"WANITA DIJAJAH PRIA SEJAK DULU...DIJADIKAN PERHIASAN SANGKAR MADU..." *:
An Ethnographic Study on a Hospital-Based Women’s Crisis Center & Help-Seeking Behavior of Women Experiencing Domestic Violence In Metropolitan Jakarta, Indonesia

* "Thus the females live dominated by the males, made into a decoration for his pleasure..."
Taken from lyrics of the song “Sabda Alam” (Human Nature) by Ismail Marzuki, Indonesian composer

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# Table of contents

List of Abbreviations and Terminology                      iv  
Summary                                                  v  
Acknowledgments                                          vi 

**Chapter 1: Introduction**                               
Formulation of the Problem                                1  
Problem Statement and Research Problems                   3  
Biases and Flaws                                         4  

**Chapter 2: Methodology**                                7  

**Chapter 3: Theoretical Background**                     12  

**Chapter 4: Data Presentation & Analysis**               14  
The Crisis Center                                        14  
"Here Our Duty is Hard...": The Culture of The Crisis Center 19  
Case Illustration                                        24  
Analysis & Reflections                                   36  

**Chapter 5: Conclusions & Recommendation**              39  

Reference List                                           40  

**Appendix 1: Map of Cipto Mangunkusumo**                 43  
Hospital- One Stop Crisis Center
Appendix 2: Samples of Transcription

Appendix 3: Organization Structure of The One Stop Crisis Center
For Women and Children (Pusat Krisis Terpadu)- Cipto Mangunkusumo Hospital (RSCM)

Appendix 4: Problem Analysis Diagram

Appendix 5: Pictures
LIST OF ABBREVIATIONS AND TERMINOLOGY

BWS - Battered Women Syndrome
DV - Domestic violence
PKT - Pusat Krisis Terpadu (One Stop Crisis Center for Women And Children)
RSCM - Rumah Sakit Cipto Mangunkusumo (Cipto Mangunkusumo Hospital)
LBH - Lembaga Bantuan Hukum (Legal Aid Institutions)

Visum et Repertum: medical report for jurisdiction purposes
Summary
Domestic violence is a worldwide known problem as a violation of human rights. It happens to women in every culture, ethnicity, level of society and affecting women's health on physical, psychological and spiritual level. Many studies on domestic violence in the Western society have been conducted, but less is studied in the Non-Western society. Cases of domestic violence that are surfacing are thought to be just the tip of an iceberg. Many women kept quiet for their experience. Not so different, in Indonesia cases that are reported are suggested to be too little compare to the real number of cases. This study is about the women's help seeking behavior that might contribute to the domestic violence reported cases. The findings showed that women do seek help and not passive in dealing with their domestic violence problems. Several obstacles that need to be addressed further including the institutional constraints and government acknowledgments.
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CHAPTER 1
INTRODUCTION

Indonesian patriarchal society showed men domination that is expressed out loudly, especially in the olden days. Like articulated in an old Indonesian ballad Sabda Alam (Human Nature) composed by Ismail Marzuki, it said that it was created nature of male and female, two beings in care of the Gods, males are destined to be powerful (berkuasa) and the females to be gentle sweet (lembut manja). With this prologue, I would like to present the old documentation of the gender inequalities that are still affecting, and perhaps underlying, the domestic violence problems recognized in Indonesia today.

There are quite a large number of studies that have been done about domestic violence among the Western society, and attention given to DV (and even broader, family violence) that are clearly increasing, as evidenced by the development of at least six new journals devoted to the topic, namely: the Journal of Interpersonal Violence, Journal of Family Violence, Violence and Victims, Elder Abuse, Sexual Abuse and Child Abuse and Neglect. This doesn't mean that the issues only occur in the Western society. Domestic violence is also an identified problem in non-western society, but due to the lack of study, and scarce information in the non-western setting, such as Indonesia, little is known about this issue, especially about their help-seeking behavior. Thus, the issue is often overlooked and not so strongly identified as a problem, and not seen as belonging to the priority matters to address. At some point, people don't want to talk about domestic violence, it is considered to be a private matter between husband and wife, especially in the Eastern countries, including Indonesia. That is why very little institutions are available to handle this problem.

Cases of domestic violence in Indonesia are no different from other countries. However it is shown that in Indonesia, perception about ideal womanhood is an ever developing concept and multifaceted because it is developing within a pluralistic
society. But perpetuation of superiority of men over women is still widely adhered to by the majority of Indonesians, men and women. This can be explained that historically and politically speaking, the existing concept of womanhood has been influenced by the dominant Javanese ideology of womanhood as a result of the process that Djayadiningrat calls ‘priyayisation’ (Sadli & Marlita, 1999, p. 85). The power imbalance makes every man a potential actor of violence against women, because it is likely manifested in a hierarchical relationship between husbands and wives within the family and between men and women in the workplace. Ironically, this hierarchical relationship is also believed to be the very factor that can contribute positively to the harmonious relationship within the family. It is irony because it is a belief shared by majority of Indonesians, which originates from the Javanese ideology that is called priyayi. The concept of womanhood, shame, obedience and the notion of family harmony are values that are praised within the priyayi. Those who are considered to be “priyayi” are the ones belonging to the Javanese elite, who have a socioeconomic position based on the fact that they are members of the Javanese aristocracy or are commoners but held high positions in the (then) Dutch administrative structure.

Multiple factors such as socialization and internalization of traditional and religious values, contributed to the occurrence of violence against women in the home. Research data showed that violence against women is not a problem faced only by women of low socio-economic class as previously believed. In Indonesia, it is the women who consciously face it as an existing problem in society. However, going to crisis center is still a traumatic experience for the women involved because it requires from them a willingness to expose their family affairs to strangers. Taking the case to court is a long and often very emotional experience which often influences the women to drop the charges altogether. Violence against women in Indonesia is influenced by existing legal, social values and religious values, in which dominance of men and unequal gender relationship is a basic issue. These values are reflected in the reluctance among women to leave an abusive husband, because they feel economically insecure, or in the tendency among husbands to solve
conflicts with violent behavior (Sadli & Marlita, 1999, p. 102). There should be a combined effort among local government officials, academics, women's studies centers, law enforcement officials, and community organizations, including religious groups.

Stereotypical images of Indonesian women as being nurturant, cooperative and passive are laudable qualities and are considered beneficial to them. These qualities at the same time will influence the power relationship between men and women. These stereotypes also justify the perception that women are inferior to men. The existing stereotypical images can therefore become real and imagined hindrances to develop equal relationship between men and women or become barriers to actualize the concept of equality, or equal partnership.

**Formulation of The Problem**

Domestic violence is a complex issue that necessitates more than governmental involvement and policy initiatives. It requires a multidisciplinary response, involving criminal justice, legislation, social service and health sectors. Of these four disciplines, the health care system's response remains the least developed (Stark & Flitcraft, 1991). Having a biomedical background and working as a medical staff in a hospital-based crisis center for women and children, I believe there is an importance to undertake a medical screening of women to detect whether violence has occurred to them as well as administering forms of help for women suffering from domestic violence, in a more medical approach. However I am also aware that this is a social and psychological problem that needs multidisciplinary assessment that is highly integrated.

According to the statistics in the One-stop Crisis Center for Women and Children (Pusat Krisis Terpadu) based in Cipto Mangunkusumo Hospital, Jakarta, Indonesia, among all new cases between June 2000 and May 2001 there were 112 cases of domestic violence recorded, or 20.8% of all new cases accepted within that period of time. However, according to Kompas, the local Indonesian newspaper supported by
other local sources, the real number of women suffering from domestic violence is believed to be much larger. Although there is no estimation as to how big the actual number of cases happening in the city, and even the country is, it is said that the domestic violence cases revealed is just the tip of an iceberg. Some factors that are thought to contribute to prevent women from reporting are fear, shame and belief about the taboo of revealing a domestic flaw.

At the moment, there are some non-governmental organization working on this issue focusing in the major cities of Indonesia, but still very few integrated facilities related to help domestic violence survivors existed, unlike in the western countries where facilities for survivors is widely known and well established.

**Problem Statement & Research question**

The problem of domestic violence has been said as the life's best-kept secrets and the number of cases reported is said to be just the tip of an iceberg (Donna, A.M, 2002; Sadli & Marlita, 1999; Heise, L., Ellsberg & Gottemoeller, 1999). My own experience have also indicated the same thing. Our funding institution, the UNFPA has just stopped their full financial support last year, because they said the incoming cases that are handled at the crisis center were very low in numbers and it was an insufficient use of the fund. Driven by this fact, I would like to know the reasons for it being the tip of an iceberg and the reasons why it is not surfacing in its actual number. Do women really kept this to themselves, or if they don’t what are the reasons that made it kept secret? If it is kept, what are their reasons? The more literal and detailed sub-questions are as follows:

- How do women describe their situation of domestic violence in their own words?
- What made women seek professional help (in the crisis center)?
- Why many women do not seek professional help?
- What are women’s ideas concerning improvement of their situation, before and after coming and to the crisis center?
In short, the purpose of the study is to explore the help-seeking behavior of women who experience domestic violence. Those questions are means to get answers to the objectives which are to give insight into the reasons why women who experience domestic violence do and do not seek professional help and to give recommendations for further improvement of crisis centers to help women in need, particularly the one that is hospital-based where the researcher is working: One stop crisis center for women and children in Cipto Mangunkusumo Hospital.

Biases and Flaws
Being aware that my self is my own research tool, I would like to make clear of my background as a researcher pursuing this fieldwork, as it would give the reader a critical idea in mind of any possible biases and flaw concerning the substance and findings of the study. It is important so that one can accept and envision the presented data and findings as objectively as possible. I would like to apologize if in some parts of the report some personal event occurred, but realizing that I am my own research tool, I believe it will be useful for explaining situations, limitations, advantages as well as disadvantages that I faced during the fieldwork.

Firstly, concerning the status that I held while doing the fieldwork that play a role in doing an ethnographic study of the crisis center, but not necessarily affecting the study on the help-seeking behavior among women experiencing domestic violence. I have been working in the crisis center as one of the medical staffs since the year 2000, presently taking a one-year off for studying medical anthropology. Having involved in the work routine of the crisis center for a year had given me stronger emic perspective of the culture of the crisis center. Thus the etic perspective that I have with me while doing the research was less dominant. Having an emic perspective dominant could be meaningful, in the way that I can understand more and thus present a more accurate interpretation to the culture of the crisis center.
Secondly, it is important to bear in mind that the research data was collected during my fieldwork in Indonesia, and thus, all the interviews were using Bahasa Indonesia (Indonesian language). In the process of transcription, the researcher was having a rather difficult time translating words and expressions from Bahasa Indonesia into English, as sometimes there seemed to be a gap between the two linguistic systems, and therefore the contents of translation can be slightly imprecise in meaning. Another crucial obstacle present while transcribing was the documentations of details of the wordings and reactions appeared during the interview, due to the objection of most of the interviewee for the use of tape recorder. The possible tool used was notes and memory. In this case although all transcription was done immediately after each interview (in less than 24 hour), the researcher might have lost some valuable details during each meeting.

Having a medical background while doing an anthropological research for this topic is quite an interesting experience. Some obstacles were faced, such as when I introduced myself and explained the purpose of the study to the women. Some women were reluctant to do the talking as soon as they know I wasn’t there for biomedical reasons. Those reactions are good, in terms of finding out what scare off these women and each point has its own values that would bring the findings of the study intriguing, if not interesting. At the same time it was not so good in terms of attractiveness, thus it limits my search for the study respondents. I will come to that more in Chapter 3 and explain what it was like, for me, to do this anthropological work with a biomedical background. In a more general view, I believe both genres (medicine and anthropology) are complimenting, especially in the field of family violence. Although controversies arises in this field due to theoretical disagreements, I would personally say that this should be a good thing, as Gelles (1993) pointed out in one of his writings "...controversy is necessary, because knowledge is advanced through controversy: controversy leads to debate, debate stirs reflection, reflection leads to research and research leads to refinement of ideas..." (Gelles 1993; p.xii)
CHAPTER 2
METHODOLOGY

The study type applied in this research is a combination of exploratory and descriptive research. These study types were used to support the main objective, which is to gain insight into the problem of domestic violence, how the women interpret the nature of the problem, and their help-seeking behavior. In the beginning, plan for data collection will be derived from the one on one in-depth interviews with respondents, discussions on the support group meetings, observation in crisis center and shelters, and spontaneous or arranged focus group discussions. Shifting of methods was inevitable during the fieldwork, because it was adjusted to unexpected situations that occurred in the field.

The fieldwork time given was 6 weeks. Starting from 27 May, I began to approach the crisis center to make myself familiar again with the place and people. New staffs were recruited while I was away, so after a brief introduction of myself, I did a small presentation as to what I am going to do for the next 6 weeks. The introduction presentation was attended by most of the staffs, including the chief and vice-chief of the center. Most of them knew already that I would be present during this time. I made contacts through e-mails and telephone some time ago with some of them before the actual fieldwork. The following days in the same week I went to the ethical board of the Cipto Mangunkusumo, as the host of the crisis center. Some changes were happening in the crisis center. Safe houses and shelters for women that we used to work congruently were closed or not functioning. One that still has a network with us refused to participate because they say none of their occupants are victims of domestic violence at the moment. Therefore, none of the observation was done in the safe houses.

In-Depth Interviews
The expected in-depth interviews were of a minimum of 6 respondents: women with experiences of repeated domestic violence, women who have been abused by their
spouse several times in their life, but reported their experience only after some time living with violence. This means that in the beginning she stayed with the abusive husband and reported later when the violence repeated. Earlier, it was intended that I would do a full day hang out in the crisis center (while at the same time doing observation), and the respondents were to be selected by a preliminary screening through anamnesis (interview) or through their medical records by the social worker. The first anamnesis usually is done by the social worker, the first person to handle a client during her first visit. This was to find out whether the candidate respondent has been experiencing domestic violence several times before the first admission to the crisis center. Women who come with an acute case, were not to be selected in first encounter, because I am aware of the more difficult situation it might possibly be. All the screening was under the permission and acknowledgement of the crisis center’s staffs, including the medical doctor who is handling the case. After they are selected, the client will then be approached during her next visit (for a psychological consultation or other meetings). If she agreed to participate, another schedule will be made in accordance to her convenience. At that time, it was not exactly done like it was planned.

As I was in the middle of my first trimester of pregnancy, there were some limitations in the mobility and dynamics of my being present in the crisis center. Some days when queasiness was very strong, I was not able to go to the center. There were also an obstetric problem occurring during my second week of fieldwork, and I took the advice from my obstetrician to have a full bed rest for the rest of the week. The back up plan was to have my research assistant do the preliminary screening of candidates for the interviews. So we did that, and I asked her to notify me by phone call for the names and next schedule of coming back to the crisis center of possible participants. Later on towards the last weeks of my fieldwork I was able to do more days of full observations.

We were able to gather only three respondents willing to participate for this study. The social-economic status of selected respondents was not specified; the same
also apply to the ethnic, age, education level, religion, and length of time living with abusive husbands. The reason for this flexibility of selection is to see different possibilities in different variations of characteristics. Each respondent was interviewed twice, consisting of an average of 1,5 hours each interview. All was conducted at the crisis center, although it was not arranged to be that way. The locations of the interviews were always discussed accordingly to the convenience of the respondent, be it at the crisis center or at a place of her choice. In all three respondents, and all two sessions each, they preferred to do the interview at the crisis center. The contents of the interview were loosely structured, sometimes unstructured. The use of checklist for list of themes (themes as presented in the Problem Analysis Diagram, see also next chapter or Appendix 5) and guidelines of questions to be asked were available to ensure that all-important issues are discussed. In the beginning, I hope to record every interview on tape if given the permission by respondents, but in the field it was not happening, because all three respondents refused to the use of tape recorder.

To gain full insight I also did some arrangements of in-depth interviews with 2 doctors and one social worker as key informants who work in the crisis center. I did one in-depth interview with each doctor, and two times with the social worker. More inputs and valuable information was taken from our daily chitchat while hanging out doing my observation. Some of the talking were taped, especially the ones that were arranged, but the chitchats were often missed to be taped as it usually happened spontaneously.

In the fieldwork, no support group meetings were established in the crisis center due to some limitations. Ever since the crisis center began its service, only two support group discussions were successfully held in April and early May. The reason to this was there was no formal technical assistance trained to conduct the discussion before, so the two times were mainly a trial session conducted by the social workers. The second obstacle was the availability of time and willingness of the women, as participants. Both sessions were considered not very successful in terms of number
of participants, as it was only attended by three participants. Unfortunately, by the time I was there, no written report was available yet. While doing the fieldwork, I tried to arrange another meeting, trying to reestablish another session of support group meeting, and I thought after they agree to meet I will do a spontaneous focus group discussion at the crisis center. It was not successful, due to the very limited time I had trying to find and contact the ones who are willing to come, while at the same time doing observations and arranging in-depth interviews. It seemed like mostly they refuse to come for a group support discussion to the crisis center because it is for a research purpose, as I asked for consent in the beginning of each call for invitation (I did telephone invitation mainly). Like one woman said on a telephone conversation, briefly, right after I describe in length what the support group discussion would be like, the purpose including anonymity, and all post-research plan (such as what to do with data findings):

".... Wah kalau untuk penelitian terus terang saya agak keberatan. Lagian waktu itu saya sudah pernah datang ke acara itu sebelumnya. Maaf ya, mungkin lain kali saja." (Oh, if it's for a research purpose, I don't feel like doing it, because anyway I have attended one session before, and I don't have that many time and chances to go to the crisis center. I am very sorry, maybe some other time)

The ones who are working said they could hardly find a time, and the ones that are not working were afraid of being caught by their husbands for being away too much from home.

Observations
As I mentioned earlier, I did not manage to do full day observations for the whole weekdays in the 6 weeks time. Then I rearrange my plans, and ask to be notified via phone call, if ever a promising possible participant came to visit the center. From then on, I did the meeting arrangements, by noting the next scheduled meeting and went to see her then.
The changes happened with the crisis center and their networking service while I was away made it unfeasible for the observations to be conducted in the shelter/safe houses. The shelter houses that used to work with us were not as many as before, two had been closed and not functioning, while the only one left was lacking of domestic violence victims occupants. Therefore I had to drop the first plan, which was to carry out the observation in the shelters and did it only in the PKT-RSCM instead.

PKT-RSCM is a relatively small functioning set of compartments with only one common room/ waiting room, two consultation rooms and one physical examination room (see appendix 1 for the map). Placing myself in the waiting room inside the crisis center was a good way to familiarize myself with the culture of the crisis center. Most of the time, the feeling that I was a doctor on duty, having once working there, distracted me. Several times I spontaneously did as if I worked there, wanting to do the phone consultation or having the initiative to handle a client. The presence of the medical doctor on duty, my colleague, usually made me realize that it was not my responsibility to do what I instinctively thought I should do. I took notes, but not pictures, which I thought of doing to document the physical being of the crisis center (not for the respondents).
CHAPTER 3
THEORETICAL BACKGROUND

To conceptualize the findings of this study, I am combining several theoretical perspectives, namely sociological, psychological, and feminist theory. The reason why I am using several is because sometimes they intertwine and complete one another, at the same time they fill in the gaps between them.

Through A Psychological Lens
According to O'Leary (1993) in the context of problem of wife abuse, a patriarchal society is a critical but not a sufficient risk factor in the development of spouse abuse. That is, wife abuse will exist as a significant problem only in societies in which males learn that domination of females is appropriate. Thus, it makes sense that in Indonesian society, the overall attention given to domestic violence is not as strong as in the Western society, due to the cultural differences, where male domination is much apparent in almost all aspects of everyday lives of the Indonesians (including a man's position in the parliament, salary, education, et cetera).

Through A Sociological Lens
The sociological perspective provides the widest and most inclusive perspective from which to understand and explain family violence. As Gelles (1993) emphasizes in his writings, the core of the sociological perspective is the assumption that social structures affect people and their behavior. In the case of family violence, including wife battering, the structure of the modern family as a social institution has a strong, overarching influence on the occurrence of family violence. Violence is viewed as a system product rather than as the result of individual pathology. He also argues that psychological explanations of violence continue to overlook and minimize the contributions of social and structural factors to the occurrence and persistence of violence and abuse in intimate relationships (Gelles 1993, p.40).
Through A Feminist Lens

Yllö (1993) emphasized that patriarchal society is a critical risk factor for wife abuse. One major strength of the feminist theory is its “praxis” or advocacy approach. It’s about women’s victimization as a social problem and the need to do something about the patterned, continuing and harmful use of psychological and physical coercion to control and dominate women (Gelles 1993; p.41). The second strength is its diverse, yet consistent, empirical support for the proposition that gender inequality explains violence toward women.
CHAPTER 4
DATA PRESENTATION AND ANALYSIS

I will separate the findings of my study into three big parts: the crisis center including its culture, the women's narratives as case illustrations, and reflections. The second part, the women's story, I will make them into sequences according to the themes they talked about. The third part, reflections, will be an analysis of the whole data, the blending of thoughts, from the crisis center to the more personal details in connection to the narratives of the women sharing their experience of domestic violence.

DESCRIPTION OF THE CRISIS CENTER

I have been involved in the center since the very beginning, not as early as from the concept-making phase, but around the early days of the establishment of the center. I was a freshly medical graduate with a 3-months experience of private clinical practice in a hospital specializing in women's reproductive health (mostly handling obstetric and gynecologic cases). The center was a pilot project signed by the Government of Indonesia and the UNFPA (United Nations Population Fund) and was executed by the UNFPA and the East & South-East Asian Regional Office of UNIFEM (United Nations Development Fund For Women), Bangkok. The agreement was signed on July 29, 1999. Their visions are to move toward women and children empowerment, through a proper and accountable response to violence against women and children. The second is to be a suitable place for multi-discipline professionals to serve the people. Missions of the PKT are to provide integrated and comprehensive services such as medical, medico-legal, psychosocial, and legal services, for women and children who are victims of violence, and second to provide an access to a multi-discipline network to get legal support and shelters, for women and children who are victims of violence.
Facility
Being built inside the Cipto Mangunkusumo Hospital (RSCM), PKT is a special unit belonging to the hospital, but differs from the other units because it is a 'functional installation' in the hospital, which coordinates various specialists from various departments in the Cipto Mangunkusumo Hospital, social workers, and NGOs in just one stop to serve women and children victims of violence. The site used is provided by the RSCM on the second floor of the emergency unit, next to the intermediate ward. The crisis center is not only physically a part of the hospital, but also administratively, therefore its clients has to register in the hospital's emergency unit's registration desk, as well as to settle administrative costs there. An indifferent triage system is applied to all clients of the crisis center as well as other patients coming to the emergency unit. The crisis center is built next to the intermediate ward and has a shared waiting room with the intermediate ward. It contains of a common room (6 x 3 sqm), two consultation rooms (3 x 2 sqm each), one examination room (3 x 2 sqm) and one toilet. The common room functions as a secretarial work space and medical record keeping, second waiting room for clients, working space for paper works of the staffs, and a pantry. The consultation rooms and examination room are separated by partition wall, are cooled with one air conditioning unit. Each consultation room has a two two-seater sofa and a small table. The examination room has a gynecologic exam seat, a medicine cabinet, and a wash bin. Details and map of the crisis center is provided in the Appendix 1.

Facilities available in the center are sets of furniture, computer with printer and scanner, a television, and a refrigerator. One telephone line and a local RSCM communication phone are available at the secretarial desk in the center. The computer network system running as a part of the hospital’s Forensic Department’s Local Area Network.

What makes PKT unique is the multidisciplinary system. Besides medical servants like doctors and nurses, there are also social worker, psychologist, and lawyers
involved. PKT staff-members are non-government employees except the managerial team.

**Structure**

PKT is lead by a chief of staff. In running the PKT three coordinators help the chief of staff, they are from the medical service, the psychosocial service, and the law and medico-legal service coordinator. PKT also has a secretary for the financial and administrative works. There is always a daily coordinator on duty on a daily basis (see Appendix 3). The PKT opens 24 hours a day, seven days a week, with 2 shifts working daily, containing one doctor, one nurse, one social worker daily.

**Management**

The chief of staff does the overall supervision, gets report from the daily coordinators for their daily supervision. A staff meeting is held once every month, reviewing all cases and discussing special cases. Weekly reports are submitted to the head of the Emergency Department.

**Services**

The PKT-RSCM provides a multidisciplinary service for women and children victims of violence, specifically for rape, domestic violence, and child abuse victims. The comprehensive services are including medical and medico-legal services, psychosocial services and access to legal aid and shelters. Being a hospital-based crisis center, PKT gives more attention to medical and medico-legal as well as psychosocial services, other services are in collaboration with NGOs and other service providers in this field.

1. **Medical and Medico-legal Services**

   Medical services begin in the triage unit where cases are being sorted and transferred to each department. Our clients with severe wound that needs emergency care will be handled first by the emergency doctors, accompanied by the crisis center’s doctor on duty. A client who has reported her case to the police will be escorted by the police officers to PKT, where she will receive
medical and medico-legal and psychological services immediately. Informed consent is always asked first. A temporary examination report will be given to the police (if present). Laboratory examinations and psychological and/or psychiatric consultation will be scheduled if needed.

Clients that have not reported the case to the authority will be given all information on medico-legal, law principles, police and law procedures, accordingly if she wanted to process further.

After the thorough medical examinations, medico-legal documentations will be performed including photograph taking if necessary (given consent by the client). Visum et repertum (medical report for juridical purpose) will be made based on the medico-legal documentation.

2. Psychosocial Services
Initially psychosocial services are given by the social worker during the client’s first drop in. The social workers will interview the client and assess the client’s need, and the impact of environment on clients whether her social environment can worsen her mental state. Based on the psychosocial assessment in combination with the medical examination, the client will then bee referred to further examinations: psychological and/or psychiatric consultations, or to a safe house, which will be scheduled immediately. In some cases, home visits are done to have more information and to provide further psychosocial assessment and treatment for the client’s family member. This kind of special service usually involves advocacy counselor, and shelter/safe houses, therefore good cooperation and collaboration with NGOs working in this field is very important. Survivor’s support group has also been planned, and two trial sessions had been done, consisting of recovered victims of violence and aimed to support the new ones in facing their future, in terms of psychosocial aspect.
3. Legal Advocacy Services
Clients coming to the crisis center are automatically receiving information about the legal advocacy services available. She will be informed about the options available concerning her case, information on the importance of reporting to the law enforcement officers (police), the procedures in court, and other legal issues. If needed, the staff will connect the client to a medico-legal expert (working in compatible with the center) who will give her further information. If the client wants to bring her case to court, the PKT will appoint its staff(s) to accompany her through the process. The client will be referred to the police office then the staff will also contact the center’s legal aid institution (Lembaga Bantuan Hukum/LBH) partners namely LBH Apik and LBH Jakarta.

4. Social Advocacy and Shelter
The social advocacy and shelter/safe house service is working together with NGOs in this field. Up til now they have referred several cases to other counselor advocate from NGOs and to shelters.

5. Networking
An informal network between PKT and some NGOs working for women and children has been working in the very beginning of the establishment of this center. There is a communication forum and working network meetings held every month in the NGO offices.

Before opening of the crisis center, the funding institution, UNFPA-UNIFEM and their partner, Cipto Mangunkusumo Hospital, held a three-day training and workshop on gender issues and operational technique for medical handling of crisis center patients, including sexual violence, domestic violence, and child abuse. The workshop was mostly to sensitize us on gender issues, to say it quite frankly, it was lacking on the practical issue for handling the cases. After the training we immediately started the work. For a start, we had 6 medical doctors, 3 nurses, 3
social workers, a psychologist and a secretary working 24 hours daily, divided into
two shifts, seven days a week.

“HERE OUR DUTY IS HARD....” : The Culture of The Crisis Center
In the crisis center's common room, used also as waiting room for the clients, is
where I did most of the observations. The space is multifunctional, sometimes it is
almost like a room for all the staffs to gather, relax and talk about their day, and most
of the time it is in use of formal activities, such as the working space for the
secretarial works, including typing of the medico-legal letters (Visum et repertum or
medical report for jurisdiction purposes). Other formal works done in the common
room are the medical records filing and completing, also the writing of laboratory
forms and other medical letters.

Aside from "interruptions" from a client coming for a consultation meeting or as a
new case registering, a typical day at the crisis center would be something like as
follows:

07.00 - 08.00: Changing of the staffs on duty. The secretary usually would be in by
this time of the morning. A person work as the cleaning service would sweep and
clean the floors. Doctor and the nurse or social worker from the night shift are
preparing to leave, some of them have other things to do, and some are retiring to
their homes. (Most of them are doing their job in the crisis center part-time, and they
have other occupations, for instances some of the doctors are also post-graduate
students, the social workers are doing research in their alumni faculty, and the
nurses are doing nursery in other clinics).

08.00 - 11.00: The new shift's staffs are getting busy with the latest. Checking on
new cases registered the day before, meetings scheduled for the day, reviewing
cases that needs to be reassess, or preparing their consultation material (if there are
some rescheduled clients). Making phone calls to remind the clients who have
appointment in the center, checking on meetings with NGOs (if any), and preparing
reports for them. In between, they sometimes make their instant noodle breakfast using the available electric pot, or some bread from the hospital's caterer who would usually arrives at these times to drop the morning snacks. Quite often I observe other staffs that are not on duty stop by to put their things there, making use of the cabinets as their locker. It is convenient for them, if they will have duty later that evening, because then they don't have to carry their belongings while attending their duty in the hospital (in this case the doctors who are studying their post-graduate course).

11.00 - 13.00: Lunch time. Another gathering time for the other staff members who happens to be around the neighborhood. Although not always, but usually lunchtime is the most hectic time of the day. It depends also on the situation of the center, if it is full and busy with clients and their companies, then the gathering is stopped, other staffs that are not on duty would slide away to have lunch elsewhere. If the center is not so busy, staffs on duty took turns to go out and have lunch, but if more people are around (other staffs) or busy with work, they sometimes prefer to stay in the center to just chitchat or simply time-saving.

13.00 - 15.00: The secretary usually went home around 14.00 or 15.00. She works most effectively during these times, because of less people around, and the day's schedule would have gradually been done. The staffs are usually tidying up their reports from today and finalizing the Visum et Repertum (if any) to hand in to the secretary. One of the staff would go down to the forensic laboratory to deliver laboratory specimen to be examined (if any).

15.00 - 18.00: The most relaxed time of the day. Usually all paper works are done, the secretarial work has stopped, as the secretary would go home by now. Some people started to come around and having chitchats and snacks. The television used to be on during this time of the day.
18.00 – 19.00: The changing time of the staffs on duty. The day staffs prepare to go, and the nurse usually cleaned up the examination room and the tools. Leaving notes to the evening shift’s people in the communication board for the unfinished work (if any, such as to hand in to the secretary some papers to be typed, etc.)

19.00 – 21.00: New staffs that are ready to do the night shift usually reads the report of the morning shift and review their cases that needs to be reassess, sometimes they are expecting consultation meetings for clients’ who prefer to come to the center at night, after work (although it is rare). The situation and activity inside the center is much quieter compared to the daytime.

22.00 – 07.00: Not much happening during this time of the evening. The staffs usually took turn on sleeping. They would lock the door, because no security personnel is available during night time. Officially our cleaning service boy, who also functions as the center’s security (although there are security officers provided by the emergency unit of RSCM) has gone home, and therefore there are no first line security to the center’s front door.

Clients are usually taken up two at a time, if there are more that two coming at the same time, because there are only two consultation rooms. The rest would be waiting in the waiting room outside the crisis center, used also as the intermediate ward’s waiting room.

The atmosphere of the crisis center was quite cheerful, especially during the prime time of the day, where other staffs would randomly dropped in for a lunch break or for finishing some work that was left during their last shift (for instance signing letters, checking up on schedules that has to be coordinated with clients). In the afternoon on some particular day, some would come to watch their favorite show on television together. I asked one of each profession how is this so, and they say:

“If we don’t enjoy our day we could be hurting ourselves too, because the work we’re doing are so close to depression, like to work on a DV
case, rape and even more, child abuse. Furthermore I don't think we have to be too drowned to the sadness, it won't be professional. I believe empathy is very important, but don't let it gets to you too much, it's not healthy."

"Kalo nggak begini, bisa suntuk sehari menangani kasus-kasus yang sedih-sedih kayak DV, perkosaan, apalagi penderaan anak. Lagipula saya rasa nggak harus otomatis kalau kita kerja di PKT dan menerima kasus-kasus yang menyedihkan, kita musti terbawa sedih. Itu kan nggak professional. Empati harus, tapi jangan sampai kita terlalu terbawa, nggak sehat itu namanya."

Even so, tension were also felt every once in a while when clients are present. Focusing on a client's case can be quite difficult for the staffs, especially the biomedical staffs, in terms of listening to their pondering confusion and jeopardy. As one staff told me:

"...sometimes it can be hard work too (to listen and at the same time staying neutral), we tend to give options and ideas, although it not right to do so. I also felt like, Oh my! ... Why would this woman want to go back to her husband after all what he did to her the whole time? And she also was willing to forgive him? That's amazing..."

"...kadangkala susah juga sih ya, kita pengen kasih pendapat, solusi, dan suka gemes sendiri juga, kalau dengar klien kok bisa udah dipukulin dan disiksa segitu lama, eh masih mau juga mempertahankan tinggal sama suaminya, bersedia maafin lagi!..."

When asked about the perceptions on why women come to the crisis center, they tend to agree that it very much varies. One interesting assumption from a colleague of mine came into a discussion. She said that these days she often found a pattern of women who report with her own initiative, for no intention of bringing it to a juridical purpose:
"They go to the police and asked for their report to be filed but not to be investigated, and then the police would refer her to us without requesting for a visum et repertum (the medical report for juridical purpose). She did not want her husband to be arrested or anything, she just want to report and then to have some sort of a proof that she is able to go further if the beating continues. In this case the proof she will get is the medical letter from us, that has a description of her physical condition."

"Mereka biasanya nggak mau suaminya ditangkap atau gimana, hanya ingin punya rekor di Polres untuk menunjang dukungan kalau-kalau kejadi pemukulan terulang lagi. Laporan itu akan jadi bukti bahwa bukan yang pertama kalinya dia dianiaya (kalau terulang)."

One thing that frustrates the staffs is the fact that for clients who go to the police first would usually suggested by the police to drop the report and make peace with her husband. Or as one of the doctor put it:

"Officers often talked the women out to make peace with their husbands instead of reporting it to be processed by them. They would told the women: ‘are you sure ma’am? It is quite normal for husbands and wife to have a quarrel, after all he is your husband.’"

"...aparat bisa-bisanya kasih opsi untuk daftar aduan resminya sementara aja, kalau temyata belum yakin masih bisa dibatalkan. Mereka sering tanya ‘apa ibu yakin?’ damai saja bu sama suami, namanya juga suami isteri, kalo ribut kan lumrah’"

On cases their handling, one staff mentioned about having problems when cases are flowing rapidly daily to the crisis center. There is a need to employ more staff, but at the same time one has to be well trained in gender sensitivity and technically competent before starting to work in a crisis center.
“On a busy day, we can handle around 4 to 6 clients within one shift. I think because we are the first hospital based crisis center with a multi discipline approach, most of hospitals or health posts refer their cases which need Visum et Repertum to us, even though all doctors are able to make Visum et Repertum. We could use more people, but at the same time it is a long process, first they need to be trained in gender sensitivity and technical competence.”

“Kalau lagi banyak kasus kita bisa sibuk sekali soalnya kan satu shift hanya bertiga. Kadang-kadang bisa 4 sampai 6 klien satu shift, soalnya kita pusat krisis yang pertama dengan pelayanan multidisiplin, jadi mungkin kasus-kasus dari rumah sakit lain di Jakarta di kirim ke kita karena kelengkapan aparat itu, padahal dokter dimana pun sebetulnya bisa sih bikin Visum. Kita perlu juga tenaga tambahan, tapi harus melalui beberapa pelatihan sensitivitas gender dan ketramilan.”

CASE ILLUSTRATIONS

On Understanding And Reactions Towards Domestic Violence
When asked about how they understand their situation (that was identified as domestic violence in literatures), these women had different ways to put it. One of the respondents formulated a very interesting and rather complex model on how her, and other women’s experiences are affecting her and their being. She (Mrs. UN) described it as a form of brainwash by men trying to control their (the wives’) lives, and that made some women, like her, dull and confused. The cycle of beating, continued with reconciliation (honeymoon phase) were confusing and thus make them passive and tend to look as if they just accept their situation. In her own words:

“When I experienced it in the beginning, after a while, I tried to think where it went wrong, what did I do and whether we could talk this over peacefully. I kind of analyze why. We, women who suffer the same experience, tend to have our minds blocked after the repeated beating cycle (of beating and reconciliation). We cannot see clearly anymore
as to what really happens. It is becoming like a learning process, and before we know it, this pattern is internalized and that we learn to accept and unquestioned. They, I mean we, were like being brainwashed."

"Saat mengalami ini, awalnya setelah beberapa kali kejadian berantem dan dia mukul, saya masih coba mikir dimana salahnya, apa yang saya bisa buat atau apa yang saya bisa bicarakan sama dia supaya ini tidak terjadi lagi.... Kita, wanita yang ngalami seperti saya, kadang sudah nggak bisa mikir lagi kalau sudah berulang kali terjadi. Kita nggak bisa memilah-milah mana dimana awal kesalahan yang menyebabkan cekcok seperti ini. Lama-lama dengan siklus ini wanita akan mengalami proses pemelajaran yang salah, dan ini akan menjadi sebuah pola yang kemudian nggak dipertanyakan lagi oleh wanita. Mereka, atau... kita lah, karena saya juga mengalaminya, seperti mengalami cuci otak."

This explanation fits the theory of 'learned helplessness' from Leonore Walker. It is a condition produced by the repeated three-staged cycle (tension building, acute battering and the batterer's loving contrition) that women experience in domestic violence. It is described as the process by which organisms learn that they cannot predict whether what they do will result in particular outcome. It does not mean they learn to behave in a helpless way.

When asked about causes of their husbands beating and abusing them, variety of answers was noted. Their first reactions and reasoning was focusing toward themselves, I noted several "self-blaming" explanations:

"In the beginning I thought maybe he is not so confident about himself. I have a better job and education background, also a better social life, I have more friends. I aslo came from a financially more settle family than his. I thought having those things made him feel worthless. I asked him once whether this is the problem for his rude attitude towards me. He denied it, and said none of those affected his
behavior. I believed him and thought, then it is not my fault, he just happened to have a personality problem and couldn't control his emotion."

"Awalnya saya pikir dia mungkin rendah diri karena pendidikan dan pekerjaan saya lebih bagus. Saya juga berasal dari keluarga yang lebih berada, dan pergaulan saya cukup luas. Jadi waktu itu saya pernah tanya baik-baik, kenapa dia kok suka perfukukan saya begitu, apa karena saya memiliki hal-hal itu yang "lebih" dari dia. Dia bilang nggak karena itu, dan dia nggak kasih penjelasan kenapa. Ya sudah, dia menyangkal itu semua, saya anggap dia ngga ada masalah dengan itu...."

"I think I did what it takes to be a good wife. But I have to admit, I often argue and did not always do what he told me, and that sometimes he is tired (from work). So, I guess that was what offended him the most, that I confronted his suggestions and those arguments took place when he just got home from work. But that's me, I don't like being told and ordered by others. One time he told me to quit my job after giving birth to our first child, and I said no. He didn't want to stop telling me and pushed me a lot to do it. After getting tired of arguing, I gave in and quit. I seldom do what he told me without arguing first. Other examples were countless, we argue over those little small daily things. That time I can rationalize his behavior, that he was probably tired."

"...Saya udah melakukan tugas saya sebagaimana layaknya seorang isteri tapi memang sering nggak nurut sama apa yang dia suruh saya. Mungkin itu yang bikin dia sebel. Saya orangnya ngga seneng diatur sih. Seperti waktu itu saya disuruh berhenti kerja setelah anak saya lahir, tapi saya nggak mau. Terus kita berantem, tapi akhirnya saya nurut juga kok, saya keluar dari kerjaan. Terus hal-hal lain yang sering saya lawan ya kecil-kecil lah, urusan rumah tangga sehari-hari. ...."

But in the end, all tend to agreed to the same ground, the causes are related to the husband's (and boyfriend's) low self-esteem and insecurity, as mentioned by two of
the respondents. One of them define it as a problem that has a psychological explanation and thus she said it has to be treated as an illness that needs a treatment:

"... I think his emotion is unstable and it was not my fault that he cannot control it. If he gets upset because I am luckier than him (in terms of financial, education and job opportunities), then I feel like I should take some part of the blame and would perhaps feel sympathy for him and would not leave him. But he... he has a problem, and I think he needs professional help, like a psychologist or a psychiatrist."

"... saya pikir emosi dia tidak stabil, dan saya tidak menyalahkan diri saya untuk itu. Kalau memang dia begitu karena kurang percaya diri yang disebabkan karena kelebihanyang saya miliki, saya baru nggak enak dan mungkin merasa simpati dan tidak akan ninggalin dia. Pokoknya saya rasa dia ada masalah kejiwaan dan perlu bantuan dari psikolog atau psikiater."

The last one (who was the only unmarried respondent) said the cause was insecurity and emotional instability that was inevitable to his aggressive character:

"He is very aggressive, it showed since the beginning, which I think was the reason I got interested on him too. But later on his aggressiveness turned negative because it was accompanied by feelings of insecurity. He cannot live without his friends and me, and thus became very protective and demanding. And whenever he felt like he lost a grip on me, he turned to another girl to make me jealous. So, those two things, I think, was the underlying cause to his bad behavior."

"Sejak awal saya liat dia orangnya agresif, dan itu juga yang bikin saya tertarik sama dia. Tapi lama-lama sifatnya makin negatif karena saya rasa ada perasaan nggak percaya. Dia kayaknya tergantung sekali sama teman-temannya dan juga saya. Kalau saya nggak perhatiin dia sedikit aja, dia langsung ngambek dan cari cara untuk menarik perhatian saya, antara lain..."
Many literatures said that domestic violence case in the world is still underreported due to existing obstacles that often limiting the options for a woman’s response, such as social stigma, fear, shame, not enough information, and other factors (Hasbianto, 1999; Heise, Ellsberg & Gottemoeller, 1999). At the same time, literatures are always mentioning that most of abused women are not passive victims (Bowker, 1993). The way the literature put it, most of the time, was almost as if the media is always trying to be careful not to use words that tend to “blame” women for the situation of underreported domestic violence cases.

The basic of this women’s passivity idea is the theory developed by Lenore Walker (1979) called the theory of “learned helplessness”. She questioned why is it that so many women endure such extreme violence for so long. This theory was a part from a bigger theory of the battered women syndrome as publicized in 1979, which has a key element of theory: that marital violence follows a three-stage cycle (tension building, acute battering, and the batterer’s loving contrition) and that the women’s experience of repeated cycles of violence produce in her a condition of learned helplessness. This theory of learned helplessness explains why so many women endure such extreme violence for so long. Walker noted that women who experience repeated physical assaults at the hands of their husbands have much lower self-concepts than women whose marriages were free from violence, and that repeated beatings and lower self-concepts leave women with the feeling that they cannot control what will happen to them (Gelles, 1999; p.86).

But according to a study done by Bowker, L.H. in 1983 battered women were not nearly as passive as they had been portrayed in the literature; instead they were active agents in trying to make their environments safer. How helpless is battered women? Bowker (1993) explains that women’s reaction to domestic violence and
their decision about whether to stay or leave a violent relationship are not the products of the personalities of battered women but rather are the result of the many social, psychological, economic and physical factors that hold women in abusive relationships. Although many battered women do not leave their abusers, and many who leave return again, battered women do resist their husbands and use a variety of strategies to protect themselves and their children (Gelles, 1999; p.87) He found that women he studied were actively resisted their victimization. The length of time it took the women to free themselves from abuse as a reflection of the intransigence of their husbands’ penchant for domination and the lack of support from traditional social institutions rather than as evidence of the women’s passivity or helplessness (Gelles, 1993; p. 155).

The findings of my study also fit Bowler’s theory that the women I talked to were not passive on facing the situation. They do resist their husbands by the use of strategies, such as reporting to the husband’s office (in order to ask for him to be given a professional punishment, as it is possible in the army):

“...First I came to my husband’s head quarter, his direct office, they then suggested me to just settle the fight and give in to make peace with my husband. They told me it’s useless to file for a divorce, and it’s costly. I was very disappointed then, but still I did what they say, I stayed with my husband... hoping there would be a change of attitude from him. There were none. This brought me to the next step, which is to go further to the higher hierarchy of my husband’s institution, the internal affairs...”

“...Awalnya saya ke atasan langsung suami saya, dianjurkan untuk rujuk dan kasih kesempatan suami. Saat itu walaupun kecewa saya dengerin juga anjuran itu, dan menunggu aja perubahan dari situasi. Tapi kemudian karena nggak ada perubahan saya dateng lagi kedua kalinya ke Paspampres dan lapor...”...
Another one was even ready for the court, as the progress of her divorce request was approved. She also manages to have new relationship with a man she knew from her office, who she said to be very supportive and that she is happier now:

"According to Islam, my request for a divorce is valid, and therefore they are now moving on and working on the legal process for my divorce... I am currently having a relationship with a man, he is a good friend of mine from my office, he is very supportive in every way. I am much better now..."

"...Saya sekarang sudah ada pacar baru dok, temen baik saya di tempat kerja. Dia sangat mendukung dan saya rasa ini sangat positif buat saya. Saya lebih tenang sekarang..."

The term 'client' is used for women and children who come to the crisis center, instead of using the word patient. This is what makes the center rather different from the hospital that are surrounding it. Just a couple of steps out from the crisis center, one might notice that it is a hospital, by the hospital's staff's use of the term “patient” as a regular word for any person who use the medical service.

**On Reaching Out and Seeking Help**

The women I interviewed had their differences in term of characteristics and background, but from their narratives, similar pattern of reaching out for relief were present quite clearly.

One woman in her early 30s came in to the center, it was her first time, she was referred by the police to have her bruises recorded and then to ask for a Visum et Repertum. She wanted to fail a divorce because her husband started hitting her since 7 years ago. She explained why she came later, instead of immediately after the first hitting (even though she knew it was not the right thing to do as husband and wife):
"...I was trying to understand, looking for reasons why he did those, at the same time giving him more time for a change, for the situation to change. But after waiting for so long, nothing has changed, in fact it got worse, especially with the presence of that woman. I could not accept it anymore, not when it involves another woman..."

"...saya masih mencoba mengerti dan mencari jawaban, sekalian memberi waktu siapa tau keadaan akan berubah, dia akan berubah. Tapi setelah tunggu sekian lama ngga ada perubahan malah tambah parah, apalagi dengan kehadiran perempuan itu, baru deh saya nggak tahan. Saya ngga bisa terima kalau ada perempuan lain..."

It is said that there is a relation of domestic violence to extra-marital affairs by husbands that was supported by the findings of a study done by Sutrisno, A.L between the years of 1992-1996. She also identified in most cases that disobedience or failure of the woman to fulfill her duties as a "good wife" was also said to be a precipitating factor (Sadli & Marlita, 1999).

All three respondents came to the crisis center as told by the police in order to have their medical report for jurisdictional purposes. But when asked whether that was their first reaction that involves a third person, they all disagree. All of them have talked to other people, namely, their parents and friends. Both respondents that are married talked to their parents as their first reaction. The reasons mentioned were because they are most close with their parents than with any other people. As they put it in their own words:

"I am very close to my mother, so I turned to her when it happened, the first time my husband hit me. I was shocked and could not accept the fact that he hit me, that's why I talked to her the next day. At that time my mother did not say much, I think she felt a little bit guilty, she was very much in support of our relationship since the beginning."

"Saya dekat dengan ibu, jadi saya cerita sama dia sejak pertama kali saya ngalamin dipukul suami. Saat itu saya kaget dan gimana ya, nggak terima. Karena itu saya langsung cari ibu saya dan cerita keesokan harinya. Saat itu ibu
When asked of their opinion was there any worry or shame when they reveal the story to others that did not affect them so much. They needed the ventilation, to release their distress, anger, and confusion.

"My family is quite a moderate one, and we don’t think that this is a disgrace. If a person is abused by his or her spouse it is not right, and therefore something must be done to do justice. That was how they taught me, and I carry that with me."

"Keluarga saya cukup moderat dan ini bukan sesuatu yang memalukan. Kalau seseorang disakiti pasangannya berarti itu tidak benar dan harus ditindak lanjuti demi keadilan. Itu yang saya lakukan sesuai dengan yang mereka ajarkan ke saya."

The other woman who is not married, did not go to her parents, because she did not want to make her parents worry too much, and especially because she has not decide what to do with the relationship. She was not sure. She turned to her friend instead, right after the first hitting.

"I did not want to tell my parents, and I haven’t until now. It is not because I don’t feel close to them, but I don’t want them to worry so much and overreact to protect me while I still don’t know what I want to do with this. I don’t even know if I want him to pay for what he did and processed by the law. So I talked to my closest girlfriend who happens to know my boyfriend. With her I feel like I can talk about everything without any worries of her judging me or anything, and she won’t be interfering too much as I know my parents would"

"Saya nggak berani bilang ke orangtua. Bukannya saya nggak dekat dengan mereka, tapi saya ngga mau mereka terlalu khawatir dan melakukan sesuatu untuk melindungi saya. Lagipula saya juga belum ngerti situasi ini dan belum
The two married women did not report to the police until the beatings repeated. Mrs. UN came after three years of living and experiencing beating by her husband. Mrs. LR was even longer, this is her first report to the police after 7 years of having beaten. Their reasons they gave were as follows:

"I did not report immediately to the police because I still want to see him change, and I was figuring things out. After 3 years, I could not see any change, and therefore I decided to end this with the help by the legal officers. I have my kid to take care and think about her future."

"Saya nggak langsung lapor karena saya masih mau liat perubahan, dan selain itu saya mencari jawaban dari semua ini. Tapi karena nggak berubah ya saya nggak bisa tunggu lebih lama lagi. Saya harus ke pihak yang berwajib untuk kemudian diproses yang betul. Anak saya masih harus saya pikirkan masa depannya."

"I tried to handle my feelings of anger and distress just for my children. I think they need an intact family and a father figure for the benefit of their development. Another reason was I did not know where to go for this problem, I just want my husband to change or pay for what he did to us (he left since the last 3 months without giving her any money). That was why I went to his office instead to ask for him to be fired which I thought would be the closest to even punishment."

"Saya tahan-tahan deh perasaan sakit hati dan marah karena saya punya anak dari dia yang saya pikir perlu figur ayah dalam pertumbuhan dan perkembangannya. Pertimbangan lain juga saya nggak tau musti ke mana. Makanya akhirnya saya ke kantor suami aja supaya dia dipecat."
On Their Hopes and Future Plans

The varying hopes and plans for the future were expressed in their narratives. Most of them wanted the situation to change, in expense of the husbands. One client tried to consult this matter to a psychiatrist hoping that her husband’s being the problematic element of their married to be treated or at least paid more attention, but she was unsatisfied with the situation:

“I went to see a psychiatrist with my husband in a military hospital. I thought that there might be a chance for the doctor to help analyze what was wrong in our marriage, be it my husband or myself. The doctor was not able to understand the problem, and always got me cornered instead of assessing the both of us, or him as the perpetrator. He was more on my husband’s side and thought I was not being a proper wife.”

“Saya dan suami pernah mencoba ke psikiater untuk mencoba memperbaiki situasi. Saya pikir dengan kehadiran professional sebagai pihak ketiga bisa ada perubahan sedikit. Tapi ternyata tidak. Dokternya bukannya menganalisa kita berdua atau ke suami malah memojokkan saya dan bilang mungkin saya kurang melayani suami seperti layaknya.”

This is often the case in health setting in Indonesia, that women go to hospitals to either consult their physical complaints in open or covered, or to go together with the husband to do a counseling like the presented case. Health care providers can play a crucial role in addressing violence against women. Especially in countries where health care systems are the only institutions that interacts with almost every woman at some point in her life. Moreover because violence increases the risk of other health problems for women, early help can prevent serious conditions that follow from abuse. But why then, health care providers have been slow in addressing violence against women? It was said that a complex interplay of professional, cultural, personal and institutional concerns shape the ability and willingness of health workers to address this problem. Some of the biggest barriers that block effective response are health care providers’ lack of technical competence, cultural
stereotypes, negative social attitudes and institutional constraints. (Heise, Ellsberg & Gottemoeller, 1999)

All the married respondents wanted to divorce their husbands, and they all did take care of the necessary process. One respondent said that she wanted to have a totally new life after the divorce will be granted successfully by the court of justice. She used the term “mistake” in addressing her marriage to her husband, that she won’t be repeating in the future:

“When all process is finished and I am a legally divorced woman, I won’t repeat the same mistake of marrying a person hastily, like now with my husband. I have to say to be married to him was not 100% my will, mother played some part on making us up... Now I am in the middle of a new relationship with a friend of mine from work. He is very supportive and I think this is positive for me. I am much happier.”

“Nanti setelah semua proses selesai dan saya sudah resmi cerai secara hukum, saya nggak akan mengulangi kesalahan yang sama. Waktu saya menikah dengan suami bisa dibilang bukan kehendah saya sepenuhnya. Ibu ada andil dalam menjodohkan... Sekarang saya udah ada pacar baru dok, temen baik saya di tempat kerja. Dia sangat mendukung dan saya rasa ini sangat positif buat saya. Saya lebih tentram sekarang.”

When they mention of future plans they always include their children’s well being and that they won’t settle for anything that might be harmful for them. Both women got their children with them and showed their strongest motivation to move on due to their children’s well being:

“My children are with me, and my parents take care of them while I am working (I started to work again now). I am sure I will try hard, and I am sure that I am be able to support them financially. I cannot rely on anybody anymore, my children are my responsibility.”
"Anak saya ada dengan saya, karena sekarang saya mulai kerja lagi saya titipin di orangtua. Saya akan cari uang sekuat tenaga untuk mencukupi kehidupan saya dan anak-anak, pokoknya saya nggak akan menggantungkan nasib di tangan orang lain, termasuk juga orang tua."

The respondent who was beaten by her boyfriend did not quite reveal her plans for the future, her hopes were less stronger but clear. She wanted her boyfriend to change his aggressive attitude and because she knew there were insecurity in him, she tend to give their relationship another chance:

"Next time if he hit me again then I will probably leave. But for now I am not sure, there are too many question marks in my mind that I have to settle with him. I want him to change, and maybe I can help, that is why I think it is better to give our relationship a try longer."

Grayson explained her findings in the study on marital violence and help-seeking patterns that more severe and frequent the attacks the more likely the woman was to seek outside help. And current study similar to findings by Gelles, found that help seeking increased only to the point of regular (once per month) abuse (Grayson, 1981; p.195).

**ANALYSIS & REFLECTIONS**

Themes that were brought up by women were about their understanding and experience of domestic violence, their reactions and help seeking behavior and hopes for the future. None expressed too strongly about the stigmatizing community holding them back to reach out and seek help. This is a good start, and although
cannot be generalized, it is good to know that some women are ready to fight back and therefore an adequate form of help should be available and accessible in a friendly and open environment.

Institutional support has to be reassessed and increased. As the working staff in the crisis center (who happens to be all women) mentioned in the early part of the chapter, that often the police or other legal support institution are not supportive towards women who report their domestic violence cases. This was crucial for women who came to the police station with still a doubt whether to report their case or not, they will be easily freaked out by the police’s reaction and will then go back home empty-handedly.

Health care providers being unsupportive was also noted from one of the respondents, and this is also very important when most women experiencing violence opt to go for a health care for help. Both institutions are a part of a society that has cultural stereotypes and negative social attitudes. Health care providers also officers of law apparatus typically share the same cultural values and societal attitudes toward abuse that are dominant in the society, which stand in the way of sympathetic and caring response to abused women who seek care.

Clinicians working with women experiencing domestic violence often feel that their institutions and colleagues value their work less than other types of clinical intervention. According to Heise et al (1999) legal liability or involvement also is a major concern that keeps health providers from doing more for these women who were abused, this is true in the case of PKT crisis center. As one staffs said, most cases that needed a Visum et Repertum from throughout Jakarta are referred to PKT as the first hospital-based crisis center, although all doctors are certified to make a Visum et Repertum. This was probably due to refusal of health workers in other institution to examine cases that are to be processed to court.

All of these problems need to be addressed in an integrated way by the government, as one of the service for public protection. The government needs to address the
problem and encourage the public services of the law apparatus and health to work in support of women with their domestic problems.
CHAPTER 5
CONCLUSION AND RECOMMENDATION

As a closure, I would like to stress out the fact that some women are able and want to make talk. Although this cannot be generalized without conducting a larger scale study, women who experience domestic violence are not all passive in terms of seeking help. Returning to the question I posted earlier, that whether women really kept their experience to themselves, that made the revelation of cases less, I believe I have reached some answers. No it is not so true, some women are ready to open up and report, as a tool to fight back and self—defense. But to get a clearer answer, a bigger scope of study is needed.

The role of the government is also needed in terms of increasing the quality and quantity of the law apparatus, including the law system, police/ army officers that are more sensitive to this issue, as well as the health care facility. Although changes are showing, such as the extension of the special unit for women’s cases in the police stations, where staffs are mostly women and are sensitive to women’s issues (such as rape and wife/spouse abuse), more efforts needs to be addressed further.

Most opinion about women who experience domestic violence is that there is a tendency to label these women as pitiable, weak and helpless. Although sounded simple, I believe it is important that one do not consider these women victims, but experts to this problem. We will have to learn from them in order to help and eradicate domestic violence. As a last remark, I would like to quote an important statement by Nabi and Homer: "...by recasting abused women as both victims and experts on domestic violence, rather than considering them simply as victims, we allow ourselves to pose the question that will enable such women to express their unique insights into the general phenomenon of spousal abuse and its potential solutions (Nabi & Homer, 2001).
References

Bowker, L.H
1986 Ending the violence: a guidebook based on the experience of 1000 battered wives. Learning Publications, United States

Bowker, L.H

Cook, R.J.
1993 Human rights in relation to women's health. The promotion and protection of women's health through international human rights law. World Health Organization, June 1993

Donna, A.M

Gelles, R.J
1997 Intimate violence in families, Sage Publications Inc.

Gelles, R.J

Grayson, J & G. Smith
1981 Marital violence and help seeking patterns in a micropolitan community. Victimology: an International Journal vol.6, no. 1-4; pp. 188-197

Hasbianto, E.N
Heise, L., M. Ellsberg & M. Gottemoeller

Kirkwood, C

Krishnan, S.T., J.C. Hilbert, D. VanLeeuwen

Lawler, Valerie
1997 Domestic violence: a case for routine screening. Key Center for Women's Health, Monograph Series. The university of Melbourne, Australia

Nabi R.L., J.R. Homer

O'Leary, K.D

Rosenberg, M.L., E. Stark & M.A. Zahn
Sadli, S & T. Marlita

Semler, V.J, et al

Shamai, M.

Stark, E & A. Flitcraft

Tomagola, T.A

Walker, L.E.A

Ylöö, Kresti A.
Appendix 1
THE MAP OF ONE-STOP CRISIS CENTER FOR WOMEN AND CHILDREN in CIPTO MANGUNKUSUMO HOSPITAL (Pusat Krisis Terpadu/PKT- Cipto Mangunkusumo/ RSCM)

Source: Cipto Mangunkusumo Hospital documents, given by permission from the Head of Pusat Krisis Terpadu (One-Stop Crisis Center), 2000
Appendix 2

SAMPLES OF TRANSCRIPTION
(Translated into English from Bahasa Indonesia)

Interview with Mrs. LR, 30 years old

SESSION 1
It was her first visit but she was in a rather calm and cooperative situation, and willing to be interviewed for this research. She didn’t want to be taped because she felt uncomfortable with its presence.

Status as a doctor and the crisis center’s staff was clearly stated, and that the purpose of the interview is for a medical anthropology study that I am doing. Confidentially was explained thoroughly. I asked her if I could take some identity information from the medical records that was taken earlier by the social worker, in order to save time and so she would not have to repeat again. She permitted me to do so.

Profile
Mrs. LR, 30 years old lives with her husband in East Jakarta, was born in Jakarta. Her religion is Islam, and has a Batak (North Sumatra) and Sundanese background. Her last education level was high school. She has been working in a travel agency for 3 months. She was working there before but her husband told her to stop working right before the first son was born. She has been married to her husband since the year 1995, and has two children, the first-born is 8 years-old boy now in his elementary school, and the second one is a 3 years old girl. Her husband is 34 years old, works in the army, and has a history of drinking alcohol. Frequency of her being abused was more than 5 times within the last 6 months.
Hello L, let us start with the reason why you're here. What was the reason you came in the first place to this center for women?

L: In the beginning I came to ask for a visum et repertum, as the Provost (military office) told me to do, to complete the process of my request to have a divorce. My husband is a police man. Next thing I know I was scheduled several times for a psychological consultation.

How do you feel now?
L: (pause) I'm rather confused ...

Why?
L: Yes, just confuse... it has been quite a long time that I have asked for a process for a divorce, and yet it is very complicated and difficult. Maybe it's because of my husband's occupation? First I came to my husband's head quarter, his direct office, they then suggested me to just settle the fight and give in to make peace with my husband. They told me it's useless to file for a divorce, and it's costly. I was very disappointed then, but still I did what they say, I stayed with my husband and buried my desire to have a divorce, at the same time hoping there would be a change of attitude from him. There were none. This brought me to the next step, which is to go further to the higher hierarchy of my husband's institution, the internal affairs. But it was the same, no one paid any serious attention to my report. I suspected that they were afraid if this is processed, then there will be a shift of position at the office, which is not good for them.

How so?
L: Yes, if my husband was to be fired, then somebody will replace him, and therefore the whole structure has to be shifted.

How is your relationship with your husband, you mentioned you want to divorce him. Can you explain to me more about this?
L: Well... (she paused, took a deep breath and looked as if she's looking for the right words)... 

Can you tell me when do this feeling of wanting to divorce him began?

L: I think it was from the year 2001, that was when I suspected the presence of another woman. My husband rarely came home, and if he did come home, it was always late. If I asked him where he had been, it would always triggered the fights.

How did you come about the presence of another woman?

L: That time I saw him coming home with a love bite on his neck, and he frequently received an sms message in his cellular. She called often too, and when he was talking to her, he sounded different, mmm, rather sweet and tender, also the contents of the talking was the kind of intimate things, like his daily activities, his dinner, lunch, ... you know those sweet nothings...

Did you ask him about her?

L: Yes, I did and when I asked of this women, he always said it's a friend, and got offended. He denied all the time if I accused him of having a relationship with this woman.

You said earlier that if you asked him about this woman or the reason why he came home late, would trigger the fights? Can you explain more about the fights?

L: Yes, he would hit me with his hands. One time he made a bruise in my face and arms which was quite awful. He would pull my hair, and sometimes throw things to me, like things that he can get a grab on.

Do you remember the first time that he hit you?

L: Actually it started right after we got married. That was back in 1995, after my child is born, I think my first child was then one month old. He is a hard man with a short temper, I kind of see this tendency every since we were going steady.
Did he ever hit you when you were going steady?
L: No, but like I said, he has a short temper and it showed.

So he started hurting you physically not long after you got married. How often was or is it and what causes it?
L: In the beginning it was not too often. It usually started if we’re having arguments. I think that would be like....(thinking) once every 2 or 3 months. What causes it? I think he’s tired and I often confronted his suggestions and ideas. I don’t think he liked that. That time I can rationalize his reasons, that he was probably tired.

You used the word rationalize, what do you mean by this?
L: What I mean is that, that time I tried to understand why he did that bad thing to me, I was trying to make sense of it all.

Does that help you understand? Did that satisfy you?
L: At least that gave me a reason to stay, and made me think and reflect what I can do to make him better. To make situation better. I was hoping things get better.

Then what happened? Is there any change?
L: No, it got worse. He even hit me more frequently and not empty-handed anymore. He threw things too. It seemed like it’s getting out of control, he did those in front of my kids and he seemed like he don’t care.

And how frequent was that?
L: It started early 2001 and the frequency is almost like once every month. Sometimes every twice a week or so. I didn’t remember so much.

Why do you think, this time, that he hit you more frequent?
L: Oh God, I don’t know why. That time I started to get very confuse and lost, I really don’t know what was the reason. Sometimes he hit me for no obvious reason, just
small things could irritate him, and caused the hitting. Til today I couldn’t figure out why. (Looked frowned and devastated)

Can you repeat it chronologically?
L: Karena seperti saya bilang tadi, saya masih mencoba mengerti dan mencari jawaban, sekalian memberi waktu siapa tau keadaan akan berubah, dia akan berubah. Tapi setelah tunggu sekian lama ngga ada perubahan malah tambah parah, apalagi dengan kehadiran perempuan itu, baru deh saya nggak tahan. Saya ngga bisa terima kalau ada perempuan lain.

**Interview with Mrs. UN, 28 years old**

**SESSION 1**
She refused the interview to be taped. The reason she mentioned was that she feel weird telling her story with a tape, feeling awkward.
My status as a doctor, and the crisis center’s staff, doing a medical anthropological research was mentioned in the introduction. Confidentiality was also stressed out.

**Profile**
Mrs. UN, 28 years old lives with her husband in Southern Jakarta. She was born in Jakarta, her religion is Islam and has a Javanese and Minang (Western Sumatra) ethnic. She has a diploma in secretarial studies as her education background. She works at for the government in the tax directory. She was married in the year 1998. Her husband is 27 years old, works at a bea cukai office, who has no history of alcohol or drug use. They have one daughter who is 3 years old.

Hello UN, let us start with the reason why you’re here. Why do you come here? (she looked puzzled) You look a little confuse, let me explain more; when did you first come here and for what reason did you came?
U: I don’t understand. Maybe it is better for you to read my medical record so that I don’t have to tell you from the very beginning again. I am rather fed up.
You don't mind me reading through you medical records?
U: Not at all.

OK. For what reason do you want to divorce your husband?
U: He hit me since the beginning of our marriage, that was 3 years ago. I want a change, for a better one, for me and my child.

Why do you think he is like that?
U: I think he has a problem of emotional instability.

How do you feel about this?
U: My mother liked him so much, and she kind of make us together. I was not totally happy when I married him. So, how do I feel about this? I feel distressed and angry.

Why were you not totally happy then?
U: Because of the responsible after one got married. I felt like I was not ready. But I did it anyway to make my parents happy, and he was nice to me so that was OK too.

Not ready? In what way?
U: I still wanted to be free and not having other person to take care. I want to have a life with my friends and explore opportunities.

Before reporting to the police and came here, did you ever talk to anyone about this problem before?
U: I am very close to my mother, so I turned to her when it happened, the first time my husband hit me. I was shocked and could not accept the fact that he hit me, that's why I talked to her the next day. At that time my mother did not say much, I
think she felt a little bit guilty, she was very much in support of our relationship since the beginning.”

**Interview with Ms.A, 22 years old**

**SESSION 1**
She came to the crisis center, accompanied by her best friend to have her visum et repertum, as told by the police who handled the case (she reported a couple of hours before coming). This was the second time her boyfriend physically violated her. She refused the interview to be taped.

**Profile**
Ms.A 22 years-old, lives with her parents in Central Jakarta. She is a student in a university in Jakarta. She was born in Jakarta, her religion is Christian and has a Javanese ethnic background. She has been physically abused by her boyfriend in the last two-months or so.

Hello A, how are you doing?
A: (smile... no reply)

Is this your first time here?
A: Yes.

Who inform you about this crisis center?
A: I was told by the police to come here to ask for visum et repertum for the process of my case.

Oh so you went there and report your case?
A: Yes, this morning.
What happened? Can you tell me?
A: My boyfriend hit me yesterday. I know I should come yesterday before the bruise fade away. But I was too shocked and did not know where to go, until my friend urged me to.

Why did he hit you? Can you tell more in detail?
A: I saw him with another girl, as I stepped in to his house. She was sitting on his lap, well they were cuddling. I immediately went after them and scolded my boyfriend, I was very furious. He then yelled at me to go away and I refused, so I yelled back at him to tell the girl to go away and go to h**l. He got mad and then hit me with his hand. I tried to hit back but he was of course stronger than I, so in the next thing I know I was lying on the floor. Then I went off.

Did he chase after you?
A: No. I ran to a friend’s house a couple of house next to his. There I called a cab and then went to another friend’s house.

How do you feel then?
A: Very angry and disappointed, and at the same time I hate myself for not being able to fight back.

How long have you been with him?
A: About a year and a half.

Where did you first meet him?
A: I was introduced to him by my friend. We got along well after that.

Is this the first time that he hit you?
A: No. I think about six month ago he slapped me. I did not like the friends that he hanged out a lot with. I asked him not to see them too much. He got angry and
thought I interfere too much. He slapped me when I told him that I think his friends are not a healthy environment for him.

Why is it not healthy?
A: Well, from what I heard... they do drugs. I don't want him to get influenced.

What happened then, when he first slap you? How were you feeling about that?
A: Well, I thought I was rude enough to accuse his friends, although I was trying to protect him. But I also would be offended if he ever talked bad about my friends, so I know I must be offended especially these guys are like his identity, you know. I never talked to him about his friends again. I knew that it would always bring on arguments and fight.

That's why you did not leave him?
A: Leaving him? Oh no, I did not think of that at all that time. I was too much in love with him, I think. Although indeed I was shocked that he could slap me for what I said, that I thought was an expression of my caring.

So, how do you feel about him now?
A: I don't know. I am still very mad about him cheating on me. I did heard from some friends that this girl is eyeing him ever since. But I believe it wouldn't change him and us. I felt betrayed. I did ask about her before, when I first heard rumors from friends. He was laughing about it and deny it and told me they were just friends. (paused, looking like she wanted to say more but could not find the words)

...and?
A: The feeling is... I think still is there, probably, but too much anger is inside me right now. What I know now is that I don't want to see or talk to him for sometime. Then I don't know. I have other male friends that are very nice to me you know. I could just leave my boyfriend anytime and not having to feel alone or insecure. They (her male friends) are ready to protect me anytime I needed them.
Appendix 3

ORGANIZATION STRUCTURE CRISIS CENTER FOR WOMEN AND CHILDREN
(PUSAT KRISIS TERPADU/PKT) - CIPTO MANGUNKUSUMO HOSPITAL
(RSCM)

Source: Cipto Mangunkusumo Hospital (RSCM) documents, given by permission from the
Head of Pusat Krisis Terpadu (One-Stop Crisis Center), 2000
Appendix 4: Problem Analysis Diagram

PROVIDER FACTOR

- poverty
- socio-cultural & economic factors

SOCIO-CULTURAL & ECONOMIC FACTORS

- religious beliefs
- belief of taboo when revealing domestic problems
- fear of being punished by husbands for telling it to a third party
- financial dependency
- poor education & no occupation
- poor knowledge about the situation
- stigma attached & shame
- assurance of behavioral change of husbands
- child's future
- belief that she deserves this treatment as a punishment for not being a good enough wife

POOR HELP SEEKING BEHAVIOR OF WOMEN SUFFERER OF DV

- poor law system
- insensitive staff of law to gender issues
- no facility (centers including save houses) available for care special for DV cases
- poor quality of service: lack of fund and priority
- acknowledgment from government

POVERTY

Note: Texts shaded with grey are coexisting assumptions not to be included in the study.
Appendix 5
PICTURES FROM THE CRISIS CENTER

Appendix 5

PICTURES FROM THE CRISIS CENTER