Review Article

Intimate partner violence in Saudi Arabia: A topic of growing interest

Sarah AlJuhani[1], Mohammed AlAteeq[2]

[1]Department of Family Medicine, College of Medicine, Majmaah University, Majmaah City 11952, [2]King Abdullah International Medical Research Center, King Saud bin Abdulaziz University for Health Sciences, Department of Family Medicine and Primary Health Care, King Abdulaziz Medical City, National Guard - Health Affairs, Riyadh, Saudi Arabia

Abstract

Intimate partner violence (IPV) is a sensitive, growing, and preventable health issue that affects many people around the world with significant physical and psychological impacts. Factors associated with an increased risk of perpetrating violence include low education, child maltreatment and exposure to violence in the family, attitudes accepting of violence, and gender inequality. However, encounters between victims exposed to IPV and healthcare providers are often not satisfactory, and therefore, several barriers preventing healthcare providers from responding to IPV have been documented. More efforts are needed at different levels to implement preventive measures and to improve the detection and management of IPV victims, especially at front-line health settings like family practices and emergency care services. Several interventions have been suggested to improve the healthcare responses to IPV, including developing protocols, training of health professionals to raise the awareness of providers, transferring know-how, and convincing them to respond to IPV.

Keywords: Domestic violence, emergency medicine, family medicine, management, readiness, women

Intimate partner violence (IPV) is a sensitive, growing, and preventable health issue that affects many people around the world. IPV is defined by the centers for disease control and prevention as "physical, sexual, or psychological harm by a current or ex-partner" and includes "acts of physical aggression, psychological abuse, forced intercourse and other forms of sexual coercion, and various controlling behaviors such as isolating a person from family and friends or restricting access to information and assistance".[1]

IPV is the most common form of violence toward women. A worldwide study undertaken by the World Health Organization (WHO) indicates that about one in three women worldwide has experienced either physical and/or sexual intimate partner violence or non-partner sexual violence in their lifetime. The prevalence ranged from 23.2% in high-income regions to 37.7% in southeast Asia. Moreover, the prevalence of intimate partner homicide, where killing is carried out by a male partner during an abusive relationship, ranged from 6% to 38% with a median of 13% worldwide.[2]

In Saudi Arabia (SA), IPV and general domestic violence have become hot topics that have been analyzed from both social and medical perspectives by governmental and non-governmental organizations.

Locally in SA, the prevalence of IPV ranges from 20% to 39%. In a study conducted in 2010 in Al-Ahsa, located in eastern SA, a 39.3% prevalence of lifetime violence against married women

Address for correspondence: Dr. Mohammed AlAteeq, Department of Family Medicine and PHC, King Abdul-Aziz Medical City, National Guard Health Affairs, P.O. Bx 22490, Riyadh 11426, Saudi Arabia.
E-mail: ateeqm@ngha.med.sa/malateeq@hotmail.com

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was reported.[3] Another cross-sectional study conducted in 2015 among female visitors to primary care centers in Riyadh, in central SA, revealed that 20% had been exposed to violence over the 1-year period prior to the study.[4] In Jeddah, which is located in western SA, a study conducted in 2012 among women found that the lifetime prevalence of violence was 34%.[5] The variation reported above is most likely attributed to the difference in the sociodemographic characteristics of each local subcommunity.

Factors associated with an increased risk of perpetrating violence include low education, child maltreatment, exposure to violence in the family, use of alcohol, attitudes accepting of violence, and gender inequality.[2] Factors associated with an increased risk of experiencing intimate partner and sexual violence include female gender, low education, exposure to violence between parents, abuse during childhood, attitudes accepting violence, and gender inequality.[2] Locally, the characteristics that were found to be associated with IPV, according to Bernawi's study, include age of younger women, longer duration of marriage, higher women education, lower husband education, working husbands, military occupation, fewer children, husbands with multiple wives, smoking husbands, aggressive husbands, presence of chronic disease in women or husbands, and insufficient family income.[4]

Intimate partner violence is associated with serious short and long-term consequences on physical, mental, sexual, and reproductive health for survivors and their children and can lead to fatal outcomes including homicide or suicide.

The WHO's 2013 report analyzing intimate partner violence found that 42% of women who experience IPV and report an injury as a consequence of this violence were 1.5 times more likely to have a sexually transmitted infection. Intimate partner violence in pregnancy also increases the likelihood of miscarriage, stillbirth, preterm delivery, and babies with low birth weights. In addition, intimate partner violence can lead to depression, post-traumatic stress and other anxiety disorders, sleep difficulties, eating disorders, and suicide attempts. Other health effects include headaches, back pain, abdominal pain, fibromyalgia, gastrointestinal disorders, limited mobility, and poor overall health.[2] In the US, the Behavioral Risk Factor Surveillance System survey showed an increased risk of chronic diseases among victims of IPV such as cardiovascular disease, stroke, asthma, and arthritis. The survey is conducted every year through telephonic questioning.[6]

Children who grow up in families experiencing violence may suffer from a range of behavioral and emotional disturbances and may have an increased risk of becoming perpetrators or experiencing violence later in life. Intimate partner violence has also been associated with higher rates of infant and child mortality and morbidity.[2]

The social and economic costs of intimate partner and sexual violence are enormous and cause ripple effects throughout society. Women may suffer isolation, inability to work, loss of wages, lack of participation in regular activities, and limited ability to care for themselves and their children.[2]

In a local study in AlAhsa, domestic violence was significantly associated with perceived bad general health among victims, increasing the probabilities of disease occurrence, abortion, hemorrhage, increase BMI, vaginal bleeding, feeling dizzy, pain, stress, and drug use.[3]

According to Bernawi's study, complications of IPV included medical or behavioral problems (72%) and psychiatric problems (58%). Moreover, in the same study, more than 90% of the children of abused women reported having symptoms suggestive of psychological or behavioral problems.[4]

The healthcare system is the most important setting where victims of violence and abuse can be identified, managed, and supported. By training healthcare providers through well-structured courses and enabling them to understand and utilize the existing interventions in healthcare settings, these providers will more effectively identify and respond to victims in abusive relationships.[7]

In September 2013, the Saudi Government approved the Law for Protection from Abuse,[8] which aims to ensure protection from all forms of abuse, provide assistance and shelter as well as social, psychological, and healthcare. In addition, it provides the necessary legal proceedings to hold violators accountable and bring them to trial; raise community awareness about the concept of abuse and its implications; address undesirable social behavior that indicates the existence of a favorable environment for abuse to occur, and establish scientific and practical mechanisms to deal with abuse.

This law clearly declares that anyone who becomes aware of any case of abuse should report it immediately, and persons who commit an act that constitutes a crime of abuse as specified in article 1 of this law shall be subject to imprisonment for a period of not less than 1 month and not more than 1 year and must pay a fine of not less than 5000 and not more than 50,000 Saudi Riyals (SAR) or to either punishment. In the case of recidivism, the punishment is doubled, and the competent court may issue an alternative punishment for freedom-depriving punishment. Accordingly, the Ministry of Social Affairs in SA established the Domestic Violence Protection Programme and set up a unified national notification number to report any case of violence.[9]

IPV can be encountered by many different practicing physicians but especially those on the front lines of the healthcare system, such as family physicians and emergency physicians.

Primary care and family physicians have a key role in the prevention, detection, and management of IPV. Their continuous therapeutic relations with their patients, their easy accessibility, their comprehensive approach, and the broad aspects of presenting symptomatology by their patients, besides other

factors, make them the best health professionals in dealing with IPV. One other important factor in this regard is the trust built by the time between the primary care physician and his patients. This is expected to reduce the barriers that usually prevent victims of IPV from disclosing their suffering.

According to current WHO guidelines, a good healthcare response to IPV includes all or a majority of the following actions: being aware of the possible signs and symptoms, providing healthcare assistance and registration, informing affected victims about available resources, coordinating with other sectors, and raising public awareness. These actions should be carried out within a victim-centered approach, namely, ensuring privacy and confidentiality, and being non-judgmental and supportive of the diverse needs that a victim might have.[10]

However, encounters between victims exposed to IPV and healthcare providers are often not satisfactory, and several barriers preventing healthcare providers from responding to IPV have been documented. Several studies have shown that rates of routine inquiry about the abuse of women by healthcare providers are generally quite low—in the range of 5–10% in primary care settings, and anywhere from 5% to 25% in emergency care settings. Women presenting to emergency departments with injuries consistent with IPV are asked about violence more often, but the largest study found an abuse inquiry rate of just under 80% in this group.[11] Likewise, antenatal care providers in South Africa, although aware of the physical and psychological impact of IPV, they usually miss cues that may indicate exposure of pregnant women to IPV.[12]

In a 1992 study conducted in Washington, D.C. in the United States of America (USA), among 38 predominantly family practitioners, it was found that physicians exploring violence in the clinical setting were analogous to "opening Pandora's box." Their issues included lack of comfort, fear of offending, powerlessness, loss of control, and time constraints.[13]

Another study conducted in 1999, in Seattle, Washington (USA), found that 10% of clinicians had never identified an abused person. In the 1 year prior to the study, 30% of the clinicians had not identified any abused persons, and 45.2% of clinicians seldom or never asked about domestic violence. In the same study, patients with depression, anxiety, or chronic pelvic pain were seldom or never screened in more than 60% of cases. For all high-risk conditions, less than 20% of clinicians always or almost always asked about domestic violence, and 70% of clinicians had not attended any educational programs about domestic violence in the past year.[14]

In a Canadian study that included physicians and nurses and sought to determine factors influencing identification of and response to intimate partner violence, over 60% of participants reported not having received specific training in this area.[11]

Another study performed in the United Kingdom in 2012 found that a minimal number of physicians and nurses had previous training in managing violence victims. Clinicians in that study were found to have only basic knowledge about domestic violence, and many perceived themselves as poorly prepared to ask questions relevant to domestic violence or to arrange for appropriate referral when necessary if the victims disclosed abuse. When a woman presented with injuries, about 40% of clinicians rarely or never asked about abuse, and 80% reported being unaware of the local resources on domestic violence.[15]

Another study conducted among obstetrician-gynecologists in Flanders, Belgium, found that only 6.8% of the respondents ever received or pursued any kind of education on IPV.[16]

In London, a survey of mental health professionals' knowledge, attitudes, and preparedness to respond to domestic violence in 2013 found that 15% of professionals routinely asked all service users about domestic violence and only 27% provided information to service users following disclosure. Most professionals (60%) felt that they lacked adequate knowledge of support services, and 27% felt that their workplace did not have adequate referral resources for domestic violence.[17]

On the other hand, a 2016 study carried out in Spain concerning the detection of IPV in primary care and related factors found two-thirds of health professional respondents said they inquired about IPV.[18]

Locally, in a study done in the military hospital in Riyadh, Saudi Arabia, on the readiness of family medicine residents to manage IPV, it was found that in the 6 months prior to the study, none of the participants had received training on IPV, none of them had training about IPV in their postgraduate training, and the majority did not perceive themselves as knowledgeable or ready to discuss IPV with patients.[19] These results may reflect the deficiency of physicians' knowledge and training in managing IPV in Saudi Arabia. Similar findings were reported in another local study.[3]

Several interventions have been suggested to improve the healthcare responses to IPV, including developing protocols and guidelines based on state-of-the-art knowledge, training of health professionals to raise the awareness of providers, transferring know-how, and convincing them to respond to IPV.[3,10] Some studies found the internet-based CME program clearly effective in improving long-term individual educational outcomes, including self-reported IPV practices. This type of CME may be an effective alternative with lower costs for live IPV training sessions and workshops.[20]

In fact, clinical guidelines have been developed by the WHO to help healthcare providers screen for IPV and other forms of domestic violence; however, as discussed above, guidelines and recommendations without training and monitoring for adherence have little effect on physicians' behaviors or practice. The common lack of adherence to clinical practice guidelines has been comprehensively modeled by Cabana *et al.*, who identified a number of barriers underlying physicians' lack of compliance with the guidelines.[16]

Tools to screen for IPV have been validated for easy use by clinicians. The easiest is the hurt, insult, threaten, and scream (HITS) tool. HITS is an easy-to-use screening tool and scale. The tool includes four questions that physicians can provide to women either verbally or via a written questionnaire to assess their risk for IPV. The tool includes a series of multiple-choice questions about how often the individual's partner hurts, insults, threatens, or screams at them, and answers are given by selecting one of the following: never, rarely, sometimes, fairly often, and frequently. The score on the tool can range between 4 and 20 points. Any score above ten indicates that the individual may be suffering from abuse.[21] Lee *et al.*, in their interventional study, reported that healthcare providers' education and integration of IPV screening tool into the electronic medical records resulted in improvement of the IPV screening readiness.[22] In their review of indicators of good teams in responding to IPV cases at primary care setting, Goicolea *et al.* identified four elements: the existence of good and motivated social workers, regular meetings to discuss issues related to IPV, friendly team environment, and implemented concert actions in the resolution of IPV.[23]

In summary, IPV is a major public health issue, both locally in SA and worldwide, and has significant physical and psychological impacts. More efforts are needed at different levels to implement preventive measures and to improve the detection and management of IPV victims, especially at front-line health settings like family practices and emergency care services.

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