Malaysian Medical Association (MMA) Position Paper on Domestic Violence in Primary Care: A National Healthcare Imperative for Early Intervention and System Reform

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Author's Note: This document is intended as a position paper aimed at policy advocacy, rather than a research paper.

Background

Malaysia has long recognised domestic violence as a serious social and public health concern. The Domestic Violence Act 1994 established the legal framework for the protection of survivors and intervention by relevant authorities.

In parallel, the Ministry of Health has established One-Stop Crisis Centres (OSCCs)[1] in many government hospitals to provide coordinated medical, legal and psychosocial support for survivors of domestic violence and other forms of violence against women. These centres provide crisis-based care and serve as an important safety net within the healthcare system.

In addition to government initiatives, Malaysia benefits from numerous non-governmental organisations (NGOs) that provide counselling, legal assistance, crisis intervention and shelter services.

Despite these important developments, much of the current response remains reactive and crisis-driven, typically occurring after significant harm has already occurred. There remains a critical need for earlier identification of domestic violence within the healthcare system, particularly in primary care settings.

Primary care clinics, both public and private, often represent the first point of contact and are uniquely positioned to identify early indicators of violence, provide initial support, and facilitate referral to appropriate services.

[1] **The One Stop Crisis Centre (OSCC) in Malaysia is a 24-hour service based in the Emergency and Trauma Departments of Ministry of Health hospitals, established to provide holistic and confidential care to victims of domestic violence, rape, sexual assault, and child abuse. It integrates medical treatment, forensic evidence collection, counselling, and police services under one roof, ensuring a coordinated response to survivors.**

1. EXECUTIVE SUMMARY

Domestic violence is a pervasive public health issue in Malaysia. Survivors frequently interact with healthcare systems long before formal reports are made.

The Malaysian Medical Association recognises that healthcare professionals, particularly those working in primary care are uniquely positioned to identify early indicators of abuse and provide critical entry points for support and intervention.
Importantly, children within domestic violence settings must be recognised as victims in their own right. Exposure to domestic violence, whether direct or indirect, can result in significant emotional trauma, behavioural disturbances, mental health conditions, neglect, and long-term developmental consequences. Domestic violence and child abuse frequently coexist, necessitating a stronger child-health and family-centred approach in clinical practice and policy frameworks.

This position paper calls for:

- Structured clinical enquiry for domestic violence in appropriate clinical settings
- Adoption of trauma-informed, family-centred care frameworks
- Recognition of children as direct and indirect victims requiring safeguarding
- Clear medico-legal guidance for healthcare providers
- Strengthened coordination between healthcare, social, and legal systems
- Enhanced training and practical guidance for primary care providers

2. CLINICAL PRACTICE: STRUCTURED ENQUIRY AND RECOGNITION OF RED FLAGS

To move beyond opportunistic identification, the MMA advocates for structured clinical enquiry supported by validated screening tools and awareness of clinical red flags.

While universal screening is not currently recommended by the World Health Organization (WHO) WHO, targeted enquiry in high-risk situations is appropriate within the Malaysian context.

High-risk presentations include:

- Examples of high-risk presentations include:
- Antenatal consultations
- Mental health presentations
- Substance misuse disorders
- Suspicious or unexplained injuries
- Recurrent injuries or frequent healthcare visits without clear medical explanation

Validated tools such as the HITS Screening Tool (Hurt, Insult, Threaten, Scream) may assist clinicians.

Children in Domestic Violence Settings

Healthcare providers should maintain a high index of suspicion for children living in households affected by domestic violence. Even in the absence of physical injury, children may present with:

- Behavioural or school difficulties
- Anxiety, depression, or developmental concerns
- Psychosomatic symptoms
- Signs of neglect

Children should be assessed as part of a **family unit**, and appropriate safeguarding pathways activated when risk is identified. Collaboration with paediatricians, child protection teams, and hospital-based services (including OSCCs and SCAN teams) is essential.

3. IMPLEMENTATION: RESOURCE ALLOCATION, REFERRAL NETWORKS AND SYSTEM COORDINATION

Malaysia's dual public-private primary care system requires tailored implementation strategies.

An effective response requires strong referral networks linking primary care providers with:

- Hospital One-Stop Crisis Centres (OSCCs)
- Social welfare services
- Child protection services
- Non-governmental organisations (NGOs) providing counselling and shelter
- Legal aid and protection services

A coordinated, multisectoral framework is essential. Survivors often face complex social realities, including:

- Financial dependence on perpetrators
- Family and cultural pressures
- Limited access to safe shelter
- Childcare responsibilities
- Lack of social support

These factors frequently result in survivors returning to unsafe environments. Healthcare responses must therefore extend beyond immediate clinical care to include **long-term, holistic, and coordinated support systems.**

A hub-and-spoke model using designated Domestic Violence Lead Clinics may be explored, supported by pilot programmes to assess feasibility.

4. ETHICAL AND MEDICO-LEGAL FRAMEWORK

Healthcare providers require clear and practical medico-legal guidance when managing domestic violence cases.

For competent adults, care must remain survivor-centred and respect patient autonomy. However, reporting without consent may be necessary in situations involving:

- Immediate danger to life
- Risk to children
- Risk to vulnerable persons

Key Areas Requiring Clarification

- Documentation standards (objective, detailed, and legally robust)
- Use of body maps and photographic evidence (with consent)
- Confidentiality and its limits
- Consent in complex family situations
- Legal obligations regarding reporting and safeguarding
- Protection of healthcare providers from legal repercussions when acting in good faith

Standardised forensic documentation templates should be promoted nationally.

Clearer national guidelines and institutional support systems are essential to reduce uncertainty and improve clinician confidence.

5. TRAINING, CULTURE AND CAPACITY BUILDING

Domestic violence training should be integrated across all levels of medical education, including:

- Undergraduate medical education

- Postgraduate clinical training
- Continuing Medical Education (CME)

Practical Training for Primary Care Providers

Training should go beyond theory to include:

- How to conduct sensitive enquiry
- Safety planning with patients
- Documentation and medico-legal considerations
- Referral pathways and available resources
- Managing follow-up and continuity of care

Resources should be culturally sensitive and available in Bahasa Malaysia, Mandarin, and Tamil.

6. CALL TO ACTION

The Malaysian Medical Association calls upon policymakers and healthcare leaders to:

- Recognise domestic violence as a system-level healthcare issue
- Strengthen early detection within primary care
- Embed child protection and family-centred approaches
- Provide clear medico-legal guidance and institutional support
- Develop integrated, multisectoral response frameworks
- Invest in training and capacity building for frontline providers

7. CONCLUSION

Domestic violence frequently presents within healthcare settings in Malaysia, often before formal disclosure.

Healthcare professionals are not merely witnesses but potential turning points in survivors' lives.

Strengthening the role of primary care, while recognizing the impact on children, addressing social realities, and supporting clinicians through clear guidance, will shift the national response from reactive crisis management toward earlier detection, compassionate care, and coordinated intervention.

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