WOMEN'S AID ORGANISATION
PERTUBUHAN PERTOLONGAN WANITA

Strengthening the Primary Healthcare Response to Domestic Violence

December 2020

A. Overview

- Primary healthcare centres, such as *Klinik Kesihatans*, are the most well-placed institution to reach domestic violence survivors, as survivors most frequently seek help from the healthcare system,[1] and primary healthcare centres are survivors' first point of contact with the system.

- Yet, there is currently no systematic response mechanism to domestic violence at the primary healthcare level. Consequently, many survivors who seek care at primary healthcare centres do not receive adequate support.

- Recommendations:

    1. Display information on domestic violence in the waiting rooms and washrooms of *Klinik Kesihatans* and hospitals.
    2. Require healthcare providers to ask about domestic violence when patients have clinical conditions associated with domestic violence.
    3. Train healthcare providers to recognise, respond to, and refer cases of domestic violence.
    4. Establish a referral system for domestic violence at the primary healthcare level.

B. Context

- In Malaysia, hospitals and health centres are the places where domestic violence survivors most frequently go to seek help—even ahead of police stations and non-governmental organisations.[2]

- Primary healthcare centres, in particular, are the most well-placed institution to detect and respond to domestic violence, as they are survivors' first point of contact with the healthcare system.

- **22% of 882 women who visited primary healthcare clinics in Kuala Lumpur had experienced domestic violence**, a 2019 study revealed.[3] This is higher than the overall prevalence of domestic violence in Peninsular Malaysia: 9% of ever-partnered women in Peninsular Malaysia have experienced domestic violence, according to a 2014 study.[4]

1 Shuib, R., Ali, S. H., Abdullah, S., Ab Ghani, P., Osman, I., Endut, N.,...Shahrudin, S.S. (2014). Executive Report, Summary of Findings: A Country Level Study of Women's Well-being and Domestic Violence Against Women (DVAW) Using WHO Multi-country Questionnaire. Women's Development Research Centre (KANITA), Universiti Sains Malaysia.

2 Ibid.

3 Othman, S., Yuen, C. W., Zain, N. M., & Samad, A. A. (2019). Exploring Intimate Partner Violence Among Women Attending Malaysian Primary Care Clinics. *Journal of Interpersonal Violence*, 088626051983942. https://doi.org/10.1177/0886260519839426

4 Shuib, R., Ali, S. H., Abdullah, S., Ab Ghani, P., Osman, I., Endut, N.,...Shahrudin, S.S. (2014). Executive Report, Summary of Findings: A Country Level Study of Women's Well-being and Domestic Violence Against Women (DVAW) Using WHO Multi-country Questionnaire. Women's Development Research Centre (KANITA), Universiti Sains Malaysia.

- Domestic violence can underlie or complicate various clinical conditions, particularly those related to mental health and sexual and reproductive health.[5] [6] [7] [8] Hence, addressing domestic violence is critical for managing these conditions effectively.[9]

C. Current gaps in the Malaysian primary healthcare response to domestic violence

Despite having the opportunity to intervene in domestic violence, primary healthcare centres often fail to do so because of at least three gaps.

1. **Some survivors have the "misconception that healthcare professionals do not assist patients with domestic violence"[10]**

   - Some survivors perceive that healthcare providers only treat injuries and diseases.[11] As a result, survivors, who may already be in contact with a healthcare provider, miss the opportunity to access further support for domestic violence.

   - This gap underscores the need to publicise the support that is available for domestic violence survivors at healthcare centres.

2. **Healthcare providers often do not ask about domestic violence**

   - 92.4% of women who visited primary healthcare centres in Selangor reported that they had never been asked by their doctor about domestic violence. At the same time, 67.3% said they would be willing to tell their doctor if they were experiencing domestic violence.[12]

   - 26.2% of primary care clinicians at the University Malaya Medical Centre had "never screened any of their patients for domestic violence", while 68.9% only asked about domestic violence "at times". Barriers to asking include lack of time, "concern about offending the patient", and being "unsure of how to ask".[13]

   - Even when patients show signs of domestic violence, some healthcare providers still fail to ask about domestic violence, missing the opportunity to intervene in the violence, as shown by the following case study by the Women's Aid Organisation.

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5 World Health Organization. (2013). *Responding to intimate partner violence and sexual violence against women Who clinical and policy guidelines.* https://www.who.int/reproductivehealth/publications/violence/9789241548595/en/.

6 World Health Organization. (2013). *Global and regional estimates of violence against women: prevalence and health effects of intimate partner violence and non-partner sexual violence.* https://www.who.int/publications/i/item/9789241564625.

7 World Health Organization. (2017, November 29). *Violence against women*. World Health Organization. http://www.who.int/en/news-room/fact-sheets/detail/violence-against-women.

8 Jewkes, R. (2013). Intimate partner violence: the end of routine screening. *The Lancet*, *382*(9888), 190–191. https://doi.org/10.1016/s0140-6736(13)60584-x

9 Ibid.

10 Othman, S., Goddard, C., & Piterman, L. (2013). Victims' Barriers to Discussing Domestic Violence in Clinical Consultations. *Journal of Interpersonal Violence*, *29*(8), 1497–1513. https://doi.org/10.1177/0886260513507136

11 Ibid.

12 Yut-Lin, W., & Othman, S. (2008). Early Detection and Prevention of Domestic Violence Using the Women Abuse Screening Tool (WAST) in Primary Health Care Clinics in Malaysia. *Asia Pacific Journal of Public Health*, *20*(2), 102–116. https://doi.org/10.1177/1010539507311899

13 Othman, S., & Adenan, N. A. M. (2008). Domestic violence management in Malaysia: A survey on the primary health care providers. *Asia Pacific Family Medicine*, *7*(1), 2. https://doi.org/10.1186/1447-056x-7-2

Case study: Healthcare providers failed to ask about domestic violence despite patient's inconsistent explanation for a domestic violence-related injury

"After getting badly beaten and injured by her husband, Kate was taken to the hospital by an ambulance. Scared and intimidated by her husband, she lied to hospital staff and stated that she had fallen off a motorbike. Although the paramedics had found her in the house with blood all over the floor and injuries that were unlikely to arise from a motor accident, they did not follow up on the likelihood that this was caused by her husband's violence. Despite the severity of the injuries, the hospital did not seem to engage in any sort of due diligence to assess the on-going risk to Kate, and whether she had children at home who may have also been at risk. The hospital staff even allowed the husband to take her back home from the hospital."[14]

3. **Currently, there are no guidelines for responding to domestic violence at the primary healthcare level**

- The only Ministry of Health guidelines for responding to domestic violence are those for the One Stop Crisis Centres (OSCC), integrated centres for responding to domestic violence, sexual assault, and child abuse located in the emergency room of government hospitals.

- Response and referral guidelines at the primary healthcare level are crucial because primary healthcare centres, such as *Klinik Kesihatans*, can help prevent or intervene in domestic violence before it escalates into a crisis that requires emergency care. Prevention and early intervention would reduce strain on emergency rooms.

- The absence of response and referral guidelines hinders primary healthcare providers from asking about domestic violence, as they may be uncertain as to what to do once a patient discloses domestic violence.

D. World Health Organization Guidelines for Responding to Intimate Partner Violence

How do we address the gaps in the primary healthcare response to domestic violence? The World Health Organization has developed guidelines for responding to intimate partner violence, which can inform our response.[15] Below is an excerpt of the guidelines:

14 Dandavati, N., & Tan, S. (2019). *Where's the Child? The Rights of Child Domestic Violence Survivors.* Women's Aid Organisation. https://wao.org.my/publications/wheres_the_child/.
15 World Health Organization. (2013). *Responding to intimate partner violence and sexual violence against women Who clinical and policy guidelines.* https://www.who.int/reproductivehealth/publications/violence/9789241548595/en/.

Recommendations	Quality of Evidence	Strength of recommendation
Women who disclose sexual assault by any perpetrator or violence of any form by an intimate partner or other family member should be offered immediate support. Health-care providers should, as a minimum, offer first-line support when women disclose violence. (see Box A)	Indirect evidence	Strong
"Universal screening" or "routine enquiry" (i.e. asking women in all health-care encounters) should not be implemented.	Low- moderate	Conditional
Health-care providers should ask about exposure to intimate partner violence when assessing conditions that may be caused or complicated by intimate partner violence, in order to improve diagnosis, identification and subsequent care. (see Boxes B & C)	Indirect evidence	Strong
Written information on partner violence should be available in health-care settings, in the form of posters, and pamphlets or leaflets made available in private areas such as women's washrooms.	No relevant evidence was identified	Conditional

Box A: First-line Support

- being non-judgmental, supportive, and validating what the woman is saying
- providing practical care and support that responds to her concerns, but does not intrude
- asking about her history of violence, listening carefully, without pressuring her to talk (care should be taken during sensitive topics when interpreters are involved)
- providing information about resources, including legal and other services that she might think helpful
- assisting her to increase safety for herself and her children, where needed
- providing or mobilizing social support.

It is important to ensure:

- that the consultation is conducted in private
- confidentiality, while informing women of the limits of confidentiality, for example if there is mandatory reporting.

Box B: Examples of clinical conditions associated with intimate partner violence

- Symptoms of depression, anxiety, post-traumatic stress disorder (PTSD), sleep disorders

- Suicidality or self-harm
- Alcohol and other substance use
- Chronic pain (unexplained)
- Unexplained chronic gastrointestinal symptoms
- Unexplained genito-urinary symptoms including frequent bladder or kidney infections
- Adverse reproductive outcomes including multiple unintended pregnancies and/or terminations, delayed pregnancy care, adverse birth outcomes
- Unexplained reproductive symptoms including pelvic pain, sexual dysfunction
- Repeated vaginal bleeding and sexually transmitted infections (STIs)
- Traumatic injury, particularly if repeated and with vague or implausible explanations
- Problems with the central nervous system – headaches, cognitive problems, hearing loss
- Repeated health consultations with no clear diagnosis
- Intrusive partner or husband in consultations

Box C: Minimum requirements for asking about intimate partner violence

- A protocol/standard operating procedure
- Training on how to ask, first-line response or beyond
- Private setting
- Confidentiality ensured
- A system for referral in place

E. What is the best way to detect domestic violence?

- Generally, there are four methods used by healthcare providers to detect domestic violence:
    - Universal screening: asking all women about their exposure to domestic violence using a standardised set of questions.
    - Selective screening: screening only high-risk groups of women.
    - Routine enquiry: asking all women about their exposure to domestic violence, though the method or questions used may differ.
    - Case findings: asking about domestic violence only if a woman has clinical conditions associated with domestic violence. [16]

- The World Health Organization **does not recommend universal screening or routine enquiry** because while they generally increase the detection of domestic violence, they have not been shown to reduce the reoccurrence of domestic violence or to improve women's health outcomes.[17]

- A systematic review also showed that while universal screening increases the identification rates for domestic violence, these rates were still relatively low compared

16 O'Doherty, L. J., Taft, A., Hegarty, K., Ramsay, J., Davidson, L. L., & Feder, G. (2014). Screening women for intimate partner violence in healthcare settings: abridged Cochrane systematic review and meta-analysis. *Bmj*, *348*, g2913. https://doi.org/10.1136/bmj.g2913
17 World Health Organization. (2013). *Responding to intimate partner violence and sexual violence against women Who clinical and policy guidelines*. https://www.who.int/reproductivehealth/publications/violence/9789241548595/en/.

to the estimated prevalence of domestic violence.[18]

- In 2006, researchers tested out the **Women Abuse Screening Tool (WAST) in primary healthcare centres in Selangor.** The study revealed **a domestic violence prevalence of 5.6%,**[19] which is modest compared to the overall domestic violence prevalence of 9% in Peninsular Malaysia.[20]

- Subsequently, in 2019, another screening tool, the **Women's Experience with Battering Scale (WEB),** was used in **primary healthcare centres in Kuala Lumpur,** revealing a significantly higher d**omestic violence prevalence of 22%.**[21] There has yet to be any studies in Malaysia about the impact of universal screening on the reoccurrence of violence, women's health outcomes, and referral rates to other agencies.

- The World Health Organization and the UK's National Institute for Health and Care Excellence **recommend the use of case findings** for detecting domestic violence.[22] One benefit of case findings is that it can improve clinical care. Given that domestic violence can underlie or complicate various clinical conditions, knowledge that a patient is exposed to domestic violence is crucial for providing relevant advice and quality care. Moreover, domestic violence survivors may be more willing to seek support when they see the impact of violence on their health. [23]

Case Study - Identification and Referral to Improve Safety (IRIS): A domestic violence intervention for primary healthcare centres in the UK

Under the Identification and Referral to Improve Safety (IRIS) programme, primary healthcare providers in Hackney and Bristol, UK, received training to detect domestic violence and to refer cases to a specific domestic violence advocate-educator from a local domestic violence agency. The training, which consisted of two two-hour sessions, was conducted by the advocate-educator together with a local clinician. The advocate-educator also provided ongoing support to the primary healthcare team.[24]

When patients exhibited clinical conditions associated with domestic violence, the ***electronic medical records automatically prompted the healthcare provider to ask about domestic violence.*** *The medical records also included a template for recording domestic violence.*[25]

18 O'Doherty, L. J., Taft, A., Hegarty, K., Ramsay, J., Davidson, L. L., & Feder, G. (2014). Screening women for intimate partner violence in healthcare settings: abridged Cochrane systematic review and meta-analysis. *Bmj*, *348*, g2913. https://doi.org/10.1136/bmj.g2913

19 Yut-Lin, W., & Othman, S. (2008). Early Detection and Prevention of Domestic Violence Using the Women Abuse Screening Tool (WAST) in Primary Health Care Clinics in Malaysia. *Asia Pacific Journal of Public Health*, *20*(2), 102–116. https://doi.org/10.1177/1010539507311899

20 Shuib, R., Ali, S. H., Abdullah, S., Ab Ghani, P., Osman, I., Endut, N.,...Shahrudin, S.S. (2014). Executive Report, Summary of Findings: A Country Level Study of Women's Well-being and Domestic Violence Against Women (DVAW) Using WHO Multi-country Questionnaire. Pulau Pinang: Women's Development Research Centre (KANITA), Universiti Sains Malaysia

21 Othman, S., Yuen, C. W., Zain, N. M., & Samad, A. A. (2019). Exploring Intimate Partner Violence Among Women Attending Malaysian Primary Care Clinics. *Journal of Interpersonal Violence*, 088626051983942. https://doi.org/10.1177/0886260519839426

22 World Health Organization. (2013). *Responding to intimate partner violence and sexual violence against women Who clinical and policy guidelines*. https://www.who.int/reproductivehealth/publications/violence/9789241548595/en/.

23 Jewkes, R. (2013). Intimate partner violence: the end of routine screening. *The Lancet*, *382*(9888), 190–191. https://doi.org/10.1016/s0140-6736(13)60584-x

24 Sohal, A. H., Feder, G., Barbosa, E., Beresford, L., Dowrick, A., El-Shogri, F., … Griffiths, C. (2018). Improving the healthcare response to domestic violence and abuse in primary care: protocol for a mixed method evaluation of the implementation of a complex intervention. *BMC Public Health*, *18*(1). https://doi.org/10.1186/s12889-018-5865-z

25 Ibid.

Additionally, cards and posters about domestic violence were displayed in the primary healthcare centres.[26]

The programme has shown promising results: primary healthcare centres that implemented the programme identified "three times more women experiencing domestic violence" and referred seven times more women to domestic violence agencies, compared to centres that did not implement the programme.[27]

What is unique about the programme is that it involved close collaboration between primary healthcare centres and local domestic violence agencies, whereby there was a ***direct referral pathway to a specific domestic violence advocate-educator****, who also provided ongoing support to the primary healthcare team. Additionally, the training was done jointly by the advocate-educator and a respected clinician, and* ***the presence of the clinician lent credibility to the training team.*** [28]

F. Recommendations

1. Display information on domestic violence in the waiting rooms and washrooms of Klinik Kesihatans and hospitals

- This recommendation is based on World Health Organization guidelines.[29]

- Placing leaflets in the women's bathroom enables survivors to obtain information in a discreet manner, which helps ensure their safety, especially if they are accompanied by their abuser to the clinic. Displaying information on domestic violence also sends the signal that the healthcare centre is sensitive to domestic violence, which may encourage survivors to seek help.

- As part of a domestic violence intervention in the US, posters on domestic violence were displayed in the waiting areas of clinics, while brochures were placed in clinic washrooms. These measures were found to be useful: several domestic violence survivors who had viewed the posters later self-disclosed the abuse to their healthcare providers. Patients also regularly took the brochures from the washrooms.[30]

26 Feder, G., Davies, R. A., Baird, K., Dunne, D., Eldridge, S., Griffiths, C., … Sharp, D. (2011). Identification and Referral to Improve Safety (IRIS) of women experiencing domestic violence with a primary care training and support programme: a cluster randomised controlled trial. *The Lancet*, *378*(9805), 1788–1795. https://doi.org/10.1016/s0140-6736(11)61179-3

27 Ibid.

28 Health Foundation. (2011). *The Iris Case Study: Implementing a Successful Primary Care Domestic Violence Service: Early Experiences*. https://www.health.org.uk/publications/case-study-identification-and-referral-to-improve-safety-iris.

29 World Health Organization. (2013). *Responding to intimate partner violence and sexual violence against women Who clinical and policy guidelines*. https://www.who.int/reproductivehealth/publications/violence/9789241548595/en/.

30 Thompson, R. S., Rivara, F. P., Thompson, D. C., Barlow, W. E., Sugg, N. K., Maiuro, R. D., & Rubanowice, D. M. (2000). Identification and management of domestic violence: A randomized trial1. *American Journal of Preventive Medicine*, *19*(4), 253–263. https://doi.org/10.1016/s0749-3797(00)00231-2

2. Require healthcare providers to ask about domestic violence when patients have clinical conditions associated with domestic violence

- This recommendation is based on World Health Organization guidelines[31] as well as the UK's National Institute for Health and Care Excellence quality standards for domestic violence and abuse.[32]

- Domestic violence can underlie or complicate various clinical conditions.[33] [34] [35] [36] Thus, asking about domestic violence enables healthcare providers to manage these conditions more effectively.[37]

- Domestic violence survivors are more willing to disclose domestic violence if healthcare providers initiate the conversation, a Malaysian study found.[38] The Identification and Referral to Improve Safety (IRIS) programme in the UK also showed that most disclosures of abuse were prompted by healthcare providers, and that "women-led disclosures were unusual".[39] Thus, healthcare providers should proactively ask women about domestic violence.

- Special attention should be given to detecting domestic violence among patients at antenatal clinics, as the health consequences of violence are graver during pregnancy.[40] Pregnant women also visit antenatal clinics multiple times throughout their pregnancy, giving healthcare providers more opportunity to detect domestic violence and provide follow-up.

3. Train healthcare providers to recognise, respond to, and refer cases of domestic violence

- Training on domestic violence is one of the minimum requirements for asking about domestic violence outlined by the World Health Organization.[41] The training can be incorporated into medical and nursing school curricular as well as continuing professional development programmes.

- Such training is crucial, as concerns about offending patients and not knowing how to ask were among the top barriers to asking about domestic violence cited by primary care clinicians at the University Malaya Medical Centre.[42]

31 World Health Organization. (2013). *Responding to intimate partner violence and sexual violence against women Who clinical and policy guidelines*. https://www.who.int/reproductivehealth/publications/violence/9789241548595/en/.
32 National Institute for Health and Care Excellence. (2016, February 29). *Quality statement 1: Asking about domestic violence and abuse: Domestic violence and abuse: Quality standards*. http://www.nice.org.uk/guidance/qs116/chapter/Quality-statement-1-Asking-about-domestic-violence-and-abuse.
33 World Health Organization. (2013). *Responding to intimate partner violence and sexual violence against women Who clinical and policy guidelines*. https://www.who.int/reproductivehealth/publications/violence/9789241548595/en/.
34 World Health Organization. (2013). *Global and regional estimates of violence against women: prevalence and health effects of intimate partner violence and non-partner sexual violence*. https://www.who.int/publications/i/item/9789241564625.
35 World Health Organization. (2017, November 29). *Violence against women*. http://www.who.int/en/news-room/fact-sheets/detail/violence-against-women.
36 Jewkes, R. (2013). Intimate partner violence: the end of routine screening. *The Lancet*, *382*(9888), 190–191. https://doi.org/10.1016/s0140-6736(13)60584-x
37 Ibid.
38 Othman, S., Goddard, C., & Piterman, L. (2013). Victims' Barriers to Discussing Domestic Violence in Clinical Consultations. *Journal of Interpersonal Violence*, *29*(8), 1497–1513. https://doi.org/10.1177/0886260513507136
39 Malpass, A., Sales, K., Johnson, M., Howell, A., Agnew-Davies, R., & Feder, G. (2014). Women's experiences of referral to a domestic violence advocate in UK primary care settings: a service-user collaborative study. *British Journal of General Practice*, *64*(620). https://doi.org/10.3399/bjgp14x677527
40 World Health Organization. (2011, November 24). *Intimate partner violence during pregnancy*. World Health Organization. https://www.who.int/reproductivehealth/publications/violence/rhr_11_35/en/.
41 World Health Organization. (2013). *Responding to intimate partner violence and sexual violence against women Who clinical and policy guidelines*. https://www.who.int/reproductivehealth/publications/violence/9789241548595/en/.
42 Othman, S., & Adenan, N. A. M. (2008). Domestic violence management in Malaysia: A survey on the primary health care providers. *Asia Pacific*

- Moreover, only 20% of primary care clinicians and 6.8% of primary care nursing staff at the University Malaya Medical Centre had ever been trained on domestic violence.[43]

- The World Health Organization has developed a training curriculum on violence against women for healthcare providers. It teaches them to provide first-line support using an approach called LIVES (Listen, Inquire, Validate, Enhance safety and Support). The recommended duration for the training is 2.5 days, but it may be reduced to two days. The World Health Organization will also be releasing an e-learning version in 2020.[44]

- It is recommended to include a respected clinician in the training team to increase its credibility, as shown by the Identification and Referral to Improve Safety (IRIS) programme.[45] In the same vein, the World Health Organization training curriculum states that the ideal trainer is one who has a clinical background, experience providing healthcare to survivors, and experience in training.[46]

4. Establish a referral system for domestic violence at the primary healthcare level

- A referral system is also one of the minimum requirements for asking about domestic violence outlined by the World Health Organization.[47]

- The referral process at the primary healthcare level can be integrated into the Guidelines for Handling Domestic Violence Cases *(Garis Panduan Pengendalian Kes Keganasan Rumah Tangga)*, which outlines how various agencies, including the police, the Social Welfare Department, the Ministry of Health, the Attorney General's Chambers, and the courts, are to respond to domestic violence.

- The implementation of the referral system can be spearheaded by the recently formed National Domestic Violence Committee, a multi-stakeholder committee that coordinates the national response to domestic violence and oversees similar committees at the state and district levels.

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Family Medicine, *7*(1), 2. https://doi.org/10.1186/1447-056x-7-2

43 Ibid.

44 World Health Organization. (2019). *Caring for women subjected to violence: A WHO curriculum for training health-care providers.* http://www.who.int/reproductivehealth/publications/caring-for-women-subject-to-violence/en/.

45 Health Foundation. (2011). *The Iris Case Study: Implementing a Successful Primary Care Domestic Violence Service: Early Experiences.* https://www.health.org.uk/publications/case-study-identification-and-referral-to-improve-safety-iris.

46 World Health Organization. (2019). *Caring for women subjected to violence: A WHO curriculum for training health-care providers.* http://www.who.int/reproductivehealth/publications/caring-for-women-subject-to-violence/en/.

47 World Health Organization. (2013). *Responding to intimate partner violence and sexual violence against women Who clinical and policy guidelines.* https://www.who.int/reproductivehealth/publications/violence/9789241548595/en/.

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