

Healthcare providers readiness to response to Spousal Abuse in Saudi Arabia: survey among medical and dental graduates

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Abstract

Objectives: Under-reporting despite high prevalence of domestic violence (DV) indicates a serious gap in identifying and reporting domestic violence. Therefore this study aims to assess the readiness of health care workers in identifying and handling intimate partner violence.

Methods: A cross-sectional study was conducted using the Domestic Violence Health Care Provider Survey tool among medical and dental interns and residents in Saudi Arabia to assess their readiness to detect, manage and prevent spousal abuse.

Results: 221 participants completed the survey; 53.8% of the respondents were interns and 43.4% were residents. The study showed that only 5.9% of respondents have participated in DV courses during their undergraduate years in medical school. 72.8% of doctors either did not know or were not sure of Saudi national policies to manage DV and 86.9% of the health care providers were not aware of the national help line number to report a suspected DV case.

Conclusion: Lack of teaching and training sessions on managing domestic violence during the undergraduate years shows that health care professionals are evidently underprepared and calls for an urgent need to introduce an interprofessional education curriculum that trains health care professionals of all concerned specialties at undergraduate level on managing domestic violence.

Keywords: Domestic violence. Intimate partner violence, medical education, health care providers

Introduction

The World Health Organization (WHO) has reported domestic violence (DV) as a global public health problem that affects the physical and psychological health of women, adolescents, children, and the elderly. Intimate partner violence (IPV) or “spousal abuse,” is a form of DV and has been defined by WHO as “any behavior within an intimate relationship that causes physical, psychological or sexual harm to those in the relationship” [1]. Women are the victims most affected because of intimate partner violence and exposure to abuse, whether physical, psychological, or sexual, and it increases the likelihood of poor health and serious mental disorders [2].

According to WHO multi-Country Study the percentage of physical or sexual violence by husband or partner reported by women varied between 5% to 71% worldwide and up to 4-12% of these abuses happened during pregnancy [3]. Studies from the Middle East Countries such as Egypt, Palestine, and Tunisia revealed that at least one out of three women are subjected to physical abuse by their husband [4]. A survey conducted in Saudi Arabia showed that the prevalence of lifetime domestic violence among women in Saudi Arabia was 35.9% for mental, 17.9% for physical, and 6.9% for sexual violence [5]. A more recent study in Saudi Arabia reported that almost 45 % of the women participants had been subjected to spousal physical abuse with a reasonable population of victims expecting appropriate treatment by healthcare providers [6]. Despite these studies that highlighted the high prevalence of spouse abuse in Saudi Arabia, only 3.3% of the cases were documented and reported [7]. A study found that practicing dentists and physicians lack sufficient knowledge about DV detection and management, which is attributed to the inadequate exposure to DV education during undergraduate training [8]. This indicates a serious gap in training first line health care workers like physicians and dentists who play a major role in identifying and managing all forms of abuse including spousal abuse.

In Saudi Arabia there are only a few studies that have assessed the readiness of first-line health care providers such as medical and dental doctors to suspect DV-inflicted injuries among patients. Therefore, this study was conducted to reflect the current preparedness of Saudi medical and dental students to detect, manage and prevent spousal abuse.

Methodology

Study design

The study was approved by the IRB at Princess Nourah university. A cross-sectional study was conducted among medical and dental interns and residents in the Saudi Arabian cities of Riyadh, Dammam, and Alhasa. The study included participants from the following public universities - Princess Nourah Bint Abdulrahman University (PNU), King Saud University (KSU), King Saud bin Abdulaziz University for Health Sciences (KSAU-HS), Al-Imam Muhammad ibn

Saud Islamic University (IMAMU) in Riyadh, Saudi Arabia, King Faisal University (KFU) and Imam Abdulrahman Bin Faisal University (IAU).

The study participants were graduates from the medical and dental colleges of the universities described above who met the following inclusion criteria: that they are currently enrolled in a clerkship (internship) or residency program, are Saudi nationals, and graduated from public universities in Saudi Arabia. Participants who met any of the following exclusion criteria were excluded from the study: graduates from private universities or from universities other than those included here (PNU, KSU, IAU, KFU, IMAMU, or KSAU-HS).

The study participants were approached through the internship program coordinator located at each of the selected public universities and through hospital internship program coordinators. Our study used purposive sampling that included interns and residents from medical and dental colleges who matched all stated inclusion criteria. The chief residents of the respective institutions were requested to distribute the survey.

Sample size

Sample size was calculated based on previous literature from the same research field [5], which stated an average score of 60.5% and with 95% confidence interval and power 85% and 20 % non-response resulting in approximately a sample size of 150 participants.

The survey tools

A combined information Letter/Consent Form formed the cover page of the survey questionnaire and stated the study purpose, method of participation, withdrawal, confidentiality and described the anonymity of the participants as well as the risks and benefits of participation.

The Domestic Violence Health Care Provider Survey Scale was used in this study, which is a validated tool that assesses provider characteristics and training needs and serves to evaluate DV policy interventions. The tool demonstrated a good internal consistency reliability with Cronbach's alpha ranges of 0.73 to 0.91. [9]

The survey had two parts; the first part of the study had questions on demographical and general characteristics of the study participants and the second part of the survey measures the healthcare providers readiness to screen for domestic violence by using the Domestic Violence Health Care Provider Survey Scale. The survey measured six domains that reflect the healthcare providers readiness to screen for domestic violence.

1. Professional role resistant/ fear domain

This domain on professional role resistant/fear of offending patients consists of 8 items that assess the healthcare providers stand on whether inquiry about domestic violence would offend patients or may conflict with the ethics of doctor patient communication.

2. Blame victim domain

The blame victim domain has a subscale with 6 items that assessed health care providers' attitudes toward domestic violence victims.

3. Victim safety domain

The domain on victim safety includes a 5 item subscale that assesses the perception of the health care provider on jeopardizing the victim's safety by questioning about domestic violence.

4. Provider safety domain

The domain on providers' safety assesses the perception of the health care provider on placing himself at risk by inquiring about domestic violence based on a 5 item subscale.

5. Perceived self-efficacy

This domain measures the healthcare providers self-perceived efficiency and confidence in inquiring and offering help about domestic violence. This domain is assessed by a 6 item subscale.

6. System support domain

This domain contains 4 items that reflect on providers' access to support networks for referral and management of intimate partner abuse victims.

Participants' responses were recorded using Likert scale that reflected participants' stand on each of the statements provided. The Likert scale had a range from 1 to 5 which reflects strongly disagree to strongly agree. The score corresponds to their stand on the scale. Some of the statements in the scale are structured in a way such that the scoring needs to be reversed to match the scores from other items. These items' scoring were reversed before doing further analysis on the scores.

The survey was self-administered and took approximately 15 minutes to complete. Completion of all items was mandatory.

Results

A total of 221 respondents completed our survey with a response rate of 88%. Although respondents' gender distribution reflected no significant differences, participant age differed to some extent. Most respondents were between the ages of 20 and 30 years. Almost half of the respondents were from KSU, while IAU had the least participants. [Table 1]

In this sample, the interns represented 53.8% of the responses, while residents represented 43.4%. Only 5.9% of respondents have participated in DV courses during their undergraduate years in medical school.

72.8% of doctors either did not know or were not sure of Saudi national policies to manage DV and 86.9% of the health care providers were not aware of the national help line number to report a suspected DV case.

The distribution of the scores obtained in each domain is shown in Figure 1. The hypothesized association between gender, age, educational level and previous training or awareness and the six domains assessing the readiness to respond to DV did not reach statistical significance (Table 2). However, male participants demonstrated higher perceived self-efficacy in comparison to females, who were more likely to blame IPV victims, showed increased confidence in the support system and were also more worried about their safety than female participants.

Participants in the older age group, who were residents or GP, who were medical doctors and who were trained on DV or aware of national policies showed better readiness to manage IPV than their counterparts, although none of the associations reached statistical significance.

The reliability coefficients (i.e. Cronbach's alphas) for the six domains ranged from 0.62 to 0.77 (Table 4). Inter-factor correlation was estimated using bivariate correlations between the various domains which showed significant correlations ranging from -0.33 to 0.912. (Table 3)

Table 1: Demographic Data of Study Participants

<u>Item</u>	<u>Number</u>	<u>Percentage</u>
Gender		
Female	103	46.6%
Male	118	53.4%
Age		
20–25	124	56.1%
More than 25 years	97	43.9%
University		
PNU	19	8.6%
KSU	106	48.0%
KSAU-HS	53	24%
IMAMU	16	7.2%
KFU	17	7.7%
IAU	10	4.5%
Specialty		
Medical	197	89.1%
Dentistry	24	10.9%
Level		
Intern	119	53.8%
Resident	96	43.4%
General practitioner (GP)	6	2.7%
Have you participated in any DV teaching courses during your years of study?		
Yes	13	5.9%
No	208	94.1%
Are you aware about any national policy (in Saudi Arabia) to manage DV?		
Yes	60	27.1%
No	88	39.8%
Not sure	73	33%
Do you know the national number to call to report suspected DV cases?		
Yes	29	13.1%
No	192	86.9%

Table 2: Association of various factors with the six domains

Factors		D1	D2	D3	D4	D5	D6
Gender	Male	2.78±0.6	2.37±0.74	3.01±0.5	3.35±0.58	3.32±0.7	3.02±0.5
	Female	2.76±0.67	2.75±0.79	2.97±0.52	3.59±0.53	3.6±0.7	3.33±0.55
Age group	20-25 years	2.75±0.61	2.53±0.73	2.97±0.49	3.46±0.55	3.39±0.69	3.22±08.57
	> 25 years	2.8±0.68	2.64±0.86	3.01±0.54	3.51±0.59	3.57±0.73	3.14±0.52
Designation	GP/Resident	2.73±0.63	2.55±0.83	2.98±0.52	3.43±0.61	3.45±0.74	3.15±0.56
	Intern	2.8±0.64	2.6±0.75	2.99±0.5	3.52±0.53	3.48±0.69	3.21±0.54
Specialty	Medicine	2.72±0.62	2.61±0.78	2.98±0.5	3.5±0.55	3.51±0.69	3.2±0.54
	Dentist	3.15±0.65	2.32±0.8	3.08±0.61	3.33±0.73	3.17±0.85	3.03±0.6
Previous training	Yes	2.68±0.54	2.45±0.85	3.11±0.57	3.9±0.44	3.85±0.63	3.25±0.63
	No	2.78±0.64	2.58±0.79	2.98±0.51	3.45±0.57	3.44±0.71	3.18±0.55
Aware of national policy on DV management	Yes	2.55±0.6	2.47±0.87	3.01±0.52	3.65±0.55	3.65±0.69	3.24±0.57
	No	2.85±0.63	2.61±0.75	2.98±0.51	3.42±0.57	3.4±0.71	3.17±0.54
Aware of national number to report DV	Yes	2.61±0.6	2.35±0.8	2.92±0.54	3.6±0.6	3.58±0.73	3.36±0.75
	No	2.79±0.64	2.61±0.78	3±0.51	3.46±0.57	3.45±0.71	3.16±0.51

D1- Professional role, D2- Blame victim, D3- Victim safety, D4- Self efficacy, D5 – System support, D6- Provider safety

Table 3: Original Domains, Maximum and Minimum Sample Values, and Cronbach's Alpha

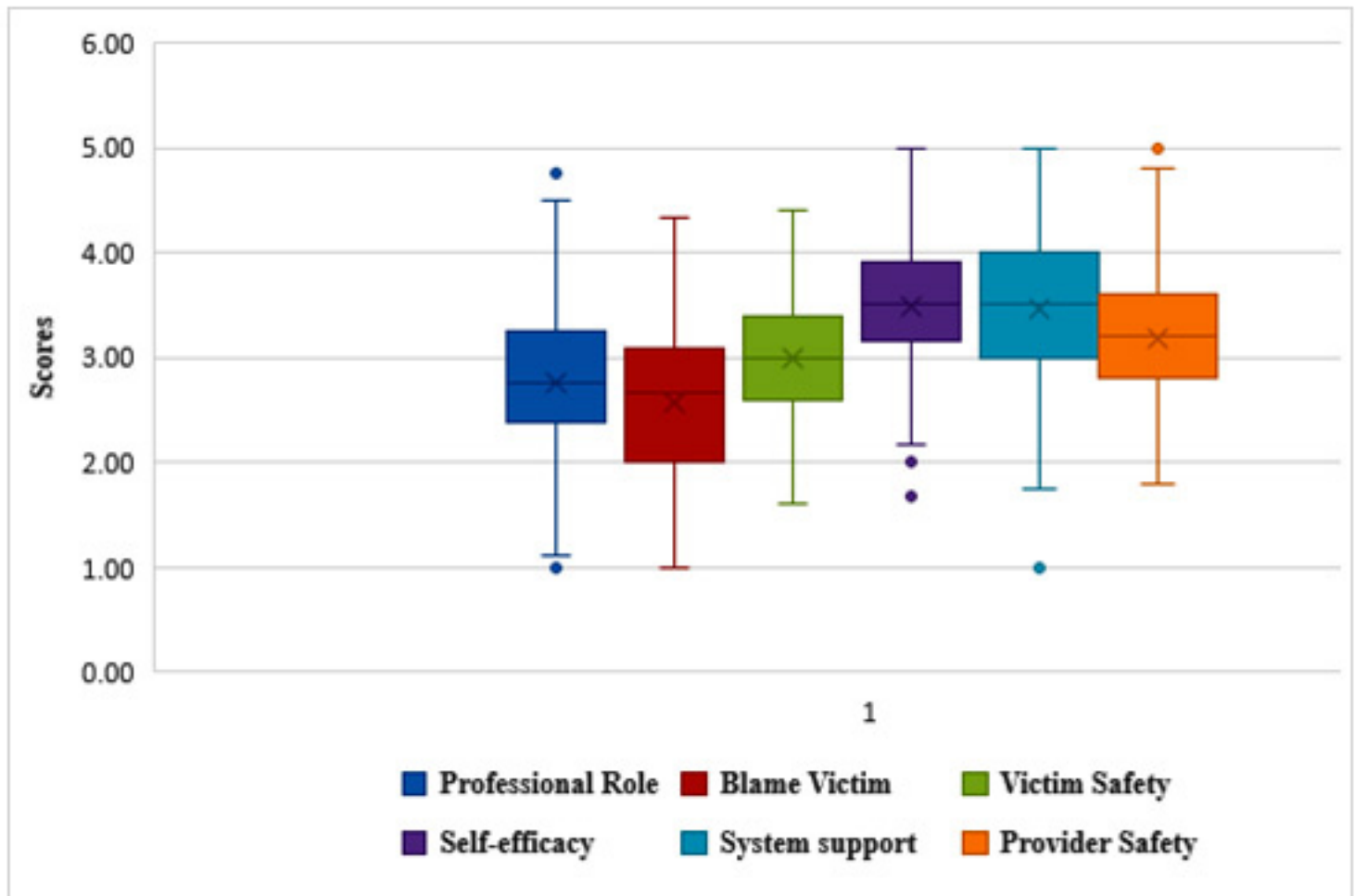
Domain	Number of items	Minimum	Maximum	Mean	Alpha original study (Maiuro, 2000)	Alpha (current study)
Provider safety	5	3.01	3.65	3.243	0.80	0.62
System support	4	3.23	3.70	3.371	0.77	0.77
Self-efficacy	6	2.33	3.71	3.255	0.73	0.72
Victims' safety	5	1.91	3.18	2.552	0.77	0.71
Victim blaming	6	2.24	2.90	2.575	0.72	0.78
Professional role	8	2.3	3.38	2.770	0.73	0.75

Table 4: Bivariate Pearson Correlations of Domestic Violence Healthcare Providers Survey Scales

	Professional Role	Blame Victim	Victim Safety	Self-efficacy	System support	Provider Safety
Professional Role	1					
Blame Victim	0.262**	1				
Victim Safety	0.303**	0.263**	1			
Self-efficacy	-0.156*	0.011	-0.028	1		
System support	-0.102	0.077	-0.005	0.912**	1	
Provider Safety	-0.258**	-0.012	-0.330**	0.357**	0.299**	1

** Correlation is significant at 0.01 level (2-tailed)

* Correlation is significant at 0.05 level (2-tailed)

Figure 1: Scores and distribution of the six domains

Discussion

Our study assessed the health care providers preparedness and ability to manage DV victims and we found that most participants lacked knowledge of Saudi policies, laws, and the national number for reporting suspected DV. About 94% did not undergo any previous teaching or training on handling DV victims. These findings reflect that the health care professionals lacked sufficient knowledge and training on managing DV victims. The health care providers who lacked any kind of previous training or who were unaware of the national policies and helpline numbers for domestic violence victims showed more fear of offending DV patients, blamed the victims more and perceived lack of access to support system and referral. This was evident from the mean scores attained on the various domains of the scale though no statistical significance was attained due to the smaller number of participants who had received training or had awareness on the policies. Most DV victims repeatedly suffer injuries and visit health care centers when acutely injured to seek medical advice from physicians or dentists for unusual trauma, behavior, or mental issues, so it is crucial that health care providers be knowledgeable and trained in identifying such victims and advising on appropriate management.

A recently published study in the USA, has also showed that health care providers were not well equipped and they needed better training to work with victims of domestic violence [10]. Studies have also shown that educational programs and training for health care providers leads to significant improvement in their readiness to identify and manage domestic violence cases [11,12].

Further analysis on factors was done on gender and its correlation to the scales which showed males were more likely than females to blame the victims, males had higher perceived self-efficacy and appeared to be more concerned about their safety as health care providers than females. However, in our study the difference was not statistically significant. Previous studies have shown similar findings that males are significantly more likely to blame victims for provoking their partners to inflict DV on them [13]. A study done in Turkey on medical students also reported that male students have higher perceived self-efficacy with academic performance [14]. This might also reflect the male-predominant culture in Saudi Arabia, which also explains the high self-efficacy scores from Imam bin Mohamad bin Saud University who has only males graduates from their college. Moreover, females are more sympathetic toward victims because they are usually the same gender as the victim, which could also explain why graduates of all-female PNU were the least likely to blame victims. This was also supported by a study done in Sweden which showed female health care providers are more likely to screen patients for domestic violence [15].

Though we did not achieve statistical significance in our study our scores showed that males appeared to be more concerned about their safety as health care providers than females, which completely differed from previous research results, which stated the opposite [16].

This study also showed that healthcare providers in the age group of 20–25 portrayed low self-efficacy, more fear for their safety and perceived less support from the system than healthcare providers who were more than 25 years old, but again we did not achieve any statistical significance. This could be due to the fact that most of the health care providers in this 20–25 years age group were interns and lacked experience as they were new graduates and haven't

As for the relationship between the various domains and level of education, interns perceived themselves to be more self-efficient yet scored high in victim blaming and feared more about their safety which is attributable to their lack of knowledge, experience and understanding of intimate partner violence. General practitioners/Residents also showed less readiness to manage DV victims possibly because the GPs who participated in our research were not working full-time in the clinical field and therefore had less exposure to DV victims and, thus, lacked experience and knowledge in dealing with the victim.

As for the relationship between domain and specialty, dentistry graduates showed low self-efficacy and high levels of fear of offending the patients, attributable to their fear that patients would be embarrassed to visit their practice again. The difference was not statistically significant which might be because we had a smaller number of participants from the dental background. Similar reports were seen from another study that showed dental students feared they might acquire a negative reputation from asking about IPV and that can have a negative impact on their practice; also about 30% did not have the confidence to refer battered victims to social administration offices [8].

Bivariate correlations were analyzed to understand the distinctiveness between the domains. These correlations though statistically significant were low except for self-efficacy and system support which showed statistically significant high correlation. Some of the domains showed negative correlation indicated that though the various domains are related to each other they represent and analyze distinctive aspects of provider readiness to screen for domestic violence. Similar correlations were established in another study done among health care providers in Nigeria. [17].

Some of the limitations of this study are the data collected in this study is self-reported data therefore liable for information bias. This was a cross-sectional survey so the results do not allow for causality interpretation. Participants were limited to government institutions and this selection bias could affect the generalizability of the results.

Conclusion

The medical and dental graduates lack knowledge of Saudi policies or regulations on response to domestic violence and are not well equipped to work with patients who are victims of domestic violence. Lack of teaching and training sessions on managing domestic violence during the undergraduate years shows that health care professionals are evidently underprepared and calls for an urgent need to introduce an interprofessional education curriculum that trains health care professionals of all concerned specialties at undergraduate level on managing domestic violence. Encouraging training courses for practicing healthcare providers would help build more proficient and capable health care providers to handle such sensitive problems in society.

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