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Early Detection and Prevention of Domestic Violence Using the Women Abuse Screening Tool (WAST) in Primary Health Care Clinics in Malaysia

Wong Yut-Lin, DrPH, and Sajaratunnisah Othman, MBBS, MMed

Despite being an emergent major public health problem, little research has been done on domestic violence from the perspectives of early detection and prevention. Thus, this cross-sectional study was conducted to identify domestic violence among female adult patients attending health centers at the primary care level and to determine the relationship between social correlates of adult patients and domestic violence screening and subsequent help/health-seeking behavior if abused. Face-to-face interviews were conducted with 710 female adult patients from 8 health centers in Selangor who matched the inclusion criteria and consented to participate in the study, using a structured questionnaire that included adaptation of a validated 8-item Women Abuse Screening Tool (WAST). Statistical tests showed significant differences in ethnicity, income, and education between those screened positive and those screened negative for domestic violence. Of the participants, 92.4% reported that during consultations, doctors had never asked them whether they were abused by their husband/partner. Yet, 67.3% said they would voluntarily tell the doctor if they were abused by their husband/partner. The findings indicate that primary care has an important role in identifying domestic violence by applying the WAST screening tool, or an appropriate adaptation, with women patients during routine visits to the various health centers. Such assessment for abuse could be secondary prevention for the abused women, but more important, it will serve as primary prevention for nonabused women. This approach not only will complement the existing 1-stop crisis center policy by the Ministry of Health that copes with crisis intervention but also will spearhead efforts toward prevention of domestic violence in Malaysia.

Keywords: screening; domestic violence; primary health care; WAST (Women Abuse Screening Tool)

Introduction

Significance of Domestic Violence

Domestic violence not only is a serious social problem, but it is emerging as a major public health problem that cuts across all age, ethnic, and socioeconomic groups. It is a growing public health concern in Malaysia and worldwide.

Health consequences of domestic violence are serious and beginning to gain the attention of clinicians and health care providers, as domestic violence is a common underlying problem in clinical practice. Studies have shown that abused women are more likely to
suffer from depression, anxiety, psychosomatic symptoms, eating problems, and sexual dysfunctions. It is alleged that violence causes extensive suffering and negative health consequences for a significant proportion of the female population, more than 20% in most countries. Abuse and domestic violence have a direct negative impact on several important health issues, including safe motherhood, family planning, and prevention of sexually transmitted diseases and HIV/AIDS. Domestic violence may also be fatal as a result of intentional homicide, severe injury, or suicide. Interpersonal violence was the 10th leading cause of death for women 15 to 44 years of age in 1998.1,2

Prevalence of Domestic Violence

Domestic violence refers to abuse of power in an interpersonal relationship between blood or affinal relatives or between kin and unrelated persons living within the same domicile or vicinity (eg, family compound, community, or village). Most research on domestic violence indicates that women and girls are the most frequent victims of violence within the family and between intimate partners. Findings also have revealed that the perpetrators of violence against women are almost exclusively men.2

In every country where reliable large-scale population studies have been conducted, results indicate that between 10% and 50% of women report they have been physically abused by an intimate partner in their lifetime.2 Thirty-five studies from various countries, both developed and developing, showed that 25% to 50% of women studied reported having been physically abused by a present or former partner. Of greater concern is the fact that domestic violence survivors reported more severe beatings when they are pregnant. Pregnant women are prime targets for abuse—namely, 1 in every 6 pregnant women was battered during their present pregnancy in the United States.3-5 In the Asia–Pacific region, the prevalence of domestic violence ranges from 16% in the Philippines to 67% in Papua New Guinea.6 Researchers have found that domestic violence occurs among all racial, ethnic, and socioeconomic groups.7-10 Residents of urban and rural areas have been shown to experience similar rates of family violence.7,11,12

In peninsular Malaysia, 39% of women older than age 15 years suffered some form of violence according to the national survey conducted by the Women’s Aid Organisation (WAO) in 1990. This survey also revealed that 68% of battered women were beaten while pregnant. Moreover, adults from all classes and ethnic groups residing in both urban and rural areas personally knew women who had been beaten.13 In 1999, the WAO reported that 69% of the women being sheltered under them were for domestic violence.14 The Department of Criminal Investigation of the Malaysian Royal Police reported 3468 cases of domestic violence in 2000, out of which 44.4% were Malays, 25.3% Indians, 21.3% Chinese, and 9% others. From 2002 to 2004, there were 14 986 domestic violence cases, or 8.21 reported cases a day.15

Crisis Interventions

In Malaysia, the escalating incidence of domestic violence has prompted many government and nongovernment organizations to respond to this issue by advocating for more service centers for crisis intervention and management, such as the one-stop crisis centers (OSCCs) being promoted in emergency departments of public hospitals by the Ministry of Health to offer medical and health services to domestic violence and sexual assault

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survivors. At the OSCCs, domestic violence survivors receive medical, psychological, and social support. The Ministry of Health reported that such OSCC services are currently provided in 108 of 114 hospitals nationwide (ie, about 95% coverage in public hospitals). The primary care system, whether primary care medicine in hospitals or in health centers, does not yet have similar services for domestic survivors.

Role of Primary Care in Identifying and Preventing Domestic Violence

However, it is critical to approach the problem of domestic violence from the perspectives of early detection and prevention, as well as crisis intervention at the level of the accident and emergency or trauma setting. We need to go back a step before the violence occurs and attempt to alleviate or prevent the violence. This is the role and responsibility of primary care providers who are gatekeepers who come into first contact with the public in our health system. Based in the community, primary care physicians are in an optimal position to address this public health problem because they are the most accessible compared with any other medical specialties. They provide health care for family units, allowing them to observe, discuss, question, and assess family interactions.

Moreover, it has been alleged that domestic violence is 1 of the 3 most common problems in primary care practice that have prevalence rates from 10% to 50% among primary care patients. Yet, several studies have documented missed identification of abusive partner violence in primary health care settings, and thus appropriate services and care often are not provided to domestic survivors. At the same time, for many women who have been abused, health workers are the main, and often the only, point of contact with public services that should be able to offer support and information.

Hence, primary health care providers, being the gatekeepers, can be a lifeline to women who experience domestic violence. By screening for domestic violence, being supportive, and offering information on resources and safety planning, primary care providers acknowledge domestic violence as a women’s health issue while providing critical services.

Thus far, much of the information on domestic violence has come from studies done in specialized settings, such as women living in shelters, student populations, or general population samples. Little research has been done on the clinical characteristics of physically and sexually abused women who present at primary care/health centers. There are no such published studies, so far, in Malaysia. Elsewhere, however, violence against women is associated with increased use of health care. Domestic violence was the most powerful predictor of physician visits and outpatient costs. Yet, studies have shown that health providers do not feel confident that they could detect or deal with domestic violence cases. A study on women’s attitudes and expectations regarding medical care of domestic violence survivors found that for 20% of the patients who informed the doctor about abuse, the doctor did nothing for them. However, it has been shown that appropriate and adequate education on domestic violence had a positive association with preparedness, beliefs about when to screen, and outcome expectations among health providers. It is noteworthy that Caralis et al’s study revealed that 50% of the women felt doctors should routinely screen for abuse. Another study on identifying violence in primary care practice found that domestic violence identification rose from 0% to 11.6% when the health history form included just 1 direct question asking the patient if a partner ever hit him or her.

Questionnaires have been developed to screen for domestic violence in primary care practice, and these are being implemented fairly widely in the United States, Canada, and the United Kingdom, for instance. Generally, these assessment instruments are for use with domestic violence survivors in protocols specific to medical settings that would incorporate rapid identification, treatment of acute injuries, follow-up of emotional and psychological issues, crisis intervention, and multidisciplinary intervention. According to Weiss, these
screening instruments vary in length, but all involve self-reports by patients, subjecting them to limitations of self-report methodologies. These include the long instruments, such as the Conflict Tactics Scales (CTS)\textsuperscript{23} and Index Spouse Abuse (ISA).\textsuperscript{24} Short instruments include the Abuse Assessment Screen (AAS),\textsuperscript{25} a 5-item structured interview developed for use with pregnant patients; the Partner Violence Screen (PVS),\textsuperscript{26} which consists of 3 questions administered as part of a routine medical interview; and the Women Abuse Screening Tool (WAST).\textsuperscript{27}

The main research objective of this study is to identify domestic violence in primary care and the social correlates associated with it. The specific objectives are (1) to identify domestic violence and its prevalence among adult women patients attending the primary care clinics or health centers, and (2) to determine the relationship between social correlates such as income, education, ethnicity, location (urban/rural) and residence of adult patients, and domestic violence screening and subsequent help/health-seeking behavior if abused.

Methods

Study Design and Sampling

This was a cross-sectional study carried out in the state of Selangor over a period of 2 months. The 15 primary health centers (HCs), each headed by a family medicine specialist (FMS), in Selangor formed the population frame for the selection of primary health centers. Stratified sampling, according to the ethnicity of patients and urban/rural strata, was applied to select 8 primary health centers, with 4 each in the urban and rural areas. Research permission was obtained from the Family Health Division of the Ministry of Health, as well as from the 8 FMSs at the 8 selected primary health centers. Ethics clearance for the study was granted by the Medical Ethics Committee of the University of Malaya Medical Center. Written informed consent from patients, who agreed to be part of the research, was requested and obtained.

Instrument

A structured questionnaire, including adaptation of the validated 8-item WAST, was used for data collection through face-to-face interviews. The questionnaire comprised questions pertaining to socioeconomic background, family well-being, and women’s health; the 8-item WAST for identifying domestic violence as well as patients’ feedback on the ease, clarity, and comfort in answering WAST; and questions on help/health-seeking behavior if they were or were to be abused by a husband/partner. For domestic violence screening, we adapted the WAST, developed by Judith Belle Brown from the Center for Studies in Family Medicine, University of Western Ontario, Canada.\textsuperscript{28} All the 8 questions in the WAST were related to, or predictive of, woman abuse. The first 2 questions, also known as WAST-Short, assessed the degree of relationship tension and the amount of difficulty that the woman patient and her husband/partner have in working out arguments on a scale of 1 to 3. The remaining 6 questions in the WAST were used to gain a more complete assessment of the abuse by asking the woman patient to rate the frequency of various feelings and experiences on a scale from 1 (\textit{often}) to 3 (\textit{never}).\textsuperscript{27}

The structured questionnaire was available in the 3 local languages—Bahasa Malaysia, Tamil, and Chinese (Mandarin as well as Cantonese, or Hokkien dialects)—common among the female patients attending health centers, besides English. Pilot testing and validation of these questionnaires were conducted prior to data collection in the 8 HCs. At the health centers, convenience sampling of consecutive patients attending the various health services during random time periods was carried out using the following inclusion criteria:
1. Women patients
2. Aged 16 and older
3. Married/ever married (if single, must have boyfriend/partner)
4. Not accompanied by husband/partner
5. Not too weak or not too unwell

Data Collection and Response Rate

Face-to-face interviews were conducted by trained female enumerators with patients while they were waiting for their checkup either in allocated rooms or a private space in waiting areas. Efforts were made to ensure that patients were interviewed in their own language or in the language they were comfortable with. To encourage participation, disclosure, confidentiality, and safety, all accompanying relatives and partners of the patients were asked to leave the room prior to the interview. Through this convenience sampling, 717 patients were identified and gave consent for the interview. Of these, 710 patients completed the interview, whereas 7 others did not due to lack of time and discomfort in discussing such “personal issues” (99% response rate). Patients were interviewed on sociodemographic background, risk behaviors (taking drugs and alcohol), health services sought at the health center, women abuse screening, women’s perceptions toward domestic violence screening, and help/health-seeking behavior if abused. At the end of the interview, information leaflets pertaining to domestic violence and services provided by the local shelter for battered women and children (WAO) were distributed to the patients.

WAST Score Computing and Data Analysis

Scoring the WAST items involved recoding the responses that reflect a higher score for higher reported frequency of violence experience and then summing the WAST scores for individuals who answered all 8 items. An overall WAST score is computed by summing the patients’ score on each of the 8 items. This involves assigning a score of 1 if the patient reported that her relationship was characterized by a lot of tension, or if she reported that she and her partner had great difficulty working out arguments (items 1 and 2, respectively). The scores ranged from 1 to 3 (ie, no tension to a lot of tension). The remaining 6 items are also on a range of 1 to 3 (ie, 1 = often, 3 = never). Then, the final overall score was computed by reversing the item score and summing all 8 items. Thus, the higher the score on the WAST, the greater the abuse.

Scores on WAST-Short, the first 2 nonthreatening questions, were also computed for correlation analysis with the overall 8-item WAST score. The WAST-Short scores were computed based on a criterion cutoff score of 1 that involved assigning a score of 1 to the most extreme positive responses for each of the first 2 items of the WAST (ie, a lot of tension and great difficulty) and a score of 0 to the other response options.

Results

Sociodemographic Background

A total of 710 female adult patients from the 8 selected HCs participated in the study, with 67.3% from the urban HCs and 32.7% from the rural HCs. Almost a quarter (22.7%) of them attended antenatal care clinics at the HCs at the time of the survey, with another quarter being outpatients; 9.7% attended follow-up clinics for either diabetes or hypertension; and slightly more than a quarter (28%) of them were accompanying a relative or taking their child for health services at the HCs.
Table 1 shows that the ethnic distribution was 56.9% Malay, 16.6% Chinese, 24.9% Indian, and 1.5% other. The mean age of the patients was 35 years (range, 17-83; SD = 11.01). Most (89.9%) were currently married, and only a very small proportion (3.1%) was single. More than 60% had secondary education, 15.6% had tertiary education, 16.1% had primary education, and the rest had no formal education (4.4%). In comparison, the husband/partner's education level was higher—namely, 65.2% had at least secondary education, and only 2.4% did not have any schooling.

Slightly more than half of the patients were employed in a range of occupations—namely, 11.4% in professional and technical work, 11.6% in clerical and administration, 14.4% in sales and services, 13.7% in production, and 1.4% in the agricultural sector—whereas 45.1% were housewives and 1.1% were students. The husband/partner's occupation was available for 687 patients, whereby the largest proportion comprised laborers and equipment operators (see Table 2). According to the Eighth Malaysia Plan 2001-2005, those
earning less than RM1500 per month are in the low-income group, those earning between RM1500 and RM3000 per month are in the middle-income group, and those earning more than RM3000 are in the high-income group. In this study, almost half of the patients (49.3%) belonged to the low-income group as they reported a total monthly household income of less than RM1500, 37.7% were in the middle-income group (from RM1500-3000), and 11.8% were in the high-income group, as shown in Table 1. Figure 1 shows that most Malay and Indian patients in the study were of low income, whereas many of the Chinese patients were of middle income.

**Prevalence of Domestic Violence**

As explained in the Methods section, the WAST score is used as a measure of abuse. The study found that the mean WAST score was 9.15 (range, 8-24; SD = 7.81). According to Table 3, 40 or 5.6% of the patients could be categorized as positive for domestic violence through the WAST screening score (12 and below = negative; 13 and above = positive). The detailed responses for each of the 8 items in the WAST are shown in Table 4.

The findings showed that the ethnic groups significantly differed (χ² = 24.247, df = 3, P = .000) between those screened positive and negative for domestic violence. Thus, among patients screened positive for domestic violence, 57.5% were Indian, 32.5% were Malay, and 10% were Chinese.

It was found that 72.5% of those screened positive were from the low-income group, and 22.5% and 5% were from middle- and high-income groups, respectively. There was a significant difference in income levels between those patients screened positive and negative for domestic violence (χ² = 8.812, df = 2, P = .012).
Education levels of both patients and their husband/partner also significantly differed between those screened positive and negative for domestic violence ($\chi^2 = 14.398$, $df = 3$, $P = .002$; $\chi^2 = 22.788$, $df = 4$, $P = .000$, respectively). Although only 7.2% of patients’ spouses were reported to consume alcohol habitually, 33% of these spouses were reported to abuse their wives/partners. There was a significant difference in the husband/partner taking alcohol/drugs habitually between those screened positive and negative ($\chi^2 = 79.299$, $df = 1$, $P = .000$) (Table 5, Figure 2).

Statistical tests thus revealed significant differences in social correlates, such as ethnicity, income, and husband/partner taking alcohol/drugs habitually between those screened positive and negative for domestic violence. However, others such as urban/rural location and patients taking alcohol/drugs habitually were found not to be significantly different.

In addition, the WAST-Short was significantly correlated with the long version of the 8-item WAST ($r = 0.668$, $P = .000$).

With regard to forms of abuse, among those patients screened positive for domestic violence, most (92.5%) were abused emotionally, 62.5% were ever abused physically, and 32.5% were ever sexually abused (see Table 6). The duration of violence ranged from 1 month to 36 years (see Table 7). Among patients screened positive for domestic violence, 30% had experienced violence in the past 12 months.

Most patients (92.4%) reported that during consultations with doctors, the latter had never asked them whether they were abused by their husband/partner. However, many (67.3%) of the patients said they would voluntarily tell the doctor if they were to be abused by their husband/partner. Two thirds of the patients were aware and knew they could be protected by law if they were abused by their husband/partner. For example, many pointed out that there is an act or legislation to protect survivors; some specified the Domestic Violence Act, whereas others referred to the police, counselors, religious bodies, shelters for survivors, and nongovernment organizations. Most (92.7%) said that a man does not have the
Table 3. Women Abuse Screening Tool (WAST) Screening for Domestic Violence (N = 710)

<table>
<thead>
<tr>
<th>WAST Score</th>
<th>Frequency</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Negative (score = 8-12)</td>
<td>670</td>
<td>94.4</td>
</tr>
<tr>
<td>Positive (score = 13-24)</td>
<td>40</td>
<td>5.6</td>
</tr>
<tr>
<td>Total</td>
<td>710</td>
<td>100.0</td>
</tr>
</tbody>
</table>

Table 4. Women Abuse Screening Tool (WAST) Item Responses and Overall Scores

<table>
<thead>
<tr>
<th>Items</th>
<th>n (N = 710)</th>
<th>(%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. In general, how would you describe your relationship with your husband/partner?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. A lot of tension</td>
<td>25</td>
<td>3.5</td>
</tr>
<tr>
<td>2. Some tension</td>
<td>113</td>
<td>15.9</td>
</tr>
<tr>
<td>1. No tension</td>
<td>572</td>
<td>80.6</td>
</tr>
<tr>
<td>2. Do you and your husband/partner work out arguments with . . .</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Great difficulty</td>
<td>14</td>
<td>2.0</td>
</tr>
<tr>
<td>2. Some difficulty</td>
<td>68</td>
<td>9.6</td>
</tr>
<tr>
<td>1. No difficulty</td>
<td>628</td>
<td>88.5</td>
</tr>
<tr>
<td>3. Do arguments ever result in you feeling put down or bad about yourself?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Often</td>
<td>12</td>
<td>1.7</td>
</tr>
<tr>
<td>2. Sometimes</td>
<td>221</td>
<td>31.1</td>
</tr>
<tr>
<td>1. Never</td>
<td>477</td>
<td>67.7</td>
</tr>
<tr>
<td>4. Do arguments ever result in your husband/partner hitting, kicking, or pushing you?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Often</td>
<td>9</td>
<td>1.3</td>
</tr>
<tr>
<td>2. Sometimes</td>
<td>35</td>
<td>4.9</td>
</tr>
<tr>
<td>1. Never</td>
<td>666</td>
<td>93.8</td>
</tr>
<tr>
<td>5. Do you ever feel frightened by what your husband/partner says or does?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Often</td>
<td>14</td>
<td>2.0</td>
</tr>
<tr>
<td>2. Sometimes</td>
<td>60</td>
<td>8.5</td>
</tr>
<tr>
<td>1. Never</td>
<td>636</td>
<td>89.6</td>
</tr>
<tr>
<td>6. Has your husband/partner ever abused you physically?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Often</td>
<td>7</td>
<td>1.0</td>
</tr>
<tr>
<td>2. Sometimes</td>
<td>25</td>
<td>3.5</td>
</tr>
<tr>
<td>1. Never</td>
<td>678</td>
<td>95.5</td>
</tr>
<tr>
<td>7. Has your husband/partner ever abused you emotionally?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Often</td>
<td>17</td>
<td>2.4</td>
</tr>
<tr>
<td>2. Sometimes</td>
<td>75</td>
<td>10.6</td>
</tr>
<tr>
<td>1. Never</td>
<td>618</td>
<td>87.0</td>
</tr>
<tr>
<td>8. Has your husband/partner ever abused you sexually?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Often</td>
<td>3</td>
<td>0.4</td>
</tr>
<tr>
<td>2. Sometimes</td>
<td>15</td>
<td>2.1</td>
</tr>
<tr>
<td>1. Never</td>
<td>692</td>
<td>97.5</td>
</tr>
</tbody>
</table>

Table 5. Differences Between Patients Screened Positive and Negative for Domestic Violence

<table>
<thead>
<tr>
<th>Independent Variables</th>
<th>$\chi^2$</th>
<th>df</th>
<th>P Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ethnicity</td>
<td>24.247</td>
<td>3</td>
<td>.000*</td>
</tr>
<tr>
<td>Location</td>
<td>1.860</td>
<td>1</td>
<td>.173</td>
</tr>
<tr>
<td>Patient’s education</td>
<td>14.398</td>
<td>3</td>
<td>.002*</td>
</tr>
<tr>
<td>Husband/partner’s education</td>
<td>22.788</td>
<td>4</td>
<td>.000*</td>
</tr>
<tr>
<td>Household income</td>
<td>8.812</td>
<td>2</td>
<td>.012*</td>
</tr>
<tr>
<td>Patient taking alcohol/drugs</td>
<td>1.955</td>
<td>1</td>
<td>.162</td>
</tr>
<tr>
<td>Husband/partner taking alcohol/drugs</td>
<td>79.299</td>
<td>1</td>
<td>.000*</td>
</tr>
</tbody>
</table>

*Significant at .05, two-tailed.
Figure 2. Association between social correlates and patients screened positive for domestic violence (DV).
right to abuse his wife/girlfriend. However, only 41.5% said they would have a place to stay or a contact number to call should they be abused by their husband/partner.

Almost all the patients (99.6%) reported that they had found the WAST screening questions clear and easy to understand. Similarly, most (97.7%) said they were comfortable answering the WAST questions. The minority who reported they were not comfortable answering the WAST questions explained that it was mainly because domestic violence and abuse was a “private,” “personal,” and “family matter” that should be kept between husband and wife.

Discussion

Of the 710 patients attending the 8 selected health centers in Selangor at the time of the survey, 5.6% were identified as domestic violence cases through WAST screening. Social correlates such as ethnicity, education, and income were significantly associated with domestic violence.

As mentioned earlier, local studies on domestic violence had been conducted in specialized settings, such as shelters, the student population, or the general population, but not as much has been done within health settings, least of all in primary care practices. However, the 5.6% rate of positive screening for domestic violence in this study is fairly comparable to some of the research done in primary care practices overseas. In the United States, McCauley and colleagues25 found that 5.5% of adult female patients in community-based primary care internal medicine practices in the Baltimore area had experienced domestic violence compared with 11.6% of new patients at another primary care internal medicine practice21 and 15% of female patients in outpatient clinics in San Francisco, California.29 Comparatively, the prevalence of domestic violence is higher among patients in accident and emergency departments and among pregnant women in prenatal care—namely, 29% and 17%, respectively.26,30

With regard to the significant associations of ethnicity (Indian origins), education (secondary level), and income (low income) with positive screening for domestic violence in this
study, other research has shown significant correlations with younger age (18-29 years), low socioeconomic status, and having witnessed violent relationships between one’s parents. However, these findings pertaining to significant correlates are considered preliminary due to the limitations of this study with regard to the confinement of patients attending only 8 selected health centers in the Selangor state. Although sampling was stratified according to ethnic distribution of patients attending the selected health centers, relatively more Chinese patients than their Malay or Indian counterparts did not consent to participate in the study. The main reason given usually was that they did not have the time, as they either had to rush back to the workplace or to the home to do housework. Given the nature of health centers being used relatively more by the lower income group compared with private clinics, this group could be inevitably overrepresented. Hence, these 3 social correlates should not be interpreted as possible “risk factors” in the screening for domestic violence. In fact, primary care physicians have cautioned against screening for domestic violence by identifying sociodemographic risk factors because in practice, none of these risk factors is sufficiently specific to use for screening. Moreover, as mentioned earlier, population studies of domestic violence have shown that this problem cuts across ethnic and socioeconomic groups both locally and in the developed countries.

The results revealed that most patients interviewed would be willing to voluntarily tell the doctor if they were to be abused by their husband/partner, although the current practice is that doctors do not ask patients whether they are abused by their spouse/partner. Studies have shown that doctors or health personnel do not ask women patients such questions due to lack of educational preparation on abuse and other barriers such as patient fears, no mention of the abuse during the interview, lack of privacy, cultural differences, and being too busy to inquire about abuse. On the other hand, various research has shown that when women feel understood, listened to, and validated by their physicians/doctors, they are more inclined to discuss the abuse and want their doctors to take responsibility for asking questions about abuse and to do so in a manner that is caring, respectful, and supportive.

Most of the patients in the study found the WAST screening questions to be clear as well as easy to understand and were comfortable answering these questions. At the same time, the significant correlation of WAST-Short with WAST-8 indicates that the 2 non-threatening questions would predict problems in the relationship between the female patient and her husband/partner, and could assist in screening for domestic violence. Indeed, there are many approaches to identify domestic violence, and the most widely recommended ways are universal screening and selective case finding. The former involves incorporating questions about domestic violence into the standard medical history for all patients. For instance, this is done by routinely asking about domestic violence along with other behaviors, such as cigarette smoking, alcohol and drug use, sexual activity, and so forth. It is alleged that universal screening reduces perceptions that questions about abuse are being asked in response to some unique characteristic of a patient. For the approach of case finding, the health provider observes markers of abuse and asks questions to determine if abuse is present.

As mentioned earlier, research has indicated that pregnant women are at greater risk in terms of domestic violence, and as a result, it has been urged that women seeking services for pregnancy thus need to be screened routinely for domestic violence risk and offered appropriate care. Because about a quarter of the women patients in our sample were pregnant and attending antenatal care clinics in the health centers at the time of the study, screening for domestic violence at the HCs would be an appropriate strategy.
Conclusion and Recommendation

These findings thus show that primary care has an important role to play in identifying domestic violence by applying the WAST screening tool, or an appropriate adaptation, with women patients during routine visits to the various clinics offered at the health centers throughout the country. Such assessment for abuse could be secondary prevention for the abused women, but more important, it will serve as primary prevention for nonabused women. As the research grant for this study specified the focus on patients, further research is needed to assess knowledge, attitudes, and competency of the primary care provider team (family medicine specialists, medical officers, and medical assistants) in health centers toward the identification and management of domestic violence survivors, and ultimately toward prevention of domestic violence at the primary care level. This approach not only will complement the current government innovations and change in legislation and health services for survivors of domestic violence—namely, the OSCC policy by the Ministry of Health—aimed mainly at crisis intervention but also will spearhead efforts toward prevention of domestic violence in the country.

To effect improvement in the identification and appropriate treatment of domestic violence survivors by health care providers that contributes to the development of effective intervention and prevention strategies, the following recommendations may be considered: (1) develop a curriculum on domestic violence for medical students, housemen, and physicians already in practice that would include understanding domestic violence from the perspectives of gender equality and rights, epidemiologic aspects of domestic violence, recognition of behaviors consistent with abuse, and how to make referrals to hospital- and community-based resources; (2) support a policy of universal screening of all female patients for domestic violence; (3) strengthen and extend hospital-based domestic violence programs, such as the OSCC, to all levels of the health delivery system, including private medical care; (4) develop intervention programs for children who witness domestic violence; (5) support the establishment of a national database for compiling incidence and other epidemiologic data on domestic violence; and (6) develop a research agenda aimed at better determining the prevalence of domestic violence as well as assessing the impact of educational initiatives in increasing the detection of domestic violence and the efficacy of various intervention strategies.

It is very pertinent to point out that these recommendations for screening domestic violence in primary care, in particular, and toward more holistic and integrated health services for domestic violence survivors, in general, should not be interpreted as a means to medicalize domestic violence, whereby doctors or health care providers are viewed as the experts taking control of yet another medical problem. This is the fear expressed by many domestic violence survivors and women as well as community organizations providing services for the former. Hence, it is also strongly recommended that at every step of this innovative process of improving health services for domestic violence survivors, a gender-sensitive and woman-centered approach must be adopted. The latter will call for, inter alia, client-centered counseling, therapy on request or with the survivor’s agreement, and basically enabling survivors to negotiate changing the unequal power relations with their husbands/partners who are the perpetrators of violence. This is part of gender-sensitive health services, a new concept promoted by the World Health Organization and the International Planned Parenthood Federation, for instance, since the post-Cairo and post-Beijing endorsement and recognition of women’s rights and women’s health as human rights in 1994 and 1995, respectively.
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