round, nine interviews were conducted with women who had experienced different permutations of emotional, physical, or sexual violence for short or extended periods. UNU-IIGH sought to recruit interviewees whose trauma, life circumstances and socioeconomic attributes could bring to light how intersectionality shaped their overall experience of care pathways. The study's population consisted largely of female GBV survivors who accessed or tried to access services at an OSCC centre. However, best attempts were made to include male and transgender survivors about their experiences with seeking help for GBV, irrespective if they managed to get services through OSCC or not. The researchers sought to conduct interviews with married and single GBV survivors from different age groups, ethnicities, religions, and educational backgrounds who felt able to speak about their experiences.

Citizenship rights was another critical intersectional attribute researchers sought to unpack. Consequently, considerable effort was made to identify and recruit immigrants and refugees residing in Malaysia. Although the type of violence experienced by survivors (mental, physical, sexual) was not a factor in the sampling, it featured prominently in the analysis of the interview transcripts and the personas' development.

The evidence base of our personas is uneven, with some personas drawing directly on GBV survivor accounts and others relying more on discussions with social workers and CSO support staff with relevant experience, and the available literature.

There are a total of 5 personas of GBV survivors presented in the study. They are drawn from primary data, and some are supported by secondary information. Details as follows:

The personas for Teng Lan, Faraz Aziz, Shreelatha A/P Venugopal, the first three personas presented in the report, draw on the following sources of evidence:

- Analysis of the eleven interviews with GBV survivors
- A comprehensive analysis of the GBV policy landscape in Malaysia prepared by UNU-IIGH.
- Experiences of other GBV survivors with similar settings drawn from the relevant, recent peer-reviewed literature focusing on Malaysia and Southeast Asia.

The transgender persona narrative Kristine Kamil draws on:

- An in-depth interview with a CSO representative who had helped a transgender woman to obtain treatment at an OSCC.
- Data gathering through informal and confidential discussions with representatives with other transgender survivors and CSO representatives. This decision was driven by the expressed concerns from participants about the risks involved in sharing sensitive information through formal, recorded interviews. Adopting this approach built trust with participants and encouraged them to share more openly, providing valuable insights that might not have been accessible through traditional data collection methods. This strategy was particularly important for ensuring the safety of our participants and for capturing a deeper, more nuanced understanding of the subject matter, highlighting its effectiveness in research contexts where sensitivity and confidentiality are paramount. Detailed notes were made from these discussions and later analysed.
- Insights gathered from transgender participants and survivors in the stakeholder workshop involved in supporting GBV survivors.

Fatima Hossain, the refugee persona narrative draws on:

- An in-depth interview with two women GBV survivors from the refugee community.
- An interview with a CSO representative who supports the refugee community and their children.
- Presentation on a GBV programme for refugees in Malaysia shared by 'Doctors Without Borders' (Médecins Sans Frontières) coordinator.
- Relevant up-to-date literature.

Along with the abovementioned, 12 more detailed case studies were analysed and reflected upon in the findings section. These case studies were documented and shared by the All Women's Action Society (AWAM), one of the key CSOs in Kuala Lumpur, who also obtained the survivors' consent to share their information. It includes details of the experiences of violence and help-seeking behaviour of the survivor. However, it does not reflect much about their long-term pathways to care and follow up services. Therefore, personas have been restricted largely to first hand data collected by UNU-IIGH.

The insights on male GBV survivors and their experiences have been included in the findings section but not presented as a standalone persona due to lack of adequate evidence. This indicates a significant gap in our understanding on GBV against men but also underscores the invisibility of men victims who are reluctant to report incidents due to prevailing gender norms and societal expectations that discourage acknowledgement of their victimhood.

Personas and Journeys

Character and origins

Personas and pathways originate in user-centered design. Personas were created to convey crucial information about a particular group by incorporating data from multiple sources to create a static snapshot of the target user demographic[41, 42]. In specific, personas were originally designed to:

1. Establish a common vocabulary and reference framework for the communities of practice involved in service and product design (e.g., web front-end and back-end software developers, marketing, and product and service professionals).
2. Serve as tangible and relatable characters to assist design teams and other stakeholders in empathising with the group whose behaviours they seek to influence by illustrating the impact of different design decisions on the target demographic.

Whereas personas offer a static, two-dimensional representation of the target population, journey maps illustrate the user's experience over time[43]. Personas and journeys use compelling visual and storytelling techniques to clarify and invite thinking and reflection. Personas often integrate storytelling and visuals, whereas journeys depend on graphical depictions. They strive to represent the GBV experiences of survivors with different type of GBV experiences and cut across different intersectionalities in Malaysia while understanding that no group of personas can completely grasp the complexities of these experiences, individual identities, or contexts.

In this study, personas and pathways illustrate the experiences of different groups of GBV survivors as they navigate the care pathways available, primarily those offered within the context of OSCC.

The personas developed for this study highlight the fraught choices GBV survivors make given their life circumstances and the care services they can access. Our portraits also reveal GBV experiences and thoughts as they interact with professionals at different service points along the care pathway, including health professionals, policemen and women, and social workers.

The journeys of this study highlight the GBV survivors' winding trajectories along the care pathways. The barriers they face, the multiple visits to get things done, garner the courage, or find the opportunity to take the next step, offer a different view of care pathways than the one described in policy documents.

Empirical basis, strengths and weaknesses

The nature and quality of evidence underlying personas and journeys may vary. In principle, personas and journey designers can draw on

different data sources, qualitative and quantitative, primary, and secondary.

When discussing the information and data underpinning personas, it is essential to note that user-centered design does not maintain the same standards of rigor for data and analysis as social science-based research approaches. Although there are established approaches for translating evidence into personas[43, 44], in practice, the accuracy of personas is frequently impossible to validate[44, 45], not least because data collection and analysis are rarely documented.

The less-than-rigorous approach of the personas methodology has raised concerns about personas' ability to communicate nuanced and challenging realities in ways that support reflection and meaningful action. Some researchers have even made the case that personas created in User Experience (UX) design often reinforce existing stereotypes, including gender stereotypes, rather than open a window into people's realities[46, 47]. These weaknesses, however, are not integral to personas design and creation. For example, Wilson et al. (2018)[48] have suggested that persona creation can become more nuanced and rigorous through a phenomenological approach to user data analysis. Similarly, this study built on analysis of qualitative interviews with GBV survivors using a thematic analysis approach, the details for which are provided later in the report.

Despite the perceived weaknesses in persona design and creation, the personas approach offers a compelling alternative to traditional reporting. Personas' and journeys' engaging and visually appealing narratives can capture readers' imagination more effectively than long documents. Additionally, personas and journeys can provide the starting point for coordination, debate, and brainstorming between different communities of practice. Lastly, the personas framework is particularly relevant for policy-oriented research on challenging and sensitive subjects, such as GBV, as it can communicate brutal realities without compromising participants' anonymity and privacy.

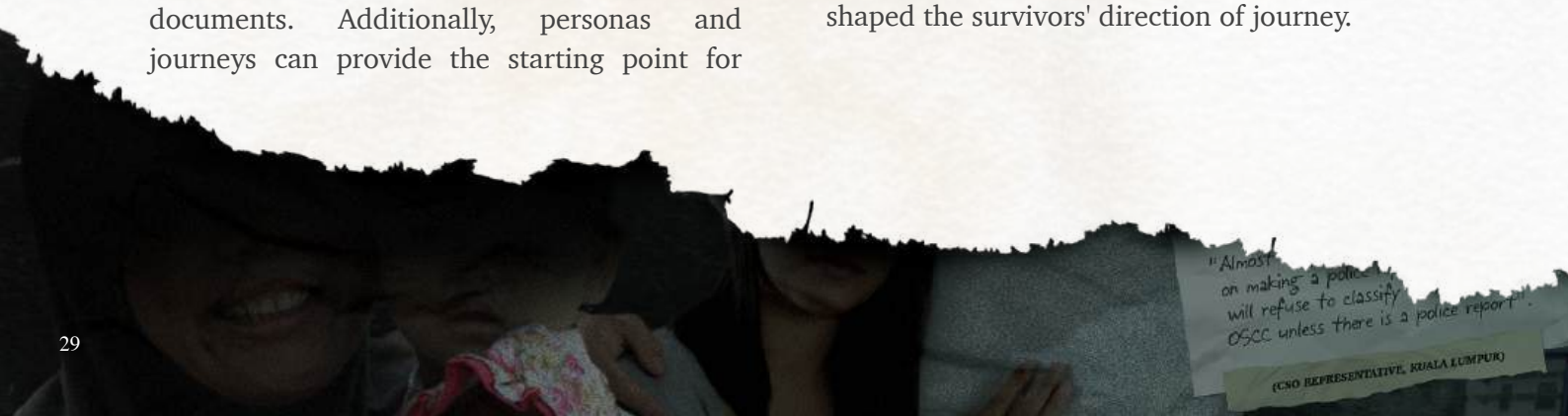
Development

User-centred design experts Pruitt and Adlin (2006)[42] see the development of evidence-based personas consisting of the following six steps:

1. Identifying important categories of users
2. Data processing
3. Developing skeletons, i.e., rough outlines for the personas
4. Transforming the skeletons into fully developed personas
5. Validating the personas

This process was adjusted in line with the resources and the goal of the study as follows:

Identifying the most critical categories of users. The character of GBV experienced by interviewees provided the distinguishing feature of each persona. This is because the nature and duration of the abuse are deciding factors in the survivors' original trajectory through the care pathway. Rape victims' trajectories were usually short and direct: They decided to seek or not seek medical help, report or not report the incident. Long-term survivors typically followed a more convoluted path, enduring abuse for years before seeking help. Against this background, intersectionality, the interplay of survivor's attributes and life circumstances, further shaped the survivors' direction of journey.



Data processing and developing the personas' skeletons: The interview guide and preliminary thematic analysis provided the initial template for the persona's skeleton, outlining the attributes and issues the personas would cover. Accordingly, each persona in the study covers five principal topics:

- **Background and demographics:** The nature of the GBV context and history of the relationship that underpins the incident and any available demographic information.
- **At the hospital:** Interviewees' experience at the emergency ward, the hospital, and the OSCC.
- **Interactions with the police:** Interviewees' interactions with the police, their treatment and advice they received, and the actions taken to protect them.
- **After the incident:** Details of what happened in the aftermath.
- **Intersectionality:** How survivors' intersecting identities affect their experiences at the different points in the care pathway.

Transforming the skeletons into personas: Detailed findings for each area were organized against the key areas in relation to the services and its interaction with survivors' experiences in terms of information and awareness, accessibility, availability, adaptability, appropriateness, safety, processes of consent and confidentiality, data collection and management and linking with other services, follow-up and advice care across the three sectors of health, justice and policing and social services. However, the focus was more drawn on services provided at OSCCs.

These findings were related to the demographic information collected during the interview, including age, marital status, nationality, and ethnicity. This analysis led to some critical choices on the attributes and story of each persona. For example, since both rape victims in our sample are young Malaysian professional women, so is our persona. Equally, the long-term GBV survivor is a married woman with children

Thematic analysis

The study adopted a thematic approach[49] to organize and analyse the information and insights shared by GBV survivors.

The thematic analysis drew on extensive notes taken from each interview and informal interactions with different stakeholders. The nine key areas across all the following essential services were assessed (UN Women, UNFPA, UNICEF 2020)[40] and presented in the findings section and based on the identified gaps, relevant recommendations are provided at the end of the report.

Thematic Analysis

Backgrounds and Demographics

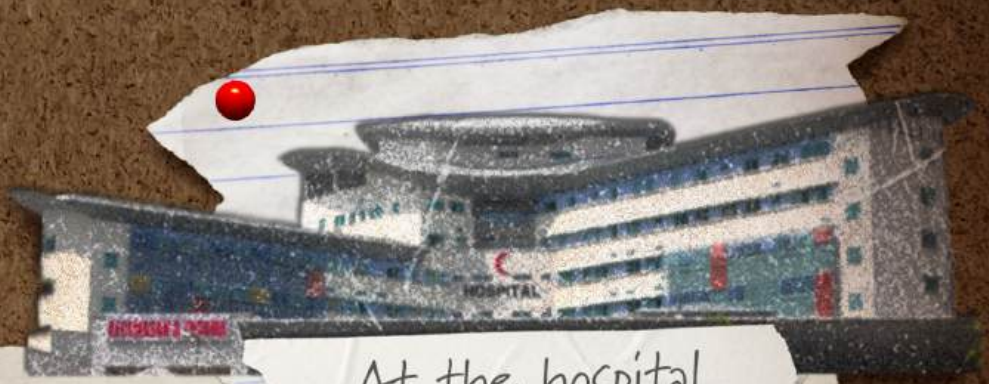
This theme captured information on the nature of the incident for which GBV survivors sought help, the context and history of the relationship that underpins the incident and any demographic information (age, marital status, profession, education) mentioned in the interview.

After the incident

Details of what happened in the aftermath of the incident.

Interactions with the police

This theme covered interviewees' interactions with the police, their treatment, the support and advice they received, and the actions taken to protect them.

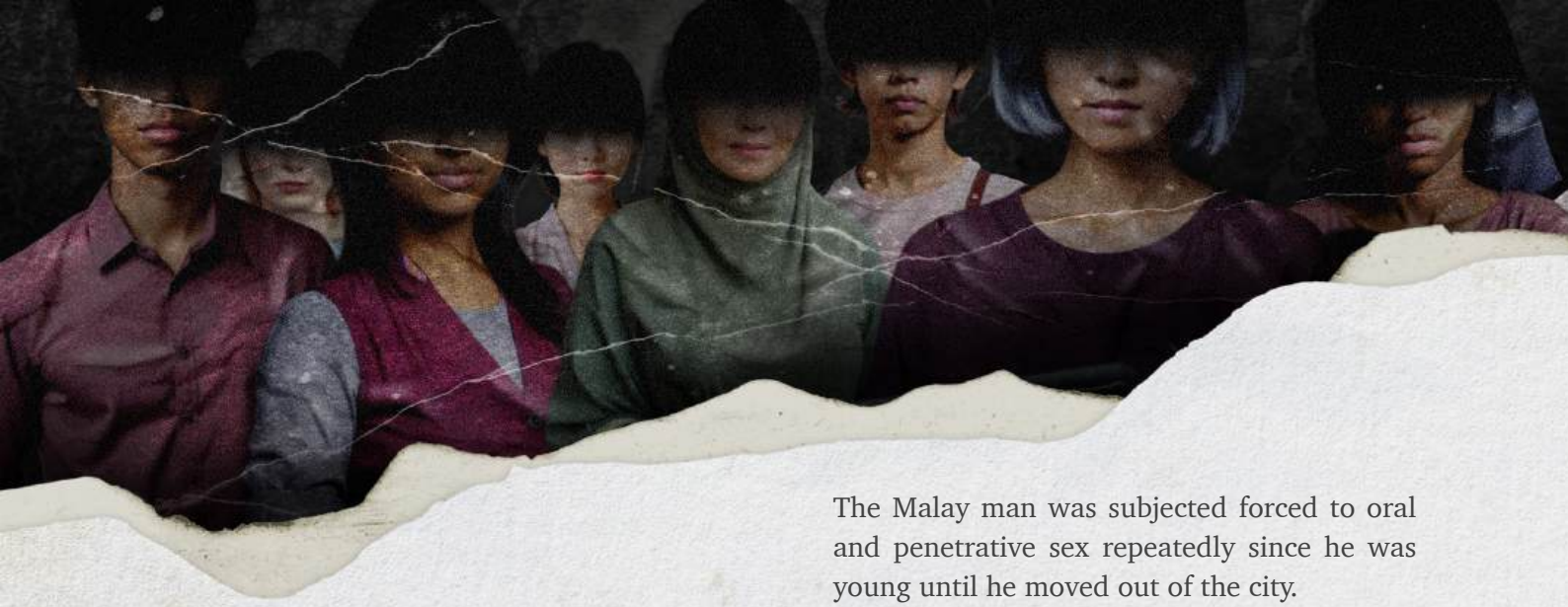


At the hospital

This theme captured the interviewees' experience at the emergency ward, the hospital, and the One-Stop Crisis Centre (OSCC). This included their treatment by the medical staff (both positive and negative), details on the physical examination and the environment in which this took place, and any advice and guidance or follow-up treatment they were offered going forward (e.g., counselling or linking with social or legal services).

Recommendations

Suggestions on how to improve care provision for GBV survivors.



Findings of the study

Survivors' background

A total of twelve in-depth interviews were conducted with GBV survivors, one of which was a male GBV survivor. The youngest four interviewees were rape survivors. Five interviewees were assaulted by their husbands and one by her relatives, specifically her mother-in-law and brother-in-law. One was unmarried but was physically assaulted by one of the men staying in the same apartment in a co-living arrangement.

Out of the three, the two rape survivors were single and held white-collar jobs, one in marketing and the other in the social care sector. The third rape survivor was a transgender woman from refugee community and was working in a community-based organization. The fourth rape survivor was a male, who was working as an admin personnel in a research organization.

Five married interviewees had been physically and emotionally abused for many years. Within this group, one had suffered sexual violence for fifteen years. The sixth married woman was physically assaulted and threatened with a knife by her mother-in-law and her older brother, along with her husband.

The Malay man was subjected forced to oral and penetrative sex repeatedly since he was young until he moved out of the city.

One interviewee was a divorcee who was assaulted publicly by her ex-husband. Another interviewee was a foreigner, single and working in an international organization.

One of the married GBV survivors was a Russian woman married to a Malay man and residing in the country legally having obtained a visa. The second interviewee was a Somalian refugee woman who experienced domestic violence. The third interviewee was a Burmese refugee seeking asylum with support from the United Nations Refugee Agency (UNHCR).

All interviewees – apart from the rape survivors, unmarried foreigner, and the male GBV survivor – had children.

It is worth noting that two of the interviewees had some knowledge of social and legal policies concerning GBV survivors: one of the rape victims had been involved in social work and used to work for UNHCR, and another one used to work for an international organization and was at the time of the interview working as an advocate of children rights.

At the hospital

Of the 11 women interviewed, seven spoke of their overall experience at the hospital negatively and four in favourable terms. One interviewee did not talk explicitly about the quality of care she received but was one of the

few referred to the psychiatric and social welfare departments following her medical examination and treatment.

The survivors who had negative experiences during their time at the hospital were the two rape survivors, the GBV survivor with a 15-year history of sexual and physical abuse, and the woman who was abused by her ex-husband. The reasons for their dissatisfaction can be summarised as follows:

- The staff attending to them were insensitive and treated them without empathy, seemingly unaware of the difficult circumstances and choices that GBV survivors must make or how trauma is expressed. In two cases, the interviewees' effort to maintain their calm was seen as evidence of falsehood, i.e., that they could not suffer abuse since they appeared so composed.

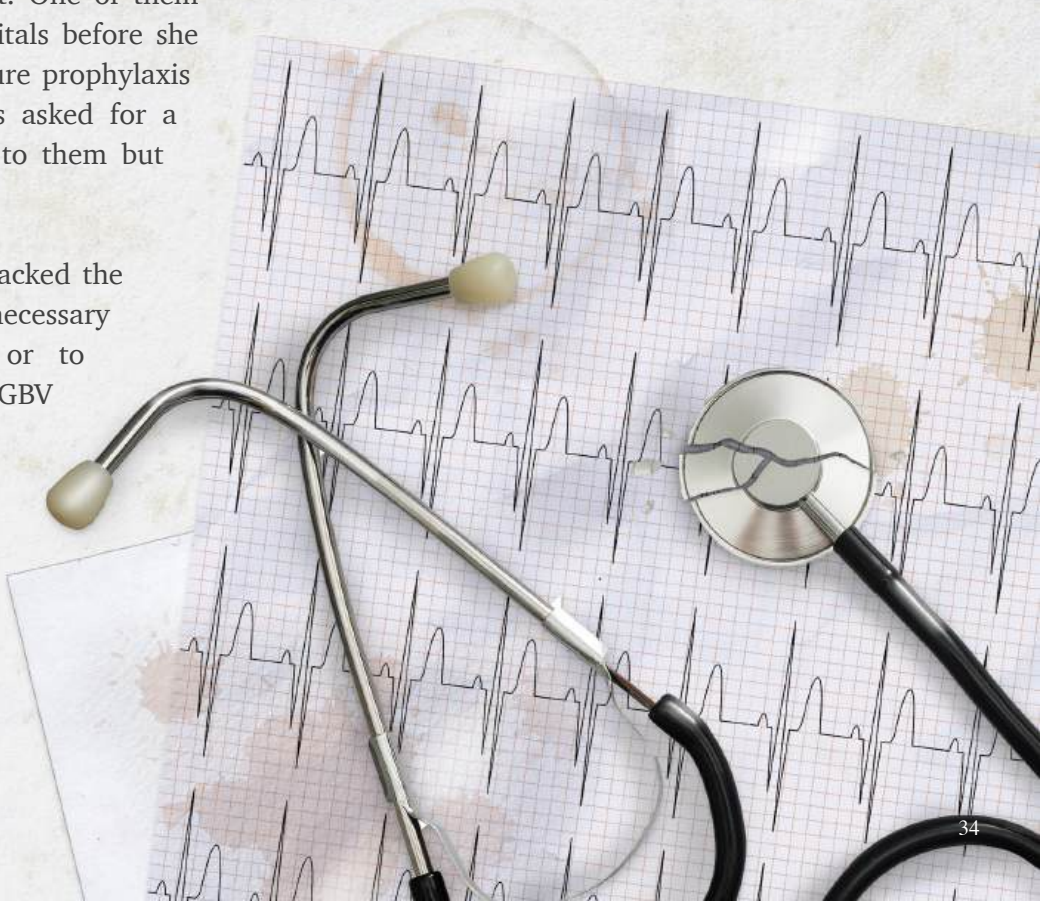
- In some cases, it was unacceptably difficult to get treated. Both rape victims were denied treatment until they had submitted a police report. One of them had to visit several hospitals before she could receive post-exposure prophylaxis (PEP). Both rape victims asked for a female doctor to attend to them but without success.

- The doctors and nurses lacked the experience and training necessary to handle such cases or to support traumatised GBV survivors.

- The space where they had to wait to be admitted and the set-up of the medical examination was far from ideal as they were in the hospital's emergency ward, which is often bustling. The interviewee whose ex-husband broke her nose felt exposed ("out in the open"), especially after her assailant also arrived at the hospital. One of the rape victims mentioned that people were coming in and out of the examination room.

- They were given little information and advice on the next steps, including counselling and social welfare support referrals. Most interviewees could not obtain a copy of their medical report, which is critical in securing a protection order and other legal proceedings.

The two women with positive experiences at the hospital noted the kindness, empathy, and insight showed by their doctors. In one of these cases, one doctor understood that her patient had suffered domestic abuse with the few words that the GBV survivor managed to utter and connected her to WAO.



Interviewees with a history of abuse had been hospitalized numerous times. They still refrained from declaring to the staff attending them that their injuries were the result of IPV because they were:

- Unconscious or too disoriented upon arrival.
- Accompanied by their assailant or his family.
- Afraid that the violence would escalate, or they would never see their children again should their assailant find out that they had reported them to the staff.

Police interactions

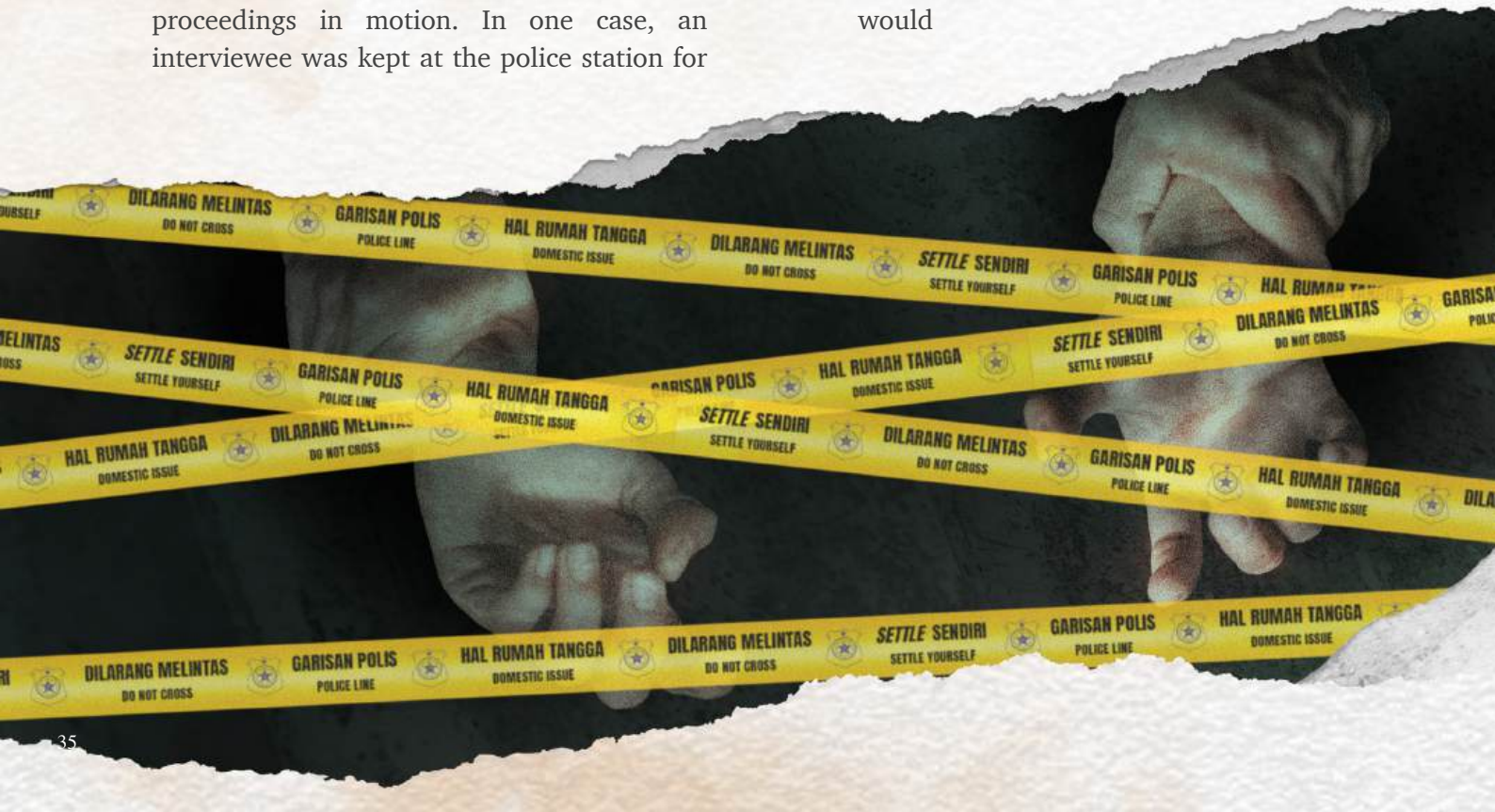
In general, all the interviewees did not trust the police to protect them and help them seek justice. Only one study participant, a married Russian woman, had a relatively constructive interaction with the police. The inspector at the police station where she submitted her report called her to ensure that she felt safe and to offer his protection.

The remaining interviewees described their interactions with the police in negative terms, albeit to varying degrees. Many interviewees spent hours and days trying to convince the police to act on their behalf and set legal proceedings in motion. In one case, an interviewee was kept at the police station for six hours and was threatened with arrest unless she dropped the charges against her mother-in-law, who had sought the intervention of the village elder on her behalf.

Interviewees indicated that police officers:

- Were often judgmental and insensitive towards GBV survivors. The young marketing professional who was raped mentioned that the police officers who accompanied her from the police station to the hospital for her medical exam told her she was essentially the one to be blamed for the rape. Another interviewee who wished to amend her original report to increase her chances of obtaining a restraining order was told that "she was creating trouble".

- Did not respond promptly to their pleas for help or take steps to ensure the safety of the victims. One interviewee who called the police while being threatened by her husband was advised to lock herself in her room and stay quiet until the following morning when a police officer would be dispatched to her home. Another interviewee was advised to drop the charges against her mother-in-law and was told that the police would



intervene the next time she was assaulted.

- Did not explain the choices available for their protection and implications. Two GBV survivors were unaware that they could obtain a restraining order against their abusive husbands, as this option was never suggested to them by the police.

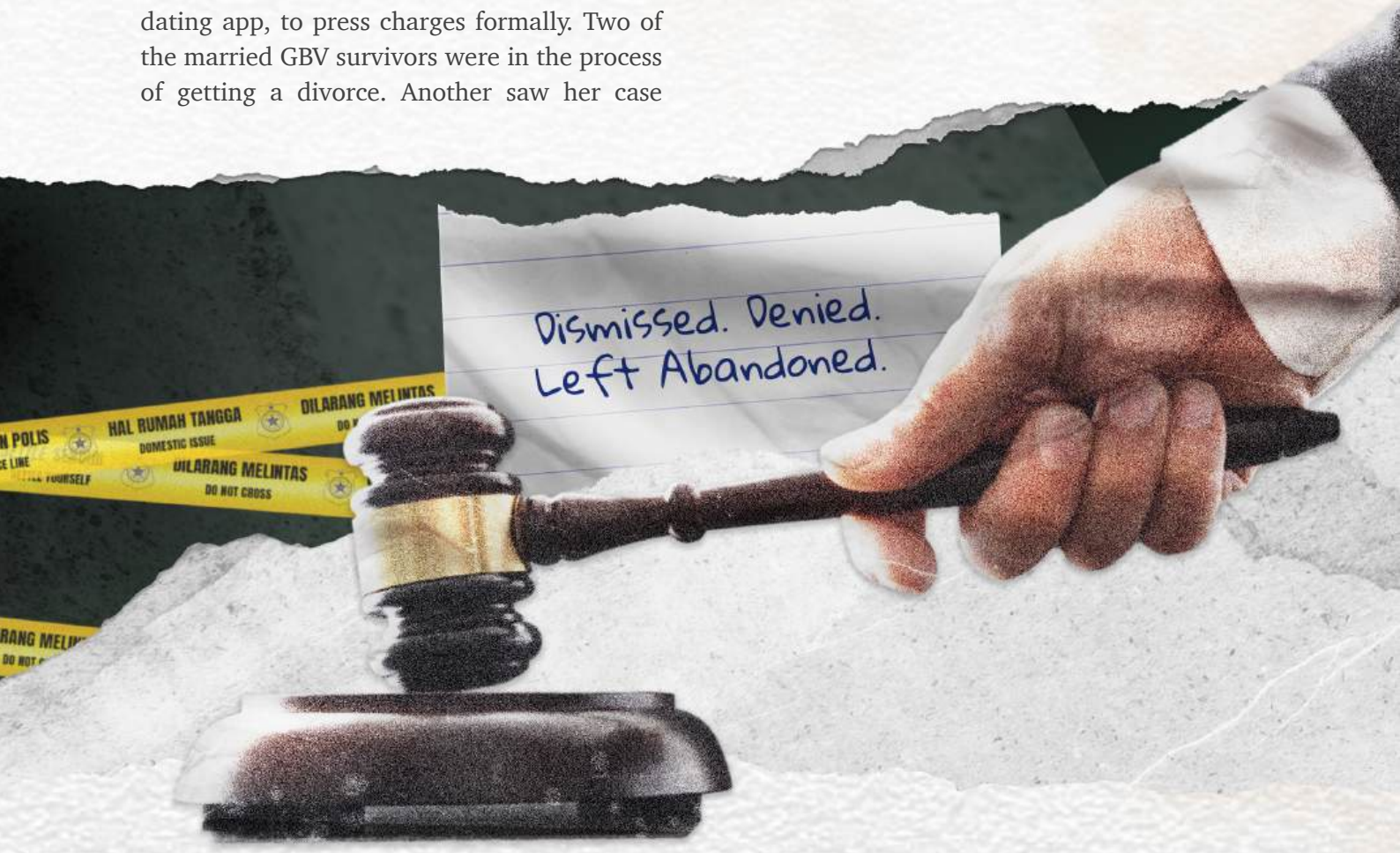
After the incident

Most interviewees had yet to find a satisfactory legal resolution and carried scars that would take time to heal. Specifically, interviewees had trouble obtaining the documentation needed to support their cases, such as copies of their medical reports.

The court hearing of the first rape survivor was repeatedly postponed, which was particularly distressing as she wanted to keep her ordeal secret from her family. The second rape survivor waged a battle to uncover the identity of her assailant, whom she had met over a dating app, to press charges formally. Two of the married GBV survivors were in the process of getting a divorce. Another saw her case dropped as she had specified in her police report that she did not wish for her husband to be arrested.

The man who abused his wife physically and sexually for over fifteen years was never brought to justice because the medical report did not support the charges. The GBV survivor in question spent two years without seeing her children and suffers epileptic seizures because of the brain injuries he inflicted on her.

Many interviewees benefited from the legal and emotional support provided by WAO. Despite their trauma, they were willing to stand up and protect others in a similar position. The woman who survived fifteen years of abuse related that after the events that she discussed in the interview, she found herself in a hospital admission room, sitting next to another woman who was, to her eyes, clearly abused and traumatised but had gone unnoticed by the medical staff. She began to shout, drawing attention to the other woman needing immediate assistance and intervention.



Advice for improving GBV care as suggested by the survivors

Interviewees made the following recommendations to improve care pathways:

1. GBV survivors should not be required to submit a police report before they are admitted for treatment. Many who arrive at the hospital require immediate medical attention. Furthermore, women who have suffered this type of abuse often need time to process what had happened to them.

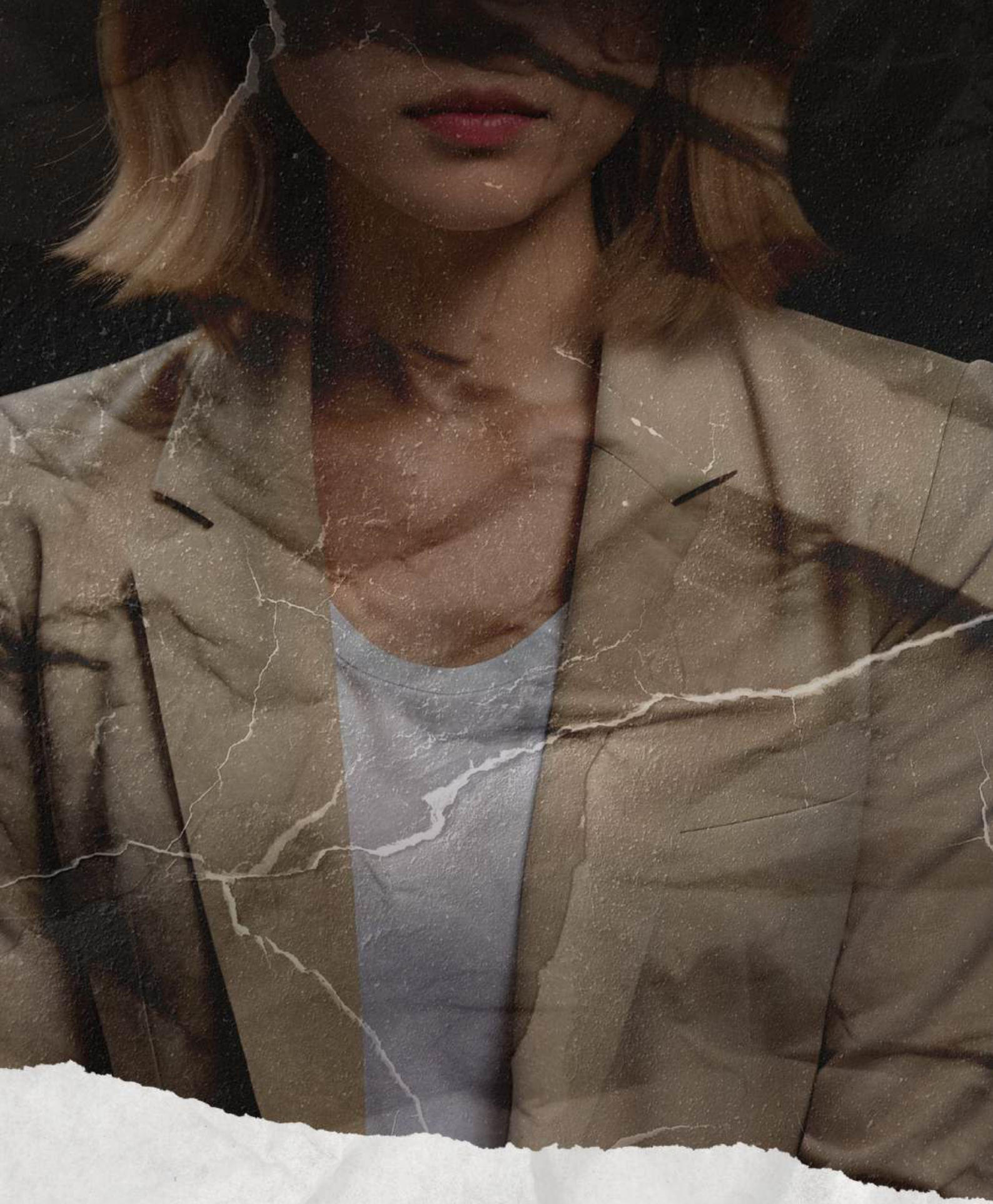
2. Medical staff and police officers attending to GBV survivors should be appropriately trained to handle such cases. They should learn the difficult choices GBV survivors must make, be aware that trauma may not be immediately apparent, and that abuse takes many forms, and be encouraged to treat GBV survivors with the empathy and respect they show to other patients.

3. Doctors should also be willing and able to alert the police, especially when survivors are too traumatised or intimidated to do so.

4. Support and counselling should be easily accessible after the incident.

5. GBV survivors should be better informed of their choices, especially the steps they can take to ensure their safety as well as their family's. Their carers must be mindful that such information cannot be conveyed by simply passing them a brochure.

6. The police should respond promptly to GBV survivors' appeals for help and take the necessary actions to protect them.



Personas and pathways

Teng Lan: Dealing with rape

Evidence base includes interviews with GBV survivors

Persona Name:	Teng Lan
GBV Incident:	Rape
Age:	28 years
Occupation:	Public Relations Manager
Education:	BA in Marketing & Public Relations from a local University
Marital Status:	Single
Children:	None
Ethnicity:	Malaysian Chinese
Citizenship:	Malaysian
Religion:	Buddhism

Lan never thought that such a thing could happen to her. Looking back, it seemed that the one thought that pervaded her thoughts the first hour after the assault was to get away and retreat to safety.

When she got to her apartment, her roommate, Lee, ran a bath for her and made her favourite tea. She did not have to explain much, and Lee did not press, although she could tell how worried she was. All she managed to tell her friend was that she was raped by two young men she met at the party.

Both women called in sick from work the next day, Lan from the high-profile public relations agency she works at, and Lee from a women's rights NGO. How could she possibly explain this to her parents and her friends? How would people at work react if they ever found out about this?

Lee's gentle probing on whether her assailants had used protection had not cut through the fog that seemed to envelop her. Denial and shame retreated somewhat and were replaced by anger and anxiety. This was not what she dreamed for herself and she felt like her life had ended. She was 28-years-old, the first person in her family with a university degree.

While she was trying to make up her mind about what she should do, Lee appeared to be one step ahead of her. She was calling friends from the party who knew Lan's assailants to learn as much about them as possible. Lan

could only recall their first names, but luckily, she was acquainted with the people who had introduced her to them.

She forced herself to get dressed, wincing as she put back clothes at the pain she felt in her genitalia, the inside of her thighs and her breasts where the two men had bitten her. She wished she had more time to think about how to handle this. Would she need to explain what happened to her to receive the post-exposure prophylaxis (PEP) drugs and the morning-after pill that, according to Lee, she needed to protect herself against a possible HIV infection and to prevent a potential pregnancy? What would happen if she reported her rapists to the police? She knew very little about them except that they came from prominent business families and were probably well-connected. All these decisions and each one with more ominous implications than the next!

Lee drove her to a private clinic first, as they thought Lan would be treated faster and more discreetly there. However, after a short conversation with the receptionist and head nurse, it became apparent that this was not the case. Only public hospitals could attend to rape victims and administer the required medication. So, they drove to the main public hospital in their area.

Lan had almost decided to see her rapists brought to justice when they arrived. Luckily, Lee's earlier efforts had paid dividends, and they now knew her assailants' full names. A quick search on social media allowed her to verify their identity.

Her courage began to ebb at the reception desk. The receptionist discussed with Lee whether Lan could be admitted without having submitted a police report. She kept glancing reproachfully at Lan, who had tried to look presentable. Her nicely tailored outfit and light make-up were like armour to her and always have been, as opposed to the preconceived notion that victims were not supposed to look well put together.

After speaking to the head nurse, Lan decided to go to the police station to report the incident. She wanted to conserve her energy, and publicizing this argument did not seem the best way to go about it.

At the police station, Lan's sense of unease and dismay increased. The female police officer who took her statement made some hurtful comments about young women's attitudes and lack of common sense as well as morals. Another police officer who joined them at some point to double-check some details mumbled something about this whole thing being her fault.

Under their uncomfortable stares, Lan tried to complete her statement as quickly and accurately as possible, giving as many details as she could remember.

Upon returning to the public hospital, Lan's dismay grew. Despite her wishes to be examined by a female doctor, she was assigned a male doctor and attendant. The young male doctor who performed the rape test was shy and would not even look her in the eye during the procedure, which made her feel even more uncomfortable. His questions and manner also implied, although not as pointedly as the police officers, that she was essentially responsible for her attack by being at the party in the first place.

She thought that a kind word and a gentler touch would have gone a long way to compensate for his inexperience. With only a flimsy curtain between her and the rest of the busy emergency room, Lan constantly felt on edge. Still, it was not until she was told that the hospital could not give her the PEP treatment or the morning-after pill that her dismay turned into desperation. The staff informed her that she was to be given the PEP only after she tested positive for HIV. However, the HIV test was not available at the hospital. Why was everything so impossibly difficult?

Lee kept asking Lan whether the doctor offered any follow-up appointment or psychological support, but she could not remember. The receptionist pointed out that the hospital did not have a psychologist and that Lan should come by in case of complications. Realizing that Lan was at the end of her tether, Lee took her back to their apartment and spent two hours on her phone trying to find a hospital or clinic to administer the medication she needed. Her contacts came through, and Lan received treatment at a private hospital that specialised in family planning that evening. ***This small win was overshadowed by the fact that she would need to wait three months for the test results.***

Lan spent the next four days at home, on medical leave, trying to deflect questions from her family and process what had happened to her. She wanted to keep the incident secret from her parents for as long as possible. Although she respected them and shared many of their values, she felt that their views on how a proper woman should behave and present herself were suffocating.

She slept poorly and was consumed with worry about her health and future. Since she had not received any follow-up support from the OSCC, Lee placed her in touch with friends from another NGO that offered counselling and legal aid to GBV survivors. She was hesitant at first, as she always considered herself a strong person, able to overcome anything independently. Still, Lan decided to try counselling after her first panic attack. She would take all the help she could get. The legal aid also proved invaluable in dealing with the police, who kept asking her for additional evidence, which Lan found highly distressing. She never received the forensic and medical reports, which, according to the hospital staff, could only be shared with the police. Over the next four months, she tried to regain a sense of normalcy. This was made increasingly challenging by her growing concerns about the possibility of contracting HIV infection. She regarded the legal proceedings as another mountain she had to climb. Lee and a dear cousin bolstered her throughout this period, showing her love and care. She slowly began to accept that she would never be the same person again and that healing would take time.

Interpretation of the indicators used in the personas and pathway illustrations are provided below:

- A location where a service was sought but not received.
- A location where a service was sought and received.
- The dotted line indicates that the survivor's journey is in progress

Figure 1: Teng Lan's care pathway.

Faraz Aziz: Healing from long-term abuse

Evidence base includes interviews with GBV survivors

When Faraz had to get patched up at the hospital after one of their 'arguments', her husband of 38 years ensured that he or another family member he trusted accompanied her. This made it almost impossible for Faraz to open up to any of the medical staff, and tried to convey her distress through her expression and subtle gestures.

While strangers and hospital staff often saw this as a sign of his concern and care, Faraz saw this as another way he sought to exert control over every aspect of her life. Her husband wanted her to remain alive but not in a position to challenge his authority over her.

She had spent so many years living in fear that she could hardly remember what it meant to be happy and in control of her life.

Her older daughter, all grown up now with her own family, often provided a window into a life she could only dream about. Knowing what their mother went through, her two daughters often urged her to let them help, but she did not want to bring her troubles into their lives.

She also dreaded the idea of her family affairs becoming public knowledge. It was enough that she had to suffer. And suffered she had.

When her older daughter insisted on taking her to the hospital to treat a severe vaginal infection without her husband or any of her other relatives, Faraz finally felt in a position to mention something about her

circumstances to the doctor. It helped that the lady doctor who examined her was kind and thoughtful.

Although Faraz could only utter a few sentences, the doctor appeared to grasp her situation quickly. With Faraz's permission, she took down her details and explained that support was there for her if she wished to leave her situation. The doctor gave her two leaflets: one with the details of the government centre and another one of an independent NGO. Faraz was surprised at first. She thought that between the police and her family, there was no one else she could turn to for help.

After reading some information on the leaflets during her ride home, she gave them to her daughter for safekeeping, fearing that her husband might discover them.

Two days after she returned home, she was contacted by the people the doctor had spoken about. It was a new experience for her to have total strangers inquiring about her wellbeing and whether she felt safe. The woman on the phone mentioned that they could arrange to have her stay in one of the houses that her organization kept for cases such as hers.

The police need not be involved if she did not wish to, and no one apart from people she trusted needed to know that she had left her home. Faraz felt better once she learned all this. She had an option now that did not involve burdening her daughters or escalating things by going to the police.

One day after another beating and what she now recognises as rape, Faraz texted her daughter, explaining that she had decided to leave home with the help of the lady who had called her.

Three days before her planned getaway, Faraz gave her daughter a suitcase with a few changes of clothes, a few heirlooms, and pieces of jewellery she had inherited from her parents. For everyone's safety, it was decided that until things settled down, Faraz and her daughters would only contact each other in case of an emergency via the NGO. It was decided that her younger daughter would move in with her older sister.

She had planned things so that the day of her escape was a market day. She hid all her essential documents at the bottom of one of her grocery bags. The lady from the NGO had arranged to pick her up in a nondescript car near one of the less busy parts of the market.

Her first two weeks at the shelter were full of anxiety. Faraz thought her husband would barge in at any minute, dragging her back to their house. When this did not happen, she started to interact with the other women in the safe house and began to calm down.

The examination lasted about ten minutes and felt rushed and superficial. Faraz was concerned that the medical report would reflect more the doctor's assumptions than the evidence inscribed on her body. After the conclusion of the medical examination, Faraz had to explain her story from the beginning to the staff psychiatrist on duty. Although the hospital offered Faraz a follow-up appointment with the psychiatrist, she decided not to take it. She was pleased with the counselling she received at the shelter and did not like her assigned doctor.

It felt so strange not to have to be afraid all the time. The first time she broke a plate while doing the dishes, Faraz had a minor panic attack that she worked through with the help of one of her housemates. Although she knew that she would not be punished for this, it appeared that it would take quite some time for her body and mind to realise that she was, at least for now, in a safe space. Her counsellor had explained as much in one of her bi-weekly visits. Knowing this added to the sense of control that Faraz slowly worked towards during the last two months.

Faraz allowed herself to think more about her future as her confidence grew, and she began to regain a sense of safety. She made long lists and plans for the next steps that she discussed with her appointed NGO staff and counsellor, trying to work through the implications of her different choices for herself and her daughters. It soon became apparent that all the solutions that would ensure her future, both in the short and longer term, involves the police.

The day she decided to report her husband to the police was one of the worst days of her life. The police behaved rudely toward her and her NGO support officer. To Faraz's dismay, people kept going in and out of the office where the two police officers held her supposedly private interview.

After she explained her situation, one of the police officers asked Faraz whether her husband provided for her and her daughters. When she admitted she had few complaints in that respect, the police officer pointed out that she should feel lucky instead of creating trouble for her husband, especially this late in the marriage. The NGO support officer's polite protestations seem to confirm the impression that Faraz was out to create trouble, because how could a 'good Muslim woman involve strangers in her marriage'?

When the police officers explained that they could not proceed unless they had some evidence, including medical reports, Faraz was at a loss. She did not even know that such documents existed, and even if she knew and was in the state of mind to ask for one, most of the time she was taken to the hospital, she was watched closely by her husband or someone else from his side of the family.

She was not given the chance to speak out, even in the privacy of the examination room. All the doctors who had treated her in the past never asked her any questions about how she was injured or tried to create space for her to confide in them.

After discussing the issue with her NGO companion, Faraz realised that the only viable option was to proceed with the medical examination. A note from the police expedited her admittance. To her dismay, the female doctor who performed the examination had very little in common with the lady doctor from her previous visit.

The doctor was brusque and lacked the compassion and kindness of her last physician. Despite Faraz taking time to explain her history and circumstances at the beginning of the examination, the doctor kept pointing out that none of her injuries were recent and that many were part of the 'wear and tear' of married life.

Telling her story repeatedly to all these different people made her feel despondent. She just hoped that something good would come of this. So even though she had to go in the next day to see her assigned social worker and retell her story, she was glad to do so, as the lady gave her some invaluable advice on what she needed to include in her police statement to obtain a protection order against her husband and issue for a divorce even if she decided to not press charges.

She and her NGO case worker had to spend four hours at the police station before she was allowed to amend her initial statement that day. Despite the resentful attitude of the police officers, she had to deal with because she apparently continued to create work for them, she considered this as time well spent.

Interpretation of the indicators used in the personas and pathway illustrations are provided below:

- A location where a service was sought but not received.
- A location where a service was sought and received.
- The dotted line indicates that the survivor's journey is in progress

Shortly after her two visits to the police station, her health, which was in bad shape after all the years of abuse, began, to deteriorate rapidly. She had trouble sleeping and developed seizures, which a later MRI revealed to be the result of repeated head injuries she had received over the years.

A couple of weeks later, her lawyer, who was paid for by the NGO, informed her that the medical report they finally obtained would not allow them to press charges against her husband. One option would be to involve her daughters as witnesses. Faraz, however, did not want her children to be dragged into the mess of her life.

She was already fifty-four years old. She wanted to get on with her life, support her daughters and their families, and do some of the things she had always dreamed of. Luckily, she obtained some good news soon after that. Her lawyer was able to file early for a divorce.

The NGO offered some professional development courses for survivors just like her. Since she had a strong passion for art and loved children, she attended an art therapy course. She liked to keep busy and took great pride in being valued by the staff at the orphanage where she did her stage. Although she believed that some of her wounds would never heal, at least now she has a sense of purpose and people that she could turn to.

Figure 2: Faraz's care pathway.

Shreelatha A/P Venugopal:

Confronting emotional and physical abuse

Evidence base includes interviews with GBV survivors

Persona Name:	Shreelatha A/P Venugopal
GBV Incident:	Emotional & physical abuse
Age:	35 years
Occupation:	Beautician
Education:	High school certificate & beauty school
Marital Status:	Married
Children:	3
Ethnicity:	Malaysian Indian
Citizenship:	Malaysian
Religion:	Hindu

When her husband lost his job as a construction supervisor during COVID-19, Shree tried to keep her spirits up. She could still work in the area where she was permitted to travel by making house calls. So, although they had to dip into their savings to make ends meet, these were not depleted as quickly as those of other families Shree knew the difficulties faced by those who could not earn a living during this challenging period. She also knew that her parents would also help with the household expenses if it came to it and considered herself all the luckier for this.

Although her husband always maintained a careful eye over their finances, his obsession with their spending seemed to get more out of control every day he was not working. Shree understood his anxiety, but she could not understand why he took out his anger and worry on her and the children.

The situation became more fraught when he got long COVID-19 and could not work following the lockdown's termination. Shree felt herself growing weary with the responsibility of the household and being the sole breadwinner. His remarks and complaints over her inability to bring in more money and the less-than-immaculate state of their home

grew more acerbic and combative as time passed. Shree ended up dreading returning home at the end of a long workday. She kept telling herself that this was a phase, that he was acting out because his pride was hurt, and that things would return to normal after he returned to work.

She was disabused of this notion when one evening, while the children were visiting their grandparents, their fight became physical. A punch to the face and a kick to the ribs saw Shree reeling on the floor. While she was down and blood was pouring from her head, her husband kept shouting at her and pulling her hair, trying to have her stand up. At this moment she realised that if she did nothing she would die.

When she could breathe again and she was able to stand up, she locked herself in their bedroom and called the women's helpline. The lady on the phone told her to stay locked in her room and wait until the police came the following morning.

Shree could not believe what she was hearing. She was hurt, her husband was still reeling outside the bedroom door, threatening her, and she was told to sit tight and wait for another eight hours? At a loss for what to say, she hung up the phone and called her younger brother, who lived half an hour away. He showed up 25 minutes later with two friends. After they assured her that her husband was nowhere to be seen, Shree unlocked her door, and her younger brother and his friend drove her to the nearest hospital.

At the hospital where the OSCC was located, she was asked to file a report before being treated to attest that her injuries resulted from domestic violence. This did not take very long, but the police officer on duty pointed out that this was not the official police report. To submit this, they would need to go to a police station. The police officer was kind, which was a relief, and he noted down the address of the nearest police station, which he passed on to her brother. However, when they arrived at this station, they were informed that they could not lodge a report as this station fell outside the jurisdiction of her home. She and her brother were forced to drive to the station nearest her home address, where she finally submitted the report.

After this, Shree was taken to the emergency room, where she discovered she had two bruised ribs. Luckily, her nose was not broken. After treating her injuries, the doctor advised her on what she needed to look out for, prescribed her some painkillers, and booked a follow-up, appointment to ensure that everything was healing correctly. The doctor also gave her referrals to the social welfare and psychiatric department.

Given how tired and shocked she was, she found all this extremely difficult to take in, but she did her best to remember everything. While the doctor spoke to her, she kept thinking how fortunate it was that her kids were not at the house that night.

Shree realised, however, that keeping the children away from their father for longer would be complicated. Her husband would not stand for this, but returning the children to their father was not an option either. Her husband would use them as a bargaining chip for her to return to him, and she would constantly worry for their safety.

Seeing how overwhelmed she was, the doctor asked her if someone had accompanied her to the hospital and whether she had somewhere safe to stay that night. He then proceeded to have a short discussion with her brother, explaining what they needed to do next. The appointment for the social worker was arranged for the following morning. The doctor pointed out that it may be better to speak to the social worker before going to the police, as she could advise them on what to include in the official report.

Fortunately, it was a relatively quiet night, so the doctor was not pressed for time. After repeated requests, a nurse at the centre made a copy of the medical report for her to take home.

As it was already 00:30 hours by the time they had finished at the hospital, it was decided that Shree would spend the night at her brother's house. They would visit the police the following day.

Her brother also called her parents, where her kids were staying and explained the situation in broad strokes. Shree had switched off her phone as her husband kept calling and texting her about how sorry he was and asking about her whereabouts.

Interpretation of the indicators used in the personas and pathway illustrations are provided below:

- A location where a service was sought but not received.
- A location where a service was sought and received.
- The dotted line indicates that the survivor's journey is in progress

Figure 3: Shreelatha's care pathway.

Kristine Kamil:

Dealing with rape as a transgender woman

Evidence base includes interviews with GBV survivors and also relies on secondary evidence

Kristine's journey hasn't been easy as she has faced many hardships since her teenage years when she could no longer hide the discomfort and anxiety caused by the feeling that she was living in the wrong body. Her desire to live authentically as a woman was met with anger and confusion by her family and immediate social circle.

Determined to stay true to herself and find her place in the world, she made some tough choices early in her life, which included moving to a different city and severing ties with most of her family.

Everything became challenging when she decided to openly assert her female identity, adding to her sense that the world was unprepared for her choices. She counted herself fortunate in her new friends and her newfound family, who accepted her unconditionally for who she was and supported her while she was transitioning.

One rainy afternoon, while returning from the market, she was stopped by three strangers who started making fun of her clothes and how she looked. Her instinct told her she was in danger, and she tried to walk away. Soon, the mockery turned into the most traumatic experience of her life. The three men dragged her to a nearby alley, where they sexually assaulted her. She managed to drag herself to her flat, worrying constantly that her attackers would follow her there too. Despite being in pain, she knew she had to reach out for medical help as she feared that her attackers may have infected her with HIV. She called her

friend Geetha, who arrived at the flat shortly after that. While listening to Kristine, Geetha was outraged. She wanted the culprits punished and behind bars even though she was aware of how challenging it would be for a transwoman to seek justice. She set these feelings aside, knowing that getting medical attention for Kristine was the priority.

Together, they went to the crisis centre at the nearest hospital. The stern receptionist regarded them with guarded curiosity. While taking down their details, the receptionist, despite Geetha's protestations, refused to use Kristine's preferred female name and filled in the form using her official male name. She explained that using Kristine's preferred name would complicate things when communicating with other services.

In the crisis centre's crowded, very public waiting room, Kristine and Geetha felt the weight of visitors and staff stares bearing down on them. They felt everyone scrutinised their appearance, dress, make-up, and build, making them acutely aware of their bodies and how they carried themselves. The glances and the ensuing whispers made them uneasy and reluctant to chat.

Kristine, visibly traumatized and in distress, whispered to Geetha, "I don't know if I can do this." With seemingly unwavering determination, Geetha whispered back, "We'll get through this together, Kristine, I promise", even though she did not feel courageous.

Geetha told the doctor who came to see Kristine that she needed to accompany her to the examination room, but the doctor insisted that it was against their protocol and that she had to wait outside.

Kristine, on her own now, waited nervously in the small waiting room, surrounded by posters that featured traditional gender binary images and advertised services not meant for queer or trans people. It was another reminder that the support centre was not meant for people like her and Geetha. Hushed conversations punctuated the silence in the room, and Kristine could sense the furtive glances from the other patients.

When her name was finally called, Kristine entered the small examination room within the emergency department. Upon seeing her, the female doctor looked perplexed, as if caught in a dilemma she had never encountered. The name written on the form was male, and the person in front of her, despite their robust build, had chosen to present themselves as a woman. Kristine couldn't help but overhear the hushed exchange as she asked the attending nurse: "Is this a male or a female patient? Who should examine her?"

Kristine began to think that her ordeal would never end. She wanted to return to her flat for a warm bath, away from probing eyes and cruel comments and questions. Wariness and fear start giving way to frustration and anger. Kristine couldn’t comprehend why the doctors were unsure about how to proceed. She was clearly in pain, both physically and mentally. Isn't a doctor's primary duty to care for their patients, regardless of religion, ethnicity, money, or education? Why was gender different? Did the way she looked and who she chose to present her gender make her someone less deserving of basic courtesy and medical attention? She had to confront bias and prejudice daily and had started to convince herself that by this point, she had become somewhat immune to it. What she was experiencing began to feel like she was being punished for being raped.

After much delay and deliberation among the medical staff, a male doctor arrived and examined Kristine. He was not careless, but he also did not ask her once about how she felt and if she was in pain. When she asked about being tested for HIV and other sexually transmitted infections (STI), the doctor responded that this was something that they should discuss with reception, "as theirs was

not a standard case".

After their examination, the receptionist informed that Kristine was required to go to the police to fill in a report about the rape before she was able to have the HIV/STI test. Kristine's fear spiked at the mere mention of the police. She informed Geetha, who was impatiently waiting outside to see her friend.

They had both heard stories of how law enforcement treated transgender individuals. The prospect of interacting with the police sent shivers down their spines. They knew that the law was not really on their side. Homosexuality was criminalised, and Kristine could end up being the one being prosecuted if the police were informed of the nature of the sexual assault and saw Kristine.

They had grown up experiencing the sting of stigma, the weight of biased hatred, and the hurtful discrimination for being transgender. Their families had long deserted them, and friends had drifted away, unable or unwilling to understand their struggles. ***What chance did they have with the police when those closest to them, when doctors and nurses sworn to prioritize the wellbeing of their patients above everything else, could hardly look them in the eye?***

By this time, Kristine's mental distress and exhaustion had become too much to bear, and she pleaded with Geetha to go back home. Geetha knew Kristine well and realized that she needed the chance to rest before deciding what to do next.

Geetha insisted that she visited a counsellor before leaving the hospital. Luckily, they did not have to wait long for one. The counsellor assigned to Kristine was well-intentioned but lacked the training needed to support transgender individuals. She stumbled over her words and kept using incorrect pronouns, inadvertently making Kristine wary and unable to feel at ease and able to trust her. Tears fell down Kristine's face as she recounted her painful experience. Although the counsellor treated her with more compassion than the rest of the medical staff, she could not provide the help that Kristine needed as she knew very little about transgender people. She did, however, mention to Kristine the name of an NGO supporting transgender individuals that she had heard from another colleague.

Kristine and Geetha left the hospital, leaning on one another. After she had ensured Kristine had something to eat, Geetha tucked her into bed and went online to search for the organization that the counsellor had mentioned. She feared that her friend would not be able to get the tests and treatment she required on time, and despite being exhausted herself, she knew that she could not yet rest.

She found the organization's webpage quickly enough. There was no telephone number listed, just an email address, which she used to send a short message describing Kristine's situation and asking if they could help. Someone must have been closely monitoring incoming messages because not ten minutes passed before she received a reply with a telephone number and name. The person on the other side of the line was calm and collected. After he got a detailed account of what had transpired from Geetha, he said they could arrange for Kristine to have the necessary tests and any follow-up treatment, if required, at a community clinic they worked with.

Interpretation of the indicators used in the personas and pathway illustrations are provided below:

- A location where a service was sought but not received.
- A location where a service was sought and received.
- The dotted line indicates that the survivor's journey is in progress

The NGO had, unofficially, trained some of the clinic's staff on dealing with cases such as Kristine's. He just needed to make a few calls to ensure that one of these nurses was on call the day Kristine would visit. He would also arrange for another colleague to drive them there the following morning as the community clinic was out of the way, and it would take them at least two and a half hours to reach it with public transport. He also reassured Geetha that she did all the right things to help her friend.

After hanging up, Geetha emailed Kristine's line manager, informing her that Kristine would need to take the next three days off sick. She knew this should not be an issue as Kristine had a lot of accumulated overtime and was very conscientious.

Only after this was done did Geetha allow herself to slightly relax and make herself a cup of tea after checking on Kristine to find her soundly asleep. The adrenaline that had sustained her since her Kristine called gave way, and she was overcome by an overwhelming exhaustion.

She would need time to process what had happened. She was so angry about what had happened to her friend. Kristine was one of the kindest and bravest people she had ever met. She had dedicated her life to helping others. For her to suffer such violence and then to be treated with such indifference and casual cruelty made her blood boil. But then, some people cared, a few more than others, like the NGO representative she spoke to on the phone, and others, like the counsellor, to the greatest extent possible by their limited education and experiences. Change takes time, she thought, and society does not change overnight. It was one thing to ponder this, however, and another to feel the weight of judgement and discrimination every day, most days. She drifted tosleep, contented that Kristine would soon get the care she needed. She also had to rest to fight the battles with her friend that the next day would bring.

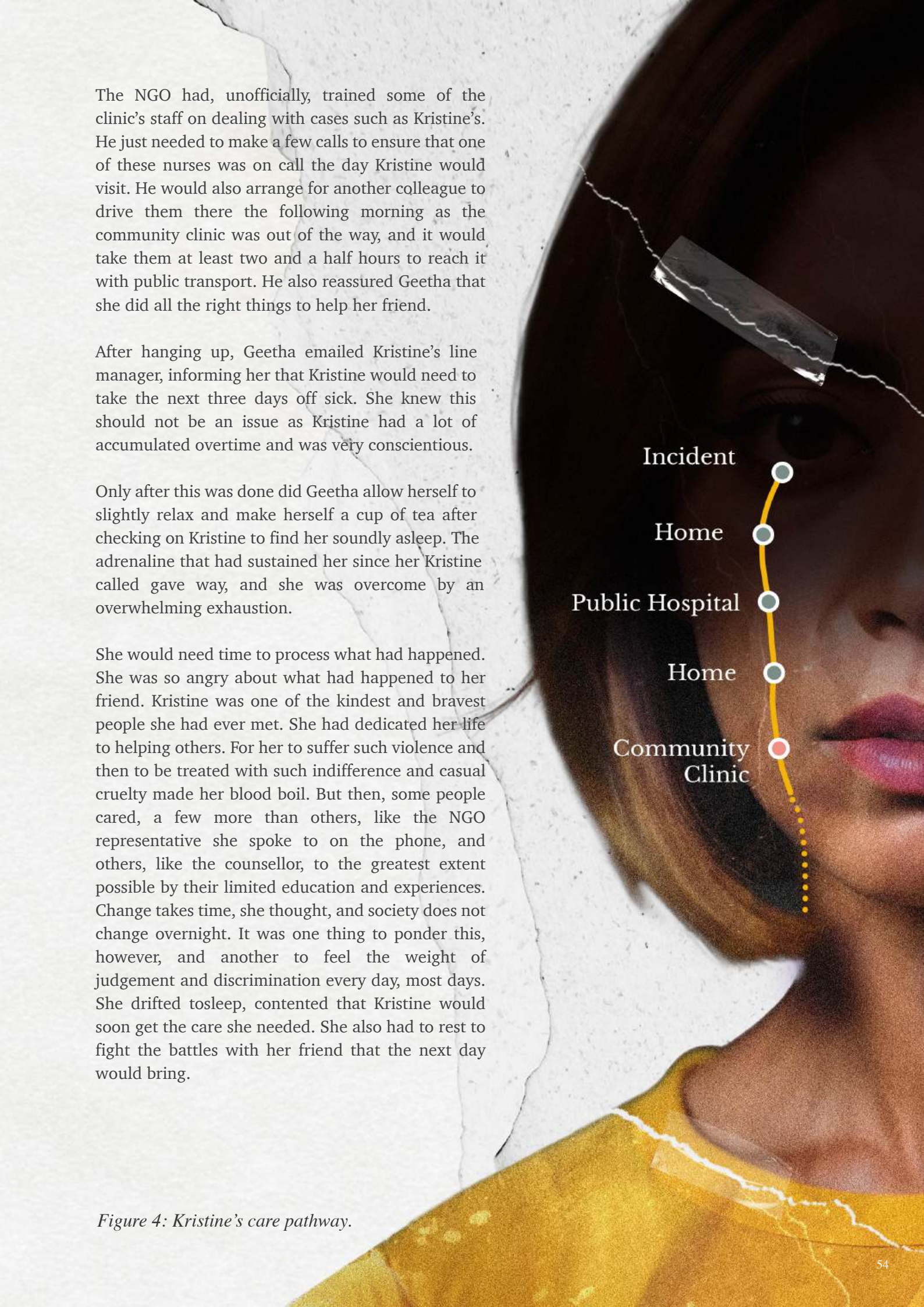
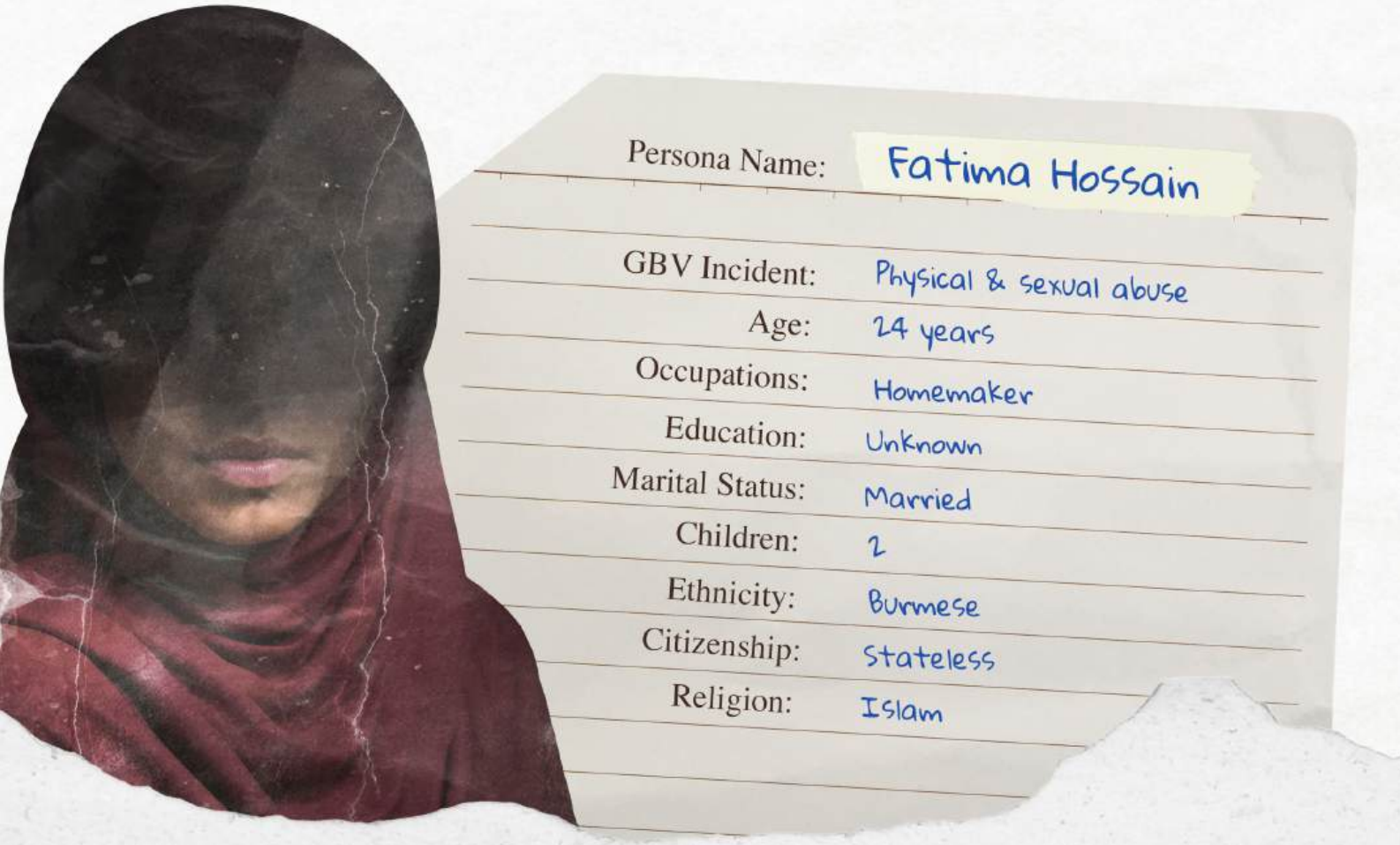


Figure 4: Kristine's care pathway.

Fatima Hossain:

Coping with intimate partner violence, a refugee perspective

Evidence base includes interviews with GBV survivors and also relies on secondary evidence



Fatima felt relief when they first arrived in Kuala Lumpur from the Myanmar's Rakhine townships. Their neighbourhood in the Ampang district, where her husband's connections lived, felt like a real neighbourhood, and their apartment was an actual apartment, even though they had to share it with another family.

With help from friends, her husband, Aziz, got a job as a parking attendant. His wages covered most of their expenses with the money that Fatima's uncle sent making up for the rest. Together with her aunt and her three cousins, her uncle had been living in Penang for five years now as a construction worker. Her uncle and aunt had pleaded with Fatima and Aziz to join them in Penang, but Aziz preferred Kuala Lumpur because the city offered more of the opportunities he wanted to pursue.

They had in fact started saving some of the money her uncle sent them each month for the capital Aziz needed to go into business with a cousin of his selling small electronic consumer goods out of the boot of his car.

Fatima was excited to be living in an actual city away from the oppressive conditions and despair of the township. Both she and her husband were also thrilled at the prospect of their two children, a boy aged three and a girl aged two, to attend school. Married at fourteen, Fatima was only able to finish

primary school and both she and her husband wanted their children to have a chance at secondary education and even college.

Her husband's deteriorating health, however, put an end to all their carefully laid out plans. Soon Aziz's fatigue became so overwhelming that he was only able to work part-time. Despite the 50% discount on medical bills they were entitled to because of their UNHCR card, the medical expenses started to pile up. Aziz started taking out his frustration and anger on Fatima. Stern words gave way to shouting, shouting gave way to slapping, slapping gave way to more serious beatings that resulted in black eyes and swollen lips. Intercourse also became violent.

Fatima put on a brave face. She had seen her mother, cousins and many of her friends and acquaintances go through the same, or worse. This is how their husbands let out steam. Luckily, her uncle was able to send them more money as he got promoted to site supervisor at the construction company he worked for. Fatima did her best to keep their finances and dreams afloat. She signed up for an NGO a programme that sought to supplement the income of stay-at-home mums by teaching them how to embroider.

Aziz, who had initially agreed to Fatima taking part in the programme, came to resent her weekly visits to the community centre where training took place. Fatima, understood his anger: as her world became larger, his got smaller and so she endured. Despite wanting to connect to, the other women in the course, she always kept her guard up, afraid of what they would think if they knew about her troubles at home.

Fatima started getting desperate as Aziz's anger and frustration began to spill over on the children. After returning home from the market one day to find her children crying and her little boy cradling his arm, she knew she had to do something. She was prepared to endure Aziz's moods, but she drew a line when it came to her children's safety and wellbeing. She decided to approach one of her trainers at the community centre, Mariam, an older Muslim Malaysian woman who spoke Rohingya, whom she felt the most comfortable with. Fatima thought that it was also safer to confide to an outsider rather than someone from her own community. Her fellow Rohingyas seemed welcoming enough, but she knew how easily word could spread about her family situation and wanted to avoid this at all cost.

Mariam listened to Fatima carefully. When she asked Fatima whether she felt that her life or her children's life were in danger, Fatima hesitated before answering. She did not think that Aziz could kill them, but would answering 'no' mean that people would not help her? This was not fair!

She did not want to give Mariam a bad impression by speaking with anger, so she explained how things have gotten progressively bad. She had no idea what could be done, which is why she approached Mariam. Perhaps she could help another community leader could approach Aziz after the Friday prayer to ask how things are going and to offer his support? Perhaps there were ways to borrow money for his operation? She knew so little about her community and about Malaysia.

After listening to Fatima carefully, Mariam mentioned that she knew some people from another NGO with experience in helping refugee women in similar situations. With sadness, Mariam added that she thought that Fatima's options were not great. Likely Fatima would need to decide whether she would leave her husband.

"Leave my husband with my kids and go where?" Fatima thought. They had resettled in Kuala Lumpur only six months ago. Apart from the other women in the course, the family with whom they shared their flat with, and her uncle who lived in another city, she

did not know anyone. She had only left her neighbourhood to accompany Aziz to the hospital, she did not speak Malay, and she was terrified every time she left the house that she would be arrested and deported, despite having been registered with the UNHCR. She needed time to think things through.

The day before the next course, Fatima banged her head on the kitchen counter after Aziz slapped her for burning the food. She walked to the centre with great difficulty as she was seeing double. Noticing her unsteadiness, Mariam asked her what was wrong. When Fatima explained Mariam insisting on taking her to the hospital as she thought she had a concussion. Fatima wanted to object, but she was also afraid, so she relented.

During the ride to the hospital, Mariam made several calls and told her that a colleague from the NGO that she had mentioned before was going to wait for them at the hospital to help with any issues that may arise. Fatima gave Mariam her uncle's contact details, the only person she fully trusted, in case the worse happened.

They went straight to the emergency department where they found Eric, Mariam's friend waiting for them. Upon seeing the state Fatima was in, Eric told her not to worry, that he would take care of everything, that he was on good terms with the staff, and that she would not get into any trouble with the authorities. Eric had to ask Fatima twice if she wanted to report that her head injury resulted from domestic abuse. He mentioned that if she decided to do so, the police might get involved, but he would help her through it.

Fatima who did not want anything to do with the police begged him not to mention anything. The last thing she needed was trouble with the police. ***She feared being arrested by the police every time she went to the hospital with her husband. She did not want to involve the authorities if she could avoid it.*** Being at the hospital and involving strangers in her family affairs would already land her into a great deal of trouble with Aziz. Fatima had asked Mariam to call a neighbour with whom she was on relatively good terms to let Aziz know that she was at the hospital 'because she had an accident on her way to class'.

Eric accepted Fatima's decision and his word about having an in with the staff was as good as gold. Despite the wary looks that the receptionist gave Fatima, she was cordial towards Eric and Mariam, and she took down Fatima's details without any delay.

When the receptionist insisted on receiving payment for the examination upfront, Eric covered the fee himself, reassuring an increasingly distraught Fatima, who had left her house with only some pocket money, not to concern herself over this. His employer had a budget for such expenses.

After registration, Eric and Mariam waited for Fatima to be called to see a doctor. When Fatima's turn came, Eric explained to the nurse that he needed to accompany Fatima as she did not speak Malay.

The doctor who examined Fatima was kind. He asked Fatima if she was in any pain and how she got injured. When he mentioned that she needed to spend the night in the hospital

Interpretation of the indicators used in the personas and pathway illustrations are provided below:

- A location where a service was sought but not received.
- A location where a service was sought and received.
- The dotted line indicates that the survivor's journey is in progress

'for observation' Fatima panicked. She could not do this. Aziz would be furious. Who would take care of her children. This would be too expensive.

She did not remember much after that. She woke up feeling well-rested, but it took her a few seconds to remember to realise that she was probably still at the hospital. The nurse who came into the room shortly thereafter did not speak Rohingya but she quickly got Eric on the phone.

Eric explained to Fatima she had been unconscious for three days. Knowing the situation at home, and afraid for the wellbeing of Fatima's children he and Mariam had decided to call Fatima's uncle. After explaining her uncle's mother had died at the hands of their father, but she was shocked by his reaction, nevertheless.

Eric said that her uncle had informed Aziz that they would help him back on his feet but that while this happened, Fatima and the children would stay at Penang where they would be taken care of. Eric would send word to her uncle as soon as Fatima was released from the hospital to come and pick her up.

Fatima felt relieved but also concerned about her family's future. What would this mean for her and Aziz? Would her children be happy and be able to attend school in Penang? How would she ever be able to repay her uncle?

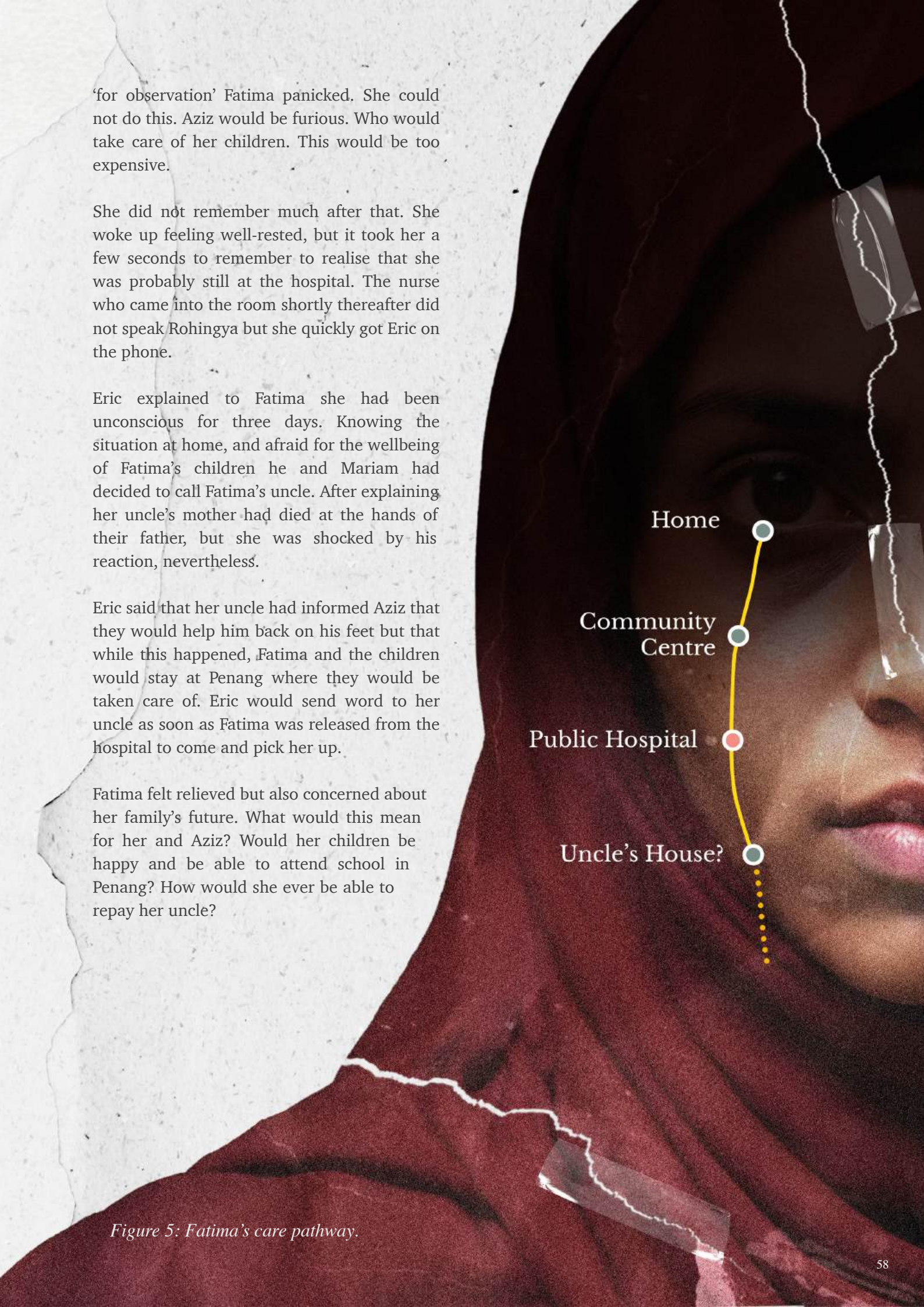


Figure 5: Fatima's care pathway.

Journey

The graphical representation of the care pathways created captures different possible trajectories by mapping the journeys of rape, long-term and short-term GBV victims represented by Lan, Faraz, Shree, Kristine and Fatima.

The journey illustrated in the following image emphasises that each survivor's journey is unique, often non-linear, and can be fraught with challenges and setbacks.

Each survivor has multiple points of entry into the care system. For some, the immediate response is to seek medical treatment, but as indicated, the experience can be met with a lack of empathy and understanding from care providers, leaving psychological and social needs unaddressed. This reflects a medical system that is often inadequately prepared for the comprehensive care required by GBV survivors.

Others may first interact with law enforcement where they may face a police force untrained in the sensitivities needed to handle domestic abuse cases. This then leads to further trauma due to social stigma and a justice system that does not seem to advocate for their protection. Such encounters can result in survivors feeling discouraged and distrusting of the system that is supposed to protect them.

Legal challenges are another hurdle; survivors who seek justice may encounter delays and obstacles in the court system, including difficulty in obtaining critical evidence or legal support, which can traumatise them further and complicate their recovery process.

The pathways also highlights that the care journey can involve multiple service providers and repeated visits to various services. A survivor may oscillate between different points of care — from hospitals to police stations to CSOs — each time navigating the system with varying degrees of support. This can lead to a cyclical pattern of seeking help, returning home, experiencing further violence, and seeking help again.

Some survivors may find temporary refuge in shelters provided by NGOs or returning to their natal home. These spaces can be crucial for the survivors' safety and the start of the long journey to rebuild their lives, care for their children, and work towards financial independence.

More importantly, the dotted lines in the pathways journey to care (Figure 6) show the uncertainty and invisibility of the long-term pathway to healing and recovery. Within the existing framework of support for GBV survivors, there is a pronounced focus on providing immediate medical attention. While this is a critical component of the response to GBV, it is also apparent that the current system may not adequately address the longer-term needs of survivors, particularly their reintegration into their communities and the ongoing support required for sustained healing. The immediate provision of medical care, while essential, is only one aspect of a multifaceted healing process. Survivors of GBV often require comprehensive services that extend beyond the physical treatment of injuries. This includes psychological counselling, legal assistance, community support, and programs that facilitate economic independence. The journey toward healing is long-term and complex, necessitating a support system that evolves to meet the changing needs of survivors as they work towards recovery and reintegration into their communities.

The varying journeys underscore the need for a holistic and survivor-centered approach to GBV care pathways, one that provides not just immediate physical care but also legal, psychological, and social support tailored to the individual's needs and circumstances. The narrative emphasises the importance of understanding these pathways to improve the system's response to GBV and to ensure survivors receive comprehensive and compassionate care that supports both their immediate needs and long-term recovery.

Figure 6: Care pathways journey map.

Key Findings

(in the framework of GBV services assessment)

This section presents the findings from a qualitative research study conducted with GBV survivors and representatives from CSOs, focusing on understanding the barriers and gaps in GBV services at the One-Stop Crisis Centre (OSCC). Through the case studies and in-depth interviews, participants highlighted several critical issues affecting the availability, accessibility, adaptability, appropriateness of the OSCC and overall efficacy of GBV services in Malaysia.

1. Availability of Services: Information and Awareness Gaps in GBV Services and at the OSCC

Participants acknowledged the presence of essential GBV services, including police protection, medical treatment, shelters, and psychological support. However, a recurring theme was that there is a lack of awareness and it was primarily due to the lack of information about the OSCC in media and in public spaces. As a result, survivors mostly navigate these services through CSO providers, and it is only with their support and linkages that the survivors can access these services.

> "I had never heard of OSCC before the NGO told me about it. It is after reaching out to them (WAO), I came to know there are some services like this for women like me."
>
> (Survivor of Domestic Violence, Malay Woman)

> "Even when the police took me to OSCC, I was scared la, I could not understand where they are taking me, there was no single sign or poster of the OSCC in the hospital, it looked like just emergency department with so many patients and crowd. Imagine if I had to go on my own or if some young girl needs to bring her parents, should we go around asking people where women with such experience can seek help la, you understand what I mean."
>
> (Survivor of Rape, Malaysian Indian Woman)

Findings from the study indicate that **adequate information and awareness of GBV support services are pivotal for empowering survivors to seek help.** The evidence points to a significant positive correlation between survivors' knowledge of available resources and their ability to access the appropriate care and support.

Participants such as Olga, a survivor of intimate partner violence (IPV), highlighted that she had never heard of OSCC and wasn't sure where to seek help. It was not until it became intolerable that she reached out to a friend who connected her to a social worker from WAO. She reported feeling empowered to take action against her husband, which she had not considered possible before being informed of these services.

"When I finally confided in a friend about the violence I was enduring at home, it was like opening a door I never knew existed. I had never heard of the OSCC any other place I could go for help, and I felt trapped in my situation. It was until the abuse became unbearable and when he forced me to have sex with a strange man to fulfil his sexual fantasies that I became desperate for an escape. My friend introduced me to a social worker from the Women's Aid Organization, and that's when I realized there was a way out, even under the Shariah law."

(Survivor of Sexual and Physical Violence, Foreigner Married to Malay Man)

A prevalent theme throughout the interviews was the perpetuation of silence and shame due to the lack of information and awareness surrounding GBV. Several participants reflected on their initial hesitance to seek help or report incidents, attributing this to a pervasive lack of understanding about the nature of GBV and the support mechanisms in place. For example, Hassan, a male survivor, noted that societal stigma and the absence of targeted information campaigns for men experiencing GBV were the reasons he did not report the abuse and access support services.

"I didn't know where to go, there is absolutely no information for men who experience GBV, maybe because there are no services available for them. Men are strong, men don't get hurt, they don't cry, this what people believe here and when there is no information there is no acknowledgement of the issue that men can also experience GBV."

(Survivor of Sexual Abuse, Malay Man)

The finding also highlights **a critical need for increased community awareness.** Without such awareness, community members often fail to recognise the signs of GBV or understand the importance of providing support to survivors. This gap was evidenced by the experience of Nadia, who described how neighbours and friends had witnessed signs of abuse but did not intervene or offer support, citing a general unawareness of what constituted GBV or what actions to take. The participants stressed the importance of community education programs to foster a supportive environment for survivors.

This gap was evidenced by the experience of Nadiah, who recounted incidents where clear red flags of abuse went unnoticed by those around her. Neighbours and friends, despite witnessing distressing signs of abuse, remained bystanders, primarily due to a lack of knowledge about what constitutes GBV and uncertainty about how to act effectively. Red flags that often go unrecognized include sudden changes in behaviour or appearance, unexplained injuries, and the individuals withdrawing from their normal activities or social circles. Moreover, subtle indicators such as increased anxiety, fearfulness, particularly around the abuser, or the abuser overt control of the survivor's life and decisions are also missed.

"My husband started having problems with me even for stepping out to send my children to school. They would often miss school. Even when I managed to step out and people could easily see my bruises, of course they heard me crying and him shouting at me all the time, but they never ask how are you? Do you need help?

(Survivor of Domestic Violence, Somalian Refugee Woman)

Although the study notes that most medical services with the OSCC are available for the survivors, **there is inadequate availability or focus on mental health services.** There is a disturbing trend of unmet mental health needs among GBV survivors. A significant proportion of participants reported experiencing symptoms of severe depression, anxiety and post-traumatic stress disorder, with many disclosing suicidal thoughts and attempts. The trauma experienced by survivors often leads to long-term psychological distress, adversely affecting their quality of life, relationships and ability to function in daily activities.

Despite these pressing needs, the study uncovered a stark deficiency in the availability of specialised counselling services tailored to the unique needs of GBV survivors. Very few participants reported receiving mental health care at the OSCC. The survivors who did receive counselling from the social workers informed that they were provided with counselling only once, i.e., during the first time they went to the OSCC. Only one participant reported receiving a follow-up call for counselling after one month of discharge. This highlights the severe lack of access to mental health services; the available care was often short-term and crisis-oriented, with little to no follow-up or support for dealing with long-term effects of trauma.

"Is it okay if I say I will suicide or hang myself at any place there? I do feel like that sometimes. I just want this pain to end. Between the procedure time and the hospital. Feel like is it... do I need to tell anything? Do I need to tell me story to these men in police and hospital again and again? Why I have to tell? This thing not supposed to happen to me. Why I must tell? They only blame me for what happened, I feel guilty and shame... I feel like dying each day, but they never asked me if I need any help, if I am comfortable, they never cared to ask me."

(Survivor of Rape, Malaysian Indian Woman)

"Although I am out of abusive relationship, I often get nightmares of how he used to beat me and force me to do abnormal sexual things. I can't sleep at night and get sweats. I fear going anywhere thinking if he finds me again. The doctor gave me sleeping medicines, but I think that doesn't work. I can't tell it to anyone. My daughters would also never understand me sometimes I feel why if happened to me I should have ended my life. I feel so ashamed."

(Survivor of Marital Rape and Domestic Violence, Malay Woman)

2. Challenges related to Accessibility of Services

Findings show that significant barriers hinder survivors' access to GBV services. Going to the crowded emergency centre, language barriers, fear of mandatory police reporting, and poorly coordinated service delivery were frequently cited as obstacles to accessing the services.

Survivors, particularly those who have recently experienced sexual violence, reported a heightened sense of vulnerability and trauma when forced to wait in overcrowded emergency centres. The lack of privacy and the potential for public exposure in such settings can deter survivors from seeking immediate assistance. One such narrative described the distress of waiting for care in a busy hospital setting, underscoring the critical need for private, secure, and comfortable spaces for survivors at the point of first contact with healthcare services. This becomes more profound when the survivor is is from a vulnerable community who feels being judged or monitored by other people

> "But it's just like the hospital outside, right? Where in emergency you have like so many patients and their families, like 10 million people just sitting outside. And, you don't know, what is the level of comfort and all of that. Like for me, somebody who has experienced sexual violence just two days ago or a day ago? You know, be in this overcrowded space, even though inside, there is a private room. Do I want to sit here waiting for my turn? And like, if I want to have a breakdown, I can't. I am scared what if people identify me, what they think of me, o this woman is... you know what I mean? Its more traumatizing and horrifying."
>
> (Physical Assault followed by Rape, Transgender Woman)

Interviews with the survivors from refugee communities show that **language barriers play an enormous role in limiting access to GBV services.** The inability to communicate effectively with healthcare providers and law enforcement officials not only impedes the delivery of care but can also further distress and humiliate the survivors. Instances of miscommunication or perceived ridicule, as reported by the friend of a survivor, highlight the necessity for language support services, including interpreters and culturally sensitive care, to ensure that all survivors are understood and treated with respect.

> "She couldn't really understand what they were saying, but there were some parts that she could understand but they were laughing at her, and this made her more conscious and nervous."
>
> (Friend of Survivor of Domestic Violence, Myanmar Refugee Woman)

The findings of this study also vividly illustrate the issue of **fragmented service delivery.** This lack of coordination not only exacerbates the survivor's trauma but also places unnecessary burden on those seeking help. The need for streamlined procedures that facilitate a seamless transition from reporting to receiving care is evident.

> "I was shuttling between the police station and then from OSCC to the police station. I was scared and angry and exhausted, why can't they just simply lodge my complaint and give me police protection. In the back of my mind, I am always worried about my children, what if he (husband) reaches them. I didn't need any medical help, why force me to go OSCC again and again, why change police stations la."
>
> (Survivor of Domestic Violence, Malaysian Indian Woman)

The narratives of different survivors of GBV also highlight that **the requirement for mandatory police reporting is a formidable barrier,** particularly highlighted by a survivor's fear of being judged or dismissed by law enforcement officials. This requirement often force survivors into a paradoxical situation where seeking medical help or preventive care becomes contingent on their willingness to navigate the complex and sometimes hostile legal landscape. Survivors, including those who have experienced domestic violence, expressed concern over their safety and the safety of their children when engaging with the legal system. The fear of retaliation from the perpetrator, coupled with the uncertainty of police protection, underscored the need for a more survivor-centered approach in handling GBV cases.

> "The doctor said you have to first make a police report to get any tests and I said, is there a way I can seek help even ... you know, not as a rape victim, not as an assault victim but as a paying patient for PEP, because now I'm very scared. I don't even know this man's full name, you know, because we met on a dating app, you get partial name, partial occupation all that. I know if I were to lodge a police report or to go anywhere else, I will be judged. Police will say o you are a bad woman, it's not rape, "it's just sex gone bad", they will not understand that I was exposed to a non-consensual, unprotected sex and I was at risk of HIV."
>
> (Survivor of Rape, Malaysian Chinese Woman)

> "I came to Klinik Kesihatan Cheras emergency department, so the doctor asked me that how this happened to you. I said, first I said I fight with my friend. So he said, you should make a police report. Then eventually I told him that it's actually my husband and he said, you have to do police report, you need to complete that. I knew that the police report will have consequences, he's going to be taken to prison and so on. But if not then he will get angry and beat me more. So I was scared that things will turns out very complicated. So that's why I didn't go to the police. And afterwards when he beat me, I never go to any clinic, because I know they will again force me to go to the police."
>
> (Survivor of Domestic Violence, Malay Woman)

3. Adaptability of Services

Findings suggest that **services currently lack the flexibility to address the unique needs of diverse populations.** For instance, there is a gap in accommodating the preferences of survivors, such as the need for a female doctor.

> "Most transgender people I know has had a poor health care experience stemming from a provider negatively interacting with our transgender identity, whether it was intentional or not. That really needs to change," they said. The doctor says we don't touch you, our religion doesn't allow, but we ask what a doctor's ethics is "first, do not harm and provide justice". We are humans too, and we all deserve medical care, why treat us as untouchable. You cannot imagine how it would feel as a GBV survivor and being transgender?? Our community deserves better."
>
> (CSO Representative, Transgender Man)

Similarly, Fatima, a sexual and domestic violence survivor, recounted her discomfort and subsequent refusal of physical medical examination because her **preference for a female doctor was not accommodated, illustrating a lack of adaptability in service provision.** Although she mentioned that there were female nurses present during the examination, the forensic doctor was male.

> "And he was male medical personnel, very young and a male attendant, orderly or something. And I'm like, why you need two men to listen to my story on that?"
>
> (Survivor of Rape, Indian Malaysian Woman)

Interviews with medical professionals and social workers highlights that **there is a noticeable gap between the ideal protocol and actual practice regarding the gender alignment between doctors and survivors of sexual assault.** This discrepancy is primarily due to the availability and specialisation of male doctors, especially those with training in forensic science and evidence collection. Protocols (One-Stop Crisis Centre: Policy and Guidelines for Hospitals, MoH, 2015)[50] advocate for the healthcare provider to be of the same gender as the survivor; however, the urgent need to collect evidence within a critical 72-hour window to prevent the case from becoming "cold" often necessitates the prioritization of available medical expertise over gender matching.

However, this study also finds that the presence of social workers and female nurses during examinations is consistently ensured, with efforts made to involve female obstetricians whenever possible. This approach highlights an attempt to balance the immediate need for specialised medical intervention with the sensitivity required in handling cases of sexual assault, striving to maintain a semblance of gender sensitivity within the limitations imposed by the availability of medical personnel and their expertise.

4. Appropriateness of Services

Survivors **do not always receive culturally appropriate support.** In some cases, service providers exhibit prejudice, and a lack of understanding and sensitivity, which can exacerbate the trauma experienced by survivors like Lan and Kristine. Prejudice and lack of understanding from law enforcement and healthcare workers can compound the trauma of GBV survivors. For example, services sometimes reflect societal biases, as shown by the dismissive attitudes of the police and some healthcare providers towards Faraz. Similarly, appropriate support systems like helpline services that could cater to the needs of male GBV survivors were missing.

> "It is extremely challenging, as a male person it is not easy to call a helpline or call centre that focuses only women, where women are sitting behind the seats to help other women. Here in Malaysia, men are seen as the protector, men are strong, men don't cry they cannot have such situation how do expect men to ask help, especially young men, teenage boys, you see there are no services at all."
>
> (Survivor of Sexual Violence, Man)

5. Prioritizing Safety

Study findings show that **the safety of survivors is not consistently prioritised,** with some individuals being advised to stay in potentially dangerous situations or rendered vulnerable during medical examinations. Moreover, preventative measures aimed to safeguard survivors during the reporting, case management and post-recovery phases are insufficient. Concerns were also raised regarding the protection of the survivors' dependents, who may be vulnerable to abuse and harm. This gap in ensuring ongoing security for survivors and their dependents highlights a systemic deficiency within current support frameworks that warrants urgent attention both at OSCC and beyond, to reinforce the safety net for those affected by GBV.

> "I feel unsafe because while the period time for my turn, I was made to sit outside alone. Later, during examination, sometimes other doctor also come and go in and out, in and out for nothing. But talking talking. They all never go to the procedure for the full focus on me. Never. They talking here talking there. It feels like they just take it as time pass case."
>
> (Survivor of Rape, Single Malaysian Chinese Woman)

> "Because I worried, something will happen to me, or my kids is that so I really worried. So I go, they gave me like an MRI scans and also after that I couldn't go to the follow-up check-ups because I don't have transport and I really scared. This fellow (husband) was like looking around where I'm going spying me. So I really can't follow do the follow-up checkup."
>
> (Survivor of Domestic Violence, Malay Woman)

"Because he forced me to discharge myself. I was signing the risk letter and discharge myself. It's not moving from there because he's worried that I will tell something about the abuse to the doctors or what. Doctors could see I was forced to take the discharge, they could see I was under fear, my bruises were so severe, yet they didn't say anything. What could I do, I was scared to death."

(Survivor of Domestic and Sexual Violence, Malay Woman)

"As a woman in a foreign country, going back to the police station at night to meet with the officer was very intimidating. In the first case why could not they lodge my complain in the morning. Why they ask me to go to another police station at night at 9pm. Walking between the blocks, there are so many dark spaces I felt unsafe. I finally made it to the officer, and he took my statement. I never planned to take any legal action; I just wanted the complaint to be recorded. However, before knowing this, I felt like the officer was already trying to discourage me from taking action."

(Survivor of Physical Assault, Foreign Woman, Unmarried)

"Yes, we know we should have a separate OSCC room, but it does not exist. We get lot of patients, so whenever a GBV survivor comes, we just do a make-shift type arrangement."

(Medical Social Worker, Kuala Lumpur)

In some OSCC they have 'bilik lily', like a separate room of OSCC clients, but most emergency department don't have. They will take the patient in one corner to first confirm if she is domestic violence case or not and then get people to move out and take her to a separate room. So, for long she is out there in public.

(CSO Representative, Pahang)

Even interviews with the survivors suggest that the **assurance of safety was notably lacking during crucial stages** such as the reporting process, investigation, and legal proceedings. The research indicates that interim protection orders, which are crucial for survivor safety, are often subject to delays. Furthermore, survivors frequently report being compelled to navigate between multiple police stations to file reports, a process that not only introduces additional delays but also poses an increased risk to the survivor and her family. These systemic obstacles during such a vulnerable time reflect a substantial shortfall in the support infrastructure, underscoring the need for an improved, survivor-centered approach that ensures continuous protection for GBV survivors and their dependents.

"They say can go, can go back then result will be in few days or something like that. I can't remember. They say like that. Then the police said, "You boleh balik sendiri kan? Macam mana you nak balik, anda boleh ambil grab?" (You can go back on your own right? How do you go back? Take the grab). Then I said nothing and nobody there can help me but it's okay nevermind, I can take Grab. Then the police also said "Okay, Okay you balik dulu" Then I taking Grab then I balik (go back) la."

(Survivor of Rape,
Malaysian Indian Woman)

"I asked for protection order, police said I can't give now, case not strong but my social worker told me I should get interim protection order because my husban can come hurt me anytime, he can even kill me, but they didn't give me until go again with my social worker."

(Survivor of Intimate Partner Violence,
Chinese Malaysian Woman)

"I went to police station, to make a report. But before that I did call once, what we call, Helpline Talian Kasih, but they said, only... I called around 12 midnight, I call them. But they can hear my husband shouting, like beating. Everything they can hear. They asking is it the one is your husband, but they said stay safe, we will send someone tomorrow morning. But it's really cannot, we really cannot stay safe there at the night. So cannot do anything."

(Survivor of Domestic Violence,
Malaysian Indian Woman)

6. Informed Consent and Confidentiality

Narratives from GBV survivors indicate potential breaches of confidentiality and concerns about informed consent. Survivors are often hesitant to share information due to fears of repercussions from their abusers or misgendering by staff.

> "You know it's just not the training that medical social workders or doctors should receive. Training should even be given to the nurses and the drivers who all are involved in the transitioning the client from one service point to another. We see so many times the client run away, don't want to continue treatment or follow up because either the driver or the one accompanying or the nurses at the OSCC start talking about her, like see what happened, who did it, why it happened and then the information keeps traveling in the village, where the person feels she is exposed to so many unwanted speculations and people are judging her."
>
> (Retired (in 2020) Medical Social Worker, Medical University Hospital, Kuala Lumpur)

> "Almost every single hospital does insist on making a police report" and "some will refuse to classify as the cases in OSCC unless there is a police report".
>
> (CSO Representative, Kuala Lumpur)

7. Effective Communication and Participation by Stakeholders in Design, Implementation and Assessment of Services

The guideline on GBV services assessment (UN Women, UNFPA 2020) stated that it is paramount that service providers demonstrate an attitude that is non-judgmental, empathetic, and supportive when interacting with women and girls who have experienced GBV. The assurance that they are being heard, and their specific needs comprehended and attended to, is foundational in their journey toward healing and justice. How information is conveyed is crucial to empower them to access vital services. Every interaction with women and girls must be conducted with the utmost respect, always upholding their dignity. This approach is essential not only in fostering trust but also in encouraging survivors to assert their rights and pursue the resources they need.

However, this study finds that significant communication barriers exist, with professionals often lacking the training to recognise non-verbal cues of distress or the nuances of culturally sensitive language, which is critical for effective support and advocacy.

Survivors have recounted instances of dismissive conduct by police officers, where the gravity of familial abuse was downplayed and survivors were advised to settle matters privately. This not only undermines the severity of the violence but also implicitly endorses the perpetrator's actions, making the police complicit in perpetuating the cycle of violence. For instance, one survivor was told by the police, "If you don't settle the case (within your family), your husband will resent you." This kind of response from law enforcement discourages survivors from seeking help and reinforces the notion that abuse is a private matter, rather than a criminal act warranting legal intervention.

"The entire process just to file a complaint took the entire day. It was emotionally and physically exhausting. I am lucky that I am in a priviledged position and this assault was just a minor incident, but if I struggled with this process, what about other women? I feel like it is set up in a way to make you give up. There is no support, compassion of useful information to help you. More can be done to create enabling environments where women can feel encourages and sage to report all types of assaults, like sensitivity training and having private rooms for women to speak openly."

(Survivor of Physical Assault, Foreign Woman, Unmarried)

"At the police station, the police told that if you don't settle the case (within your family), your husband will resent you. If you report about your mother-in-law, your husband will be upset with you. Family matters are common, and a good woman should not go out. So, the police advised me to settle the problem within my family. If this happens again, then we will see."

(Survivor of Domestic Violence, Malay Woman)

Medical professionals have exhibited a similar pattern of minimization, especially concerning sexual violence within marriage. A survivor's narrative highlighted the trivialisation of marital rape, as the doctor perceived it as a husband's right, effectively denying the existence of consent within the marriage. Such attitudes are not only medically unsound but morally reprehensible, denying survivors the validity of their trauma.

"The doctor said to me, ini kan biasa, the word they say 'ini kan biasa' (this is normal). Husband has the right to do the sexual thing, it's normal for the husband to do something sexual the way he likes, this we cannot call rape. They say, like that. They say like, there's no any symptoms like 'rape' or it's normal thing like a husband wife relation like sexual relationship, they never did any internal examination. They just tell like that. So, I feel it's really unfair."

(Survivor of Marital Rape, Malay Woman)

Moreover, **the issue of victim-blaming** was glaringly evident in the attitudes of service providers. A police officer, making a character judgment based on the survivor's appearance, directly questioned her virtue and implied complicity in her victimisation by saying, "From your face I already know you're not a good woman." This is not only unprofessional but also a gross violation of the survivor's dignity, and it stands in stark contradiction to the principle of unbiased law enforcement.

"After a long waiting period, my IO, one of the police. He's a guy come. The police is a guy. He called me to the room and then asked me to wait there then he asked me some questions. The questions will be like this, "Tengok muka pun sudah tau, you bukan perempuan baik." (From your face I already know you're not a good woman). Dari muka boleh nampak meh? Perempuan baik buruk? (Can you tell is someone a good or bad woman by looking at their face?) "So... saya sendiri pun boleh tarik tangan you, sekarang apa you boleh buat?" (So now I can also pull your hand, what can you do?) The police questioning like that. Is it the way of the police had to be like that, for the inquiry section?"

(Survivor of Rape,
Malaysian Indian Woman)

Additionally, **gender stereotypes and societal expectations** of women's conduct were used to justify the denial of support and blame the survivors. A doctor's reprimand, suggesting that a woman should not be out at night and should instead stay home, reflects deep-seated biases and negates a woman's autonomy and equal status in society.

"The doctor said "kenapalah you percaya orang luar? Tengok sekarang? Ini macam keh? Perempuan tak boleh keluar malam. Perempuan duduk rumah." (Why do you believe someone and go out? See what happen now? Woman can't go out at night. Woman should stay at home.) Then I said, "kalau perempuan duduk rumah, watch the time now. Are you female or male? For the job description, you are a doctor, you are a nurse or something like that. You can work until midnight, after midnight, 24 hours, why perempuan (woman) cannot go out? Why? I said I am a businesswoman, I also need to travel sometime, why you question me like that."

(Survivor of Rape,
Malaysian Indian Woman)

Our study emphasizes the importance of training service providers to be non-judgmental, empathetic, and informed so that they may offer survivors the understanding and assistance they critically need. This entails validating survivors' concerns, providing accurate and empathetic documentation of their accounts, and equipping survivors with information that empowers them to make informed decisions for their future.

8. Data Collection and Information Management

Data collection and management of GBV incidents are not systematically implemented, especially within refugee communities, making it challenging to understand the full scope of the issue and to tailor services accordingly.

The findings based on the narratives of GBV survivors and social workers in Malaysia indicate critical shortcomings in data collection and information management at OSCC. These challenges significantly impede the effectiveness of support services and obstruct survivors' access to justice.

Firstly, there is a profound lack of communication and consistency in the sharing of medical reports and documentation with survivors. This lapse is exemplified by a survivor's testimony of not receiving any hospital notes, thereby leaving her without crucial evidence to seek justice. The absence of a clear protocol for sharing documents directly with survivors undermines their autonomy and can delay or deny their legal recourse.

"It's very, very sad to say that. If they took my complaint seriously, I wouldn't be waiting for my divorce for two years. I would be waiting to get the full custody of my children. They just closed the case shut like that. And the reason they are giving is my medical report is not strong. So, I feel very unfair for these. It's really, really unfair and the main thing, the doctors or the police will say, it's your husband. So, it's not, it's not wrong, to be, can't tell it's a rape, so it's really very ridiculous. I still didn't officially haven't got my divorce yet. So I keep thinking about children. I didn't see my kids for two years. My heart shatters and pains even to think of it."

(Survivor of Marital Rape and Long-term Physical Violence, Malay Woman)

"I never received any report or hospital note. They told me that they will share directly with the police or to the court. But the thing is it is about me. If I decide to seek justice today I absolutely I do not have any papers to show from hospital. Do you think the attending doctor that day... will still be available today to give me a proof of my case. None!"

(Survivor of Domestic Violence, Malaysian Indian Woman)

Secondly, there is **no standardised approach to record-keeping and data sharing among different entities.** While some professionals report meticulous documentation and sharing of details with referring teams and social welfare officers, others note an absence of data sharing, particularly with the Ministry of Health (MoH). A senior medical social worker highlighted the disconnect, revealing that data at their medical university is not shared with the MoH due to differing ministerial oversight.

> "We document everything in the system, the same thing. We write all the details in the case note also and share it with the referring team, like the tertiary hospital or to the social welfare officer. Once we do the assessment and it is identifying as a violence case we decide the intervention for the client we lodged everything in the system. This cannot be changed later; all the records go to MoH."
>
> (Medical Social Worker, District Hospital, Sabah)

> "We record everything, but we don't share anything to MoH. That is probably because we are the medical university, and we fall under the Ministry of Education. Not sure."
>
> (Senior Medical Social Worker, Medical University Tertiary Hospital, Kuala Lumpur)

The implications of such discrepancies are far-reaching. Without a unified system, there is an inability to accurately tally and reconcile data across the police, MoH, and social welfare departments. This fragmentation leads to a disjointed understanding of the GBV situation, making it difficult to assess the scope of the issue, allocate resources effectively, and implement comprehensive support services.

The importance of ensuring that survivors have access to their documentation cannot be overstated. It empowers them in their pursuit of justice and serves as a critical tool for advocacy and policy change. The findings suggest an urgent need for standardised protocols for data management and sharing, as well as the establishment of integrated systems that enable seamless communication among different support services.

9. Linking with Other Sectors and Agencies through Coordination

While OSCCs are conceptualised as holistic support centres that offer a suite of services from medical care to legal aid and psychological support, this study finds that many survivors face obstacles in accessing complete and timely information. This deficiency notably extends to critical areas such as mental health counselling and the availability of shelter homes.

Challenges stem from a variety of systemic issues, including a lack of information and choices provided to the survivors about the full range of services at OSCCs, attributed to a lack of clarity on the protocols and guidelines among the attending medical staff at the emergency department.

> "Yes, we refer to the black book (referring to the OSCC guidelines) for any case management, but for some cases we don't know how to do the intervention. At times the client is scared and don't want any follow up, at times the welfare officer not clear like for example, they would send the person back to the village, where the perpetrator is next door, but we don't do this risk assessment, maybe it's the police who should do the follow up and all of that."
>
> (Medical Social Worker, District Hospital, Sabah)

Moreover, the fragmentation of services due to coordination challenges amongst different departments exacerbate the situation, leading to a scenario where survivors might receive medical care but remain uninformed about the psychological or legal support at their disposal. The capacity and training of OSCC staff also play a pivotal role in this context; without adequate training in handling the complexities of GBV and the nuances of effective communication, staff may fall short in ensuring that survivors are fully informed about the resources available to them. This gap in information provision not only hampers the recovery process by leaving survivors feeling isolated and unsupported but also poses a significant risk of further harm. To bridge this gap, a concerted effort is needed to enhance staff training, improve service coordination, and raise awareness about OSCCs' services, ensuring that survivors receive the comprehensive, timely, and empathetic support they critically need.

> "We used to give training to the doctors, nurses, and other staff. We tell them how to manage domestic violence case, rape case, sodomy case. We talk about privacy and respect. But these trainings happen once or twice in a year. But this is something we should do as refresher training. Doctors and others should have training in their medical school. So, all doctors posted in emergency know about it, so even if they miss here, they know how to deal with it sensitively."
>
> (Retired (in 2020) Medical Social Worker, Medical University Hospital, Kuala Lumpur)

"After assessment and treatment, we call the social worker from the CSO and tell them to help the client. We know they are good and can be trusted but it is not that we have a government list of CSOs to contract. We just know them on our own. We know they work here and so on..."

(Medical Social Worker, Medical University Hospital, Kuala Lumpur)

"It is only because of the Woman's Aid Organization that I could manage to come out of my situation. I don't know otherwise what would have happened. He would have killed me... I felt trapped and depressed. From taking me to OSCC to providing me shelter at their homes, counselling me and training me for art skills they helped me a lot. You know today I make art and teach children."

(Survivor of Long-term Domestic Violence, Malay Woman)

The pivotal role played by NGOs and CSOs in filling the information and service provision gap is underscored. Remarkably, most of the critical information regarding mental health counselling and shelter homes, along with the actual delivery of these services, are predominantly facilitated by NGOs. This reliance on CSOs underscores a significant dependency on their efforts to drive the support system for survivors, often working in close collaboration with government entities. However, it has been observed that despite their commendable dedication and invaluable contributions, these CSOs may not possess the full capacity to shoulder the responsibility of providing all-encompassing support. The inherent limitations in resources, reach, and authority compared to governmental bodies pose challenges in their ability to offer comprehensive assistance to every survivor.

Therefore, this reflects a broader issue within the support ecosystem for GBV survivors, indicating a crucial need for stronger institutional frameworks and enhanced collaboration between the government and civil society to ensure that survivors receive the holistic and sustained support they require.

A significant portion of the support system also relies on CSOs. These entities often shoulder the responsibility of providing key services such as shelter, counselling, and legal aid. Our interactions with representatives from various CSOs revealed a genuine commitment to aiding survivors. However, a notable challenge identified was the lack of an official, authorised list of CSOs for social workers and OSCC staff to refer survivors to. Currently, referrals are largely based on personal trust and familiarity with the CSOs operating within specific regions. This approach, while functional on some level, lacks the structure and reliability of a coordinated referral and follow-up system. The absence of a formalised collaboration mechanism between government entities and CSOs at the OSCC level hampers the effectiveness of the support network.

"We have the resources to provide information, temporary shelters, but we can't keep them (the survivors) for long. Like they ask us for legal help, but our team don't have the capacity, so we refer them to another CSO who can provide such information. But sometimes it's challenging because we are in Johor and the other CSO in Kuala Lumpur, it is difficult for survivor to follow up."

(CSO Representative, Johor)

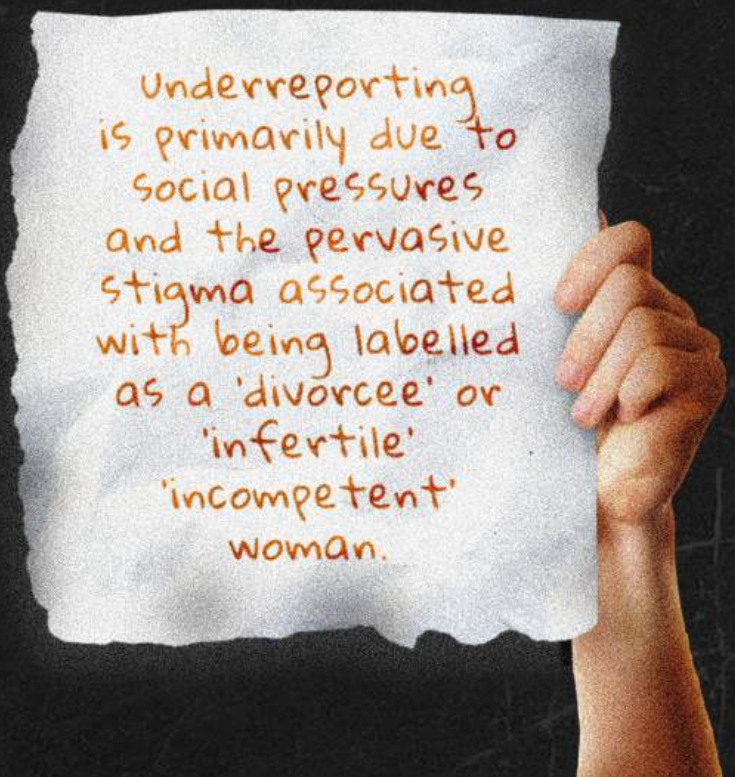
Gender Norms, as a Barrier to Accessing GBV Support Services

One of the key findings from accessing the GBV services is that gender norms play a critical role in shaping responses to GBV and significantly influence the decision-making process for survivors seeking help. These norms, deeply rooted in patriarchal traditions, often dictate societal expectations and behaviours, leading to a pervasive culture of silence and stigma surrounding GBV. Women, traditionally seen as bearers of family honour, may endure violence silently due to fears of societal shame, family disgrace, and financial dependency on their abusers. These concerns are compounded by victim-blaming attitudes that suggest women are somehow responsible for the violence inflicted upon them, be it through their attire, behaviour, or mere presence in public spaces at perceived inappropriate times.

The reluctance to disclose or report GBV is further exacerbated by the responses of law enforcement and healthcare providers, who, influenced by the same patriarchal norms, may minimise the severity of GBV, particularly in cases of IPV or marital rape. Police and medical professionals, operating within a framework that views GBV as a private family matter, often advise survivors to settle disputes internally, thereby reinforcing the notion that GBV is not a serious criminal offense but rather a domestic issue. Such interactions not only retraumatise survivors but also perpetuate a cycle of violence and silence.

Our interactions with CSO representatives providing support services also pointed out that many women who reached out to them through helplines still choose not to legally report GBV even though they are informed, educated, and economically independent. This underreporting is primarily due to social pressures and the pervasive stigma associated with being labelled as a 'divorcee' or 'infertile' ' incompetent' woman. These societal stigmas create an environment where women fear social ostracism and negative labelling, which can severely impact their social standing and personal relationships. This fear of being judged or blamed for their circumstances often outweighs their willingness to seek justice or support, leading to a troubling silence. Gender norms significantly affect women's experiences with GBV, causing many to continue suffering in silence; however, the manifestation of these norms varies across different sections of women, necessitating tailored strategies to effectively address and combat the issue.

The study findings show that for men and gender-diverse individuals, the barriers to seeking help are more pronounced. Prevailing gender norms that equate masculinity with strength and invulnerability make it difficult for men survivors to come forward.



Gender and its Intersectionality

The intersectionality of gender, race, and socio-economic status plays a pivotal role in shaping survivors' experiences with GBV and their interactions with support services. The research identified that survivors from vulnerable communities face compounded challenges in accessing services. These challenges range from systemic biases and discrimination to lack of culturally sensitive and inclusive support. Such intersectionality underscores the necessity for GBV services to adopt a more nuanced and empathetic approach that recognises and addresses the specific needs and barriers faced by diverse survivor groups.

However, this study underlines a significant correlation between economic conditions, education levels, financial independence, urban residency, and the presence of a supportive family or friend circle with the ability to seek help and access GBV support services in Malaysia. These findings suggest that intersectionalities, such as socioeconomic status and social support networks, interact with gender in ways that can create an enabling environment for survivors to overcome barriers to accessing help.

Survivors with better economic conditions and higher education levels demonstrated a greater awareness of available GBV services and were more proactive in seeking help. Financial independence, in particular, was identified as a critical factor that empowered survivors to make decisions free from the constraints of economic dependency on their abusers. Moreover, education was noted not only to enhance awareness but also to cultivate a sense of entitlement to rights and services, thereby encouraging women to assert their needs and seek support.

Living in Kuala Lumpur or a bigger city emerged as another facilitator in accessing GBV support services. Survivors reported a higher awareness of the services and greater ease in accessing them due to better transportation and less community stigma compared to rural settings where people know each other more closely.

The study also noted that the presence of a supportive family or friend circle was paramount in enabling survivors to seek and access help. Participants highlighted how emotional support and encouragement from loved ones played a crucial role in their decision to reach out to GBV services.

Therefore, it is evident from the study that intersectionalities such as economic condition, education level, urban residency, and the presence of a supportive social network play a pivotal role in navigating the challenges presented by entrenched gender norms and patriarchal values. These factors, fundamentally influencing the capacity of GBV survivors to overcome barriers to support, underscore the need for a multi-dimensional approach to GBV – one that considers the broad spectrum of individual circumstances – and works towards dismantling the structural inequalities that underpin GBV.

This study highlights the critical necessity for systemic change that extends beyond addressing the immediate needs of survivors. Training for service providers on gender sensitivity and cultural competence, alongside legal reforms to protect all survivors of GBV, emerge as foundational steps towards creating an inclusive and supportive environment. Additionally, public awareness campaigns aimed at dismantling the stigma surrounding GBV are essential in shifting societal perceptions and attitudes that contribute to the silencing and marginalisation of survivors.

Existing Strengths and Potential in Malaysia's OSCC Model

Despite the identified gaps in Malaysia's system for addressing GBV from the survivor's perspective, this study highlights significant potential for improvement, leveraging on the existing framework. The OSCC model in Malaysia stands as a testament to this potential, characterised by its comprehensive guidelines, legal support mechanisms like the Stronger Domestic Violence Act and Anti-Stalking Law, amongst others, and the integration of multisectoral services in a single location. Furthermore, the substantial support from CSOs, which currently bear a significant portion of the service provision load, underscores the system's foundational strengths and ability to adapt and support organizations that are closer to the community.

For example, the OSCC's approach to offering medical, legal, and psychological support under one roof exemplifies the model's integrated service provision. Moreover, the collaboration between the Ministry of Women, Family and Community Development and the Ministry of Health illustrates a concerted effort towards a unified response to GBV. However, the entity accountable to monitor and ensure that the prevention and response strategies to GBV are best met in Malaysia remains vague.

> "We are working together with other departments like the welfare officer, the CSOs and we refer to psychiatric or Ob-gyns on priority basis if needed. I think it has a good system in place and we try to provide good care to the client."
>
> (Medical Social Worker, Tertiary Hospital, Kuala Lumpur)

Such collaboration not only streamlines the process but also ensures that survivors receive a holistic response tailored to their diverse needs. During the stakeholder's workshop with CSO representatives, it became more evident that CSOs have a critical position in not only providing services to the survivors but also ensuring that the pathways to care and healing are survivor-centered.

> "You see our role in supporting survivors goes beyond immediate assistance, we're here to advocate for systemic changes that ensure every individual's safety and dignity, irrespective of who they are, where they come from or what religion they have. We see it as responsibility and ethics to provide not only with information or link with services but make sure they are taken care even after that."
>
> (CSO Representative, Kuala Lumpur)

Their proactive involvement is pivotal in pushing for advancements within the system and ensuring that services remain survivor-centered.

Legal professionals and healthcare providers within the OSCC network also contribute to its strengths. As the lawyer and medical social worker involved in GBV cases noted.

"The legal framework, including the Domestic Violence Act, provides a solid foundation for us to protect survivors' rights effectively but it is the cultural norms of GBV acceptance that need to change for women to come up and seek justice."

(Senior Lawyer and Human Rights Advocate, Kuala Lumpur)

"Having clear guidelines and support from various agencies allows us to offer comprehensive care that addresses more than just physical injuries. But I think it will be good if we know of their SOPs too."

(MEDICAL SOCIAL WORKER, OSC)

These examples and testimonials from various stakeholders highlight the OSCC model's inherent strengths and the collective resolve to refine and expand its impact.

Understanding the strengths of the response system and the OSCC model along with the barriers and gaps in the implementation of these measures, helps to identify focus areas and provide recommendations. This approach enables us to build on the existing foundation—leveraging on the comprehensive guidelines, multisectoral service integration, and robust civil society support that underpin the OSCC model—while addressing the critical areas where survivors' needs may not be fully met. By recognising the OSCC's role in offering a holistic response through immediate access to medical, legal, and psychological support, we acknowledge the model's potential to offer a seamless experience for survivors. However, it's equally important to confront the challenges survivors face, such as navigating these services, the variability in service quality, and the need for greater awareness and training among service providers. Our goal, therefore, is to propose targeted improvements that refine the OSCC's operational efficacy, expand access to and awareness of GBV services, and ensure that the system's design and implementation are truly survivor-centric. This balanced perspective not only highlights the critical need for ongoing evaluation and adjustment but also aligns with the broader commitment to enhance the safety, dignity, and recovery of GBV survivors.

Recommendations

Ensuring that survivors of GBV have accessible avenues to seek assistance through OSCC transcends mere adherence to regulatory standards; it mirrors the depth of our collective empathy and the foundational values we uphold. By prioritising inclusivity in the design of spaces dedicated to medical support or the pursuit of justice, we do more than just accommodate a diverse populace. This approach is a conscious effort to empower individuals by providing them with a multitude of options tailored to their unique needs and circumstances, thereby reaffirming their autonomy and dignity in the aftermath of violence. Adopting a survivor-centric model in the context of GBV support services demands that we challenge our set systems. It invites us to innovate and reimagine the environments we create for healing and justice, ensuring they are not just safe and welcoming, but also reflective of the varied experiences and identities of survivors. This commitment to inclusivity and diversity fosters a culture of respect and understanding within the first-line responder teams and the broader workforce, creating a ripple effect that enhances collaboration, empathy, and mutual support. Moreover, by embedding these values into the very fabric of the operational model of OSCC, we can set a new standard for what it means to support survivors of GBV. This holistic approach not only facilitates a more empathetic and effective response to individual needs but also contributes to a broader cultural shift towards inclusiveness and respect for diversity. In doing so, we cultivate a nurturing environment that not only aids in the healing and empowerment of GBV survivors but also enriches our collective experience, driving innovation and fostering a community where everyone is valued and can thrive.

Specific recommendations for each area of GBV services assessed in this study:

1. Strengthening Service Availability (information and awareness)

The study finds that even when the services are available, often community and survivors do not have the information and awareness about these services. Therefore, it is essential to have targeted strategies to improve public awareness at the community level. Information shared to the public should be made inclusive and diverse, reflecting the multiculturalism of Malaysia ; for example, languages used should be varied Bahasa Malaysia, English, Mandarin, Tamil and native dialects for wider outreach and comprehension.

Media and Digital Strategy

- **Public Service Announcements:** Collaborations with local media outlets to broadcast public service announcements can effectively reach a wide audience. These announcements should focus on the signs of GBV, available support services

particularly at OSCC, 24/7 helpline numbers and how to access these services.

- **Social Media Campaigns:** Leveraging social media platforms for awareness campaigns can engage younger demographics and spread information rapidly. These campaigns can utilise interactive content, such as live Q&A sessions with experts, survivor stories, and informational graphics.

Enhancing Digital Presence

- **Development of Websites and Apps:** Creating easily navigable websites and mobile applications that provide detailed information about GBV support services, including OSCC locations, contact information, and services offered, is crucial.

- **Online Support Services:** Implementing online chat support and counselling services can offer a discreet and immediate form of assistance to those in need. The numbers of these call centers should be widely circulated in public spaces like metro stations, buses, hospitals and shopping areas. There is a need for a separate call centre to cater to and support the needs of male and gender diverse GBV survivors.

Partnerships and Collaborations

- **Engagement with Educational Institutions:** Partnering with schools and universities to incorporate GBV awareness and prevention into their curriculum can educate young people early on.

- **Corporate Engagement:** Working with businesses to include information about GBV support services as part of their corporate social responsibility programs can extend the reach of awareness efforts to the workforce

- **CSO Engagement:** Due to their grassroots connections and profound understanding of community needs, CSOs are uniquely positioned to tailor and disseminate awareness campaigns effectively. They can facilitate through community dialogues, collaborate on multi-platform awareness campaigns, and train volunteers and community leaders about the services.

Public Space Information Dissemination

- **Billboards and Public Kiosks:** Placing information in high-traffic public areas, including transportation hubs, shopping centers, and parks, can significantly increase the visibility of GBV support services.

- **Public Transportation Advertising:** Utilising buses, trains, and metro stations for advertising can ensure that information about GBV support services reaches a broad audience regularly.

Professional Training and Sensitisation

- **Training for Frontline Workers:** Offering specialised training for healthcare providers, law enforcement officers, and other frontline workers can enhance the sensitivity and effectiveness of the response to GBV cases.

- **Legal Aid Workshops:** Organizing workshops and providing information about legal rights and support services available to GBV survivors can empower individuals to seek justice and support.

Community-Based Efforts

- **Peer Support Networks:** Establishing support groups facilitated by peers or survivors can provide a powerful platform for sharing experiences and information about accessing support services.

- **Engaging Community Leaders:** Involving respected community figures in awareness efforts can lend credibility and amplify the reach of messaging regarding GBV support services and OSCC.

Community Outreach and Educational Initiatives

- **Door-to-Door Awareness Campaigns:** Conducting direct outreach in communities, especially in areas with limited access to digital resources, can ensure that information about GBV support services reaches the most vulnerable populations.

These strategies represent a comprehensive approach to improving public awareness and accessibility of GBV support services and OSCC. Successful implementation of these initiatives requires coordinated efforts among various stakeholders, including government agencies, non-profit organizations, community groups, and the media.

2. Enhancing Service Accessibility

Removing barriers related to accessibility requires implementing specific changes, such as waiving upfront payment requirements for medical services, including for non-citizens. For example, a hospital could establish a GBV victims' fund to cover expenses and this can be an indicator for MoH to gauge the number of GBV cases that require medical support.

Legal services should be made accessible without the precondition of a police report, acknowledging that the police might represent a barrier rather than a recourse for some survivors. Furthermore, offering services in multiple languages through the employment of multilingual staff or interpreters can make a significant difference.

3. Improving Service Adaptability

Services must be flexible to cater to the diverse needs of GBV survivors. This could include offering survivors the choice of the gender of their healthcare provider to respect their comfort and privacy.

Cultural mediation services could also be strengthened to help bridge cultural gaps, making survivors feel more understood and supported. For instance, if the survivor is more comfortable communicating in their native language rather than in Malay or English, a cultural mediator who speaks the same language can facilitate clearer and more empathetic communication. Furthermore, understanding the community's view on family, religion, hierarchy, and social support enables mediators to navigate these topics sensitively, ensuring that the survivor feels safe and respected throughout their journey towards healing and justice.

4. Ensuring Appropriateness of Services

Cultural sensitivity training for service providers is crucial. This training should include understanding the realities and challenges faced by victims, including in terms of different cultural backgrounds, gender norms and practices, and religious beliefs and practices to avoid prejudices that can exacerbate survivors' trauma. Therefore, service providers need to undergo comprehensive gender and cultural sensitivity training. This training should equip them with the skills and knowledge necessary to offer support that is both respectful and understanding of diverse cultural backgrounds. For example, the training materials should cover:

- **Inclusive Understanding of GBV:** Develop training modules that emphasize the inclusive nature of GBV, highlighting how it affects individiuals, especially those from vulnerable communities. It can use statistics, case studies, and survivor stories to illustrate the breadth and depth of GBV.

- **Bias Recognition Exercises:** Integrate exercises designed to help individuals identify and understand their unconscious biases and stereotypes. These could include self-assessment tools, interactive workshops, and guided discussions that encourage personal reflection.

Skills Development

- **Empathetic Communication:** Provide training on empathetic communication techniques, ensuring that service providers know how to interact with survivors in a manner that is respectful, supportive, and free of judgement.

- **Cultural Competence:** Offer sessions on cultural competence that cover various cultural backgrounds, gender identities, and expressions, focusing on the specific needs and sensitivities of diverse groups.

Policy and Procedure Review

- **Inclusive Policies:** Review and update organizational policies and procedures to ensure they are inclusive and address the needs of all survivors.

- **Guidelines for Inclusive Care:** Develop clear guidelines for providing care that respects the individual's socioeconomic background, gender and expression, including protocols for addressing and referring to survivors in a respectful manner.

Ongoing Support and Supervision

- **Continued Education:** Implement a system for ongoing education and training on GBV that includes updates on best practices for supporting diverse survivors and this should be made mandatory and should be monitored every quarter or half yearly.

- **Supportive Supervision:** Establish a system of supportive supervision where service providers can discuss cases, reflect on their interactions with survivors, and receive feedback in a constructive environment.

Collaboration and Partnership

- **Community Engagement:** Actively engage with communities to raise awareness about the inclusivity of GBV services and to build trust among diverse populations.

- **Engage with community-based and diverse organizations:** In line with a targeted approach, engagement with organisations should be more diverse and should reach more vulnerable communities. These organizations should be integrated into OSCC teams or accepted as referral partners. This inclusion will facilitate peer support and peer counselling, ensuring that GBV services are more inclusive, comprehensive, and responsive to the needs of all survivors.

5. Prioritising Safety

Establishing protocols that ensure the immediate safety of GBV survivors is vital.

This may include discreetly located shelters that do not disclose their address publicly and have strict security measures.

Although as per the OSCC guidelines there should be a separate private “OSCC” room for the GBV survivors, many hospitals do not have them due to insufficient space or infrastructure. Therefore, medical facilities should have dedicated rooms for private examination and case management where survivors feel safe to disclose their experiences without fear of being overheard or exposed to others at the emergency department.

6. Enforcing Informed Consent and Confidentiality

Training for all GBV service providers on the importance of informed consent and maintaining confidentiality is necessary. Based on the study, the following strategies could be considered:

a. Institute Informed Consent Procedures:

- Develop clear guidelines to ensure survivors are fully informed about their options, including the potential benefits and consequences of each choice, whether it pertains to medical treatment, legal action, or police involvement.

- Require explicit, written (recorded) informed consent from survivors before proceeding with any intervention or sharing their information.

b. Strengthen Confidentiality and Data Security:

- Train all staff on data privacy laws and the ethical handling of sensitive information.

c. Respect Survivor Autonomy in Legal and Police Engagement:

- Establish a clear policy guideline that no action involving police or legal proceedings is taken without the survivor's consent, acknowledging their right to choose their course of action.

- Facilitate discussions where survivors can freely express their preferences regarding legal or police intervention, ensuring that they are supported regardless of their decision. This can also be done by ensuring that survivors receive comprehensive copies of all their medical reports, case notes, and any documentation relevant to their case in a timely and understandable format.

7. Facilitating Effective Communication

Training for professionals in recognising non-verbal cues of distress and employing culturally-sensitive language can significantly improve communication with survivors. This could be complemented by the presence of trained advocates who can navigate systemic barriers alongside the survivor, ensuring their voice is heard and their needs are met. In this context, there is a need to conduct specialised training sessions for OSCC doctors on identifying potential risks and complications associated with repeated experiences of GBV. This should include understanding the cumulative impact of trauma on physical and mental health and recognizing the signs that may indicate a survivor is at increased risk. Similarly, there is a need to equip doctors with the knowledge and tools to develop personalised care plans that address both the immediate and long-term needs of survivors, with an emphasis on minimising further trauma.

8. Coordinating Across Sectors and Agencies

To provide comprehensive care, a coordinated network involving medical services, law enforcement, legal aid, and NGOs is necessary. This could be facilitated through the following strategies:

a. Formation of a Central Coordination Committee:

A committee should be established, comprising representatives from healthcare, law enforcement, welfare, legal services,

mental health providers and NGOs. Its primary function would be to oversee the integration of services and ensure efficient inter-agency communication and referral processes are smooth in every OSCC.

b. Development of an Integrated Referral System:

Implement an integrated referral system to enable smooth transitions for survivors between different services. This should include standardised protocols for sharing information securely, respecting the privacy and consent of survivors and ensuring that the survivor has all the safety and support including financial ability, transport facility, childcare etc to navigate between different service providers.

c. Provision of Comprehensive Mental Health Support:

Ensure that mental health and counselling services are not merely options but integral components of the long-term care plan for survivors, with regular follow-up and assessments to address ongoing and evolving needs.

d. Access to Shelter and Protection Services:

Establish clear, immediate pathways for survivors (and their children and dependents, where applicable) to access safe shelter and protection services. This is crucial for those at imminent risk of further violence. If the government shelter homes are not available, then an authorised list of CSOs that provide shelter services should be made available to the medical social worker.

e. Legal Aid and Advocacy:

Ensure survivors have direct access to legal support services that can guide them through the legal system, inform them of their rights and provide advocacy in legal proceedings.

9. Addressing Intersecting Identities

Programs must recognise the compounded challenges faced by individuals with intersecting identities. Tailored support services that consider the nuances of refugee status, gender identity and cultural background can offer more effective support.

10. Integrating GBV Training Across Health Sectors

GBV awareness and response training should be mandatory across all health sectors, ensuring that professionals are equipped to provide appropriate support to refugees and other marginalised groups. This includes training on specific health issues related to GBV, such as sexual and reproductive health services, that are respectful and inclusive of all survivors' needs. A mandatory training course and integration of gender mainstreaming and survivor-centric GBV response should be given to all medical students including doctors and nurses irrespective of their specialisation.

11. Developing Comprehensive GBV Guidelines

There is a need for revised guidelines and SOP for GBV services that respect the complexities of survivor identities and enhance responsiveness and support. These guidelines should be developed in consultation with survivors and the CSOs, ensuring their experiences and needs are at the forefront of the service design and delivery. These guidelines should lay out clear protocols, processes and mechanisms and include a minimum checklist for any hospital to provide services and should include a regular monitoring and evaluation system to continuously feed the services and improve its

implementation. Preferably these guidelines should be made separately for SGBV cases, cases of child abuse, sodomy, domestic violence, IPV, etc. It should also be gender inclusive with clear instructions on how to manage cases of gender diverse individuals. Lastly, it must integrate gender intersectionality as a lens in the service provision to ensure that no one is left behind in accessing support services at the OSCC.

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By systematically integrating these detailed strategies and recommendations, the support system for GBV survivors can be significantly improved. Ensuring that every individual, regardless of their background or circumstances, has access to the care and support they need and deserve is not just a moral imperative but a practical one that can lead to healthier, more resilient communities.moral imperative but a practical one that can lead to healthier, more resilient communities.

12. Leveraging the existing CSO support in GBV response

Our findings underscore the critical need for governmental recognition of CSOs and the invaluable services they provide. Therefore, supporting CSOs in expanding their capacities is essential for a more equitable sharing of responsibilities between the government and civil society in addressing GBV. This will not only strengthen the network of support available to survivors but also ensures that the services provided are comprehensive, accessible and, most importantly, effective in aiding the recovery and empowerment of GBV survivors.

13. Need for further research, data and information and regular reviews of protocol.

The need to collect nuanced evidence and comprehensive national statistics on GBV in Malaysia is crucial, as it forms the backbone of understanding the scope and specifics of GBV in the country. This detailed understanding will also allow for targeted interventions and helps ensure that Malaysia meets its international obligations. Therefore, the following are recommended:

1. Routine Evaluation of Case Management Protocols:

A systematic process should be established to periodically review the case management protocols. This review should assess their effectiveness in addressing the needs of survivors, with adjustments made based on findings to improve service delivery and outcomes.

2. Establishment of Feedback Mechanisms:

It is crucial to create avenues through which both survivors of GBV and service providers can offer feedback on the case management protocols. This direct input will be invaluable in the ongoing development and refinement of these protocols, ensuring they remain relevant and effective.

3. Enhanced Data Collection and Analysis:

To inform and guide the interventions or support system, a robust strategy for collecting detailed evidence and national statistics on GBV must be put in place. This strategy should, focus on gathering data on the prevalence of GBV, the characteristics of survivors and the efficacy of services provided. Such comprehensive data collection is essential for crafting targeted interventions, efficiently allocating funds and resources, and meeting Malaysia's international commitments to combat GBV.

14. Policy level changes to make the services more inclusive.

As part of the recommendations to improve services at OSCC, it is crucial to address the legislative gaps surrounding domestic violence.

This includes the expansion of the legal definition to cover unmarried intimate partners, thus recognising the occurrence of violence in non-marital relationships. Additionally, it is imperative to advocate for the legal recognition of marital rape as a crime. Acknowledging marital rape within the legal framework is essential to ensure that all survivors of IPV, regardless of their marital status, have access to the necessary legal protections and support services offered by the OSCC. This acknowledgment represents a significant step forward in the provision of equitable and holistic care for all survivors of gender-based violence.

It is also recommended that state policy explicitly recognise all individuals' rights to healthcare and support services. This recognition should permeate all areas of legislation and public policy, thereby affirming the experiences and rights of these individuals, in the realm of healthcare and support services.

Lastly, to truly empower survivors and facilitate their access to necessary support services, policy efforts and further research must aim to bolster these enabling factors. Ensuring that all survivors, irrespective of their socioeconomic, educational background, or urban versus rural residency, have equal access to support services is paramount. Moreover, recognising and addressing the unique challenges faced by survivors from diverse backgrounds is crucial in fostering an environment where every individual feels validated and supported in their journey towards healing and justice. In conclusion, acknowledging and leveraging the intersectionalities in gender and other socio-economic factors are essential in shaping effective and responsive GBV support services. Only through a concerted effort that addresses these deeply ingrained biases and structural inequalities can we hope to forge a path towards a society where all survivors of gender-based violence have the resources and support they need to seek help and pursue justice confidently.

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